PUBLIC HEARING

Professional Conduct Committee
Initial Hearing
(remitted)

28 November 2025

Name:	SINGH, Abhishek
Registration number:	105433
Case number:	CAS-200892

General Dental Council:	Tom Stevens of Counsel Instructed by Daniel Watson of IHLPS
Registrant:	Present Represented by Simon Butler of Counsel Instructed by Paul Grant of BSG Solicitors

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Conditions imposed (with a review)
Duration:	12 months
Immediate order:	Immediate order of conditions

Committee members:	Helen Wagner	(Lay) (Chair)
	Yasmin Lawton	(DCP)
	Sukhninder Sandhar	(Dentist)
Legal adviser:	Paul Moulder	
Committee Secretary:	Paul Carson	

Mr Singh,

1. This is a remitted hearing to reconsider sanction pursuant to the sealed order of MacDonald J on 15 July 2025.

2. On 29 November 2024 a differently constituted panel of the Professional Conduct Committee (PCC) found your fitness to practise as a dentist to be impaired by reason of misconduct and directed that your name be erased from the Register with an order for immediate suspension.

3. The misconduct found by the November 2024 PCC encompassed both clinical concerns and dishonesty, as summarised in its determination:

> *'The Committee's factual findings relate to your care and treatment of Patient A, and to your co-operation with the GDC. The Committee found that, between 4 April 2019 and 8 January 2021, you failed to provide an adequate standard of care to Patient A, in that, at one or more appointments, you treated Patient A in the absence of an appropriately trained member of the dental team who was required to be present at all such times. The Committee went on to find that you failed to adequately assess the risks to Patient A's safety, in that there were increased risks of choking, complications during extraction, and an inefficient response to medical emergencies such as cardiac arrest, associated with not having another appropriately trained colleague with you. The Committee also found that you failed to obtain informed consent for your extraction of Patient A's lower left wisdom tooth (LL8) at an appointment that took place on 1 June 2019, in that you did not discuss the heightened risk of inferior alveolar nerve damage and the option of a referral to a specialist with Patient A.*
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> *The Committee has also found that you failed to co-operate with the GDC's investigation by failing to provide the GDC with proof of your indemnity insurance arrangements covering the period of 4 April 2018 to 22 September 2020, and failing to provide the GDC with Patient A's dental records. The Committee also found that you failed to keep your registered address up to date. The Committee also found that, on 30 June 2023, you contacted the GDC to state that you worked at the practice on a part-time basis between 2013 and 2017, and that the practice had had an NHS inspection but closed down due to the COVID-19 pandemic. The Committee determined that your actions in this regard were misleading, and were also dishonest, in that you had in fact treated Patient A between 2019 and 2021. Finally the Committee determined that on 25 October 2023 you again contacted the GDC and stated that the practice was closed, and that you had no access to any records. The Committee found that this statement was misleading.'*

4. In finding your fitness to practise to be impaired, the November 2024 PCC stated:

> '*The Committee considers that your misconduct arising from your clinical failings is in theory capable of being remedied, relating as it does to discrete and identifiable aspects of your practice. The Committee has had regard to the*

CPD that you have undertaken. In the Committee's judgement this learning does not demonstrate that you have adequately addressed the specific shortcomings that this Committee has identified. Whilst the Committee has had regard to the testimonials and reviews submitted about patients, these do not appear to demonstrate that you have improved your practice to the required extent in the specific areas of concern. The Committee is also mindful that these clinical shortcomings arose at a time when you were subject to conditions imposed as a result of separate FtP proceedings. In the Committee's judgement this suggests that it might be more difficult for you to remedy your clinical shortcomings, as the Committee would expect a registrant in such circumstances to be all the more likely to be practising to the required standard.

Whilst the Committee has taken careful account of your submissions and other information, the Committee considers that the information with which it has been provided suggests that you lack insight into your clinical failings. Your reflections focus on your own personal circumstances at the time, as well as the personal consequences for you of these and other regulatory proceedings. You have provided little in the way of detailed and considered reflections on the impact of the failings in your care and treatment of Patient A on her. In light of the shortcomings that the Committee has identified in respect of your insight and remediation, the Committee finds that you are liable to repeat your clinical failings, and that you therefore continue to pose a risk to the public. The Committee therefore finds that your misconduct in relation to its clinical findings mean that your fitness to practise is currently impaired.

The Committee also considers that the misconduct that it has found in relation to your co-operation with the GDC, including your misleading and dishonest conduct, means that your fitness to practise is impaired. Your conduct represents a persistent and repeated failure to co-operate with GDC over a period of almost two years. The Committee is mindful that such conduct is likely to be more difficult to remediate than the clinical failings referred to above, as it might be suggestive of an attitudinal or behavioural failing. The Committee finds that you have not remedied that misconduct. You have had a considerable period of time in which to develop and demonstrate your insight and remediation. The Committee has however been provided with little in the way of information to suggest that you have developed any significant insight into your conduct, or that you have taken steps to address and rectify your actions. Indeed, that which the Committee has received from you by way of your reflections relates more to the consequences that the GDC's proceedings, both historic and current, have had on you, with little mention of any understanding of how your conduct might affect the public's perception of the profession.

The Committee has received only limited information from you as to how you might act differently in the future, and attaches little weight to your assertion that you would not act in such a manner in the future. The Committee therefore considers that your misconduct is liable to be repeated. Its findings relate to a sustained and repeated failure to co-operate with the GDC, including an act of dishonesty, in relation to formal regulatory dealings and in connection with a

patient. The Committee considers that a repeat of such conduct, which in its judgement cannot be said to be highly unlikely, might put the public at unwarranted risk of harm. Accordingly, the Committee finds that your fitness to practise is currently impaired in relation to its findings about your co-operation with the GDC.

The Committee considers that a finding of impairment is also, and undoubtedly, required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. Your actions were liable to have brought the reputation of the profession into considerable disrepute. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made given the nature of your misconduct, and particularly your misleading and dishonest conduct.'

5. On 15 July 2025 the High Court allowed your appeal against the decision of the November 2024 PCC and quashed the findings of misleading and dishonest conduct: *Singh v General Dental Council* [2025] EWHC 1761 (Admin). In quashing these findings, MacDonald J stated:

> *'73. None of the above is to fail to recognise the seriousness of the actions taken by Dr Singh in treating Patient A in the manner and in the circumstances in which he did, described by Mr Thomas* [GDC Counsel] *as a species of "backstreet dentistry"…'*

6. MacDonald J remitted the question of sanction for hearing before a differently constituted panel of the PCC. The finding by the November 2024 PCC of misconduct and impairment still stands but is now confined to the clinical matters and to the other (non-misleading or dishonest) failures to cooperate with the GDC's investigation, which were your failures to: (i) provide the GDC with proof of your indemnity insurance arrangements covering the period of 4 April 2018 to 22 September 2020; (ii) provide the GDC with Patient A's dental records; and (iii) keep your registered address up to date.

7. It is the role of this Committee to hold the remitted hearing and to decide the question of sanction in respect of these matters.

8. The Committee heard the submissions made on behalf of the GDC by Mr Stevens and to those made on your behalf by Mr Butler. The Committee also heard oral evidence from you. The Committee had regard to all of the remediation evidence you put before it, including your written statement and your Continuing Professional Development (CPD) records.

9. The Committee had regard to your fitness to practise history, as summarised in the determination of the November 2024 PCC:

> *'In March 2019 you appeared before the PCC in relation to concerns about the standard of care and treatment that you provided to a patient, your record-keeping of the appointments that you had with that patient, and your failure to*

respond adequately to the patient's complaint about your treatment. That Committee also found that you had acted in a misleading and dishonest manner, and in a manner that was lacking in integrity, in presenting notes that were not contemporaneous without indicating that they were not contemporaneous. That Committee determined that your fitness to practise was impaired by reason of the misconduct that arose from those factual findings, and that it would be appropriate to direct that you be made subject to a direction of conditional registration for a period of two years. That direction was reviewed by the PCC on 15 March 2021, with that reviewing Committee determining that your fitness to practise was no longer impaired. The extant conditions were revoked.

In addition, you were the subject of an unpublished warning made by the IC on 29 May 2014 following its consideration of allegations relating to your standard of care, record-keeping and probity.'

10. The Committee also had regard to the immediate order of suspension which was imposed by the November 2024 PCC pending the disposal of your appeal. Your registration was suspended from 29 November 2024 until the immediate order was terminated by the Court on 15 July 2025. Whilst there is no automatic credit in respect of interim or immediate orders, as these interlocutory orders serve a different purpose to a substantive sanction, the Committee did consider it relevant that your registration has already been suspended in respect of an erasure decision which has now been quashed on appeal. The eight month period during which your registration was suspended pending the outcome of your appeal is, in the Committee's judgment, a relevant factor to take into consideration when considering the proportionality of any sanction which is now to be imposed.

11. Mr Stevens submitted that a period of conditional registration for 12 months would be the appropriate sanction. Mr Butler's primary submission was that no further sanction is needed.

12. The Committee accepted the advice of the Legal Adviser.

13. The Committee is bound by the finding of misconduct and impairment reached by the November 2024 PCC, in so far as this relates to the remaining facts. The Committee was however mindful to read the reasoning in the determination of the November 2024 PCC contextually rather than as absolute. In this regard, the Committee examined for itself the exhibits which were before the November 2024 PCC so as to gain a fuller understanding of the evidence and submissions which were before the PCC and on which the PCC had exercised its careful judgment.

14. In deciding on sanction, the Committee considered the aggravating and mitigating factors present in this case, as they present themselves today.

15. In mitigation, the Committee recognised that you were treating the patient who was subject of these proceedings out of a desire to help them and not for financial gain: you were treating them as a favour because they were in your social circle and because you felt a social and cultural expectation to serve your close community in this way. You had apologised directly to the patient and in your oral testimony you

said you had looked back at the incident and there was 'misjudgement'. The Committee also recognised that the passage of time is a mitigating factor and that this case relates to your care and treatment of a single patient six years ago. However, this was not as strong a mitigating factor as it might normally be, given the seriousness of your clinical failings, your other fitness to practise history (much of which is thematically similar) and the fact that you were already working under conditional registration at the time of your clinical failings in the present case.

16. The Committee also had regard to what it considered to be your developing insight and remorse in relation to your clinical failures. These were mitigating factors but were limited in that your reflections were focused more on the impact of these proceedings on you personally, rather than the effect your misconduct had on the patient and the harm you have caused to public confidence in the profession. In your reflections, you have focused on your own reputation rather than that of the profession. You have undertaken a large amount of CPD to address the concerns in this case, but you did not provide the Committee with any written reflections on your learning. There was little evidence on how (if at all) you had reflected upon your learning from each CPD activity and there was no evidence of how you have embedded any such learning into your practice. In answer to Committee questions, you were able to provide some oral reflection when prompted but this was limited. For example, when answering questions on your learning in relation to obtaining valid consent, you discussed the defensive importance of writing things down to document the process of consent but expressed no meaningful reflection on the importance of ensuring that the patient in fact understands what is being explained to them and is therefore able to give their informed consent.

17. The Committee also had regard to the testimonials which you had put before it. However, it could only attach limited weight to these as they consisted simply of patient feedback forms without any indication that the patients in question were aware of the allegations in these proceedings.

18. The aggravating factors present in this case include a real risk of harm to the patient and your related fitness to practise history, including the fact that you were already subject to conditions of practice at the time of your clinical failings in the present case. These failings are serious, representing fundamental breaches of basic clinical standards, and are thematically similar to other matters raised in your fitness to practise history. The reference to 'backstreet dentistry' quoted in the High Court judgment colloquially reflects the way in which the public may see your failings in this case. Whilst you were treating the patient as a favour and out of a desire to help her, there were unacceptable shortcomings in her care and treatment. It appears that because she was in your social circle you did not give due regard to matters such as consent and chairside assistance. However, the same clinical and professional standards apply regardless and, even at this stage of the regulatory process, it is not clear that you fully appreciate this.

19. Your failure to have cooperated with the GDC investigation also showed a disregard for the role of the GDC and the systems regulating the profession and so is also an aggravating factor, notwithstanding that the November 2024 PCC's findings were undermined to a degree by the appeal judgement of the Court.

20. The Committee considered sanction in ascending order of severity. To conclude this case with no further action or a reprimand would be inappropriate given the seriousness of the remaining findings of the November 2024 PCC, your still developing insight and the risk of repetition. It is essential that any sanction protects the public from the risk of harm identified.

21. The Committee next considered whether to direct that your registration be made subject to your compliance with conditions for a period of up to 36 months, with or without a review. In assessing the potential sufficiency of conditions, the Committee also had regard to suspension.

22. The Committee determined that to suspend your registration would be disproportionate, as you have already served an 8 month period of suspension as part of the immediate order and the Committee is entitled to take this into consideration. The Committee also considered that suspension would frustrate your continued remediation and return to clinical practice.

23. In the Committee's judgment, a period of conditional registration would be sufficient to protect the public and to meet the wider public interest. A workplace supervisory requirement would serve as a formal structured framework within which you can continue your remediation whilst ensuring that patients are not placed at a risk of harm.

24. Accordingly, the Committee directs that your registration be made subject to your compliance with conditions, which shall appear against your name in the Register in the following terms:

    1. At any time he is employed, or providing dental services, which require him to be registered with the GDC; he must place himself and remain under the supervision* of a workplace supervisor nominated by him, and agreed by the GDC.
    2. He must work with the workplace supervisor to formulate a Personal Development Plan, specifically designed to assist him in returning to unrestricted dental practice and to address the deficiencies in the following areas of his practice:
        - Informed consent;
        - Risk assessment of patients
    3. He must forward a copy of his Personal Development Plan to the GDC within three months of the date on which these conditions become effective.
    4. He must allow his workplace supervisor to provide reports to the GDC at intervals of not more than three months.
    5. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services.
    6. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and any

workplace supervisor referred to in these conditions.

7. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.
8. He must inform the GDC if he applies for dental employment outside the UK.
9. He must not engage in single-handed practice.
10. He must inform promptly the following parties that his registration is subject to the conditions, listed at (1) to (9), above:
    - Any organisation or person employing or contracting with him to undertake dental work
    - Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application)
    - Any prospective employer (at the time of application)
    - The Commissioning Body on whose Dental Performers List he is included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application)
11. He must permit the GDC to disclose the above conditions, (1) to (10), to any person requesting information about his registration status.

**Supervised: the workplace supervisor must supervise the registrant's day-to-day work in a way prescribed in the relevant condition or undertaking. The workplace supervisor does not need to work at the same practice as the registrant, but they must be available to provide advice or assistance if the registrant needs it. Where the workplace supervisor is unavailable through illness or planned absence, the registrant must not work, unless an approved alternative workplace supervisor is in place.*

The workplace supervisor must review the registrant's work at least once a fortnight in one-to-one meetings and case-based discussions. These meetings must focus on all areas of concern identified by the conditions or undertakings. These meetings should usually be in person. If this is not possible, at least one of every two fortnightly meetings must be in person.

25. The period of conditional registration shall be for 12 months and shall be reviewed prior to its expiry. This is the appropriate period to allow you to undertake further remediation and develop further insight, taking into account the fact that your registration has already been suspended for 8 months.

26. The Committee now invites submissions on the question of an immediate order.

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27. Mr Stevens applied for an immediate order of conditional registration to be made under section 30(2) of the Dentists Act 1984, on the grounds that an immediate order is necessary for the protection of the public and is otherwise in the public interest to cover the 28-day appeal period and the period of any appeal.

28. Mr Butler did not oppose the making of an immediate order.

29. The Committee accepted the advice of the Legal Adviser on the making of immediate orders.

30. The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to make an immediate order of conditional registration. It would be inconsistent with the decision the Committee has reached not to make an immediate order. There remains a risk of repetition of your serious clinical failings. The public would therefore be at risk in the Committee's judgment if no conditions were to be in force on your registration to cover the 28-day appeal period and the period of any appeal. Public confidence in the profession and its regulation would also be undermined if no immediate order were to be made.

31. The effect of this immediate order is that your registration is now subject to the above conditions.

32. Unless you exercise your right of appeal, the substantive 12 month period of conditional registration shall take effect upon the expiry of the 28-day appeal period. Should you exercise your right of appeal, this immediate order shall remain in force pending the disposal of the appeal.

33. That concludes this determination.