GENERAL DENTAL COUNCIL

AND

HARRIS, Michelle

[Registration number: 73491]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

An inquiry conducted by the Professional Conduct Committee opened on 2 June 2025 and concluded part-heard on 5 June 2025. The hearing will resume on 19 to 23 January 2026.

Please note that this hearing will be conducted remotely by video conference.

The heads of charge contained within this sheet are current at the date of publication. They are subject to amendments at any time before or during the hearing. For the final charge, findings of fact and determination against the registrant, please visit the Recent Decisions page at https://www.dentalhearings.org/hearings-and-decisions/decisions after this hearing has finished.

Committee members

Helen Wagner	Lay Chair
Estelle Williams	Dentist
Kirsty Payton	DCP

Advisers:

Alastair McFarlane	Legal Adviser

CHARGE

Michelle HARRIS, BDS University of Bristol 1997 was 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. You prescribed an antibiotic, Erythromycin without adequate justification on 23 May 2022;

7. You prescribed an antibiotic, Clarithromycin without adequate justification on 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 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 bests 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."

*Schedule A[1]

[1] *Schedule A is a private document that cannot be disclosed