

PUBLIC HEARING

Professional Conduct Committee Initial Hearing

2 – 5 June 2025
19 – 21, 23 January 2026

Name: HARRIS, Michelle
Registration number: 73491
Case number: CAS-207071-V4K1C8

General Dental Council: Christopher Saad, Counsel.
Instructed by Claire Elam-Cooke, IHLPS

Registrant: Present
Represented by Gavin Irwin, Counsel.
Instructed by Weightmans

Fitness to practise: Impaired by reason of misconduct

Outcome: Fitness to Practise Impaired. Reprimand Issued

Committee members: Helen Wagner (Lay) (Chair)
Estelle Williams (Dentist)
Kirsty Payton (Dental Care Professional)

Legal adviser: Lucia Whittle-Martin (2 – 5 June 2025)
Alastair McFarlane (19 – 21 January 2026)
Trevor Jones (23 January 2026)

Committee Secretary: Andrew Keeling

At this hearing the Committee made a determination that includes some private information. That information shall be omitted from any restricted version of this determination and the document marked to show where private material is removed.

CHARGE

Michelle HARRIS, BDS University of Bristol 1997 is summoned to appear before the Professional Conduct Committee on 2 June 2025 for an inquiry into the following charge:

“That being registered as a dentist:

Patient A

1. You failed to provide an adequate standard of care to Patient A between 15 September 2020 to 20 August 2022 in that:

UL7

- a) you failed to identify a file fracture at UL7 and/or inform Patient A of the file fracture at UL7 on 15 September 2020;*
- b) you failed to identify that roots were left in situ at UL7 and/or inform Patient A of the roots left in situ at UL7 on 22 September 2020;*

Bridge Treatment between LL7-LL5

- c) you failed to discuss all treatment options in relation to restoring the space at LL6 on or before 27 October 2021;*
- d) you failed to discuss the risk and benefits of restoring the space at LL6 with a bridge from LL7-LL5 on or before 27 October 2021;*

UL6

- e) You caused iatrogenic damage to the distal surface of the UL6 in or around June 2022;*
- f) You failed to identify a distal radiolucency at the UL6 and/or inform Patient A of the distal radiolucency at UL6 in or around June 2022;*

2. By virtue of your conduct at 1(c) and/or 1(d) you failed to obtain Patient A’s informed consent to the bridge treatment provided from LL7-LL5.

3. Your conduct at 1(a) and/or 1(b) and/or 1(f) was:

- a) misleading; and/or*
- b) lacking in candour.*

Prescribing practice

4. You prescribed an antibiotic, Clarithromycin without adequate justification on 29 October 2021;

5. You prescribed an antibiotic, Clarithromycin without adequate justification on 3 November 2021;

6. [AMENDED] You prescribed an antibiotic, Erythromycin or Clarithromycin without adequate justification on 23 May 2022;

7. [AMENDED] You prescribed an antibiotic, Clarithromycin without adequate justification on or around 25 May 2022;

8. You prescribed an antibiotic, Clarithromycin without adequate justification on or around 20 August 2022;

Patient B

9. You failed to provide an adequate standard of care to Patient B between 18 December 2018 to 27 July 2022 in that:

LL4 Root Canal Treatment

- a) you failed to discuss the poor prognosis of the LL4 with Patient B on 21 February 2019 prior to Root Canal treatment at the LL4 commencing;
- b) you failed to discuss the poor prognosis of the LL4 with Patient B on 26 February 2019 prior to Root Canal treatment at the LL4 completing;

LL2 Crown

- c) you prepared the LL2 for a crown without adequate clinical justification on 14 August 2019;
- d) you failed to discuss the risks and benefits of providing a crown at the LL2 on or before 14 August 2019;

Bridge treatment between LR3 and LR1

- e) you failed to discuss all treatment options to restore the space at LR2 on 29 August 2019 and/or 26 September 2019;
- f) you failed to discuss the risks and benefits of the proposed bridge treatment between LR3 and LR1 on 29 August 2019 and/or 26 September 2019;

- g) you failed to identify retained roots at LR2 and/or inform Patient B of the retained roots at LR2 on or before 26 September 2019;*
- h) you adopted a conventional full fixed bridge on the LR2 when such a bridge was not in Patient B's best interests on 26 September 2019;*

Bridge treatment between LL4 and LL7

- i) you failed to identify that a root remained in situ at the LL5 after the extraction procedure on 10 April 2019 and/or informed Patient B that a root remained in situ at the LL5 after extraction on 10 April 2019;*
- j) you failed to discuss all treatment options to restore the space at LL5 and LL6 on or before 31 October 2019;*
- k) you failed to discuss the risks and benefits of the proposed bridge treatment between LL4 and LL7 on or before 31 October 2019;*
- l) you failed to discuss the increased risk of failure of the proposed bridge treatment between LL4 and LL7 on or before 31 October 2019, given the lack of coronal tooth tissue at LL4;*
- m) you commenced bridge treatment to restore the space at LL5 and LL6 on 31 October 2019, when such treatment was not appropriate.*

10. By virtue of your conduct at 9 (a) and/or 9 (b) you failed to obtain Patient B's informed consent in respect of the LL4 root canal treatment.

11. By virtue of your conduct at 9 (d) you failed to obtain Patient B's informed consent in respect of the LL2 crown treatment.

12. By virtue of your conduct at 9 (e) and/or 9 (f) and/or 9 (g) you failed to obtain Patient B's informed consent in respect of the Bridge treatment between LR3 and LR1.

13. By virtue of your conduct at 9 (j) and/or 9(k) and/or 9(l) you failed to obtain Patient B's informed consent in respect of the Bridge treatment between LL4 and LL7.

14. Your conduct at 9 (g) and/or 9 (i) was:

- a) misleading; and/or*
- b) lacking in candour.*

And that by reasons of the matters alleged above, your fitness to practise is impaired by reason of misconduct."

Miss Harris,

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct. You attended the hearing and were represented by Mr Gavin Irwin, Counsel. Mr Christopher Saad, Counsel, presented the General Dental Council's (GDC) case. Stage 1 of the hearing took place remotely on Microsoft Teams between 2 and 5 June 2025. The hearing adjourned part-heard and Stage 1 resumed remotely on 19 January 2026.

Preliminary Matter: Rule 18 Application to Amend the Charge (2 June 2025)

2. At the outset of the hearing, Mr Saad made an application under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ("the Rules") to amend heads of charge 6 and 7.
3. In respect of head of charge 6, Mr Saad submitted that the words '*or Clarithromycin*' should be inserted after the word '*Erythromycin*' so that it should now read as follows (with the proposed amendment highlighted):

*'You prescribed an antibiotic, Erythromycin **or Clarithromycin**, without adequate justification on 23 May 2022'.*

4. In respect of head of charge 7, Mr Saad submitted that the words '*or around*' should be inserted before the date '*25 May 2022*' so that it should now read (with the proposed amendment highlighted):

*'You prescribed an antibiotic, Clarithromycin without adequate justification on **or around** 25 May 2022'.*

5. Mr Saad submitted that he was applying for these proposed amendments following your comments regarding the relevant dental records in respect of these heads of charge.
6. Mr Irwin, on your behalf, submitted that he had no objection to the application as he accepted that these were minor clarifying amendments and no prejudice would be caused to you.

The Committee's decision on the Rule 18 application

7. The Committee accepted the advice of the Legal Adviser on the Rule 18 application. The Committee was satisfied that the proposed amendments more accurately reflected the information contained in the dental records. It further determined that it was in the

interests of justice for these amendments to be made and they could be made without injustice to either party.

8. The Committee, therefore, acceded to Mr Saad's application to amend the charge.

Background

9. This case relates to the standard of care you provided to two of your patients, namely Patient A and Patient B, who were wife and husband respectively. You treated Patient A between 2019 and the Summer of 2022 and Patient B between December 2018 and Summer of 2022.
10. Since 23 August 2022, Dentist A has been treating Patient A. In his witness statement for this hearing, dated 15 May 2025, Dentist A stated that Patient A had told him at their first appointment that she was not happy about the treatment she had received from you. At a further appointment with Dentist A on 7 September 2022, Patient A attended with Patient B and discussed their concerns with him. These concerns were recorded by Dentist A in Patient A's records and formed the basis for the allegations you faced at this hearing.
11. These concerns, in respect of Patient A, included alleged failures in identifying a file fracture at UL7 and roots that were left in situ following the extraction of the tooth. It is also alleged that you were misleading and lacking in candour in not informing Patient A of these two matters. Concerns were also raised about your bridge treatment between Patient A's LL7 and LL5 in October 2021 and Patient A's UL6 in June 2022. It is alleged that you failed to obtain Patient A's informed consent for the bridge treatment. Lastly, it is alleged that you prescribed antibiotics to Patient A on various occasions between October 2021 and August 2022 without adequate justification.
12. In his witness statement, Dentist A stated that he first met Patient B when he attended Patient A's appointment on 7 September 2022. Dentist A then had his first appointment with Patient B on 4 October 2022 during which Patient B raised concerns about the bridge provided by you between his LL4 and LL7. Patient B also raised concerns about other treatment provided by you which also formed the basis of the allegations at this hearing.
13. These allegations about your alleged inadequate standard of care of Patient B included your root canal treatment of LL4, the crown treatment on LL2, bridge treatment between LR3 and LR1 and the bridge treatment between LL4 and LL7. It is alleged that you failed to obtain informed consent for these treatments in that you failed to discuss with Patient B the poor prognosis of the LL4 or the risks and benefits of the bridge treatments. It is also alleged that you were misleading and lacking in candour in not informing Patient B of the retained roots at LR2 and LL5 and providing a bridge (between LR3 and LR1) which was not in Patient B's best interests.

14. On 12 October 2022, Dentist A raised his concerns about your treatment of Patients A and B to the GDC.

Evidence

15. By way of factual evidence from the GDC, the Committee was provided with a signed witness statement from Dentist A, dated 15 May 2025. Exhibited to Dentist A’s witness statement were his clinical records for Patients A and B. Further records were also provided by Dentist A’s practice. Dentist A gave oral evidence at this hearing.

16. The Committee received an expert report, dated 11 September 2025, and an addendum report dated 14 May 2025, from Dr Balraj Dhami, who also gave oral evidence.

17. As part of your case, the Committee was provided with your signed witness statement, dated 30 May 2025. You provided copies of your clinical records for Patients A and B, and copies of your text messages with Patient A between 15 September 2020 and 20 August 2022 . The Committee also heard oral evidence from you.

18. Neither Patient A nor Patient B attended the hearing to give oral evidence and no witness statements were obtained from them for this hearing. The Committee noted that what Dentist A reported Patient A and B had said to him, was hearsay evidence. It had been agreed that their hearsay evidence should be admitted. However, the Committee bore in mind the fact that neither Patient A nor Patient B had given direct evidence tested by cross-examination, in determining what weight to give their reported complaints.

The Committee’s Findings of Fact

19. The Committee has considered all the documentary evidence presented to it. It took account of the submissions made by Mr Saad, on behalf of the GDC, and by Mr Irwin, on your behalf. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are found proved on the balance of probabilities.

20. The Committee’s findings in relation to each head of charge are as follows:

Patient A	
1.	You failed to provide an adequate standard of care to Patient A between 15 September 2020 to 20 August 2022 in that:
	<u>UL7</u>



- a) you failed to identify a file fracture at UL7 and/or inform Patient A of the file fracture at UL7 on 15 September 2020;

Found Proved (failed to identify)

During oral evidence, you accepted that the file must have fractured during your treatment of Patient A on 15 September 2020. However, you deny that you were aware of it at the time and, therefore, could not have informed Patient A.

In his expert report, Dr Dhami stated that, *'the fractured file was at least four to five millimetres in length and therefore would be easy to identify upon removal of the file'*.

It is the GDC's case that it was more likely than not that you would have noticed the file fracture, either by examining the x-ray or by inspecting the file after treatment, and that you subsequently failed to inform Patient A.

The Committee had sight of Patient A's records and noted that there was no mention of the file fracture. It noted the x-rays taken before and after your treatment of Patient A, which showed that the file fractured when you treated Patient A on 15 September 2020. However, the Committee considered that although the file fracture could easily be seen in later radiographs, the file fracture could not easily be seen on the x-ray taken on 15 September 2020 (the date of this charge). Therefore, it considered your evidence, that you missed it when viewing the radiograph, to be plausible. It further noted your evidence that you had used a 31mm file, and not the 24/25 mm file you would usually use, and therefore you did not notice that it had fractured.

The Committee found your overall evidence in respect of this head of charge to be credible and reliable. It noted that you had later accepted that the file fracture must have taken place during your treatment of Patient A on 15 September 2020. In the Committee's view, this acceptance at a later date made your assertion regarding your failure to identify it on 15 September 2020 more credible.

For these reasons, the Committee determined that it was more likely than not that you had failed to identify that the file had fractured on 15 September 2020. The Committee also determined that failing to identify a file fractured would amount to an inadequate standard of care. It accepted Dr Dhami's evidence in this regard in which he stated in his report that, *'The failure to identify the fractured file would be a failure in the standard of care provided'*.

The Committee did not go to consider whether you had failed to inform Patient



A of the file fracture as it noted Mr Saad's submissions that the charge should be read in the alternative rather than as an '*and/or*'. He submitted that if the Committee do not find proved that you had identified that the file had fractured then it would then not need to go to determine whether you had informed the patient, as you could not have informed the patient of something you were not aware had happened.

Therefore, the Committee found this head of charge proved in that you failed to identify a file fracture at UL7 on 15 September 2020, and that this amounted to a failure to provide an adequate standard of care.

- b) you failed to identify that roots were left in situ at UL7 and/or inform Patient A of the roots left in situ at UL7 on 22 September 2020;

Found Proved (failure to identify)

You accepted that roots were left in situ at UL7 on 22 September 2020. However, you deny that you were aware of it at the time and, therefore, could not have informed Patient A.

In oral evidence, you stated that as the appointment took place during Covid, your Dental Nurse disposed of the tooth straightaway, and therefore you did not look at the tooth. Furthermore, you stated that Patient A was a challenging and anxious patient and your focus after the extraction was to comfort her. You therefore accepted that you failed to identify that the roots were left in situ.

It is the GDC's case that it is not credible that you failed to identify the roots in situ owing to your many years' experience as a dentist and that you accepted that to check a tooth after extraction was basic and routine. The GDC allege, therefore, that you were aware that roots were left in situ and failed to inform Patient A.

The Committee gave careful consideration to your oral evidence and found it to be credible and reliable. It accepted your recollection of events as Patient A was '*challenging and demanding*' and therefore, it was likely that this would have stayed in your memory. The Committee accepted your evidence that you were concentrating on the immediate aftercare of the patient and had failed to examine the tooth as you should have done. The Committee also noted that your Dental Nurse disposed of the tooth straightaway as the treatment took place during Covid. The Committee further noted that you noticed the roots at a later date and took steps to deal with it. The Committee concluded that this made it more likely than not that you would have taken action at the time if you had been aware of it.



For these reasons, the Committee determined that it was more likely than not that you had failed to identify that roots were left in situ at UL7 on 22 September 2020. The Committee also determined that this would amount to an inadequate standard of care.

As stated above, as the Committee determined that you had not identified that roots were left in situ you could not have informed Patient A. It therefore did not go on to consider this part of the charge.

Bridge Treatment between LL7-LL5

- c) you failed to discuss all treatment options in relation to restoring the space at LL6 on or before 27 October 2021;

Found Proved

The Committee noted that there was no evidence in the records for 27 October 2021 that showed that you discussed all treatment options with Patient A.

You denied this head of charge. You stated that an absence in the records does not necessarily mean that a discussion did not take place. You asserted that your note for the appointment with Patient A on 5 October 2021 which stated that *'patient does not want a gap wants bridge'* was indicative that you had held a discussion with Patient A.

The Committee had sight of Dentist A's records and also noted his oral evidence that Patient A had informed him that all treatment options were not discussed as it would have been her preferred option to opt for implant treatment.

The Committee had sight of Dr Dhami's expert report and noted his opinion that there was a failure to discuss all the treatment options. It also noted that Dr Dhami had set out in his report a list of what the options would usually be.

The Committee carefully considered all the evidence. It noted the assertion by you that there was evidence in your notes that treatment options were discussed. However, the Committee was not satisfied that the entry *'patient does not want a gap wants bridge'* was evidence that *'all'* treatment options were discussed, albeit that some may have been.

Therefore, the Committee determined that it was more likely than not that you had failed to discuss all treatment options in relation to restoring the space at LL6 on or before 27 October 2021.

- d) you failed to discuss the risk and benefits of restoring the space at LL6



with a bridge from LL7-LL5 on or before 27 October 2021;

Found Proved

The Committee noted from the records that there was no evidence that you had discussed the risks and benefits with Patient A despite your assertion in oral evidence that you had.

The Committee noted Dr Dhami's evidence that if the risks and benefits had been discussed, it was unlikely that Patient A would have chosen to have a bridge owing to the inherent unlikeliness that the treatment would have been successful.

The Committee accepted Dr Dhami's evidence on this charge and agreed that it would have been unlikely that Patient A would have chosen a treatment option that was likely to fail if she had been sufficiently aware of all the necessary risks and benefits.

Accordingly, the Committee found this charge proved.

UL6

e) You caused iatrogenic damage to the distal surface of the UL6 in or around June 2022;

Found Not Proved

The Committee noted Dr Dhami's evidence that a dark area on the radiograph of the UL6 shows that damage was caused to the tooth by an implement. He stated that the dark area could not be caries owing to its shape, and therefore must have been caused by you when you were treating the UL7.

You denied this head of charge. You stated in evidence that you did not use a rotary burr tool at or near the UL6 and therefore could not have caused the damage as alleged.

The Committee carefully viewed the relevant radiographs of the UL6. It considered that the radiographs were inconclusive and it was not satisfied that the radiographs showed iatrogenic damage had been caused to the UL6. It also accepted your evidence that you did not use a rotary burr at or near the UL6 as the bone density on the radiographs is the same before and after the extraction, which is consistent with your evidence about this point. The Committee did not accept Dr Dhami's opinion, as in its judgement, the radiographs showed evidence of a radiolucency already extant. For these reasons, the Committee determined that the GDC had not proved to the relevant standard that you had caused the damage to the UL6.



	<p>Accordingly, it found this charge not proved.</p> <hr/> <p>f) You failed to identify a distal radiolucency at the UL6 and/or inform Patient A of the distal radiolucency at UL6 in or around June 2022;</p> <p>Found Proved (failure to identify)</p> <p>You accepted that you failed to identify the radiolucency at the UL6 in or around June 2022. However, you deny that you were aware of it at the time and, therefore, could not have informed Patient A.</p> <p>The GDC allege that common sense dictated that you would have identified the distal radiolucency on the relevant radiograph and that you failed to inform Patient A</p> <p>The Committee noted that there was no mention in the records that you identified the radiolucency or anything to suggest that you made a plan to treat the UL6. The Committee noted from the records that there was such an obvious radiolucency and therefore, if seen by you, it was likely that you would have mentioned this in the notes or made a note to the effect that it should be monitored in future. The Committee concluded therefore that you did not identify the radiolucency.</p> <p>The Committee also noted that you were under an obligation to identify the radiolucency, particularly in circumstances where it had been present on multiple previous radiographs.</p> <p>As stated above, as the Committee determined that you had not identified the distal radiolucency you could not have informed Patient A. It therefore did not go on to consider this part of the charge.</p>
2.	<p>By virtue of your conduct at 1(c) and/or 1(d) you failed to obtain Patient A's informed consent to the bridge treatment provided from LL7-LL5.</p> <p>Found Proved</p> <p>The Committee noted and accepted Dr Dhami's evidence in his expert report in respect of this charge that, <i>'...you had a duty to discuss all the reasonable treatment options, and their associated risks and benefits. A failure to do so would result in a failure to gain informed consent and could result in potential harm'</i>.</p> <p>Accordingly, the Committee found this charge proved.</p>



3.	Your conduct at 1(a) and/or 1(b) and/or 1(f) was:
	<p>a) misleading; and/or</p> <p>Found Proved</p> <p>The Committee noted that the GDC's case is that your omissions at 1(a), 1(b) and 1(f) in failing to identify the matters mentioned in those charges were objectively misleading. The Committee noted that the GDC case here was not put on the basis of intentional misleading.</p> <p>The Committee agreed and determined that your failure to identify the issues at 1(a), (b) and (f) could have led Patient A to believe that there had not been a file fracture at UL7, that roots were not left in situ at UL7 and there was not a distal radiolucency at the UL6, when this was not the case.</p> <p>Accordingly, the Committee found this charge proved in as much as your conduct was objectively misleading.</p>
	<p>b) lacking in candour.</p> <p>Charge Falls Away</p> <p>The Committee noted that the GDC put this as an alternative to charge 3(a). Given that the alternative limbs in charges 1(a), (b) and (f) were not proved, charge 3(b) falls away.</p>
	<p><u>Prescribing practice</u></p>
4.	<p>You prescribed an antibiotic, Clarithromycin without adequate justification on 29 October 2021;</p> <p>Found Not Proved</p> <p>The Committee noted Mr Saad's submissions that following the evidence provided by Dentist A in respect of Patient A's tolerance of the antibiotic that the GDC would no longer be pursuing this charge and that the Committee should find this charge not proved.</p>
5.	<p>You prescribed an antibiotic, Clarithromycin without adequate justification on 3 November 2021;</p> <p>Found Proved</p>



	<p>You denied this charge as you believed there was clinical justification for prescribing the antibiotic, although you accepted that your prescribing practice required improvement.</p> <p>The Committee noted Dr Dhami's oral evidence that there was no clinical justification for prescribing this antibiotic as you were able to take local measures and Patient A's swelling had improved.</p> <p>The Committee agreed and accepted Dr Dhami's evidence on this charge.</p> <p>Accordingly, it found this charge proved.</p>
6.	<p>You prescribed an antibiotic, Erythromycin <i>or Clarithromycin</i> without adequate justification on 23 May 2022;</p> <p>Found Not Proved</p> <p>The Committee noted Mr Saad's submissions that following the evidence provided by Dentist A in respect of Patient A's tolerance of the antibiotic that the GDC would no longer be pursuing this charge and that the Committee should find this charge not proved.</p>
7.	<p>You prescribed an antibiotic, Clarithromycin without adequate justification on <i>or around</i> 25 May 2022;</p> <p>Found Not Proved</p> <p>The Committee noted Mr Saad's submissions that following the evidence provided by Dentist A in respect of Patient A's tolerance of the antibiotic that the GDC would no longer be pursuing this charge and that the Committee should find this charge not proved.</p>
8.	<p>You prescribed an antibiotic, Clarithromycin without adequate justification on or around 20 August 2022;</p> <p>Found Proved</p> <p>You denied this head of charge. You referred to your text messages with Patient A on 20 August 2022 and stated that this provided adequate justification for prescribing the antibiotic.</p> <p>The Committee noted Dr Dhami's evidence that as you prescribed the antibiotic without assessing Patient A then this was not clinically justified.</p>



	<p>The Committee accepted Dr Dhami’s evidence that without assessing the patient, it could not be said that your prescribing was clinically justified. Furthermore, the Committee determined that there was nothing in your text message exchange which showed that it was clinically justified.</p> <p>Accordingly, the Committee found this charge proved.</p>
<p>Patient B</p>	
<p>9.</p>	<p>You failed to provide an adequate standard of care to Patient B between 18 December 2018 to 27 July 2022 in that:</p>
	<p><u>LL4 Root Canal Treatment</u></p>
	<p>a) you failed to discuss the poor prognosis of the LL4 with Patient B on 21 February 2019 prior to Root Canal treatment at the LL4 commencing;</p> <p>b) you failed to discuss the poor prognosis of the LL4 with Patient B on 26 February 2019 prior Root Canal treatment at the LL4 completing;</p> <p>Found Not Proved</p> <p>The Committee considered charges 9(a) and (b) together.</p> <p>You denied this charge. You stated that, despite it not being recorded in the records, <i>‘I spent some time discussing the risks...The patient did not want another extraction...’</i>.</p> <p>The Committee noted Dentist A’s evidence that Patient B had informed him that the poor prognosis of the LL4 was never discussed with him.</p> <p>The Committee also noted the following from Dr Dhami’s report:</p> <p><i>‘There were significant risks and increased risks of treatment failure of the proposed root canal treatment at LL4. There is no record or evidence that these risks were considered and discussed. Without this information, [Patient B] would not have been able to provide informed consent.’</i></p> <p>The Committee noted from Patient B’s records that there was no evidence that you discussed the poor prognosis of the LL4 with patient B on 21 February 2019. However, the Committee did note that you had had a discussion with Patient B at a previous appointment on 18 December 2018 in respect of the LL4 as you stated that it, <i>‘needs root filling or extracting’</i>.</p>



	<p>The Committee carefully considered all the evidence. It considered that there was evidence in the records of some discussion having taken place with Patient B on 18 December 2018 about the prognosis of the LL4. Therefore, the Committee determined that although you did not note that any discussion took place on either 21 or 26 February 2019, it was more likely than not that you would have referred back to your discussion before. Given the previous discussion, the Committee considered it unlikely that you would simply commence the treatment without a further conversation. The Committee accepted your consistent oral evidence in this regard. It noted that you would have gained no advantage in not discussing the options available to Patient B before such an invasive procedure. The Committee further noted that you stated in oral evidence that Patient B was clear about the treatments he did and did not want, including that he told you he did not want another extraction. The Committee also took into consideration that it has not been able to cross-examine Patient B and test his evidence.</p> <p>For these reasons, the Committee determined that charges 9(a) and 9(b) are not proved.</p>
	<p><u>LL2 Crown</u></p>
	<p>c) you prepared the LL2 for a crown without adequate clinical justification on 14 August 2019;</p> <p>Found Not Proved</p> <p>The Committee noted Dr Dhami's expert report that. <i>'The records did not provide any clinical reasoning or justification for why such an invasive treatment option was required and/or provided at LL2'</i>.</p> <p>The Committee noted from the records that no clinical justification was provided for the appointment on 14 August 2019. However, the Committee noted from a previous appointment on 18 December 2018 that there was evidence that the LL2 was a root-filled tooth and needed a large restoration. The Committee also noted your evidence that this was an elective cosmetic treatment.</p> <p>The Committee determined, therefore, that there was sufficient evidence in the clinical records to show that there was clinical justification for preparing the LL2 for a crown.</p> <p>Accordingly, the Committee found this charge not proved.</p>
	<p>d) you failed to discuss the risks and benefits of providing a crown at the LL2 on or before 14 August 2019;</p>



Found Not Proved

The Committee noted there was no evidence from the records that you discussed the risks and benefits with Patient B. However, it did note that as the records showed that the treatment plan of the LL2 had changed from a filling to a crown, it was more likely than not that some form of discussion had taken place. The Committee also accepted your evidence that you would have discussed the risks and benefits with Patient B.

The Committee was mindful that it had not been able to test Patient B's evidence as he has not taken part in these proceedings. Therefore, it gave more weight to the contemporaneous clinical records, which recorded a different approach.

The Committee determined, therefore, that it was more likely than not that you had discussed the risks and benefits with Patient B.

Bridge treatment between LR3 and LR1

- e) you failed to discuss all treatment options to restore the space at LR2 on 29 August 2019 and/or 26 September 2019;
- f) you failed to discuss the risks and benefits of the proposed bridge treatment between LR3 and LR1 on 29 August 2019 and/or 26 September 2019;

Found Proved

The Committee considered charges 9(e) and (f) together.

You denied both charges. You stated that you had discussed with Patient B all the treatment options and the risks and benefits, but that Patient B was adamant that he wanted a bridge.

The Committee noted Dr Dhami's report which stated:

'There is no evidence the risks of the bridge were considered and discussed and weighed up against other options. As this failure would have resulted in other less invasive options being considered, the failure could and did result in significant harm for [Patient B].'

The Committee noted that there was no evidence in the records to show you had discussed all treatment options with Patient B. The Committee accepted Dr Dhami's evidence and determined that it was unlikely that Patient B would have chosen to have a conventional bridge if he would have been aware that



there were other suitable and less invasive options available, such as a resin-retained bridge, which were less likely to fail.

Therefore, the Committee found that it was more likely than not that you had failed to discuss all treatment options and all the necessary risks and benefits for the bridge treatment between LR3 and LR1, though it accepted your account that some treatment options and risks and benefits may have been discussed.

Accordingly, the Committee found charges 9(e) and 9(f) proved.

g) you failed to identify retained roots at LR2 and/or inform Patient B of the retained roots at LR2 on or before 26 September 2019;

Found Not Proved

You denied this charge. You explained that you were not aware at the time that there were any retained roots at LR2, although you accept that that must have been the case. As you were not aware, you stated that you could not have informed Patient B about it.

The Committee had sight of the radiograph of the LR2 in the records. It considered that it was plausible that the LR2 retained roots could have been missed by you as it was not clear from the radiograph. Furthermore, the Committee noted from the records that another dentist had extracted the LR2. Therefore, the Committee considered that if you would have identified the retained roots, it would have been likely that you would have taken steps to address it as there would have been no benefit to you in not doing so if you had identified it.

For these reasons, the Committee determined that it was more likely than not that you had failed to identify the retained roots at the LR2. As you were not aware of the retained roots, you therefore could not have informed Patient B.

However, owing to the difficulties in identifying the roots on the radiograph, the Committee determined that your failure to identify the retained roots did not amount to a failure to provide an adequate standard of care to Patient B.

The Committee considered that the failure to identify the retained roots in the circumstances here, does not reach the threshold to amount to a failure to provide an adequate standard of care. Whilst this failure, in the Committee's judgment, may have breached a 'gold standard', it was not a culpable failure judged by the standards of a reasonable competent dentist.

Accordingly, the Committee found this charge not proved.



	<p>h) you adopted a conventional full fixed bridge on the LR2 when such a bridge was not in Patient B's best interests on 26 September 2019;</p> <p>Found Proved</p> <p>The Committee noted your oral evidence in which you agreed that a conventional full fixed bridge was not in Patient B's best interests:</p> <p><i>'It was what the patient wanted, but yes it is probably not in [Patient B's] best interests, but he is going for cosmetic as opposed to function in this case.'</i></p> <p>The Committee has determined above that a conventional bridge was not a suitable treatment as there were other less invasive options, such as a resin-bonded bridge, which would have been more appropriate and would have had more chance of success.</p> <p>Accordingly, the Committee found this charge proved.</p>
	<p><u>Bridge treatment between LL4 and LL7</u></p>
	<p>i) you failed to identify that a root remained in situ at the LL5 after the extraction procedure on 10 April 2019 and/or informed Patient B that a root remained in situ at the LL5 after extraction on 10 April 2019;</p> <p>Found Not Proved</p> <p>You denied this charge. You explained that you were not aware at the time that a root remained in situ at the LL5, although you accept that that must have been the case. As you were not aware, you stated that you could not have informed Patient B about it.</p> <p>The Committee noted Dr Dhami's expert evidence in which he stated that it can easily be seen from the relevant radiograph that a root remained in situ.</p> <p>The Committee had sight of the radiograph and noted that this was specifically taken by you to see if the LL5 had been fully extracted. However, the Committee considered that it was not clear or obvious from that x-ray that a root remained in situ at the LL5. In the Committee's view, therefore, it was plausible that this could have been missed.</p> <p>The Committee, therefore, accepted your evidence that you had failed to identify that a root remained in situ at the LL5. It further determined that you could not have informed Patient B of something that you were not aware of.</p>



The Committee also determined that, owing to the quality of the radiograph, an ordinary and reasonably competent dentist may also have missed the root. Therefore, for similar reasons expressed in 9(g) above, your failure did not amount to a failure to provide an adequate standard of care to Patient B.

Accordingly, the Committee found this charge not proved.

j) you failed to discuss all treatment options to restore the space at LL5 and LL6 on or before 31 October 2019;

k) you failed to discuss the risks and benefits of the proposed bridge treatment between LL4 and LL7 on or before 31 October 2019;

Found Proved

The Committee considered charges 9(j) and 9(k) together.

You denied this charge. The Committee noted the following from your witness statement:

'The risks and benefits, advantages and disadvantages were discussed of implants, dentures, resin retained bridges and extra coronal bridges. The patient had a denture, but he did not want a denture and did not want implants. He did not want resin retained bridges as it wouldn't change the shape of his teeth in the arch, and he did not like "wonky teeth" ... The patient was advised that having full coverage crowns can cause the nerve in the tooth to die and he might need root canal treatment or extraction in the future.'

It is alleged by the GDC that, on balance, the bridge treatment was more likely to fail than succeed and that it was unlikely that Patient B would have agreed to treatment with such high risk if he was aware of all the treatment options and the risks and benefits.

The Committee found your evidence on this charge to be unreliable. It noted from your witness statement that you maintained you had discussed resin retained bridges with Patient B. However, this type of treatment would have been unsuitable and therefore the Committee considered it less likely that the discussion took place as you described.

The Committee also noted Dentist A's evidence, in which he stated that Patient B was unaware that the LL4 had a high risk of failure and bridge treatment was not really a viable option.

Taking all of this into consideration, the Committee determined that it was more likely than not that you had failed to discuss all treatment options and the



	<p>necessary risks and benefits with Patient B as it would have been unlikely that he would have chosen a treatment that was unlikely to succeed.</p> <p>Accordingly, the Committee found charges 9(j) and 9(k) proved.</p>
	<p>l) you failed to discuss the increased risk of failure of the proposed bridge treatment between LL4 and LL7 on or before 31 October 2019, given the lack of coronal tooth tissue at LL4;</p> <p>Found Proved</p> <p>The Committee has found proved above, that you had failed to discuss with Patient B the risks and benefits of the proposed bridge treatment between LL4 and LL7. The Committee, therefore, also find this charge proved for the same reasons.</p>
	<p>m) you commenced bridge treatment to restore the space at LL5 and LL6 on 31 October 2019, when such treatment was not appropriate.</p> <p>Found Proved</p> <p>The Committee noted Dr Dhami's opinion that bridge treatment was not appropriate to restore the space at LL5 and LL6.</p> <p>The Committee accepted Dr Dhami's evidence in this regard, and found this charge proved.</p>
10.	<p>By virtue of your conduct at 9 (a) and/or 9 (b) you failed to obtain Patient B's informed consent in respect of the LL4 root canal treatment.</p> <p>This charge falls away as the Committee found charges 9(a) and 9(b) not proved.</p>
11.	<p>By virtue of your conduct at 9 (d) you failed to obtain Patient B's informed consent in respect of the LL2 crown treatment.</p> <p>This charge falls away as the Committee found charge 9(d) not proved.</p>
12.	<p>By virtue of your conduct at 9 (e) and/or 9 (f) and/or 9 (g) you failed to obtain Patient B's informed consent in respect of the Bridge treatment between LR3 and LR1.</p> <p>Found Proved</p>

	<p>The Committee only considered this charge in respect of charges 9(e) and 9(f) as it had found 9(g) not proved.</p> <p>The Committee accepted Dr Dhami’s opinion and determined that as you had failed to discuss all treatment options and the necessary risks and benefits for the bridge treatment between LR3 and LR1, it is clear that you failed to obtain Patient B’s informed consent for the treatment.</p> <p>Accordingly, the Committee found this charge proved.</p>
13.	<p>By virtue of your conduct at 9 (j) and/or 9(k) and/or 9(l) you failed to obtain Patient B’s informed consent in respect of the Bridge treatment between LL4 and LL7.</p> <p>Found Proved</p> <p>The Committee accepted Dr Dhami’s opinion and determined that as you had failed to discuss all treatment options and the risks and benefits for the bridge treatment between LL4 and LL7, it is clear that you failed to obtain Patient B’s informed consent for the treatment.</p> <p>Accordingly, the Committee found this charge proved.</p>
14.	<p>Your conduct at 9 (g) and/or 9 (i) was:</p>
	<p>a) misleading; and/or b) lacking in candour.</p> <p>The Committee did not go on to consider these charges as it had found 9(g) and 9(i) not proved.</p>

21. We now move to Stage 2.

Stage 2

22. Having announced its decision at Stage 1, the Committee then went on to consider whether the facts found proved amounted to misconduct and, if so, whether your fitness to practise is currently impaired by reason of your misconduct, and if so, what sanction, if any, should be imposed.

Summary of Findings

23. The Committee has found proved that you provided an inadequate standard of care to Patients A and B between December 2018 and August 2022.

24. In respect of Patient A, the Committee found proved that you failed to identify a file fracture at UL7 and the roots that were left in situ following the extraction of the tooth, and that you failed to identify a distal radiolucency at the UL6. The Committee found this conduct to be objectively misleading. Furthermore, the Committee found proved that you failed to obtain Patient A's informed consent for the bridge treatment between LL7 and LL5 as you failed to discuss all treatment options and the necessary risks and benefits of the treatment. Lastly, the Committee found proved that you prescribed antibiotics to Patient A in November 2021 and August 2022 without adequate justification.
25. In respect of Patient B, the Committee found proved that you failed to obtain Patient B's informed consent for the bridge treatment between LR3 and LR1 as you failed to discuss all treatment options and the necessary risks and benefits of the treatment. The Committee also found proved that the bridge treatment you provided was not in Patient B's best interests. In respect of the bridge treatment between LL4 and LL7, the Committee again found proved that you failed to obtain Patient B's informed consent as you failed to discuss all treatment options and the necessary risks and benefits of the treatment. The Committee further determined that this bridge treatment was also not appropriate.

Documents

26. You provided further documents for this stage of the hearing. These included reports from your two mentors, your two written reflection documents, testimonials, your curriculum vitae, Personal Development Plan, your Continuing Professional Development (CPD) log, audits and aide memoirs.

Oral Evidence

27. The Committee heard oral evidence from your two mentors who provided the reports stated above. You also gave oral evidence.

Submissions

28. In accordance with Rule 20 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), the Committee then heard submissions from Mr Saad, on behalf of the GDC, and from Mr Irwin, on your behalf, in relation to the matters of misconduct, impairment and sanction.
29. Mr Saad, on behalf of the GDC, first informed the Committee that you have no fitness to practise history.
30. Mr Saad then addressed the Committee on the matter of misconduct. As far as clinical failings proved, he submitted that this is at the more serious end. He submitted that

there were several instances in which you failed to obtain the patients' consent for the treatment undertaken. He submitted that you had also provided treatments to both patients that were not appropriate and which neither patient would have chosen had they been aware of the all the options. He further submitted that the treatment provided resulted in significant harm to both patients.

31. Mr Saad next addressed the Committee on the matter of impairment. He submitted that impairment could be divided into two components (personal and public). In terms of the personal component, he submitted that you have clearly engaged at length with the remediation process and this should be to your credit. Further, he submitted that your two mentors, who gave oral evidence at this stage of the proceedings, were credible witnesses and spoke highly of you. Furthermore, the amount of CPD and audits undertaken by you are substantial. He also submitted that it should be remembered that the allegations took place some time ago and there have been no further issues since. However, Mr Saad submitted that the issue is finely balanced and the Committee should also consider whether, despite the remediation you have undertaken, you have sufficiently addressed the root cause of the shortcomings in this case and shown full insight.
32. In respect of the public component, Mr Saad referred the Committee to the GDC's *Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020)* (the 'GDC's Guidance'). He submitted that this states that, '*The issue of informed or valid consent is a cornerstone of the public interest...*' and that, '*failure to obtain consent is a serious matter...*'. He also referred to the significant harm both patients suffered as a result of your treatment. For these reasons, he submitted that a finding should be made to uphold public confidence in the profession.
33. In respect of sanction, Mr Saad submitted that if the Committee find that the personal component is not engaged in respect of impairment of fitness to practise, it may feel that a reprimand would be appropriate to mark the seriousness of the case. However, if the personal element is engaged, then he commended a sanction of conditions.
34. Mr Irwin submitted that you concede that the findings in this case do amount to misconduct. However, he submitted that the misconduct is not at the upper end of scale of seriousness, rather it was towards the lower end.
35. In respect of impairment, Mr Irwin submitted that there is overwhelming evidence that your fitness to practise is not currently impaired. He referred to the GDC'S Guidance and submitted that any finding must relate to current fitness to practise. He asked the Committee to consider the evidence from your two mentors, which he submitted would be crucial in this regard. He submitted that you have meaningfully changed the way you approach things and this is evidenced in the reports from your mentors, who noticed improvements in your practice and were satisfied that the care you are

currently providing is at an appropriate standard. He submitted that your engagement with your mentors demonstrates a level of engagement that is insightful.

36. Mr Irwin submitted that each and every one of the concerns has been dealt with, including your record keeping which, although was not alleged in this case, underpinned the informed consent failings. He submitted that when considering all the remediation material in the round, it touches on each and every one of the concerns. He submitted, therefore, that there were no ongoing concerns about your insight and standards of practice, and therefore simply no evidence of impairment.
37. Furthermore, he submitted that in terms of the public interest and the matter of informed consent, it was clear that you had discussed some information about their treatments with both patients. He did not seek to go behind the Committee's findings though and accepted that the failure to obtain informed consent was serious. However, he invited the Committee to conclude that a finding of impairment was not required in the public interest.

Committee's Decision

38. The Committee has borne in mind that its decisions on misconduct, impairment and sanction were matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's *Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020)* (the 'GDC's Guidance'), which is the applicable guidance to your case. The Committee also received advice from the Legal Adviser which it accepted and had regard to the relevant case law. The Committee first considered whether the facts found proved amounted to misconduct.

Misconduct

39. The Committee had regard to the GDC's *Standards for the Dental Team (2013)* (the GDC Standards) and determined that you had breached the following sections in particular:
- 1.1.1 *You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.*
 - 2.3 *You must give patients the information they need, in a way they can understand, so that they can make informed decisions.*
 - 3.1 *You must obtain valid consent before the starting treatment, explaining all the relevant options and the possible costs.*

7.3 *You must update and develop your professional knowledge and skills throughout your working life.*

40. The Committee has found proved that you failed to provide an adequate standard of care in respect of both Patient A and Patient B. In particular, you did not obtain informed consent from either of the patients, which resulted in you providing invasive treatment that was not in their best interests, inappropriate and which resulted in both patients suffering harm.

41. The Committee determined, therefore, that your failings in this case were serious and clearly amounted to misconduct.

Impairment

42. The Committee then considered whether your fitness to practise is currently impaired by reason of your misconduct. The Committee first noted that as the failings in this case solely related to your clinical practice they were capable of being remedied. The Committee then went on to consider whether they had been sufficiently remedied and carefully considered your remediation evidence.

43. The Committee noted from the documentary and oral evidence provided at this stage that since your treatment of Patients A and B, you have accepted the shortcomings in your practice and the seriousness of your misconduct, and have shown a willingness to make fundamental changes to the way you work. In particular, the Committee noted the evidence from your two mentors. Both of your mentors have provided oral evidence and documentary evidence in the form of audits and reports, to show that there are currently no concerns about your standard of practice. The Committee was reassured that you would now discuss all treatment options and the necessary risks and benefits with all patients and would no longer provide treatments that were not in a patient's best interests. You have undergone training through CPD of antibiotic prescribing and are more aware of the guidelines and now follow these strictly. The Committee concluded that these improvements to your practice have now been fully embedded to the extent that your mentors stated that they have also taken advice from you in respect of clinical matters. [PRIVATE.]

44. The Committee found your oral evidence to be genuine and meaningful. The Committee noted the extent and depth of your remediation and that it has taken place over a long period of time. The Committee believe that these proceedings have had a salutary effect on you. You have learnt from your mistakes and developed into a better practitioner as a result. For example, the Committee noted the changes you have made to improve your radiographic practice by investing in higher-resolution laptops so you can now see radiographs more clearly. Also, the move from handwritten to digital records which will ensure all data is in one place and all required details are recorded at every appointment.

45. In conclusion, the Committee found your remediation evidence to be significant and thorough and was satisfied that you had fully remediated the clinical failings in this case and have practised safely without further concern since the referrals. The Committee considered that any repetition of the clinical failings would be highly unlikely given the evidence it has seen.
46. Accordingly, the Committee determined that your fitness to practise is not currently impaired on public protection grounds.
47. The Committee then went on to consider whether your fitness to practise is impaired on public interest grounds.
48. The Committee was mindful of its role in reference to the over-arching objective, which includes:
- The protection of patients, colleagues and the wider public from the risk of harm;
 - Maintaining public confidence in the dental professions;
 - Upholding the reputation of the dental professions; and
 - Declaring and upholding appropriate standards of conduct and competence among dental professionals.
49. The Committee noted that you provided inappropriate invasive treatment to two patients, which resulted in them suffering harm. You also failed to obtain informed consent in respect of those treatments and the Committee was mindful of the *GDC's Guidance* in respect of informed consent:
- 'The issue of informed or valid consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment or investigation. Failure to obtain consent is a serious matter and, if the panel is satisfied that it amounts to misconduct the PCC should consider whether a finding of impairment and the imposition of a sanction is appropriate in the public interest. ...'*
50. The Committee considered your misconduct, therefore, to be at the higher end of the spectrum of seriousness. It determined that a finding of impairment for your misconduct was necessary in the wider public interest to maintain public confidence and uphold proper standards of conduct and competence among dental professionals. The Committee concluded that a reasonable and informed member of the public, fully aware of the facts of the case, would lose confidence in the profession and the dental regulator if a finding of impairment were not made in the circumstances of this case.
51. The Committee therefore determined that your fitness to practise is currently impaired on the ground of public interest.

Sanction

52. The Committee next considered what sanction, if any, to impose on your registration. It recognised that the purpose of a sanction was not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing your interest with the public interest. It also took into account the *GDC's Guidance*.

53. The Committee considered the mitigating and aggravating factors in this case as outlined in the *GDC's guidance* at paragraphs 5.17 and 5.18.

54. The mitigating factors in this case include:

- Evidence of the circumstances leading up to the incident in question – [PRIVATE];
- Evidence of good conduct following the incident in question, particularly your remedial action;
- Evidence of previous good character;
- Evidence of remorse shown, insight and apology given;
- Evidence of extensive steps taken to avoid a repetition;
- Time elapsed since the incident.

55. The aggravating factors in this case include:

- Actual harm to two patients;
- Breach of trust – in that you failed to obtain informed consent.

56. Taking all these factors into account, the Committee considered the available sanctions as set out in paragraph 6.4 of the *GDC's Guidance*, starting with the least restrictive, a reprimand.

57. The Committee had regard to the *GDC's Guidance* and noted the following:

“A reprimand does not impose requirements on a registrant's practice and should therefore only be used in cases where he or she is fit to continue practicing without restrictions. A reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice.”

58. Furthermore, the Committee noted from the *GDC's Guidance* that a reprimand may be suitable where the following factors were present:

- There is no evidence to suggest that the dental professional poses any danger to the public;
- The dental professional has shown insight into her failings;
- The behaviour was not deliberate;

- The dental professional has genuinely expressed remorse
- There is evidence that the dental professional has taken rehabilitative/corrective steps;
- The dental professional has no previous history.

59. Having given the matter careful consideration, the Committee has determined that a reprimand was the appropriate sanction to impose in the particular circumstances of this case. The Committee was satisfied that you had fully remediated the clinical concerns and it had found that your fitness to practise is not currently impaired on the ground of public protection. The Committee also bore in mind the context in which the clinical failings took place. It noted that they took place during a particular period and were confined to two patients, who were challenging. The Committee noted that there were no previous concerns about your fitness to practise and there has been no repetition of these incidents.
60. In all the circumstances the Committee considered that the issuing of a reprimand was sufficient to mark the seriousness of the matters identified by this case. A reprimand meets the public interest considerations of trust and confidence in the profession and the declaring and upholding of proper professional standards engaged in this case. The Committee was satisfied that a reasonable informed observer would note the Committee's findings of facts, misconduct and impairment, and would consider that the sanction of a reprimand represents a necessary and proportionate disposal of this case.
61. Having determined that a reprimand was the appropriate sanction to impose, the Committee found that to impose a higher sanction would be disproportionate in the circumstances of the case. A period of conditional registration would not be proportionate or appropriate given that you have fully remediated your clinical failings and do not currently pose a risk to the public.
62. The Committee has therefore determined that a reprimand should be recorded against your name in the Register. The fact of this reprimand, and a copy of this determination, will appear alongside your name in the Register for a period of 12 months. The reprimand forms part of your fitness to practise history and is disclosable to prospective employers and prospective registrars in other jurisdictions.
63. That concludes this hearing.