

PUBLIC HEARING
Professional Conduct Committee
Initial Hearing

15- 24 June 2026

Name: LATOS, Kacper Jakub

Registration number: 289372

Case number: CAS-209690-Z0F1H4
CAS-209696-T7R1B1

General Dental Council: Mr Guy Micklewright, Counsel
Instructed by Rosie Geddes, IHLPS

Registrant: Not Present
Unrepresented

Fitness to practise: Impaired by reason of misconduct

Outcome: Erased with Immediate Suspension

Immediate order: Immediate suspension order

Committee members: Gaon Hart (Chair and Lay Member)
Emily Gilmour (Dentist Member)
Samantha Snoad (Dental Care Professional Member)

Legal adviser: Jayne Wheat

Committee Secretary: Kate Anderson

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against Mr Latos that his fitness to practise is impaired by reason of misconduct.
2. Mr Latos was not present at the hearing and was not represented. Mr Guy Micklewright, Counsel, appeared on behalf of the General Dental Council (GDC).

The Charges

3. The charges in this case are as follows (note later amended):

'That being registered as a dentist Kacper Latos's (289372) fitness to practise is impaired in that:

1. *You failed to provide an adequate standard of care to Patient A, from August 2020 to August 2023 including by/in relation to;*
 - a) *not carrying out sufficient treatment planning;*
 - b) *your radiographic practice;*
 - c) *by not discussing the full risks and benefits of the proposed treatment;*
 - d) *by not diagnosing, including, the need for further treatment.*
2. *You provided a poor standard of treatment and care to Patient A, from August 2020 to August 2023.*
3. *You failed to obtain informed consent for the treatment provided to Patient A from August 2020 to August 2023.*
4. *From 28 June 2021 to 31 August 2023, you failed to hold adequate indemnity insurance.*
5. *You failed to co-operate with any relevant formal or informal inquiry and give full and truthful information.*
6. *On 3 June 2024, at Highbury Corner Magistrates' Court, an order was granted under Section 30(1) of the Health and Social Care Act to cancel the registration of BRL Dentos Ltd.*
7. *Between 24 May 2024 and 26 May 2024, during the inspection, you were found to not be complying with the Health and Social Care Act 2008 Regulations 2014, including;*
 - a) *Regulation 12,*
 - b) *Regulation 17,*
 - c) *Regulation 18,*
 - d) *Regulation 19.*
8. *You failed to maintain adequate standards of cross infection control.*
9. *You failed to maintain adequate standards of clinical practise in relation to choice of equipment, surgery, and / or medicines.*

10. You failed to adhere to current (laws and) regulations (in force at the time) in respect of:

- a) Medical emergencies;
- b) Radiography;
- c) Decontamination.

11. Your actions in relation to allegations 6, 7(a) – (d), 8, 9 and 10 put patient safety at risk.

12. From 14 June 2024 to 8 April 2025, you failed to co-operate with investigations conducted by the GDC by not providing the GDC with any or insufficient evidence of;

- a) Indemnity and/or,
- b) Employment information.

And, by reason of the matters set out above, your fitness to practise is impaired by reason of your misconduct.'

Preliminary Matters

Application to proceed with the hearing in the absence of the registrant

4. At the outset, Mr Micklewright made an application under Rule 54 of the GDC (Fitness to Practise) Rules Order of Council 2006 ('the Rules'), to proceed with the hearing notwithstanding Mr Latos' absence.
5. Mr Micklewright drew the Committee's attention to the relevant documents on service and submitted that Mr Latos had been notified of this hearing in accordance with the Rules. He outlined that a copy of the Notice of Hearing dated 5 May 2026 was sent to Mr Latos at his registered address and registered email address.
6. The Notice of Hearing was returned to the GDC on 11 May 2026, marked 'R. T S.' Mr Micklewright reminded the Committee that there is no requirement under the Rules for the Council to prove that the Notice of Hearing was received, only that it was sent, and he submitted that the GDC had met this requirement.
7. Mr Micklewright submitted that Mr Latos had voluntarily absented himself. Mr Micklewright submitted that there had not been any request from him for an adjournment, and there was no indication that he would attend a hearing on a future date. He referred the Committee to correspondence between the GDC and Mr Latos dated 15 July 2025, in which he stated that '*I will not attend either online or in person.*' Additionally, in an email dated 12 June 2026, Mr Latos implied that he would not attend and had not resided in the UK since 2021 and had no intention to return. He also indicated that, '*I reject unequivocally all allegations...To the extent that such allegations continue to be relied upon I maintain that they are unsupported, disputed and denied in their entirety.*' Mr Micklewright therefore submitted that Mr Latos had waived his right to attend the hearing, and that it is fair and in the public interest for the hearing to proceed and for the matters to be dealt with expeditiously.
8. The Committee took account of Mr Micklewright's submissions, and the supporting documentation he drew to its attention. The Committee accepted the advice of the Legal Adviser in relation to the issues of service and proceeding with a hearing in the absence of a registrant.

Decision on service

9. The Committee considered whether notice of the hearing had been served on Mr Latos in accordance with Rules 13 and 65 of the Rules and section 50A of the Dentists Act 1984 (as amended) (hereby referred to as 'the Act').
10. The Committee had before it a copy of the Notice of Hearing, dated 5 May 2026 (hereafter 'the notice'), which was sent to Mr Latos' registered address. A copy was also sent to him by email to his registered email addresses.
11. The Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the notice, only that it was sent. Therefore, whilst the Committee noted from Royal Mail's Track and Trace that the post was returned, it was satisfied from the proof of postage information provided, that the GDC had met the requirement in sending the notice to Mr Latos. The Committee also considered that Mr Latos had corresponded with the GDC on 12 June 2026 with regard to the hearing, and therefore was satisfied that he was aware of proceedings.
12. The Committee was further satisfied that the notice sent to Mr Latos complied with the 28-day notice period required by the Rules, and that it contained all the required particulars, including the date and time of the hearing, and that it was intended that the hearing would take place remotely by Microsoft Teams video-link. Mr Latos was also advised in the notice that the Committee had the power to proceed with the hearing in his absence.
13. On the basis of all the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Latos in accordance with the Rules and the Act.

Decision on whether to proceed with the hearing in the absence of the registrant

14. The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Latos. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones* [2002] UKHL 5, and as affirmed in subsequent regulatory cases. The Committee also had regard to paragraphs 33 onwards (under the heading 'Proceeding in the absence of the registrant') of the GDC's 'Fitness to Practise: Guidance for the practice committees' (effective from 6 January 2026) (the GDC's Guidance).
15. It took into account that fairness to Mr Latos was an important consideration but also bore in mind the need to be fair to the GDC and to act expeditiously in the public interest.
16. The Committee was satisfied that all reasonable efforts had been made by the GDC to notify Mr Latos of the hearing. In reaching its conclusion, it took into account the email from Mr Latos to the GDC dated 15 July 2025, in which he stated '*I will not attend either online or in person*'. The Committee was therefore satisfied that Mr Latos had voluntarily absented himself from this hearing.
17. It was the conclusion of the Committee that adjourning the hearing would serve no meaningful purpose in the circumstances. It noted that Mr Latos had not requested an adjournment and there was no information before it to suggest that deferring the hearing would secure Mr Latos' attendance in future. The Committee also considered that Mr Latos had requested to be erased on multiple occasions, most recently in correspondence dated 12 June 2026, and considered that he would be unlikely to attend at a further date.

18. The Committee remained mindful of the overarching statutory objective of the GDC, which is the protection of the public and the wider public interest, and its duty to act expeditiously in the public interest. The Committee also took into account the need to be fair to the GDC, noting that it is prepared and ready to present its case and that witnesses had been warned and were available, including the complainant (Patient A).
19. The Committee was satisfied, having balanced the public interest and fairness to the regulator with fairness to Mr Latos, that the balance weighed in favour of proceeding with the hearing in Mr Latos' absence.

Application to Admit Hearsay evidence

20. Mr Micklewright made an application under rule 57(1) of the rules for documents relating to the Care Quality Commission (CQC) investigation to be admitted as hearsay.
21. The documents relating to the CQC investigation included of significance:
- An email dated 6 June 2024, from CQC staff member Lisa Harwood Bird stating:
 - *'Please see attached some information we are sharing with the GDC. I have completed two separate forms as they relate to fitness to practice and illegal practice'*
 - A 'Standard form for sharing information' ('sharing form') stating the intended recipient was John Cullinane (GDC), which included:
 - *'Urgent cancellation...This was granted but is subject to appeal'*
 - *'CQC believes that care and treatment to service users by individuals who do not have current registration...poses a serious risk to the life, health or well-being of service users'*
 - *'Is the individual concerned aware that this information has been shared?...No-as this is an informal sharing'*
 - *'Decision to share information taken by...[redacted]...'*
 - A CQC Archived extract ('archived extract') which included:
 - *'Judgements section' shows 'Caring...Regulations met'*
 - *'Responsive...Regulations met'*
 - *'Patients care and treatment was not provided in line with current guidance...During this assessment we have not included the key questions of Caring and Responsive'*
22. Mr Micklewright submitted that documents were provided as part of Aimee McLaughlan's, GDC caseworker, witness statement but that these were not produced by her. He however submitted that that the documents were created by the CQC, and one was signed by two members of CQC staff as to the decision that the information can be shared.
23. Mr Micklewright submitted that the CQC evidence is sound in relation to the CQC findings, but it is only hearsay as to the underlying conduct. He submitted that it was therefore demonstrably reliable evidence, even if it was sole and decisive.
24. Mr Micklewright invited the Committee to have regard to the law in considering the application. He set out a number of principles including Rule 57.
25. Mr Micklewright informed the Committee that it must consider whether there is a good and cogent reason for the lack of a witness or witness statement, and submitted that the CQC had not provided either. Mr Micklewright submitted that the GDC had made all efforts to correspond with the CQC and to obtain a witness statement, however the CQC had informed the GDC that

it was uncomfortable to give a statement and that it was uncomfortable to provide more in-depth information in light of its own regulatory work. Mr Micklewright submitted that further correspondence between the CQC and the GDC took place at the beginning of this hearing to attempt to obtain a witness statement. The GDC provided a note to the Committee summarising the correspondence that has taken place since 28 August 2025. The note informs the Committee that the CQC maintains that while there is a memorandum of understanding between the regulators, it is not expected to provide witness statements and it is unlikely to change its view around providing documents or witnesses and would not attend this hearing. Mr Micklewright submitted that the CQC's view is that it would be prejudicial to their own regulatory functions to take time to give evidence at a GDC hearing. Mr Micklewright submitted that the GDC cannot be criticised as it had done all it can to obtain a witness statement and the presence of a CQC witness at this hearing.

26. Mr Micklewright submitted that the CQC evidence is multiple hearsay because it is likely that the investigation was conducted by different individuals to those who signed off on the documents being shared with the GDC. He however submitted that without a witness statement or oral evidence, the evidence would be classified as hearsay anyway.
27. Mr Micklewright submitted that Patient A's evidence corroborated some of the CQC evidence. Patient A stated that she was treated by a Person A in 2020. Mr Micklewright submitted however that Person A was erased in 2019, and therefore part of the cause for concern in the CQC investigation related to the delegation of work and breaching section 31 of the dentists act.
28. Mr Micklewright submitted that the CQC evidence was demonstrably reliable, and that it was fair to admit despite being the sole and decisive evidence. He submitted that it had been produced by the CQC as a regulator exercising its function, and there is no reason to suggest or believe that it was misleading. He submitted that the CQC would have taken care when collecting documents and information for its investigation. Mr Micklewright therefore submitted that the CQC evidence should be admitted as hearsay evidence.

Committee's decision on admitting Hearsay evidence

29. The Committee has considered the submissions made by Mr Micklewright. It accepted the advice of the legal adviser on the approach it should take. The Committee bore in mind that hearsay evidence is admissible in these proceedings. The Committee throughout its deliberations had regard to its overarching objective.
30. The Committee firstly considered the relevance of the CQC evidence. It considered that the evidence is relevant given that the CQC investigation directly relates to 6 of the charges at this hearing, and the information provided by the CQC is the sole and decisive evidence in relation to these charges. It noted that the CQC document refers to urgent and severe failures that form the basis of the GDC's case. The Committee was therefore satisfied that the CQC evidence was highly relevant.
31. The Committee next considered the reliability of the evidence and whether it was fair to admit it as hearsay evidence.
32. The Committee took into account that these documents are information provided by a statutory regulatory body, and the inference is that the organisation can be trusted not to have a reason to invent or manipulate evidence. The Committee considered that when they provided the 'sharing form', they were likely to have understood the significance of what they were sending to the GDC and were likely to have taken care to take the information from the inspection

report. However, there was no evidence provided of the original sources of the information nor was any witness available to the Committee to clarify.

33. The Committee considered the significant efforts made by the GDC to obtain a witness statement and oral witness from the CQC, and noted its concerns that the CQC were unwilling to provide clear and transparent reasons for non-attendance especially considering that it is another regulatory body. The GDC appeared to challenge whether there was a clear and logical reason for the CQC not to attend. The Committee was satisfied that the GDC had undertaken all possible steps to secure a statement and attendance at the hearing, but they were unsuccessful. The Committee considered carefully the reasons for non-attendance and determined that there seemed to be no transparency or clarity as to why the CQC would not support the GDC case. Therefore, the Committee was not satisfied that it had been provided with good or cogent reasons for non-attendance.
34. The Committee considered that there was no information before it as to who carried out the inspections, and no witness statements from them setting out their findings. The Committee noted that there was no clear indication as to who completed the 'sharing form'. The email from the CQC dated 6 June 2024, provided to support the sharing form stated '*...attached some information*' and in the next sentence, '*I have completed two separate forms*'. It was not clear to the Committee whether the 'sharing form' was one of the 'two separate forms', as only one document had been provided and no witness was available to ask. In addition, there was no indication where the information in the 'sharing form' came from and who else was in the chain of evidence. The 'sharing form' was also marked as an 'informal' document, and the signature only attested to the '*decision to share information taken by*'. The Committee noted that the signature did not attest to the veracity or validity of the information. The Committee considered that this point could likely have been clarified by an oral witness from the CQC, but given their unwillingness to attend and do so, there is no means of testing the reliability of the evidence.
35. The Committee determined that it would have questions for the CQC, if a witness were to attend. For example, it noted a potential inconsistency within the CQC documentation. The 'archived report' in the 'Judgements section' states, '*Caring...Regulations met*'. However, in the body of the document it states, '*patients care and treatment was not provided in line with current guidance...During this assessment we have not included the key questions of Caring and Responsive*'. Had a witness attended to address the contents of the documents, the Committee would have had questions for the CQC regarding this and other potential clarifications.
36. The Committee bore in mind Mr Micklewright's submission that some of Patient A's evidence corroborated the CQC evidence, in that Patient A alleges that she was treated by the unregistered Person A and the 'sharing form' refers to the use of unregistered individuals in the practice. However, the 'sharing form' stated '*CQC believes that care and treatment to service users, by individuals who do not have current registration...poses a serious risk*'. The Committee considered that this aligns to Patient A's evidence, however noted that the 'sharing form' does not provide sufficient clarity as to whether unregistered individuals were giving treatment at the practice. With no means of testing the evidence, the Committee was concerned about its reliability.
37. The Committee considered that while Mr Latos had voluntarily absented himself from the hearing, this was based upon the information he had received before it commenced, and he was therefore not aware that a hearsay application was to be made at the hearing. The Committee noted that Mr Latos had indicated in his email dated 12 June 2026, that he denied the allegations and they were '*unsupported*'. While it was unclear to the Committee exactly

what charges he may have been referring to, this could be relevant to the hearsay application, had he known that one was to be made.

38. The Committee considered that the CQC evidence, as the sole and decisive evidence, could lead to a significant adverse consequence on Mr Latos' registration given the seriousness of the case. The Committee considered fairness to Mr Latos in its decision on admissibility.
39. Overall, the hearsay documents were inconclusive as to where the evidence was derived from, from where its contents were taken, and whether it constituted the totality of the evidence that would have been available from the original reports. The Committee had questions around clarity which could have been resolved simply if a witness for the CQC was available. The hearsay evidence was the sole and decisive evidence on charges which could have significant and severe consequences for Mr Latos, and he was not aware of the hearsay application. The Committee did not consider that there was a good and cogent reason for non-attendance, and took into account that admission of hearsay should not be regarded as a routine matter. The CQC clearly had no reason to fabricate information, and there was some limited support from Patient A as to the reliability of the content. The documents were clearly relevant to the charges. However, the fact that this was multiple hearsay with no evidence of the original source meant that inadvertent errors in the information could not be identified. Considering all of the issues raised above, the Committee was not satisfied that admitting the hearsay evidence was fair.

Application to Amend to the Charges

40. Mr Micklewright made an application under rule 18 to amend the charges at this hearing. Mr Micklewright submitted that the proposed amendments are appropriate and could be made without injustice.
41. Mr Micklewright firstly submitted that charges 4-10 should be deleted following the decision made by the Committee to refuse the admittance of hearsay evidence. Mr Micklewright submitted that the absence of the hearsay evidence removes the evidential basis of these charges and that without its presence, there was no reasonable prospect of charges 4-10 being proven. He submitted that no further steps could be taken in regard to obtaining evidence for these charges and that any further discussions with the CQC could take considerable time. He submitted that Patient A was present and ready to give evidence at this hearing and that it would be in the public interest to proceed given her readiness. He therefore submitted that it was reasonable for the Committee to accede to the application to amend the charges and remove charges 4-10.
42. Mr Micklewright also applied for charge 1(a) to be amended to reflect the further advice from the professional expert's second report. He submitted that in the original charge sent as part of the Notice of Hearing, this charge was not included as the expert had concluded that there was insufficient evidence to support its existence. However, the professional expert later received radiographic records and created a supplementary report that contained advice in relation to this charge after the NOH had been served on Mr Latos. The GDC therefore applied to now include this charge based upon the evidential basis of the professional adviser's supplementary report. Mr Micklewright submitted that a draft set of charges including this amendment was provided to Mr Latos on 12 June 2026, and therefore he had been put on notice about this amendment. He submitted that Mr Latos had been given the opportunity to comment, but had not done so and therefore no injustice would be caused by amending the charges to include this allegation. Mr

Micklewright submitted that it was in the public interest for this charge to be heard given the realistic prospect of this being proved.

43. Mr Micklewright lastly submitted that the Committee had received a set of amended charges which contained an amendment to the dates at charge 2 to extend these to August 2023. He however submitted that given Mr Latos' direct care only lasted until December 2020, he no longer wished to apply for this amendment to be made.

Committee Decision on Amendment to the Charges

44. The Committee accepted the advice of the legal adviser in relation to amending the charges. The Legal Adviser drew the Committee's attention to the cases of *Ruscillo v CHRE* [2004] EWCA Civ 1356 ('Ruscillo'), *PSA v GPhC* and *Ahmed* [2024] EWHC 333, and *PSA v NMC and X* [2018] EWHC 70 Admin. It bore in mind that charges can be amended at any point throughout the hearing.
45. The Committee considered firstly the matter of removing charges 4- 10. Having determined not to adduce the hearsay evidence partly out of fairness to Mr Latos, the Committee also considered fairness to Mr Latos in determining whether to remove these charges.
46. The Committee accepted that if the GDC were to continue to pursue the CQC it would likely be a lengthy process, but that Patient A and the expert witness were present and ready to present their evidence to the Committee. It therefore considered that the hearing should go ahead in a timely manner given their presence.
47. The Committee considered whether any injustice would be caused by removing charges 4-10, however it determined that there was still sufficient evidence and allegations in this case which need to be considered for public protection and in the public interest. It also noted that patient A had provided sufficient evidence to examine Mr Latos' conduct, and that this was enough to warrant continuing with the hearing in reference to the remaining allegations in the public interest and for the protection of the public.
48. The Committee was satisfied that the amended charge 1a, not carrying out sufficient pre-treatment investigations, was supported by the expert reports and that Mr Latos had been informed of the proposed charge on 12 June 2026. As such, the Committee determined that there was no injustice caused by admitting the charge and that the evidence could be examined appropriately to assess whether it was found proved. Therefore, the Committee accepted the amendment as requested.
49. The Committee having heard Mr Micklewright's submission that he was no longer applying to amend charge 2, recognised that it did not need to make any further determination on amending this charge.

The Amended Charges

50. The charges as amended are as follows:

'That being registered as a dentist Kacper Latos's (289372) fitness to practise is impaired in that:

1. *You failed to provide an adequate standard of care to Patient A, from August 2020 to August 2023 including by/in relation to;*
 - a) *not carrying out sufficient pre-treatment investigations;*
 - b) *not carrying out sufficient treatment planning;*
 - c) *your radiographic practice;*
 - d) *by not discussing the full risks and benefits of the proposed treatment;*
 - e) *by not diagnosing the need for further treatment.*
2. *You provided a poor standard of treatment and care to Patient A, from August 2020 to August 2023.*
3. *You failed to obtain informed consent for the treatment provided to Patient A from August 2020 to August 2023.*
4. *From 14 June 2024 to 8 April 2025, you failed to co-operate with investigations conducted by the GDC by not providing the GDC with any or insufficient evidence of:*
 - a) *Indemnity and/or,*
 - b) *Employment information.*

AND, by reason of the matters set out above, your fitness to practise is impaired by reason of your misconduct.'

Background to the case and summary of allegations

51. In opening the case for the GDC, Mr Micklewright provided the Committee with oral submissions of the background of this case.
52. Mr Micklewright submitted that there are two strands to this case, these being the inadequate care of Patient A and the failure to cooperate with the GDC.
53. Mr Micklewright told the Committee that Mr Latos had worked at the Practice at various times between 2014 and 2021, as a Company Director, a Registered Manager, and a Dentist.
54. Patient A first attended the Practice in 2020 after receiving a recommendation from a colleague. Mr Micklewright told the Committee that her witness statement indicated that she attended with issues with a bridge on the lower left quadrant of her mouth. Patient A was recommended a *'Hollywood smile'* treatment. Her statement is that she was not informed of the full process and risks of this treatment, in that she did not know that she would be receiving full crowns and not overlays and that she was not informed about the risks of the treatment.
55. Mr Micklewright told the Committee that Patient A was seen by Person A, who was a director at the Practice but had been erased from the dental register in 2018. Mr Micklewright told the Committee that Mr Latos delegated tasks to Person A despite her not being permitted to work as a dentist following her erasure. Mr Micklewright told the Committee that Patient A described

Person A as managing patients, carrying out pre-treatment work, and creating treatment plans but that Mr Latos would sign off the plans and carry out the treatments himself. He submitted that it was not appropriate for a regulated professional and director of the Practice to delegate work to someone not appropriately qualified or registered, and was therefore responsible for all work carried out by Person A. Mr Micklewright also told the Committee that the clinical notes relating to Patient A are dated September 2020 to December 2020, which is when Patient A states that she was told that Mr Latos returned to Poland and Person A took over the dental care of the Patient. Following Mr Latos' return to Poland, Patient A returned to the practice for continued care but between March and June 2021 and in 2022 she presented with a number of infections in her mouth. In 2023, Patient A went to a different dentist for a second opinion whose conclusion in summarising her care was that *'this case was one of the most professionally and emotionally challenging situations I have encountered. [Patient A] arrived at my care in pain, deeply distraught, and hesitant to trust dental professionals again'*.

56. Mr Micklewright told the Committee that the GDC had instructed an expert witness to provide a report. Dr Stankiewicz's report concluded that Mr Latos' conduct fell far below the standard expected for practise including but not limited to poor radiographic practice, poor pre-treatment, insufficient treatment, failure to discuss risks and benefits, failure to diagnose the need for further treatment. There was little to no justifications for the care carried out, he allowed Person A to treat patients as an erased former dentist, there was an excessive removal of teeth for crowns, and a lack of clear conversations surrounding consent.
57. In relation to the failure to cooperate with the GDC, Mr Micklewright submitted that Mr Latos had the duty to cooperate and keep his contact details updated, regardless of where he was geographically. He told the Committee that the GDC had attempted to contact Mr Latos to receive up to date contact information, evidence of his indemnity, and to record where he was currently working, but that it had been unsuccessful. Mr Mickelwright submitted that there was evidence that Mr Latos had downloaded chaser emails asking him to update his contact details, and therefore it was likely that he did know that the GDC was trying to contact him but that he did not cooperate.
58. Mr Micklewright submitted that Mr Latos had not made any formal admissions in this case in relation to any of the charges, however the Committee should consider that he had sent an email dated 12 June 2026 in which he stated *'The only matter I acknowledge is that I did not provide details of my current employment during 2024 and 2025. However, my present employment is entirely outside the jurisdiction, regulatory authority, and legitimate remit of the General Dental Council'*. Additionally, the email indicated *'I reject unequivocally all allegations relating to alleged deficiencies in my clinical practice or professional competence. I do not accept any of those allegations, either in whole or in part. To the extent that such allegations continue to be relied upon, I maintain that they are unsupported, disputed, and denied in their entirety.'*

Evidence

59. The evidence provided to the Committee by the GDC was both documentary and oral. The documentary evidence comprised of signed witness statements and associated exhibits of:
- Patient A
 - Iyaz Ausaluth, GDC FtP Case Worker
 - Malgorzata Carter, Polish Interpreter
 - Mohammed Khan, GDC Registration Officer
 - Aimee McLaughlan, GDC FtP Caseworker

- Majed El-Giathi, GDC Paralegal

60. Patient A also gave oral evidence at the hearing, aided by a Polish interpreter.

61. Dr Stankiewicz, the Professional expert, gave oral evidence at the hearing.

62. The documentary evidence received by the Committee on Mr Latos' behalf in response to the allegations was an email dated 12 June 2026, along with other relevant emails (no others specific to his defence). This email stated that Mr Latos did not agree with the allegations, and had requested to be voluntarily removed.

The Committee's findings of fact

63. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Mr Micklewright on behalf of the GDC.

64. The Committee accepted the advice of the Legal Adviser, including in relation to the burden and standard of proof, the need to consider the alleged matters separately, the need to have regard to the specific wording of each allegation and how to approach the evidence. The Legal adviser advised the Committee to bear in mind that Mr Latos has no previous regulatory matters that amounted to a finding of misconduct. The Committee, throughout its decision-making, took this into account.

65. In making its findings on the facts, the Committee bore in mind that the burden of proof rests with the GDC. There was no requirement for Mr Latos to prove anything. Also, that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities. The Committee has had to decide whether it is more likely than not that the alleged matters are proved.

66. The Committee were cognisant to the fact that Mr Latos was not present nor represented so took extra care to assess his statement and the fairness of all matters on his behalf.

67. The Committee considered each head of charge separately and made the following findings:

<i>That being registered as a dentist Kacper Latos's (289372) fitness to practise is impaired in that:</i>	
1	<i>You failed to provide an adequate standard of care to Patient A, from August 2020 to August 2023 including by/in relation to;</i>
1a	<p><i>not carrying out sufficient pre-treatment investigations</i></p> <p>Found Proved</p> <p>The Committee first considered whether Mr Latos was responsible for the care of Patient A for the dates in this charge. It noted the evidence from patient A, that Mr Latos may not have treated Patient A for this whole period as a dentist and that Person A, was treating Patient A directly and without Mr Latos being involved in the early pre-planning. Although Patient A's statement indicated that she met '<i>him and [Person A], at the practice around this time.</i>' In oral evidence,</p>

Patient A confirmed that all her initial investigations, radiographs, treatment planning, discussions and diagnosis was originally undertaken by Patient A, before she met Mr Latos.

As the expert evidence confirmed and the Committee identified from the evidence before it, Mr Latos was the Director and Registered Manager of the Practice. The expert confirmed that the Registered Manager has an overarching duty to provide a good standard of care in the Practice. S.38 of the Dentists Act prohibits conduct by non-registered people and the committee accepted that the registrant, as the Registered Manager, was overwhelmingly responsible for permitting Person A to provide clinical services to Patient A. This indicated he carried some responsibility for the work carried out, particularly when there was a poor standard of treatment and care, as alleged in Charge 2.

However, the Committee considered that the expert was more ambiguous as to the granularity and extent of Mr Latos' responsibility for the specific actions of a dentist in the Practice.

As a Registered Manager, practice director and the fact that Person A was known to Mr Latos, there was a realistic inference that he knew that Person A was unregistered. Indeed, this was supported by the fact that he signed all treatment plans and clinical notes were made under his name. In addition, as the registered manager, he would have seen GDC registration details for all dentists in his practice. Finally, he signed all treatment plans and all clinical notes were in his name, again inferring knowledge that she was not permitted to practice.

The expert indicated and committee accepted, that permitting an unregistered dentist (Person A) to carry out clinical work, made him generally responsible for a poor standard of treatment and care.

However, the expert was less clear as to whether being the registered Manager made him directly responsible for specific clinical failings of Person A, such as pre-treatment investigations etc. However, the expert was clear that at the point of signing treatment plans, Mr Latos adopted direct responsibility as a registered dentist under GDC standards to ensure or complete all matters alleged in charge 1. The committee noted in the clinical notes dated 1 September 2020 it indicates, 'Treatment Plan: 1) OHI, Diet Advice, No treatment...3) Occlusal prosthodontic rehabilitation' which were under the 'Executing doctor' name of Mr Latos. Patient A indicated that the registrant signed off on all treatment plans, which supports these clinical notes. It is accepted, as per the expert evidence, that the clinical notes are predominantly standard un-adapted templates. However, these specific notes had been clearly adapted from the original template and had been inserted specifically by someone.

The committee concluded that it was generally ambiguous as to how involved and engaged the registrant was in Patient A's specific treatment up to the point that he signed the treatment plans. In oral evidence, Patient A inferred that all her initial investigations, radiographs, treatment planning, discussions and diagnosis was originally undertaken by Person A. Therefore, the committee concluded that it could not decide on a balance of probabilities that Mr Latos was responsible, as Registered Manager, for the specific treatment of Patient A

until the point of signing the treatment plans, at which time he adopted responsibility for the specific treatment to Patient A. However, he was responsible as registered Manager and Director of the practice for any treatment or care that was of a poor standard generally in the practice and specifically where he knew that an unregistered dentist was working in the practice.

Having considered the degree and timing of Mr Latos responsibility for the treatment of patient A, the committee next considered the facts in relation to charge 1a.

The Committee had regard to the clinical notes and Dr Stankiewicz's expert report. The expert opinion of Dr Stankiewicz is that *'in my opinion the diagnostic assessment of the Informant's dental care needs were insufficient and far below the standard expected due to the reported harm of prolonged pain associated with unresolved dental problems'*. Dr Stankiewicz considered the records of Patient A provided by the subsequent Dentist she visited, whose *'findings and subsequent treatment are broadly consistent with undiagnosed or unmanaged dental issues'*. He opined that *'had the Registrant adequately assessed and informed the patient of their dental needs, I think it is likely the Informant would have been aware of the issues earlier and received (or at least been advised of) the treatment required.'*

The Committee noted that there was limited evidence in the form of records from the Practice. It also noted that Dr Stankiewicz provided two expert reports, including a supplemental report following the receipt of further radiographic records. It noted that Dr Stankiewicz's remained largely consistent in that even after having received further records, he stated that *'the OPG in Figure 1 on its own was insufficient to justify the root canal treatment of the lower canines. Whilst the absence of a record of findings and tests does not mean they were not conducted, the radiographic appearance of these teeth alone in my opinion is sufficient to support the allegation.'* The Committee accepted this expert opinion, noting that overall in the expert's evidence and in its review of the details within the clinical notes, there appeared to be no recorded statements that supported the diagnosis for any root canal treatment.

The Committee concluded that it had no reason to contravene the opinion of Dr Stankiewicz and that he was fully capable within his scope of expertise to provide an independent opinion on this issue. The Committee was satisfied that he was credible and reliable, and further noted that in oral evidence he had made it clear when he did not understand or when it fell outside of his remit of expertise. It therefore accepted the opinion of Dr Stankiewicz that Mr Latos' conduct fell far below the standards expected.

The Committee determined that having analysed the evidence provided, that by 1 September 2020 Mr Latos had signed the treatment plan as indicated within the clinical notes as supported by Patient A. Therefore, Mr Latos had a clear responsibility at that point. The Committee determined that the GDC had proved that Mr Latos failed to provide an adequate standard of care to Patient A by not carrying out sufficient pre-treatment investigations. Accordingly, it found this charge proved.

<p>1b</p>	<p><i>not carrying out sufficient treatment planning;</i></p> <p>Found Proved</p> <p>As above, the Committee determined that Mr Latos had the responsibility to provide an adequate standard of care to Patient A as from 1 September 2020, when he signed the treatment plan.</p> <p>The Committee considered the credibility of Patient A. It noted two potential inconsistencies between her oral evidence and her witness statement. One potential inconsistency related to her witness statement that indicated that she had a bridge already which caused her to attend the practice as it was causing pain. In her oral evidence she stated that she had no bridge and that she went to the practice as she was experiencing pain and thought she needed a bridge. Another potential inconsistency was that her original witness statement implied that she had seen both Mr Latos and Person A on her initial visit to the practice, whereas in oral evidence she stated she had only seen Person A until the treatment plan came to be signed. In addition, in oral evidence Patient A indicated that she wanted a decision in this case so that she could 'use it in Poland'. The use was ambiguous, but the inference was that she intended to take action in Poland if the Committee found against Mr Latos.</p> <p>However, despite these minor differences, both of which could be explained by language difficulties and were minor in context, the Committee considered that Patient A had overwhelmingly been consistent with her own and other evidence. For a few examples, Patient A stated her front teeth were breaking after treatment and this was confirmed by the evidence from the dentist she saw after attending the practice of Mr Latos. She also claimed her original problem was not resolved which was consistent with later X-rays. In addition, her evidence was supported by the WhatsApp messages (as translated) including consistency between the WhatsApp messages, Patient A's oral evidence and the later practice X-rays which showed gingivitis. Additionally, Patient A's timings and details of responsibility reflects the clinical notes. In oral evidence Patient A was coherent, transparent and answered all questions asked. Indeed, she admitted when her memory was incomplete. The Committee did not consider that Patient A's reference to her desire for a positive outcome to use in Poland, undermined the veracity of her evidence when considered as above.</p> <p>Overall, the Committee found her to be a credible and reliable witness.</p> <p>Patient A told the Committee that she was not informed of any risks, and was only informed of the post-operative instructions. Patient A in her witness statement also stated that <i>'It was discussed that the bridge on my lower left would be replaced when the new crown was placed, but there was no written treatment plan provided to me at the relevant time'</i>.</p> <p>The Committee accepted Dr Stankiewicz's expert knowledge that <i>'once treatment outcome aims have been identified, sufficient treatment planning would ordinarily include ensuring the patient understands the proposed benefits, the associated risks, the alternatives, and the likely consequences if no</i></p>
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	<p><i>treatment is undertaken</i>'. The Committee noted that Patient A's evidence was that no such discussion took place.</p> <p>The Committee also had regard to the Whatsapp messages between 22/8/21 and 25/9/21 where Patient A referred to ongoing failings. Dr Stankiewicz opined that this showed that Patient A experienced <i>'prolonged pain, temporary and failing restorations, and ongoing functional and aesthetic problem'</i> and that <i>'due to insufficient treatment planning, care was far below the standard expected and resulted in actual harm'</i>. The Committee accepted this opinion.</p> <p>The Committee also noted the evidence of the subsequent treating dentist who saw Patient A shortly after her three years of care at the Practice, and who had noted a diagnosis of ill-fitting crowns, bleeding gums, and poor treatment completion. The subsequent dentist stated that <i>'findings and subsequent treatment are broadly consistent with undiagnosed or unmanaged dental issues'</i>. The Committee accepted Dr Stankiewicz' opinion that <i>'had the Registrant adequately assessed and informed the patient of their dental needs, I think it is likely the Informant would have been aware of the issues earlier and received (or at least been advised of) the treatment required'</i>.</p> <p>The Committee noted that there was a record in the clinical notes of <i>'gingivitis mild'</i> dated 1 September 2020. The Committee however had no evidence before it of a periodontal treatment plan despite reference to a periodontal health issue.</p> <p>The Committee considered that the evidence before it sufficiently proved that Mr Latos failed to carry out sufficient treatment planning and therefore failed to provide an adequate standard of care. The Committee accordingly found this charge proved.</p>
1c	<p><i>your radiographic practice;</i></p> <p>Found Proved</p> <p>As above, the Committee determined that Mr Latos had the responsibility to provide an adequate standard of care to Patient A as from 1 September 2020, when he signed the treatment plan.</p> <p>The Committee had regard to the clinical records, and noted that there appeared to be a lack of justification for x-rays taken of Patient A's mouth. It noted that on 1 September 2020 an OPG radiograph was taken and the justification was noted as <i>'IP caries detection and bone levels'</i>. The Committee noted however that there was no report provided alongside the clinical notes.</p> <p>Dr Stankiewicz opined that there were failures in Mr Latos' radiographic practice. For example, he stated in his report in reference to root canal treatment carried out that <i>'With the caveat that an OPG may be inferior resolution to an intraoral radiograph, in my opinion as a general dentist, the OPG in Figure 1 on its own was insufficient to justify the root canal treatment of the lower canines'</i>.</p>

	<p>Dr Stankiewicz noted that while justification for periapical X-rays taken on 3 and 10 September 2020 was present in the clinical records, it was justified incorrectly.</p> <p>Dr Stankiewicz also noted in his report that in relation to an appointment on 10 September <i>'Although an itemised x-ray has not been documented. It would be expected to take a radiograph after a root filling has been completed to verify the treatment has been done correctly and for monitoring healing.'</i> The Committee noted that there was no such recorded radiograph.</p> <p>Dr Stankiewicz's opinion overall is that X-rays showed inadequate clinical assessment. He opined that these <i>'represent a failure of adequate care related to radiographic practice, either through insufficient use, or inadequate clinical assessment. As such, this failing is far below the standard expected of a reasonable dentist, as it is a significant departure from the standard of care expected.'</i></p> <p>The Committee accepted the opinion and report of Dr Stankiewicz.</p> <p>The Committee therefore concluded that the GDC had discharged its burden of proof that Mr Latos' radiographic practice was flawed, and that this amounted to a failure to provide an adequate standard of care. The Committee therefore found this charge proved.</p>
1d	<p><i>by not discussing the full risks and benefits of the proposed treatment;</i></p> <p>Found Proved</p> <p>As above, the Committee determined that Mr Latos had the responsibility to provide an adequate standard of care to Patient A as from 1 September 2020, when he signed the treatment plan.</p> <p>The Committee had regard to Patient A's witness statement and oral evidence, both of which confirmed that Mr Latos did not discuss the risks of the proposed treatment. The Committee considered that she stated in her oral evidence that the benefits were discussed but that the risks were not mentioned. Patient A's written statement was that <i>'[Person A] nor the Registrant told me that my teeth would die away, or the risk involved, to the extent that when I asked [Person A] if it would be painful, she said absolutely not and that everything would be in order'</i>.</p> <p>The Committee considered the Whatsapp messages provided, and noted that these infer that there was confusion over the risks that could be involved in Patient A's treatment. This included a message from Patient A to Person A dated 20 August 2021 stating <i>'This is not what we agreed on. I've had enough of reassuring me that it will be fine.'</i> The Committee also considered there to be an inference in the Whatsapp messages that Patient A was being informed of the benefits and not the risks as evidenced in Patient A's message dated 26 August 2021 of <i>'I'm fed up with the stories about perfect teeth because what's happening with mine is a nightmare'</i>.</p>

	<p>The Committee accepted the opinion of Dr Stankiewicz that <i>'Patient A's concerns detailed in the WhatsApp transcripts, the seeking of care at another dentist both in the UK and Poland and lodging a complaint with the GDC all support there was inadequate discussion of the full risks of the proposed treatment.'</i></p> <p>The Committee considered whether there were any difficulties caused by language given that Patient A informed the Committee that English was not her first language. However, the Committee heard and noted from the evidence that the correspondence both in person and written was in Polish and therefore on the balance of probabilities was not the cause of communication issues.</p> <p>The Committee took the clinical notes into account. It analysed the records available and noted that there was no record of a discussion of the risks of the proposed treatment during the period of this charge. The Committee noted that the only risks recorded in clinical notes were that of alcohol and smoking, and poor oral hygiene. It was satisfied that there was no evidence of a discussion of risks of the treatment in the clinical notes.</p> <p>The Committee determined that the GDC had discharged its burden of proof that Mr Latos provided an inadequate standard of care in that he failed to discuss the risks of the proposed treatment.</p> <p>The Committee however was not satisfied that he had not discussed the benefits, as Patient's A's consistent evidence was that the benefits of the proposed treatment were presented to her on multiple occasions.</p> <p>The Committee therefore found this charge proved on the basis solely that Mr Latos did not discuss the risks of the proposed treatment.</p>
1e	<p><i>by not diagnosing the need for further treatment.</i></p> <p>Found Proved</p> <p>As above, the Committee determined that Mr Latos had the responsibility to provide an adequate standard of care to Patient A as from 1 September 2020, when he signed the treatment plan.</p> <p>The Committee considered Dr Stankiewicz's expert report and his reference to the assessment of Patient A's teeth by a subsequent Dentist on 5 September 2023, a week after attending Mr Latos' practice. This Dentist recorded the following diagnosis: <i>'failing crowns and bridges, poorly restored teeth, gingivitis caused by ill-fitting restorations (veneers, crowns and bridges).'</i></p> <p>The Committee noted the expert's caveat that <i>'A later diagnosis by another dentist does not establish that the original dentist failed to recognise the condition. Long term problems may have been previously identified and were being monitored, or a stage had not yet been reached at which intervention was indicated or agreed as part of a staged or phased plan.'</i> However, Dr Stankiewicz opined that the Whatsapp messages between Patient A and Person A supported that Patient A had had ongoing issues for a significant period of time that had not been diagnosed or were awaiting</p>

	<p>treatment. Dr Stankiewicz referred specifically to a message dated 13 September 2021 in which Patient A stated <i>‘Do you understand that I have a problem with teeth 3 and 4, and it is not getting any better? Something has been done wrong, and I’m starting to have a problem. I’m tired of delays and postponing; It’s time for a consultation with another dentist. I’m fed up with being treated like an idiot. Please send me all the medical documentation from the entire year.’</i></p> <p>The opinion of Dr Stankiewicz based upon the clinical findings made by the subsequent dentist and alongside Patient A’s messages documenting pain was <i>‘that the need for further treatment had not been adequately diagnosed’</i> and that <i>‘this was a failing far below the standard expected of a reasonable dentist’</i>.</p> <p>The Committee accepted Dr Stankiewicz’s opinion in relation to the evidence and was satisfied that there was sufficient evidence to suggest that Mr Latos had not diagnosed the need for further treatment. The Committee therefore considered that he had failed to provide an adequate standard of care to Patient A and consequently found this charge proved.</p>
2	<p>You provided a poor standard of treatment and care to Patient A, from August 2020 to August 2023.</p> <p>Found Proved</p> <p>For the reasons as above in allegation 1a, the Committee determined that Mr Latos had the responsibility for the standard of treatment care to Patient A as a Registered Manager and Director who knowingly permitted an unregistered Dentist to practise dentistry in his Practice.</p> <p>The Committee therefore next considered whether the treatment and care Mr Latos provided from August 2020 to in or around August 2023 was of a poor standard.</p> <p>The Committee considered the witness statement and oral evidence of Patient A. In her witness statement, Patient A stated that were many issues with the treatment she received including that <i>‘My teeth were still alive during the preparation for the crowns, but the Registrant sanded them down too much and my teeth started dying’</i> and <i>‘the crowns placed by the Registrant have been replaced 3 times since initial placement as they were too big and unsuitable’</i>. She also referred to numerous infections as a result of the care she received, and stated that <i>‘[Person A] and the Registrant’s treatment led to my bones and gums being destroyed’</i>. In oral evidence Patient A confirmed that she was experiencing ongoing issues as a result of the care provided. She also told the Committee that she was not informed of the risks to the treatment.</p> <p>The Committee had regard to the Whatsapp messages sent by Patient A to Person A about the care received at Mr Latos’ practice, and noted multiple messages in which Patient A referred to cancelled appointments, an inability to get in contact with the Practice, and a poor standard of treatment.</p> <p>The Committee also considered the assessment of Patient A’s teeth by the subsequent treating Dentist who diagnosed <i>‘failing crowns and bridges, poorly</i></p>

	<p><i>restored teeth, gingivitis caused by ill-fitting restorations (veneers, crowns and bridges), retained roots, a fractured root at the upper left canine, periapical pathology and bone loss.</i> Dr Stankiewicz’s opinion in relation to this dentist’s assessment was that these issues had not been adequately diagnosed by Mr Latos and this was a <i>‘failing far below the standard expected of a reasonable dentist who failed to listen to their patient, manage their patient’s pain appropriately, and to take a holistic approach to patient care appropriate to an individual patient’</i>. The Committee accepted Dr Stankiewicz’s opinion.</p> <p>The Committee concluded that there was sufficient cogent and credible evidence of a poor standard of treatment and care to Patient A from August 2020 to August 2023. The Committee was satisfied that the GDC had discharged the burden of proof in relation to this allegation. It accordingly found this charge proved.</p>
<p>3</p>	<p><i>You failed to obtain informed consent for the treatment provided to Patient A from August 2020 to August 2023.</i></p> <p>Found Proved</p> <p>For the same reasons as above in allegation 2, the Committee determined that Mr Latos had the responsibility for the treatment and care to Patient A. The Committee considered that there is a professional duty to gain informed consent for any treatment provided to a patient. The Committee therefore was satisfied that Mr Latos had a duty to obtain informed consent from Patient A.</p> <p>Dr Stankiewicz’s expert opinion in relation to the messages was that <i>‘In my opinion, where the Informant refers to “constant new stories and promises” it indicates reassurances to continue with care were being provided rather than clear information about the benefits, risks and alternatives to the proposed treatment. This also supports the allegation that informed consent was not provided as the treatment plan changed.’</i> The Committee considered that this was also supported by Dr Stankiewicz’s oral evidence, in which he explained that discussing risks and benefits and potential outcomes are important when deciding whether valid, informed consent has been received. The Committee therefore accepted Dr Stankiewicz’s expert opinion that while there may have been some evidence of written consent provided through vague references in the clinical notes, the evidence before it suggested that this was neither valid nor informed.</p> <p>Patient A’s witness statement and oral evidence were that Mr Latos at no stage explained the risks of treatment to her. The Committee, having accepted Dr Stankiewicz’s expert opinion, therefore considered that in not knowing about the risks of treatment she could not provide informed consent. In oral evidence, Patient A stated that she was asked to sign forms <u>after</u> treatment. The Committee had regard to Patient A’s witness statement in which she stated that <i>‘Neither [Person A] nor the Registrant told me that my teeth would die away, or the risk involved, to the extent that when I asked [Person A] if it would be painful, she said absolutely not and that everything would be in order’</i>.</p> <p>The Committee also noted the WhatsApp messages between Patient A and Person A relating to her treatment. It noted that Patient A was unhappy with her</p>

	<p>treatment and stated in a WhatsApp message dated 20 August 2021 <i>'This is not what we agreed on. I've had enough of reassuring me that it will be fine.'</i> The Committee considered that this evidence suggested that Patient A had not given informed consent in that she was not treated in the manner agreed.</p> <p>Having already found proved that Mr Latos did not discuss the risks to the treatment he provided, the Committee considered the evidence around informed consent. It concluded that this includes understanding the risks involved in treatment, alternative treatments and other such matters. The Committee noted the expert opinion and the clinical notes agreed with Patient A's evidence, and concluded that Mr Latos failed to obtain informed consent for the treatment provided to Patient A. It accordingly found this charge proved.</p>
4	<p><i>From 14 June 2024 to 8 April 2025, you failed to co-operate with investigations conducted by the GDC by not providing the GDC with any or insufficient evidence of:</i></p>
4a	<p><i>Indemnity and/or,</i></p> <p>Found Proved</p> <p>The Committee firstly considered that there is a duty upon registrants to co-operate with investigations conducted by the GDC, as set out in the standards for Dental Professionals (standard 9.4).</p> <p>The Committee also noted that an indemnity certificate from 2022 had been provided to it, however this had been retained as part of another case examiners investigation, which did not result in a finding of misconduct, and was not directly related to the investigation of these matters.</p> <p>The Committee noted from the evidence that the GDC made at least 8 distinct attempts between June 2024 and April 2025 to contact Mr Latos by phone, email, and post. It bore in mind that some days, multiple methods had been used but that there was no evidence that Mr Latos cooperated by responding and providing his indemnity.</p> <p>The Committee considered the witness statement and associated exhibits of Iyaz Ausaluth in which he provided evidence that the only response received to the GDC's attempts to contact Mr Latos about this matter was in an email received on 3 October 2024 in which he stated <i>'Hello could you specify which concerns do you have in mind ??'</i>. The Committee was satisfied that Mr Latos had therefore received and acknowledged the emails requesting information, but that there was no evidence of him providing this.</p> <p>The Committee accepted the advice of Dr Stankiewicz in which he stated that <i>'GDC registrants are required to hold appropriate indemnity insurance and to be able to demonstrate that it exists... Although failing to provide evidence is not the same as lacking indemnity failure to comply with this requirement constitutes a breach of the Act... Such a breach may be treated as misconduct... This conduct therefore in my opinion falls below the standard expected of a reasonable registrant, as it is a breach of both GDC standards and the law.'</i></p>

	<p>The Committee considered that there was no evidence that Mr Latos had provided evidence of his indemnity when requested for these charges. It therefore concluded that he had failed to co-operate with the GDC investigation and accordingly found this charge proved.</p>
4b	<p><i>Employment information.</i></p> <p>Found Proved</p> <p>The Committee, as above, considered that a registrant has a duty to co-operate with investigations conducted by the GDC as per standard 9.4.</p> <p>The Committee noted that Mr Latos was sent a letter on 31 July 2024 which included the following request- <i>'We need to know where you are currently working and where you were working at the time that the events occurred. We may contact your employers to request further information about you and ask if there are any other issues for us to consider.'</i> Attached to this letter was an information request form. The Committee was satisfied that a clear attempt had been made to Mr Latos to provide the details of his employment. It also noted that there were further requests across 8 distinct occasions, but that there was no evidence of him providing this information.</p> <p>The Committee considered that while Mr Latos had not made formal admissions in this case, he made a statement in an email dated 12 June 2026 that <i>'The only matter I acknowledge is that I did not provide details of my current employment during 2024 and 2025. However, my present employment is entirely outside the jurisdiction, regulatory authority, and legitimate remit of the General Dental Council. I am under no legal duty to disclose information concerning employment that bears no relevance to any current registration, practice, or regulatory function within the United Kingdom.'</i> The Committee was satisfied that Mr Latos himself had accepted that he did not provide the required information when requested.</p> <p>The Committee accepted the advice of Dr Stankiewicz in which he stated that <i>'In my opinion, if the Registrant failed, without reasonable excuse, to provide the requested information, this would constitute a failure to cooperate with a lawful regulatory request, contrary to the law and GDC standards'</i> and concluded in his report that this fell far below the standard expected of a reasonable registrant.</p> <p>The Committee determined that there was no evidence that suggested Mr Latos had provided evidence of his employment to the GDC when requested and it was therefore satisfied that he had failed to co-operate with the GDC investigation. The Committee consequently found this charge proved.</p>

68. We move to stage two.

69. Following its announcement of its decision on the facts, the hearing moved to Stage 2. At Stage 2, the Committee considered whether the facts found proved amounted to misconduct and, if so, whether Mr Latos' fitness to practise is currently impaired by reason of his

misconduct. If it found that Mr Latos' fitness to practise is impaired, it would consider what sanction, if any, should be imposed.

Submissions

70. Mr Micklewright first addressed the Committee in respect of Mr Latos' fitness to practise (FtP) history, and stated that the GDC Case Examiners had previously considered matters in relation to Mr Latos' conduct in 2023. He submitted that while no misconduct had been referred to a Professional Conduct Committee for these matters, the Case Examiners had established that there was a real prospect of all the factual allegations being found proved and advice was provided to Mr Latos from the Case Examiners in relation to his clinical practice. Mr Micklewright told the Committee that the previous matters were relevant despite no positive finding as it was related to similar conduct, and therefore he would refer to these previous matters throughout his submissions on misconduct, impairment, and sanction.
71. With regard to misconduct, Mr Micklewright referred the Committee to the relevant case law, the test for finding misconduct, and the GDC's *Standards for the Dental Team (2013)*.
72. Mr Micklewright submitted that the facts found proved all amount to serious professional misconduct. He submitted that the conduct was serious, having taken place over a lengthy period including three months of direct care and not carrying out sufficient pre-treatment investigations, not carrying out sufficient treatment planning, issues with radiographic practice, by not discussing the full risks and benefits of the proposed treatment, and by not diagnosing the need for further treatment. Mr Micklewright also submitted that the committee's finding that Mr Latos bore broader responsibility when Person A treated Patient A in 2020 and between 2021-2023, constituted serious misconduct.
73. Mr Micklewright submitted that there was evidence of actual harm to Patient A. He submitted that she had to seek additional treatment following issues from her initial treatment at the Practice and there was emotional impact on Patient A evident from the WhatsApp messages provided and her oral and written evidence.
74. Mr Micklewright also submitted that Dr Stankiewicz had deemed the conduct of Mr Latos to fall far below the standard expected of a registered dentist.
75. In relation to charge 4 that the Committee had found proved, Mr Micklewright submitted that there was an expectation for registered professionals to cooperate with any investigation by their regulator. He submitted that during the previous FtP matter in 2023, Mr Latos had been asked to cooperate and had done so. He therefore submitted that Mr Latos knew that there was an expectation to cooperate with a regulatory investigation and that he had made the choice not to.
76. Mr Micklewright submitted that the matters proved were serious, and therefore submitted that Mr Latos' conduct can be properly judged as serious misconduct.
77. Mr Micklewright next dealt with the issue of current impairment. He referred to the relevant case law, and submitted that impairment can be considered in two parts: the public protection component and the public interest component.
78. Mr Micklewright submitted that in considering whether Mr Latos is currently impaired, it must consider whether the conduct is remediable, whether it has been remedied, and the likelihood of repetition. He submitted that the facts found proved related to clinical skills and

communication with the GDC, both of which were remediable. Mr Micklewright submitted however that there was no evidence of remediation, and therefore the conduct was likely to be repeated, especially given the previous fitness to practise history.

79. Mr Micklewright submitted that impairment could be found on both grounds in this matter. He referred in his submissions to the three factors as above. In respect of public protection, Mr Micklewright submitted that Mr Latos' conduct appeared to be a flawed manner and approach to practising as a dentist. He submitted that Mr Latos had provided no evidence of remediation or Continued Professional Development (CPD), suggesting that there was no evidence of a change in his manner. Mr Micklewright also submitted that there was no evidence of insight on Mr Latos' part, including in relation to why he believed that he did not need to cooperate with the GDC such as telling them about his employment. Mr Micklewright drew the Committee to the previous FtP matters and submitted that these were relevant to the matter of insight, in that whilst these did not amount to serious professional misconduct, there were criticisms of a similar nature to those found proved at this hearing. Mr Micklewright submitted that Mr Latos was provided with advice after the previous matters (dated 29 April 2024), which was some time before the matters at this hearing. He submitted that one would reasonably expect that this advice would impact Mr Latos' response to the matters at this hearing given that the Case Examiners had expressed concerns relating to the lack of insight and CPD into the previous FtP matters. Given that Mr Latos has not sought a better approach, Mr Micklewright submitted that there was an ongoing lack of insight and attitudinal problem which increased the risk of repetition of similar conduct. Mr Micklewright therefore submitted that there was a public protection risk given the repetition of the conduct and the risk of further repetition should no finding of impairment be made.
80. Mr Micklewright submitted that a finding of impairment could also be made in respect of the public interest. He submitted that Mr Latos had conducted extensive restorative treatment without valid consent and had not communicated with his regulator in its investigations. He submitted that a member of the public would be shocked by these facts found proved and that a finding of impairment was required to maintain the public confidence in the dental profession given such serious matters.
81. Mr Micklewright lastly addressed the Committee on the matter of sanction. He submitted that the Committee must consider proportionality and consider the range of sanctions available to it. Mr Micklewright submitted that there was a vague suggestion of financial and personal impact on Mr Latos from the correspondence he had provided for the Committee to consider at this stage of the proceedings, however he also noted that Mr Latos had stated his intentions on several occasions and that he no longer wished to work with and be registered with the GDC.
82. Mr Micklewright submitted that there were limited mitigating factors that the Committee could consider. He submitted that the only factor it may consider is Mr Latos' previous good character, in that no finding of serious professional misconduct had been made by the Case Examiners in their assessment of his previous conduct.
83. Mr Micklewright submitted however that there were three clear aggravating factors to be considered. These were that there was evidence of actual harm to Patient A, Mr Latos had shown a blatant and wilful disregard of the role of the GDC and the systems regulating the profession, and there was a lack of insight into his conduct. Mr Micklewright submitted that the Committee may also find that the misconduct whilst relating to one patient, it was sustained over a significant period of time. He also submitted that the Committee may consider that Mr Latos' employment of an unregistered person in a dental capacity is an aggravating feature.

84. Mr Micklewright submitted that the facts found proved in this case did not fall at the lower end of the scale of seriousness, Mr Latos had provided no insight, the behaviour was not an isolated incident, the behaviour could not be judged as not deliberate, he had not expressed any genuine remorse, and there was no evidence of rehabilitative steps taken. Mr Micklewright therefore submitted that a reprimand was not suitable.
85. Mr Micklewright submitted that the sort of conduct in this case could be managed by a sanction of conditions. However, due to Mr Latos' lack of insight and remediation, the suggestion of an attitudinal problem, and statements that he no longer wants to be registered with the GDC, conditions would be both unworkable and inappropriate.
86. Mr Micklewright submitted that a sanction of suspension was also not appropriate as there was evidence of a harmful deep-seated personality and professional attitudinal problems, and that the matters were so serious that a lesser sanction would be insufficient to meet the public interest.
87. Mr Micklewright therefore submitted that erasure was the only appropriate sanction to meet the public interest and to protect the public. His reasons were that Mr Latos has shown no insight into his misconduct, he has stated he wished to be voluntarily removed from the GDC register, and has had, and continues to have, no regard to the GDC as a regulator. Mr Micklewright submitted that Mr Latos had shown a greater degree of cooperation with the GDC at the previous FtP investigation than this one, suggesting that his behaviour is worsening. These factors suggest a fundamental incompatibility with continued registration, and therefore erasure was the appropriate sanction to impose. Mr Micklewright submitted that the Committee may note the potential impact this may have on Mr Latos and his ability to earn a living, however it must be viewed in the context that Mr Latos has requested voluntary removal on multiple occasions.

Committee's Decision

88. The Committee has borne in mind that its decisions on misconduct, impairment and sanction are 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 document, *'Fitness to Practise: Guidance for the practice committees' (6 January 2026)* (the Guidance) and the relevant case law. The Committee also received advice from the Legal Adviser which it accepted.

Misconduct

89. The Committee first considered whether the facts found proved amounted to misconduct. In doing so, the Committee had regard to the GDC's publication, Standards for the dental team (September 2013).
90. The Committee considered that the matters were serious in that actual harm was caused to Patient A and she suffered considerable pain which still continues today, three years later. Additionally, Mr Latos deliberately chose not to cooperate with the GDC and he had the broad responsibility of allowing an unregistered and erased former dentist to carry out treatment on Patient A. The Committee considered that this conduct was seriously reprehensible and particularly egregious, and that the significant period of time of this conduct (over 6 months with the consequences still ongoing) also increased the level of seriousness. The Committee

considered that the Whatsapp messages highlighted Patient A's pain and the lack of response nor remedial help, and that this fell far below the standards.

91. It considered that Mr Latos' failure to inform Patient A of the risks of treatment created a real imbalance in her information and knowledge of the treatment she received. It also considered that the ignoring of Patient A's initial issue in favour of providing a 'Hollywood smile' prioritised cosmetics over health and function which further increases the seriousness of the conduct. The Committee considered that cooperating with the GDC is a fundamental requirement of a registered professional as it enables the GDC to fulfil its statutory engagement. The Committee therefore concluded Mr Latos' conduct was serious and had breached the fundamental standards of dentistry.

92. The Committee determined that Mr Latos had breached the following standards:

- 1.3 *Be honest and act with integrity* (in relation to the overall manner in which Patient A's care was conducted and in Mr Latos' dealings with the GDC).
- 1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation.
- 1.7 Put patients' interests before your own or those of any colleague, business or organisation.
- 1.7.1 You must always put your patients' interests before any financial, personal or other gain.
- 1.7.6 When you are referring patients to another member of the dental team, you must make sure that the referral is made in the patients' best interests rather than for your own, or another team member's, financial gain or benefit.
- 2.3 Give patients the information they need, in a way they can understand, so that they can make informed decisions.
- 2.3.6 You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.
- 2.3.11 You should provide patients with clear information about any referral arrangements related to their treatment (considering his referral back to Person A who was unregistered)
- 3.1 Obtain valid consent before starting treatment explaining all the relevant options and the possible costs.
- 3.2 Make sure that patients (or their representatives) understand the decisions they are being asked to make.
- 3.3 Make sure that the patient's consent remains valid at each stage of investigation or treatment.
- 3.3.2 When carrying out an on-going course of treatment, you must make sure you have specific consent for what you are going to do during that appointment.
- 3.3.4 You must document the discussions you have with patients in the process of confirming their ongoing consent.
- 6.2.2 You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting.
- 6.3 Delegate and refer appropriately and effectively.

- 6.3.1 You can delegate the responsibility for a task but not the accountability. This means that, although you can ask someone to carry out a task for you, you could still be held accountable if something goes wrong. You should only delegate or refer to another member of the team if you are confident that they have been trained and are both competent and indemnified to do what you are asking. For more information, see the 'Scope of Practice' document.
- 6.6.2 You should make sure that relevant team members are appropriately registered with the GDC or another healthcare regulator, appropriately in-training to be registered with the GDC or another healthcare regulator and that those who are registered with the GDC are also indemnified.
- 7.1 You must provide good quality care based on current evidence and authoritative guidance.
- 9.4 Co-operate with any relevant formal or informal inquiry and give full and truthful information.

93. As a result of the breaches of the standards identified and the seriousness of the conduct in the facts found proved, the Committee determined that the facts found proved amounted to misconduct.

Impairment

94. The Committee next considered whether Mr Latos' fitness to practise is currently impaired by reason of his misconduct on the grounds of the protection of patients and/or is in the wider public interest.
95. The Committee first considered whether Mr Latos was impaired on the grounds of public protection. It considered that there was a lack of evidence of insight and remedial action taken by Mr Latos in relation to his conduct. It also considered that there was no evidence of a change to his manner of practise such as by CPD. The Committee considered that the conduct in this case could have been remedied, as it was primarily based on clinical failings, but that there was no evidence of Mr Latos having done any work to do so. The Committee therefore considered that there was a high risk of reoccurrence which posed a risk of unwarranted harm to the public. In addition, the Committee noted that Mr Latos had not responded to the words of advice given by the previous Case Examiners, and as such, this suggested that it was unlikely that he would change his practises in the future.
96. The Committee also considered that Mr Latos' conduct suggested an attitudinal problem. His correspondence with the GDC in both 2023 and 2026 showed a disregard of it's responsibility and disrespect to it's key role as regulator. It also considered that his failure to respond, apologise, or show remorse for the consequences of his treatment to Patient A, demonstrates an attitudinal lack of care for patient safety. The Committee therefore considered that Mr Latos had breached the fundamental tenets of the dental profession in his conduct which posed a risk of harm to the public and showed an attitudinal problem around his care and concerns for patients, and therefore determined that his fitness to practise is currently impaired on public protection grounds.
97. In relation to the public interest, the Committee considered that Mr Latos' actions were wholly deplorable and had brought the profession into disrepute. It considered that he had shown a

lack of appreciation for the role of his regulator, and serious actual harm was caused to Patient A. The Committee considered that a member of the public would be shocked considering the serious and ongoing harm to Patient A, the lack of evidence of insight, the lack of evidence of remorse, and the lack of engagement with his regulator. The Committee considered that a finding of impairment was necessary to maintain public trust and confidence in the profession and to uphold the standards expected of a dental professional.

98. Accordingly, the Committee determined that Mr Latos' fitness to practise is currently impaired by reason of his misconduct on the grounds of the protection of the public and the public interest.

Sanction

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

100. The Committee considered the mitigating and aggravating factors in this case and took into consideration the relevant paragraphs in the GDC's Guidance on these matters.

101. The mitigating factors in this case were that:

- There was evidence of relative good character in that no finding of misconduct was made at the previous FtP investigation;
- Mr Latos did have indemnity insurance during some of the relevant period as he provided this to the GDC in 2024 in respect of the previous investigation;
- He accepted, without making a formal admission, that he did not provide information around his employment to the GDC when requested. Additionally, he had stated a specific reason for his failure to provide the information;
- He has engaged with the process, to a limited extent by sending an email dated 12 June 2026 with his broad defence.

102. The aggravating factors in this case were that:

- Mr Latos was previously investigated for similar allegations which led to advice being issued;
- Actual and ongoing serious harm was caused to Patient A;
- There was financial gain by Mr Latos, particularly of significance was the fact that he had focused on the '*Hollywood Smile*' cosmetic work and failed to provide basic dental care and essential treatment required for Patient A's needs;
- Mr Latos showed a blatant and wilful disregard of the role of the GDC and the systems regulating the profession by not engaging with its investigation;
- The misconduct was sustained over a significant period of time;
- There was a complete lack of evidence of insight, remorse, and remediation provided.

103. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest nor protect the public sufficiently given the serious harm caused to Patient A over a lengthy period of time, the serious matter of not gaining informed consent, and for ignoring the GDC as his regulator.

104. The Committee considered a sanction of a reprimand; however it determined that this would be insufficient to address the findings for the same reasons as above.
105. The Committee next considered a sanction of conditions. The Committee reminded itself that conditions were only suitable when it could be confident that a registrant would comply and that they were workable. It noted that the facts found proved ostensibly look like failings that would suit a sanction of conditions as the clinical failings and failure to engage with the GDC are easily remediated. However, it noted that Mr Latos was unlikely to comply with conditions given his lack of insight and remorse into the conduct and the fact that he did not follow the advice provided by the previous FtP investigation. Mr Latos is currently living abroad and has stated on multiple occasions that he no longer wishes to be registered with the GDC. It also considered that there was evidence of an attitudinal issue in the lack of evidence around his remorse or appreciation of the impact upon, pain, and distress he had caused Patient A. In addition, his attitudinal refusal to engage with the GDC's investigation and process was serious. Therefore, the Committee determined that conditions would neither protect the public nor satisfy the public interest.
106. The Committee considered whether a sanction of suspension would be appropriate and proportionate. However, the Committee considered that there was a significant lack of insight and remorse demonstrated, and that there was no evidence, considering his attitudinal issues, that any period of suspension would be effective to change his behaviours. It determined that there was no timeframe in which it was suggested that Mr Latos may change and improve his practice and attitude towards the GDC. The Committee considered the seriousness of the harm to Patient A, the risk of repetition of this harm, the lack of insight, lack of CPD, lack of apology to Patient A, and therefore what appeared to be a serious attitudinal problem, suggested a real risk to the public and there was no evidence that a suspension would change anything. It considered that in the public interest, if a member of the public knew all of the facts, they would not be satisfied with a sanction of suspension given that there was no suggestion that Mr Latos would change his practice and attitude.
107. In all the circumstances, the Committee determined that the only appropriate and proportionate sanction in this case is one of erasure. Mr Latos' deep seated attitudinal problems and his failure to engage meaningfully with the GDC's process combined with the clinical failings, and lack of insight and remediation, represents conduct that is fundamentally incompatible with continued registration. It noted that his conduct was a serious departure from a number of the relevant professional standards, there is serious actual harm to Patient A which is ongoing despite the length of time that has passed since his involvement in her dental care, and there is a persistent lack of insight into the seriousness of his actions and their consequences. The Committee considered that an erasure was therefore necessary for the protection of the public and a lesser sanction would be insufficient to meet the public interest.
108. The two interim orders of suspension currently in place on Mr Latos' registration are hereby revoked, given the sanction imposed at this hearing.
109. Unless Mr Latos exercises his right of appeal, his name will be erased from the Dental Register, 28 days from the date that notice of this Committee's determination is deemed to have been served upon him.
110. The Committee next invited submissions from Mr Micklewright, as to whether an immediate order of suspension should be imposed on Mr Latos' registration to cover the 28-day appeal period, pending the taking effect of its substantive direction for suspension.

Decision on an immediate order

111. The final stage at this hearing was to consider whether an immediate order should be placed upon your registration.
112. Mr Micklewright made an application for an immediate suspension order to be imposed on Mr Latos' registration under Section 30 of the Dentists Act 1984. He submitted that an immediate order for suspension is necessary for the protection of the public and is otherwise in the public interest. Mr Micklewright submitted that if Mr Latos were to appeal the order of erasure, there would be a significant period of time in which Mr Latos was under no interim order nor substantive order, and that the public need to be adequately protected during this period.
113. Mr Micklewright submitted that the Committee had determined that there was a high risk of reoccurrence and that Mr Latos had a serious attitudinal problem. Mr Micklewright submitted that the Committee had therefore determined that there was no prospect of even a period of suspension that would mean Mr Latos would change his attitude to the GDC and its processes, and to the way he treats patients. Mr Micklewright therefore submitted that there plainly continues to be a fear of harm to the public should no immediate order be imposed.
114. Mr Micklewright also submitted that the findings of serious impairment means that an order is necessary and appropriate in the public interest for the reasons as set out by the Committee earlier in their determination.
115. The Committee accepted the advice of the Legal Adviser, who drew its attention to the relevant guidance contained in the GDC's Fitness to Practise: Guidance for the practice committees (January 2026).
116. The Committee considered that an order is necessary to protect the public, given the serious misconduct relating to the harm of Patient A, a serious attitudinal issue in relation to the poor treatment provided, an attitudinal issue leading to non-compliance with the GDC, and a high likelihood of repetition of the conduct. Given these serious findings, the Committee considered that an immediate order was necessary to protect the public from any further potential harm before the direction for erasure comes into force.
117. The Committee also determined that the imposition of an immediate order of suspension on Mr Latos' registration is otherwise in the public interest. It considered that the nature of his conduct was serious as detailed in the final determination. The Committee determined that immediate action would be necessary and proportionate and therefore imposed an immediate order of suspension in order to maintain the public's confidence in the dental profession and its regulator.
118. The effect of this immediate order is that Mr Latos' registration is suspended. Unless he exercises his right of appeal, the substantive direction of erasure will replace the immediate suspension upon the expiry of the 28-day appeal period. Should he exercise his right of appeal, this immediate order shall remain in force pending the resolution of the appeal.
119. That concludes this determination.

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