HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

2 to 10 and 15 September 2025
16 to 24 July 2026

Name:	SIKANDER, Waqas
Registration number:	249351
Case number:	CAS-201610

General Dental Council:	Natasha Tahta, Counsel Instructed by Clare Hastie, Kingsley Napley
Registrant:	Present Represented by Simon Cridland, Counsel Instructed by Lily Lloyd, MDDUS

Fitness to practise:	Deficient professional performance not found Impaired by reason of misconduct
Outcome:	Conditions imposed with immediate conditions (with a review)
Duration:	12 Months
Immediate order:	Immediate conditions of practice order

Committee members:	Val Evans	(Chair, Lay Member)
	Katarzyna Richards	(Dental Care Professional Member)
	Vatsal Amin	(Dentist Member)
Legal Adviser:	Trevor Jones	
Committee Secretary:	Gareth Llewellyn (September 2025) Lola Bird (July 2026)	

Determination on preliminary matters – 4 September 2025

Mr Sikander

1. This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held remotely using Microsoft Teams in line with the Dental Professionals Hearings Service's current practice.

2. You are present and are represented by Simon Cridland of counsel, instructed by Lily Lloyd of the Medical and Dental Defence Union of Scotland (MDDUS). Natasha Tahta of counsel, instructed by Clare Hastie of Kingsley Napley solicitors, appears for the GDC.

Adjournments

3. The hearing commenced on 2 September 2025. On that day parties addressed the Committee concerning delays with starting the hearing. The Committee determined that it would be appropriate and fair to adjourn the hearing until the afternoon of 3 September 2025.

4. Upon resuming on the afternoon of 3 September 2025 Ms Tahta asked for further time to prepare the GDC's case following the disclosure of the report of your expert witness, and the outcome of a meeting between the GDC's expert witness and your expert witness. Mr Cridland did not oppose Ms Tahta's application. The Committee acceded to the application, and determined to adjourn the hearing until the morning of 4 September 2025.

5. The hearing resumed at midday on 4 September 2025, and the preliminary matters set out below were addressed.

The charge

6. The charge that you face at this hearing, amended as referred to below, reads as follows:

"That being registered as a dentist, your fitness to practice is impaired by reason of misconduct and/or deficient professional performance. In that:

Patient A

1. *You failed to maintain an adequate standard of care in that you provided patient A with treatment that was not clinically indicated on 22 October 2021, namely a filling at the UR6.*
2. *You failed to maintain an adequate standard of radiographic record keeping in that you made an inaccurate report on the radiograph taken of Patient A on 1 October 2021.*
3. *You failed to obtain informed consent from Patient A to the filling at the UR6 on 22 October 2021.*

Patient B

4. *You failed to maintain an adequate standard of care in that you failed to take bitewing radiographs of Patient B between 19 March 2020 and 22 October 2021.*
5. [withdrawn]

Patient C

6. *You failed to maintain an adequate standard of care in that you provided patient C with treatment that was not clinically indicated on 26 November 2021, namely a filling at the UL7*
7. *You failed to maintain an adequate standard of radiographic record keeping in that you made an inaccurate report on the radiograph taken of Patient C on 22 October 2021.*
8. *You failed to obtain informed consent from Patient C to a filling at the UL7 on 26 November 2021.*

Patient E

9. *You failed to maintain an adequate standard of care in that you provided patient E with treatment that was not clinically indicated on 3 November 2021, namely a filling at the LL7.*
10. *You failed to obtain informed consent from Patient E to a filling at the LL7 on 3 November 2021.*

Patient G

11. *You failed to provide an adequate standard of care to Patient G in that you:*
    a. *failed to carry out percussion testing of the LL1, LL2 and/or LR1 on 18 June 2021;*
    b. *commenced root canal treatment to the LR1 instead of the LR2 on 8 July 2021;*
    c. *provided a poor standard of treatment to the LR1 on 8 July 2021;*
    d. *failed to adequately diagnose the source of infection between 18 June 2021 and 16 July 2021;*
12. *You failed to maintain an adequate standard of record keeping in that you failed to make a record of treatment that you carried out to the LR1 on 8 July 2021.*
13. *You failed to maintain an adequate standard of radiographic record keeping in that you failed to record that the radiograph taken on 18 June 2021 showed periapical pathology at the LR1, LL1 and/or LL2.*
14. [withdrawn].

Patient H

15. *You failed to maintain an adequate standard of care in that you:*
    a. *provided patient H with treatment that was not clinically indicated on 15 August 2019, namely a filling at the UR6;*
    b. *failed to diagnose caries at the LR7 between 24 May 2017 and 18 August 2017;*
16. *You failed to obtain informed consent from Patient H to a filling at the UR6 on 15 August 2019.*

Patients 1 – 28 and A – H

17. *You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:*
    a. *Failed to record adequate details of extra-oral examinations for the patients and appointments at Schedule 1.*
    b. *Failed to record the assessment of dietary factors for the patients and appointments at Schedule 2.*
    c. *Failed to record the clinical appearance of caries at the UR6 in patient B on 19 March 2020;*
    d. *Failed to record the clinical appearance of caries at the LL6 in patient B between 27 August 2021 and 22 October 2021;*
    e. *Failed to record the clinical appearance of caries at the UL7 in patient C on 22 October 2021;*
    f. *Failed to record the clinical appearance of caries at the UL8 in patient C on 22 October 2021;*
    g. *Failed to record the clinical appearance of caries at the LL7 in patient E between 20 September 2021 and 3 November 2021;*
    h. *Recorded an inaccurate mouth cancer risk factor for patient 2 on 23.11.21;*
    i. *Recorded an inaccurate mouth cancer risk factor for patient 3 on 11.05.21;*
    j. *Recorded an inaccurate mouth cancer risk factor for patient 9 on 11.11.21;*
    k. *Recorded an inaccurate mouth cancer risk factor for patient 13 on:*
        i. *28 June 2022;*
        ii. *6 December 2022;*
    l. *Recorded an inaccurate mouth cancer risk factor for patient 14 on:*
        i. *10 June 2022;*
        ii. *18 January 2023*
    m. *Recorded an inaccurate mouth cancer risk factor for patient 18 on 26 May 2022;*
    n. *Failed to record a Basic Periodontal Examination ("BPE") for:*
        i. *Patient 1 on 03.03.20*
        ii. *Patient 7 on 14.12.21*
        iii. *Patient 8 on 04.05.21*
        iv. *Patient 10 on 19.05.21*
        v. [withdrawn]
        vi. *Patient 17 on 30.06.22*
        vii. [withdrawn]
        viii. *Patient 24 on 05.06.17*
        ix. [withdrawn]
        x. [withdrawn]
    o. [withdrawn]

i. [withdrawn]

ii. [withdrawn]

p. *Failed to record any dietary advice given to:*

i. *Patient 11 on 24.01.23;*

ii. *Patient 12 on 01.07.22;*

iii. *Patient 17 on 30.06.22;*

iv. *Patient 28 on 23.07.21;*

v. *Patient 28 on 11.03.22;*

18. [intentionally omitted]

19. [withdrawn]

20. *You failed to maintain an adequate standard of radiographic record keeping in that you failed to record that the radiograph taken of patient 22 on 11 December 2018 showed widening of the periodontal ligament in the distal root of the LL6*

21. *You failed to provide an adequate standard of care to patient 22 between 11 December 2018 and 13 February 2019 in that you crowned the LL6 without offering root canal treatment.*

22. *Between 30 September 2022 and 22 November 2022 you failed to inform NHS England of the conditions imposed by the General Dental Council ("GDC") on your registration.*

23. *Between 16 August 2023 and 10 October 2023 you failed to inform NHS England of the amended conditions imposed by the General Dental Council ("GDC") on your registration.*

24. *Your conduct at 22 and/or 23 above was:*

a. *misleading;*

b. *dishonest."*

Schedules to the charge

Schedule 1

Patient	Date
A	01.10.21
B	19.03.20
B	27.08.21
C	17.01.20
C	22.10.21
D	15.09.20
D	16.03.21
D	06.10.21
E	31.08.21
F	22.10.20
F	03.06.21
H	07.06.17
H	06.06.18
H	23.11.18
H	15.08.19
H	28.02.20

H	11.06.21
H	25.01.22
1	14.06.17
1	24.11.17
1	02.05.19
1	03.03.20
1	11.05.21
1	23.11.21
2	05.05.21
2	23.11.21
3	13.06.19
3	11.05.21
4	20.03.17
4	28.09.17
4	07.03.18
4	07.09.18
4	27.09.19
4	25.05.21
5	20.05.21
6	11.10.17
6	26.04.19
6	16.12.20
7	06.05.21
7	14.12.21
8	08.05.19
8	04.05.21
9	01.10.20
9	03.03.21
9	11.11.21
10	08.11.18
10	29.05.19
10	19.11.19
10	19.05.21
10	04.11.21
10	14.04.22
11	01.07.22
11	24.01.23
12	01.07.22
13	28.06.22
13	06.12.22
14	10.06.22
14	18.01.23
15	16.06.22
15	05.01.23
16	30.06.22
17	30.06.22
18	26.05.22
19	28.06.22
20	09.06.22
21	15.02.22
22	11.12.18

22	15.11.19
22	20.05.21
22	23.11.21
22	18.05.22
23	21.09.17
23	06.06.22
24	05.06.17
24	01.06.21
24	06.06.22
25	27.04.18
25	25.10.18
25	24.04.19
25	29.11.19
25	09.02.21
25	25.05.21
25	06.06.22
26	06.05.21
26	09.11.21
26	15.02.22
28	23.07.21
28	11.03.22

Schedule 2

Patient	Date
A	01.10.21
B	19.03.20
B	27.08.21
C	17.01.20
C	22.10.21
D	15.09.20
D	16.03.21
D	06.10.21
E	31.08.21
F	22.10.20
F	03.06.21
H	07.06.17
H	06.06.18
H	23.11.18
H	15.08.19
H	28.02.20
H	11.06.21
H	25.01.22
1	14.06.17
1	24.11.17
1	02.05.19
1	03.03.20
1	11.05.21
1	23.11.21
2	05.05.21

2	23.11.21
3	13.06.19
3	11.05.21
4	20.03.17
4	28.09.17
4	07.03.18
4	07.09.18
4	27.09.19
4	25.05.21
5	20.05.21
6	11.10.17
6	26.04.19
6	16.12.20
7	06.05.21
7	14.12.21
8	08.05.19
8	04.05.21
9	01.10.20
9	03.03.21
9	11.11.21
10	08.11.18
10	29.05.19
10	19.11.19
10	19.05.21
10	04.11.21
10	14.04.22
11	24.01.23
13	28.06.22
13	06.12.22
14	10.06.22
14	18.01.23
15	16.06.22
15	05.01.23
16	30.06.22
18	26.05.22
19	28.06.22
20	09.06.22
21	15.02.22
22	11.12.18
22	15.11.19
22	20.05.21
22	23.11.21
22	18.05.22
23	21.09.17
23	06.06.22
24	05.06.17
24	01.06.21
24	06.06.22
25	27.04.18
25	25.10.18
25	24.04.19

25	29.11.19
25	09.02.21
25	25.05.21
25	06.06.22
26	06.05.21
26	09.11.21
26	15.02.22

Application to add further allegations and to amend and withdraw allegations

7. On 4 September 2025 Ms Tahta applied to add further heads of charge to those that you already face pursuant to Rule 25 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). The new proposed charges relate to your standard of care towards Patient H, the standard of your record-keeping concerning Patients 13 and 14, and whether you informed NHS England about amended GDC conditions in place on your registration. Ms Tahta did not proceed with an application to add a further head of charge in relation to Patient 18, although parties agreed that the revised numbering that would have arisen had that new allegation been added should be retained for the avoidance of further confusion.

8. Ms Tahta also applied to amend and withdraw other heads of charge in accordance with Rule 18, more particularly to withdraw heads of charge 5 and 18 as numbered and set out in the notice of hearing. In addition to these proposed withdrawals Ms Tahta applied to amend the some of the words at head of charge 11 (d), so that the words, '*the source of infection'* are replaced with the words, *'that the LL1 and/or LL2 were sources of infection'.*

9. Mr Cridland on your behalf did not oppose the applications, although he did oppose Ms Tahta's application under Rule 18 to amend the wording of head of charge 11 (d) on the basis that it amounts to a significant change in what is being alleged.

10. The Committee, having accepted the advice of the Legal Adviser, determined to accede to the unopposed application made under Rule 25 on the basis that it was fair and appropriate for the new allegations to be joined to the existing allegations. The Committee notes that the new allegations are founded on the same alleged facts, are of a similar kind, have not yet been heard and that you have, of course, been referred to the PCC. The new heads and sub-heads of charge that were joined to the existing allegations are those set out above at 15 (b), 17 (k) (ii), 17 (l) (ii), 23, and 24 in respect of references to head of charge 23. As stated above, although the GDC did not proceed with an application to add a further head of charge in relation to Patient 18, the numbering that would have applied to that head of charge, namely head of charge 18, has been retained to minimise confusion.

11. The Committee, having again accepted the advice of the Legal Adviser, determined to accede to the unopposed application made under Rule 18 to withdraw heads of charge 5 and 18 as numbered in the notice of hearing. The Committee considered that it was fair and appropriate for these two heads of charge to be withdrawn. Head of charge 18 as set out in the notice of hearing had been due to be renumbered as head of charge 19 had Ms Tahta proceeded with a proposed application to add a further head of charge in relation to Patient 18, and that revised

numbering has been retained to minimise confusion. Therefore, heads of charge 5 and 19 were withdrawn as set out in the amended schedule of charge above.

12. In relation to Ms Tahta's application to amend the wording of head of charge 11 (d), the Committee determined that it would not be fair or appropriate to amend the wording in the terms proposed. In the Committee's judgement the proposed amendment would amount to a significant change in the meaning of the allegation, and that making the amendment would cause undue prejudice to you. The Committee therefore rejected Ms Tahta's application.

13. Prior to the Committee announcing its decisions on Ms Tahta's applications Ms Tahta made a further application to amend the charges by way of withdrawing a number of other heads of charge that you face, namely heads of charge 14, 17 (n) (v), 17 (n) (vii), 17 (n) (ix), 17 (n) (x), 17 (o) (i) and 17 (o) (ii). Ms Tahta also applied to amend the wording of head of charge 17 (i) so that the date is changed, and corrected, from 23 November 2021 to 11 May 2021. Mr Cridland did not oppose this further application.

14. The Committee, having again accepted the advice of the Legal Adviser, determined to accede to the unopposed application made under Rule 18 to withdraw heads of charge 14, 17 (n) (v), 17 (n) (vii), 17 (n) (ix), 17 (n) (x), 17 (o) (i) and 17 (o) (ii) and the unopposed application to amend head of charge 17 (i). The Committee considered that it was fair and appropriate for these heads of charge to be withdrawn and amended.

15. The schedule of charge was duly amended in the terms summarised, and is set out in its amended form above. In making these amendments the Committee also removed an extraneous 'i' at head of charge 17 (k) (i) which appears to have arisen as a result of a typographical or typesetting error.

Admissions

16. Following the amendments and additions to the schedule of charge as referred to above, Mr Cridland on your behalf tendered admissions to some of the heads of charge that you face. The heads of charge that you admitted were, namely, heads of charge 12, 13, 15 (b), 17 (a), 17 (c), 17 (d), 17 (e), 17 (f), 17 (h), 17 (i), 17 (j), 17 (k) in its entirety, 17 (l) in its entirety, 17 (m), 17 (n) in its entirety, 17 (p) in its entirety, and head of charge 22.

17. The Committee, having accepted the advice of the Legal Adviser, determined and announced that the facts alleged at those heads and sub-heads of charge were proven on the basis of your admissions in accordance with Rule 17 (4) of the Rules.

Factual inquiry

18. We now move to the factual inquiry stage of the hearing.

19. In opening the case for the GDC, Ms Tahta told the Committee that you worked as an Associate Dentist at a dental practice ('the Practice') from January 2017 to March 2023. She stated that the clinical allegations in this case arise from patient records that were obtained by the GDC

as a result of a complaint made by an employee at the Practice. The patients concerned are referred to in the charge as Patients A to H and Patients 1 to 28.

20. Ms Tahta stated that the GDC asked its expert witness in this case, Mr Abhijit Pal, General Dental Practitioner, to review the patient records. Mr Pal initially identified a number of alleged failings in relation to your treatment of Patients A to H and subsequently Patient 22. Ms Tahta told the Committee that the set of patient records relating to Patients 1 to 28, were obtained slightly later and they relate to an audit that had been carried out at the Practice. Ms Tahta said that Mr Pal was also asked to look at that later set of records. She highlighted that head of charge 17 within the charge relates to specific record-keeping issues that Mr Pal identified regarding your treatment of Patients 1 to 28, along with similar record-keeping failures within the first set of records for Patients A to H.

21. With reference to the expert evidence of Mr Pal and that of the expert witness on your behalf, Mr Balraj Dhami, Ms Tahta took the Committee through the outstanding clinical allegations from heads of charge 1 to 21 and outlined the differences in the expert's opinions.

22. Ms Tahta explained in her opening submissions that the GDC is alleging misconduct in relation to those allegations where Mr Pal considered the alleged clinical failings fell seriously below the standard expected of a reasonably competent General Dental Practitioner. Ms Tahta stated that the Council is also alleging deficient professional performance on the basis that the allegations, if found proved, demonstrate a pattern of conduct that is unacceptably low.

23. Ms Tahta also addressed the non-clinical matters included in the charge, namely those set out at heads of charge 22 and 23. These are the allegations that you failed to inform NHS England, on whose Dental Performers List you were included, of the conditions imposed on your registration by the GDC and when those conditions were subsequently amended.

24. In respect of these non-clinical matters, Ms Tahta submitted that during the course of the GDC's investigation into the complaint made against you and the patient records obtained, you were made subject to an interim conditions of practice order on 30 September 2022. She stated that one of the requirements of your interim conditions was that you should inform, within 7 days, the Commissioning Body or Health board in whose Dental Performers List you were included or seeking inclusion (at the time of the application), that your registration had been made subject to the conditions. Ms Tahta told the Committee that one of the GDC's witnesses would be Emily Eason, NHS Programme Manager for Professional Standards. Ms Eason's evidence, as stated in her witness statement provided for this hearing, is that you did not inform NHS England of your interim conditions.

25. It is the GDC's case that your alleged failure to inform NHS England about the interim conditions of practice order imposed on your registration in September 2022 and its subsequent amendment, was conduct that was misleading and dishonest.

Summary of the evidence up to 10 September 2025

26. The evidence presented by the GDC was both documentary and oral. The documentary evidence provided by the Council was as follows:

- The clinical records for the patients in this case.
- A main expert report dated 19 March 2025 prepared by Mr Pal and his addendum report dated 23 July 2025.
- The witness statement of Ms Eason dated 14 April 2025.
- A witness statement provided by the Director of Compliance at the Practice, dated 9 April 2025, in which she set out information regarding audit practices at the Practice.

27. In addition, the Committee heard oral evidence from Mr Pal and from Ms Eason.

28. The Committee also received documentary and oral evidence adduced on your behalf. This evidence included:

- Your witness statement dated 28 August 2025.
- The witness statement of Witness 1, who is your wife, dated 28 August 2025.
- Mr Dhami's expert report dated 28 August 2025.

29. The Committee heard oral evidence from both you and Witness 1.

30. The Committee also received a joint expert report prepared by Mr Pal and Mr Dhami signed by both experts on 2 September 2025.

31. Following the oral evidence of Witness 1, the hearing adjourned part heard. The Chair of the Committee handed down a determination in respect of the adjournment which is summarised as follows:

Determination on adjournment – 15 September 2025

32. "…The Committee's factual inquiry commenced on the morning of 5 September 2025 and continued on 8, 9 and 10 September 2025. The Committee did not sit on 11 or 12 September 2025.

Adjournment

33. On the morning of 15 September 2025 the Chair, absent her colleagues, announced that the hearing could not proceed in the time available due to health matters relating to the Committee. The Chair announced that the remaining days set aside for the hearing, namely 15 to 19 September 2025, would be vacated.

34. The hearing adjourned during the course of the Committee's factual inquiry, and more particularly during the course of your case on the facts. Oral evidence having been heard from Abhijit Pal, Emily Eason, from you, and from [Witness 1]. The final remaining witness, namely Balraj Dhami, who is your expert witness, had not started his evidence. Save for the

Committee's findings of fact in relation to the admissions that you made under Rule 17, the Committee made no factual findings.

35. The hearing then adjourned part heard. The hearing will resume on dates to be identified. In adjourning the Chair announced that a minimum of seven additional days is likely to be needed for the continuation and conclusion of the hearing.

36. The Chair asks that parties afford every assistance to the Listings team of the Dental Professionals Hearings Service for the expeditious relisting of this hearing.

37. That concludes this determination".

Resumption of the hearing – July 2026

38. The hearing resumed on 16 July 2026 with the continuation of the evidence being presented on your behalf, namely the oral evidence of Mr Dhami, who was the final witness to be heard in this case. Prior to the resumption of the hearing transcripts of the earlier part of the hearing in September 2025 were made available to all parties.

The Committee's Findings of Fact – 22 July 2026

39. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made in respect of the outstanding allegations by Ms Tahta on behalf of the GDC and by Mr Cridland on your behalf.

40. The Committee accepted the advice of the Legal Adviser in relation to the burden and standard of proof, how to approach the evidence, and the legal principles and guidance applicable to its decision-making, including the test for dishonesty as set out in the case of I*vey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.

41. The Committee considered each of the outstanding heads of charge separately, bearing in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, the balance of probabilities. The Committee has had to determine whether it was more likely than not that the alleged matters occurred.

42. The Committee's findings are set out in the table below. For completeness, they include the factual matters that were announced as proved on the basis of your admissions at the beginning of the hearing:

Patient A	
1.	*You failed to maintain an adequate standard of care in that you provided patient A with treatment that was not clinically indicated on 22 October 2021, namely a filling at the UR6.* **Found proved.**

	In respect of a bitewing radiograph taken of Patient A on 1 October 2021, you recorded in the clinical records "*B/W taken to asses [sic] caries/bone loss, exam grade A……ur6 decayed"*. A PDF copy of the radiograph was provided as part of this case and neither expert witness could see a radiolucency at UR6 to indicate the presence of caries. Mr Pal stated in his main expert report that *"In my opinion caries at UR6 is not evident in the radiograph"* and he maintained this view in his oral evidence. Mr Dhami's opinion, as set out in his report was that *"…caries may be present and diagnosable clinically but may not be visible on radiographs. Therefore, in my opinion, it is not reasonable to conclude that caries must not have been present, simply because it was not visible on a radiograph"*. In his oral evidence, Mr Dhami stated that interpreting radiographs is *"not an exact science"*, and therefore two clinicians can have differing opinions in relation to what can be seen on them. Mr Dhami stated that a practitioner could make a diagnosis that is incorrect, but not unreasonable. In respect of the filling you provided to Patient A's UR6, Mr Dhami highlighted both in his report and in his oral evidence that you had added advantage of being able to clinically assess the tooth and thereby reached a diagnosis of caries that required intervention. He stated that there was a clear entry in the clinical records that you diagnosed caries at UR6 and that treatment commenced. Therefore, he was not critical. The Committee also heard a considerable amount of expert evidence, as well as evidence from you, about the ability to use computer software to manipulate digital radiographs, such as the one taken of Patient A on 1 October 2021, to facilitate diagnoses. The Committee noted, however, that in answer to one of its questions, Mr Dhami accepted that the manipulation of digital radiographs can be subjective. He stated that whilst using computer software to manipulate digital radiographs can be helpful in making positive findings, there is also a risk that manipulation can lead a practitioner to see something that is not there. It was Mr Dhami's opinion that a practitioner should not rely solely on radiographs, but that other clinical findings should be used alongside any radiographic assessment. The Committee was told by you that you were using software that enabled you to manipulate digital radiographs. However, it was not provided with any enhanced radiographs in relation to the patients who are the subject of the allegations or any distinct recollection on your part of having used this software in any of the specific appointments that are the subject of the allegations. The Committee also noted that there was no reference to the radiographs having been enhanced in the clinical records. It was the conclusion of the Committee that it could place little weight on your ability to manipulate digital radiographs in these circumstances. Furthermore, the Committee took into account that both experts agreed that all the PDF copies

	of radiographs available in this case were of good diagnostic quality in any event. In reaching its decision, the Committee had regard to the relevant radiograph provided in respect of Patient A. It also considered the information present in the patient's clinical records. It was the view of the Committee, having considered the patient's notes, that Patient A was a patient who took their oral health seriously. The clinical records showed that Patient A had been a regular attender at the Practice over a number of years and had been seen by multiple dentists. The Committee noted that Patient A had only one filling prior to the one you provided to the UR6 on 22 October 2021. Furthermore, the patient's caries risk had been assessed as low by a previous dentist in September 2019. Taking into account this clinical picture of Patient A, together with the fact that neither expert in this case could identify caries at the patient's UR6 from the relevant radiograph, the Committee was satisfied, on the balance of probabilities, that caries was not present and therefore the filling you provided was not clinically indicated. The Committee was further satisfied that providing treatment that was not clinically indicated was a failure to maintain an adequate standard of care for Patient A. The Committee accepted the opinion of Dr Pal in his main report that *"Given the lack of previous caries experience, the previous low caries risk recorded, the absence of pain…any lesion that was seen was either an early lesion or a lesion which was remineralised".* Mr Pal opined that a more preventative approach should have been adopted such as to leave, monitor and provide preventative advice. In all the circumstances, the Committee found this head of charge proved.
2.	*You failed to maintain an adequate standard of radiographic record keeping in that you made an inaccurate report on the radiograph taken of Patient A on 1 October 2021.* **Found proved.** This allegation relates to the same bitewing radiograph on which you based your decision to provide Patient A with the filling at UR6. As noted at head of charge 1, you recorded in the clinical records *"B/W taken to asses [sic] caries/bone loss, exam grade A……ur6 decayed".* Having found proved on the balance of probabilities that caries was not present at Patient's UR6, the Committee was satisfied that this report you made on the radiograph indicating the presence of decay was not accurate. Accordingly, this head of charge is proved.
3.	*You failed to obtain informed consent from Patient A to the filling at the UR6 on 22 October 2021.* **Found proved.**

	It was the Committee's finding, based on the evidence before it, that your diagnosis of caries and the need for a filling at UR6 were incorrect. In the absence of any clinical indication for the filling on 22 October 2021, the Committee concluded that any consent for that treatment that you obtained from Patient A could not have been informed. Therefore, the Committee was satisfied on the balance of probabilities that this allegation at head of charge 2 is proved.
Patient B	
4.	*You failed to maintain an adequate standard of care in that you failed to take bitewing radiographs of Patient B between 19 March 2020 and 22 October 2021.* **Found proved.** On 19 March 2020, you recorded in the clinical records for Patient B that caries was seen at the patient's UR6 on an OPG radiograph that had been exposed on 23 September 2019. Mr Pal's evidence was that an OPG radiograph is not an appropriate view from which to diagnose early caries. He stated in his main report that caries is usually only seen on an OPG when a lesion is quite advanced. He told the Committee that bitewing radiographs are much better for the detection of interdental caries and early caries. It was his opinion that bitewing radiographs were indicated for Patient B, given that you had identified a lesion at UR6. Mr Dhami set out in his report that *"OPGs can be used to diagnose caries and assess bone levels, same as bitewing radiographs"*, although he stated in his oral evidence that bitewings were ideal. It was Mr Dhami's opinion that the OPG radiograph of Patient B taken on 23 September 2019 was adequate to infer the need for treatment of the patient's UR6. Mr Dhami told the Committee that, as a clinician with access to a diagnostic OPG, one would have had to weigh up the benefit of also taking bitewing radiographs against the risk of exposing the patient to further radiation. He stated that if an existing OPG is sufficient, a practitioner could reasonably consider not taking bitewing radiographs. Mr Dhami's opinion was that there was no failure on your part to expose bitewing radiographs on 19 March 2020, as you had the OPG radiograph available to you and it was diagnostic. It was his view that the failure to expose radiographs only arose at your appointment with Patient B on 22 October 2021, as this was two years after the OPG radiograph has been exposed in September 2019 but, he stated, this was only just outside the two-yearly interval. In this regard, Mr Dhami relied on the Faculty of General Dental Practice (UK) (FGDP) Selection Criteria for Radiography guidelines which advise that bitewing radiographs for low caries risk patients should be exposed every two years.

	The Committee took into account that it is not disputed that caries was seen on Patient B's UR6 on the OPG radiograph of 23 September 2019. What is alleged is that you should have taken bitewing radiographs to check if there was early caries in other teeth, given that OPG radiographs are not considered to be ideal for detecting early and interdental caries. The Committee noted that in your oral evidence under cross-examination, you stated that you are now of the opinion that you should have taken bitewing radiographs in the circumstances. You stated that it was your usual practice at the time to take bitewing radiographs for every new patient. You told the Committee that you could not recall why you did not follow your usual practice with Patient B, but that it could have been that the patient did not want to be exposed to additional radiation. However, the Committee noted that there is nothing in the clinical records to suggest that Patient B had declined bitewing radiographs and on what basis. Mr Pal's evidence in his main report, was that it is accepted by the dental profession that the benefit gained from bitewing radiographs far outweighs the radiation risks. Also, in response to a question from the Committee, Mr Dhami explained that compared to OPG radiographs the radiation dose of bitewing radiographs is minimal. In the circumstances, the Committee would have expected to see a record in the clinical notes had Patient B declined bitewing radiographs or if you had decided not to take them for any other reason. The Committee further had regard to Mr Dhami's reference to the relevant FGDP guidelines and his opinion that you were only just outside the two-year time period for taking bitewing radiographs of Patient B. However, in the Committee's view, the FGDP guidelines are very specific in advising that bitewing radiographs are required as a baseline for every new patient, and thereafter, for low caries risk patients, at two-yearly intervals. The Committee noted that in this case, no bitewing radiographs were taken at all of Patient B. Furthermore, the Committee noted Mr Pal's evidence that the patient was assessed as having a medium risk of caries. He stated in his main report that *"Given that fillings were placed at UR6 and LL6 for managing caries, bitewing radiographs should have been taken".* It was the finding of the Committee, taking into account the opinion of Mr Pal, and your concession that bitewing radiographs should have been taken for Patient B, that this head of charge is proved. The Committee was satisfied on the balance of probabilities that there was a failure on your part to take bitewing radiographs. In all the circumstances, the Committee found this head of charge proved.
5.	[withdrawn]

Patient C	
6.	*You failed to maintain an adequate standard of care in that you provided patient C with treatment that was not clinically indicated on 26 November 2021, namely a filling at the UL7* **Found not proved.** In respect of a bitewing radiograph taken of Patient C on 22 October 2021, you noted in the clinical records "*B/W taken to asses caries/bone loss, exam grade A……ul7,8 both decayed. no pain no ttp, adv fills there".* The Committee took into account Mr Pal's evidence, as set out in his main report that *"In my opinion the radiographs do not show the presence of caries in UL7 and very little of UL8 is visible.".* However, Mr Pal stated in the joint expert report that *"…if caries was not visible on the radiograph, taking into account the patient's caries risk profile (presence of caries elsewhere and previous restorations), if caries had been seen clinically, restorative intervention was reasonable".* As also set out in the joint expert report, Mr Dhami considered that he could see radiographically a radiolucency indicative of caries at UL7. It was his opinion that *"…if the Registrant diagnosed caries clinically and/or radiographically, then the treatment was clinically indicated…".* In view of the joint expert opinion that providing a filling to the UL7 was a reasonable approach to take if caries was seen, the Committee concluded that this allegation is not proved on the balance of probabilities. In reaching its decision, the Committee took into account that Mr Dhami considered that he could see caries from the radiographs taken, and Mr Pal acknowledged that this was a patient with a high caries risk profile.
7.	*You failed to maintain an adequate standard of radiographic record keeping in that you made an inaccurate report on the radiograph taken of Patient C on 22 October 2021.* **Found not proved.** In making its finding in respect of this allegation, the Committee took into account that your report on the radiograph taken of Patient C on 22 October 2021 included reference to the UL7 and the UL8. Mr Pal's assessment of the radiograph was that very little of the UL8 could be seen on the radiograph in question. However, the Committee considered that the GDC's focus in setting out its case in respect of this head of charge was on the UL7, given that this allegation is linked to heads of charge 6 and 8, both concerning the treatment you provided to Patient C's UL7. In these circumstances, taking into account the way in which the GDC put its case, the Committee was satisfied that your report on the radiograph in respect of UL7 was accurate. The Committee considered that it was more likely than not that you did identify decay at the UL7, given the risk profile of

	this patient as outlined by Mr Pal. Therefore, this allegation at head of charge 7 is not proved.
8.	*You failed to obtain informed consent from Patient C to a filling at the UL7 on 26 November 2021.* **Found not proved.** In view of the Committee's finding at head of charge 6. In the joint expert report, both experts opined that if you saw caries clinically and/or radiographically, the management of such lesions could include preventative or restorative management. They stated that, as both would be considered reasonable managements options, if your opinion was that the most appropriate management was a restorative approach, then there was no failure in obtaining informed consent from Patient C. The Committee had regard to your notes within the clinical records regarding your discussions with Patient C, including in relation to treatment options, risks and benefits, procedure complications and limitations. In all the circumstances, the Committee found this allegation at head of charge 8 not proved.
<u>Patient E</u>	
9.	*You failed to maintain an adequate standard of care in that you provided patient E with treatment that was not clinically indicated on 3 November 2021, namely a filling at the LL7.* **Found not proved.** Whilst neither expert witness could see radiographically any occlusal caries at Patient E's LL7, it was stated in their joint expert report that *"Given the limitations already discussed about caries diagnosis radiographically for marginal radiolucencies, both experts opine, if the Registrant saw caries clinically then treatment was clinically indicated".* The Committee also took into account that whilst you did not record a pre-operative diagnosis of caries at Patient E's LL7 in the clinical notes, post-operatively, you noted *"caries removed"*. In his oral evidence under cross-examination, Mr Pal conceded that, although made post-operatively, this note reflected that caries had been present in the tooth. When asked if this head of charge would fall away on that basis, Mr Pal said that it would. The Committee took into account that the burden of proof is on the GDC at these proceedings, and in light of Mr Pal's evidence under cross-examination, the Committee was not satisfied that the Council proved this allegation to the requisite standard. Accordingly, it found it not proved.
10.	*You failed to obtain informed consent from Patient E to a filling at the LL7 on 3 November 2021.*

	Found not proved. For the same reasons given in respect of head of charge 9 above. Both experts opined that it you saw caries clinically, then the filling provided to Patient E's LL7 on 3 November 2021 was clinically indicated. Mr Pal conceded that the post-operative note that you made in the clinical records about caries having been removed was evidence that caries had been present in the tooth. The experts also stated in their joint expert report that the management of such lesions could include preventative or restorative management. They stated that, as both would be considered reasonable managements options, if your opinion was that the most appropriate management was a restorative approach, then there was no failure in obtaining informed consent from Patient E. The Committee noted from the clinical records your confirmation that *"Pt advised we will be completing COMPOSITE PRIVATE filling on lr7 today, pt happy to do so and gives consent".* In all the circumstances, this allegation at head of charge 10 is not proved.
Patient G	
11a.	*You failed to provide an adequate standard of care to Patient G in that you:* *failed to carry out percussion testing of the LL1, LL2 and/or LR1 on 18 June 2021;* **Found not proved.** Patient G attended this emergency appointment on 18 June 2021 complaining of pain in their lower anterior teeth. In the clinical records, you noted that the patient's LR2 was *"ttp"* (tender to percussion). Your evidence was that you carried out percussion testing on all the patient's teeth in both the lower left and lower right quadrants, but that you only recorded your positive findings, as was your usual practice. In their joint expert report, both expert witnesses agreed that a reasonable body of dentists would only record their positive findings from clinical tests, such as percussion testing. In his oral evidence under cross-examination, Mr Pal stated that if only positive findings were recorded in this instance, then it was still possible that you tested all the teeth concerned. In light of the experts' joint opinion, the Committee was not satisfied that the GDC proved on the balance of probabilities that you failed to carry out percussion testing of Patient G's LL1, LL2 and/or LR1 on 18 June 2021.
11b.	*You failed to provide an adequate standard of care to Patient G in that you:* *commenced root canal treatment to the LR1 instead of the LR2 on 8 July 2021;* **Found proved.**

	This allegation is that on 8 July 2021, you started root canal treatment (RCT) on Patient G's LR1 instead of the LR2 in error. Your evidence was that you did not recall commencing RCT on the LR1, but that you did remember placing a Glass Ionomer Cement (GIC) filling in that tooth to address a lingual fracture that had occurred previously due to trauma. In your witness statement you accepted that you had not recorded placing a GIC filling at LR1 and you acknowledged that this should have been included in the patient's clinical notes. Mr Pal's evidence was that your explanation about dealing with a lingual fracture at LR1 was not consistent with the radiographic evidence. He stated in his main report that *"The periapical radiograph of 08.07.21 taken after RCT to LR2 was completed shows that the LR1 (which was already root filled satisfactorily) had a much larger composite restoration after the RCT to LR2 compared to before. However, the root filling at LR1 appears to be the same as before this tooth was re-filled. This suggests that the registrant commenced treatment to LR1".* The Committee was taken to two periapical radiographs, one dated pre-operatively on 18 June 2021 and the other was the 8 July 2021 radiograph referred to by Mr Pal in his main report. Mr Pal's opinion, when comparing the two radiographs, was that on the radiograph of 8 July 2021, taken after the RCT to LR2, it looked like a poor access cavity had been filled on LR1. The Committee understood an access cavity is what is created to facilitate RCT and thus suggests that you attempted to root fill LR1 by mistake. The Committee noted that in their joint expert report that both experts opined that if your account of having placed a GIC filling at LR1 was accepted there would be no failure in the standard of care provided to Patient G. The Committee took into account that you were cross-examined at length on this issue, including in relation to there being no reference in the clinical records of 18 June 2021 or 8 July 2021 to a GIC filling to LR1. The Committee found that you were inconsistent in your responses about the lack of a clinical record, initially stating that you may have provided the GIC filling to Patient G as a goodwill gesture and that is why it was not recorded, so the Practice did not charge for that treatment. You later appeared to suggest that the lack of any record had been an oversight on your part and that you did not do it deliberately. Taking into account the evidence, the Committee concluded that it was more likely than not that you commenced RCT on Patient G's LR1 by mistake and therefore this head of charge is proved. The Committee was also satisfied on the evidence that this mistake amounted to a failure to provide the patient with an adequate standard of care. In all the circumstances, the Committee found this head of charge proved.

11c.	*You failed to provide an adequate standard of care to Patient G in that you:* *provided a poor standard of treatment to the LR1 on 8 July 2021;* **Found proved.** The Committee noted that both expert witnesses opined in their joint report that if it was found proved that the RCT was commenced at LR1 and a large access cavity was created, then this was an inadequate standard of care. The Committee also had regard to Mr Pal's opinion in his main expert report that *"…what has been done on LR1 given the appearance of the radiograph, is a poor standard of care… because the cavity made on LR1 was much larger than needed to even if it required treatment".* The Committee was satisfied on the basis of the evidence that this allegation at head of charge 11c is proved.
11d.	*You failed to provide an adequate standard of care to Patient G in that you:* *failed to adequately diagnose the source of infection between 18 June 2021 and 16 July 2021;* **Found not proved.** The indication from the clinical records is that over this period of time, Patient G saw you for three appointments on 18 June 2021, 8 July 2021 and 16 July 2021, which the Committee was asked to consider to be emergency appointments. The Committee noted Mr Pal's opinion in his main report that "*If percussion testing was not carried out to LR1, LL1 and LL2 then it would not be possible to determine on 18.06.21 if these teeth also had symptoms of an infection present".* However, as indicated in its finding at head of charge 11a above, which relates to the appointment on 18 June 2021, the Committee accepted the likelihood that you carried out percussion testing to the patient's lower left and lower right quadrants after the patient attended that appointment complaining of pain in their lower anterior teeth. Having carried out the percussion testing, you recorded the positive finding that LR2 was *"ttp".* Mr Dhami stated in his oral evidence that an emergency appointment is different from a routine appointment, when a practitioner would be looking at the holistic picture. He acknowledged the possibility of other teeth being involved on 18 June 2021, but that in the context of an emergency appointment the focus of the care would have been on the tooth causing the pain. It was his opinion that because the LR2 was tender to percussion and mobility in that tooth had also been noted, it was reasonable for you to have concluded that the LR2 was the source of the infection at that time. The Committee noted from the clinical records of 16 July 2021 that you did go on to consider the involvement of other teeth, and that there is reference to LR1

	being a possible source of infection with you having diagnosed that the RCT in that tooth was possibly failing. Having taken the evidence into account, the Committee was not satisfied on the balance that you failed to adequately diagnose the source of infection between 18 June 2021 and 16 July 2021. Accordingly, this head of charge is not proved.
12.	*You failed to maintain an adequate standard of record keeping in that you failed to make a record of treatment that you carried out to the LR1 on 8 July 2021.* **Found proved on the basis of your admission.**
13.	*You failed to maintain an adequate standard of radiographic record keeping in that you failed to record that the radiograph taken on 18 June 2021 showed periapical pathology at the LR1, LL1 and/or LL2.* **Found proved on the basis of your admission.**
14.	[withdrawn].
<u>Patient H</u>	
15a.	*You failed to maintain an adequate standard of care in that you:* *provided patient H with treatment that was not clinically indicated on 15 August 2019, namely a filling at the UR6;* **Found not proved.** You recorded in the clinical records for Patient H on 15 August 2019 that in respect of a bitewing radiograph taken on 18 July 2019, you saw caries at UR6. You also recorded that you saw the caries clinically. Mr Pal's evidence, as set out in his main report, was that *"The bitewing radiographs of 18.07.19 do not show a radiolucency under the occlusal surface at UR6 suggestive of caries".* However, he went on to state that it was possible that caries was seen clinically. Mr Pal noted that the patient had a history of caries. In the joint expert report, he opined that *"…if the Committee accept caries was present clinically and was visible radiographically by the Registrant on his system, then the treatment was clinically indicated and there was no failure in care".* Mr Dhami also gave the opinion in the joint expert report that "*…if the Registrant diagnosed caries clinically and/or radiographically, then the treatment was clinically indicated and there was no failure in care".* In view of the evidence, which included Mr Pal's evidence that Patient H was at medium risk of caries, as well as the notes in the clinical records indicating the presence of caries and then *"caries removed"*, the Committee concluded that this allegation was not proved on the balance of probabilities. The

	Committee considered that you made a relatively comprehensive note of seeing caries both clinically and radiographically, and in those circumstances both experts agreed that a filling to the UR6 was indicated and there was no failure in care.
15b.	*You failed to maintain an adequate standard of care in that you:* *failed to diagnose caries at the LR7 between 24 May 2017 and 18 August 2017;* **Found proved on the basis of your admission.**
16.	*You failed to obtain informed consent from Patient H to a filling at the UR6 on 15 August 2019.* **Found not proved.** The finding of the Committee was that it was more likely than not that the filling you provided to Patient H's UR6 was clinically indicated for the reasons set out in respect of head of charge 15a above. The Committee took into account that both experts opined in their joint expert report that *"… if the Registrant saw caries clinically and/or radiographically, the management of such lesions could include preventative or restorative management. As both would be considered reasonable managements options, if in the Registrant's opinion, the most appropriate management was a restorative approach, then there was no failure in gaining consent".* The Committee had regard to your notes within the clinical records regarding your discussions with Patient H, including in relation to treatment options, risks and benefits, procedure complications and limitations. In all the circumstances, the Committee found this allegation at head of charge 16 not proved.
<u>Patients 1 – 28 and A - H</u>	
17a.	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record adequate details of extra-oral examinations for the patients and appointments at Schedule 1.* **Found proved on the basis of your admission.**
17b.	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record the assessment of dietary factors for the patients and appointments at Schedule 2.* **Found not proved.** Your evidence in respect of this allegation was that there was a system at the Practice whereby prior to a patient attending for an appointment, they would

	be sent an electronic link asking them to complete their updated medical histories which would include questions regarding any dietary factors. You stated that the information provided by the patient would not be included within the standard printing of the records but saved in a separate part of the records. The GDC's case was that the system you described, namely that patients would be asked to complete or update their medical histories online, was a new system introduced in March 2020. The GDC maintained that prior to March 2020 there was an old-style system whereby medical histories were recorded within a patient's clinical records. In this regard, the Committee was referred to examples where other practitioners had recorded patients' medical histories within the clinical records, but you had not. However, the Committee considered that there was a lack of clarity about when the new system you described came into existence at the Practice. It took into account that it received no independent evidence from the GDC to verify when the new system was put into place at the Practice. Neither expert could provide an exact date, and in his oral evidence Mr Pal stated that he thought the new system of taking medical histories from patients via an electronic link had been in place prior to March 2020. The Committee also took into account that no evidence was adduced by the GDC in relation to what other practitioners at the Practice did and were expected to do regarding the recording of dietary requirements over the material time. In all the circumstances, the Committee was not satisfied that the GDC had provided sufficient evidence to discharge its burden of proving this allegation at head of charge 17b.
17c.	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record the clinical appearance of caries at the UR6 in patient B on 19 March 2020;* **Found proved on the basis of your admission.**
17d.	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record the clinical appearance of caries at the LL6 in patient B between 27 August 2021 and 22 October 2021;* **Found proved on the basis of your admission.**
17e.	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record the clinical appearance of caries at the UL7 in patient C on 22 October 2021;*

	Found proved on the basis of your admission.
17f.	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record the clinical appearance of caries at the UL8 in patient C on 22 October 2021;* **Found proved on the basis of your admission.**
17g	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record the clinical appearance of caries at the LL7 in patient E between 20 September 2021 and 3 November 2021;* **Found not proved.** The Committee noted that there is reference in the post-operative section of the relevant clinical records for Patient E to caries having been removed from the LL7 and that an occlusal filling was provided. In his oral evidence under cross-examination, Mr Pal conceded that this was information relating to the clinical appearance of the caries, and on that basis this allegation at head of charge 17(g) should fall away. In light of this evidence, the Committee found this head of charge not proved.
17h	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 2 on 23.11.21;* **Found proved on the basis of your admission.**
17i	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 3 on 11.05.21;* **Found proved on the basis of your admission.**
17j	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 9 on 11.11.21;* **Found proved on the basis of your admission.**
17k(i)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 13*

	on: *28 June 2022;* **Found proved on the basis of your admission.**
17k(ii)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 13 on:* *6 December 2022;* **Found proved on the basis of your admission.**
17l(i)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 14 on:* *10 June 2022;* **Found proved on the basis of your admission.**
17l(ii)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 14 on:* *18 January 2023* **Found proved on the basis of your admission.**
17m.	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Recorded an inaccurate mouth cancer risk factor for patient 18 on 26 May 2022;* **Found proved on the basis of your admission.**
17n(i)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record a Basic Periodontal Examination ("BPE") for:* *Patient 1 on 03.03.20* **Found proved on the basis of your admission.**
17n(ii)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record a Basic Periodontal Examination ("BPE") for:* *Patient 7 on 14.12.21*

	Found proved on the basis of your admission.
17n(iii)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record a Basic Periodontal Examination ("BPE") for:* *Patient 8 on 04.05.21* **Found proved on the basis of your admission.**
17n(iv)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record a Basic Periodontal Examination ("BPE") for:* *Patient 10 on 19.05.21* **Found proved on the basis of your admission.**
17n(v)	[withdrawn]
17n(vi)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record a Basic Periodontal Examination ("BPE") for:* *Patient 17 on 30.06.22* **Found proved on the basis of your admission.**
17n(vii)	[withdrawn]
17n(viii)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record a Basic Periodontal Examination ("BPE") for:* *Patient 24 on 05.06.17* **Found proved on the basis of your admission.**
17n(ix)	[withdrawn]
17n(x)	[withdrawn]
17o(i)	[withdrawn]
17o(ii)	[withdrawn]
17p(i)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record any dietary advice given to:* *Patient 11 on 24.01.23;* **Found proved on the basis of your admission.**

17p(ii)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record any dietary advice given to:* *Patient 12 on 01.07.22;* **Found proved on the basis of your admission.**
17p(ii)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record any dietary advice given to:* *Patient 17 on 30.06.22;* **Found proved on the basis of your admission.**
17p(iv)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record any dietary advice given to:* *Patient 28 on 23.07.21;* **Found proved on the basis of your admission.**
17p(v)	*You failed to maintain an adequate standard of record keeping between 20 March 2017 and 24 January 2023 in that you:* *Failed to record any dietary advice given to:* *Patient 28 on 11.03.22;* **Found proved on the basis of your admission.**
18	*[intentionally omitted]*
19	*[withdrawn]*
20	*You failed to maintain an adequate standard of radiographic record keeping in that you failed to record that the radiograph taken of patient 22 on 11 December 2018 showed widening of the periodontal ligament in the distal root of the LL6* **Found proved.** In reaching its decision, the Committee took into account the differing opinions of the expert witnesses in relation to the radiographic evidence. It was Mr Pal's observation in relation to the periapical radiograph taken of Patient 22's LL6 on 11 December 2018 that there are signs of widening of the periodontal ligament in the distal root. Mr Pal commented in his main expert report on the absence of any radiographic report on this periapical radiograph in the patient's clinical records.

	Mr Dhami stated in his report that *"I have reviewed the periapical radiograph exposed on 11/12/18 and cannot see any easily identifiable widening of the PDL, and therefore I would not be critical if WS did not identify or record as such".* The Committee also had regard to your evidence that, having reviewed the relevant periapical radiograph, you could not see a widening of the periodontal ligament in the distal root of the LL6. The Committee found that Mr Pal was clear in his evidence that he could see from the periapical radiograph of 11 December 2018 an obvious widening of the periodontal ligament in the distal root of the patient's LL6. However, in reaching its decision, the Committee also had regard to the clinical records. It considered that the absence of any report at all on the radiograph in question was significant, particularly given Mr Pal's evidence that there were other notable areas of pathology around the LL6. In his main report, Mr Pal referred to the LL6 being fractured with subgingival caries seen. Taking into account this evidence, the Committee considered that there was enough concern regarding the LL6 for you to have reported on the radiograph and had a discussion with the patient about the tooth. There is nothing in the clinical records to show that you assessed the radiograph and therefore the Committee concluded that it was more likely than not that you did not do so. It considered that this was the more likely reason that you did not see and record the widening of the periodontal ligament in the distal root of the patient's LL6, which the Committee accepted was present from Mr Pal's evidence. It found his detailed description of the periapical radiograph and what he could see from it to be clear and compelling. Accordingly, the Committee was satisfied that you failed to maintain an adequate standard of radiographic record keeping in that you failed to record that the radiograph taken of patient 22 on 11 December 2018 showed widening of the periodontal ligament in the distal root of the LL6.
21	*You failed to provide an adequate standard of care to patient 22 between 11 December 2018 and 13 February 2019 in that you crowned the LL6 without offering root canal treatment.* **Found proved.** Mr Pal's opinion, as set out in his main report, was that the widening of the periodontal ligament at the distal root of the LL6 was an indication of periapical periodontitis which can be caused by the spread of the carious process to the pulp. He stated that *"A reasonably competent dentist on seeing such a feature and contemplating a crown would suggest a RCT to the tooth before the crown is provided. Not doing so carries the risk of future pain and infection to the tooth".* Mr Dhami's opinion in his expert report was that it was reasonable for you to have considered that root canal treatment was not required. However, the

	Committee noted that his conclusion is predicated on there having been no radiographic evidence of pulpal pathology at LL6. The Committee's finding at head of charge 20 above was that there was such pathology, and that you did not observe this, as you failed to assess the periapical radiograph of 11 December 2018. It was the conclusion of the Committee in respect of this allegation at head of charge 21 that if you did not see the pathology, then you could not have discussed with and offered Patient 22 a RCT. Indeed, the Committee noted that there is no record that you recognised the presence of the periapical radiolucency or offered a RCT to the patient before commencing the crown treatment. The Committee accepted the opinion of Mr Pal that you should have offered a RCT in the circumstances, and that by not doing so, you failed to maintain an adequate standard of care for Patient 22.
22	*Between 30 September 2022 and 22 November 2022 you failed to inform NHS England of the conditions imposed by the General Dental Council ("GDC") on your registration.* **Found proved on the basis of your admission.** The Committee noted that you admitted this head of charge on the basis that you had not understood that the requirement within your interim conditions regarding informing *"the Commissioning Body or Health board in whose Dental Performers List you were included or seeking inclusion (at the time of the application)"* meant that you had to inform NHS England. You stated that you did not recognise that NHS England was *"the Commissioning Body".*
23	*Between 16 August 2023 and 10 October 2023 you failed to inform NHS England of the amended conditions imposed by the General Dental Council ("GDC") on your registration.* **Found proved.** The Committee took into account that by this period of time, you were aware of your requirement to inform NHS England regarding any amendment to your interim conditions. Your evidence was that you had asked Witness 1 to send an email to Ms Eason at NHS England to advise her of your amended interim conditions. The Committee also heard oral evidence from Witness 1 whose evidence was that she sent an email on 17 August 2023 to Ms Eason regarding your amended interim conditions on your behalf. Ms Eason's evidence was that she did not receive an email from you or Witness 1 on 17 August 2023. Furthermore, Ms Eason stated that she had been away from work on that date and therefore if your email had been received by her, you would have received an email notification in reply stating that she was out of the office. Ms Eason also stated that she looked for the email, both in her spam and deleted folders and was unable to find it. The Committee found Ms Eason to be a credible witness, who despite close cross-examination remained consistent and reliable to the appropriate

	standard. The Committee, mindful of the wording of this head of charge, bore in mind that the burden of proving this allegation rested with the GDC. The Committee took into account that you were given ample opportunity during these proceedings to try and locate the email you said was sent to Ms Eason by Witness 1, but you could not. You told the Committee that you suspected that you might have deleted the email. This was despite other emails sent from the email account on 17 August 2023 still being available to view. The Committee further took into account that there was no record of you having received any automated response notifying you that Ms Eason was out of the office at the time. The Committee considered it significant that the original email that both you and Witness 1 say was sent to Ms Eason on 17 August 2023 did not appear in the sent items along with other emails sent that same day. The Committee considered this together with Ms Eason's evidence of not having received the email. It was the conclusion of the Committee, taking these factors into account, that on the balance of probabilities, an email was not sent to Ms Eason by you or Witness 1 on 17 August 2023 and therefore this head of charge is proved.
24a	*Your conduct at 22 and/or 23 above was:* *misleading;* **Head of charge 24a found proved in relation to head of charge 22:** The Committee accepted the advice of the Legal Adviser and took account of the submissions of the parties as to the ordinary meaning of the word 'misleading', which is to give the wrong idea or impression by some act or omission. It also took into account that something can be objectively misleading, that is, without intention, and that it is not necessary for anyone to have been misled by the action or omission. It was the view of the Committee that your admitted failure between 30 September 2022 and 22 November 2022 to inform NHS England of the conditions imposed by the GDC on your registration was conduct that was misleading. This is because during this period NHS England were not aware of the true position in relation to your registration, and whilst not a necessary component, Ms Eason stated in her evidence that she had been misled by your omission. **Head of charge 24a found proved in relation to head of charge 23:** The Committee found proved that it was more likely than not that Witness 1 did not inform NHS England of the amendment to your interim conditions by email on 17 August 2023. As a result, there was a period, as set out in the charge, during which NHS England was not aware that your interim conditions had been changed. The Committee noted that Ms Eason only

	became aware of the amendment on 10 October 2023. The Committee was satisfied on the balance of probabilities that your failure to inform NHS England was conduct that was misleading for the same reasons given in respect of your conduct at head of charge 22.
24b	*Your conduct at 22 and/or 23 above was:* *dishonest.* **Head of charge 24b found not proved in relation to head of charge 22:** In reaching its decision, the Committee took into account that your conduct at head of charge 22 was your first omission in informing NHS England of your interim conditions. This was at an early stage in the regulatory process and your first time being subject to those interim requirements. The Committee accepted your confusion regarding NHS England being *"the Commissioning Body".* It also noted Ms Eason's evidence that she did not regard herself as being an officer of a Commissioning Body, but an officer of NHS England. In all the circumstances, the Committee was satisfied that your failure to inform NHS was a genuine oversight which arose from your confusion over the use of terminology. The Committee was satisfied that ordinary decent members of the public would not regard your conduct to have been dishonest. Therefore, head of charge 24b is not proved in relation to head of charge 22. **Head of charge 24b found not proved in relation to head of charge 23:** Having been made aware of the initial breach of your interim conditions, in that you did not inform NHS England when they were first imposed, the Committee was satisfied that you knew by 16 August 2023, when the conditions were amended, that you had a duty to inform NHS England of the change. The Committee was made aware that you frequently asked Witness 1 to deal with many administrative matters on your behalf, including in relation to your work. You consistently told the Committee that it was your genuine belief that Witness 1 had forwarded your solicitor's email setting out your amended interim conditions to NHS England. The Committee concluded NHS England was objectively misled, as it found it to be the case that NHS England did not receive such a notification from you or sent on your behalf. The Committee considered whether you reasonably held the belief that NHS England had been notified of your amended interim conditions of practice order. It accepted that you would routinely delegate such matters to Witness 1 and that until the issue was raised with you by the GDC, you had no reason to enquire further or look for the email that you said was sent on your behalf. Despite extensive questioning, the Committee considered that your belief in this regard was genuinely held by you. When considering the objective standards of ordinary decent people in light

	of these conclusions, the Committee did not consider that the GDC made out its case that you were dishonest. Accordingly, head of charge 24b is not proved in relation to head of charge 23.

43. The hearing now moves to Stage Two.

Stage Two of the hearing – 23 to 24 July 2026

Summary of the facts found proved

44. The facts found proved in this case, a number of which you admitted, relate to failings in the standard of care you provided to multiple patients over a number of years. The Committee also made findings in respect of your failure on two occasions to inform NHS England about the interim conditions imposed on your registration by the GDC.

45. With regard to the clinical matters, the Committee's findings cover a broad range of issues relating to your period of practice between March 2017 and January 2023. In summary, the Committee found proved that you failed to provide or maintain an adequate standard of care for a number of patients, in that:

- You provided a filling to a patient that was not clinically indicated. Your report on the radiograph you used to make your decision to provide the filling was inaccurate, and as the filling was not clinically indicated, you failed to obtain informed consent for the treatment (Patient A, heads of charge 1 to 3).

- You failed to take bitewing radiographs in respect of one patient (Patient B, head of charge 4).

- In respect of another patient, you commenced RCT on the wrong tooth, and the care that you provided to that tooth was of a poor standard, as the access cavity you made was much larger than needed, even if RCT had been required. (Patient G, heads of charge 11b and 11c).

- There was one instance when you failed to record the treatment that you had carried out (Patient G, head of charge 12).

- You failed to diagnose caries in one patient (Patient H, head of charge 15b).

- There were issues with your radiographic record keeping, in particular two instances where you failed to record radiographs that you had taken (Patient G, head of charge 13 and Patient 22, head of charge 20).

- You provided a patient with a crown without offering RCT, when RCT was clinically indicated (Patient 22, head of charge 21).

- There were several other instances where you failed to maintain an adequate standard of record keeping (head of charge 17), in that:

    - You failed to record adequate details of extra-oral examinations for a number of patients.
    - There were a number of occasions when you failed to record the clinical appearance of caries.
    - You recorded an inaccurate mouth cancer risk for a number of patients.
    - You failed to record BPEs on multiple occasions; and
    - On several occasions you failed to record any dietary advice given.

46. In addition to your clinical failings, on the basis of your admission, the Committee found proved at head of charge 22 that, between 30 September 2022 and 22 November 2022 you failed to inform NHS England of the interim conditions imposed on your registration by the GDC. Informing NHS England was a requirement of the conditions. The Committee also found proved at head of charge 23 that on a second occasion, between 16 August 2023 and 10 October 2023, you failed to inform NHS England that your interim conditions had been amended.

47. The Committee found proved at head of charge 24a, that in relation to both notification failures, your conduct was misleading, in that NHS England had remained unaware for periods of time of the true position in relation to your GDC registration. However, the Committee found that both failures did not amount to dishonesty.

The Committee's considerations at Stage Two

48. The two statutory grounds of impairment on which the GDC brought this case are misconduct and deficient professional performance. Accordingly, the Committee's considerations at this second stage of the hearing have been whether the facts found proved amount to misconduct and/or deficient professional performance, and if one or both of these statutory grounds are made out, whether your fitness to practise is currently impaired. The Committee noted that if it found current impairment, it would need to consider what sanction, if any, to impose on your registration.

Evidence

49. The Committee had before it all the evidence presented at the fact-finding stage (Stage One), as well as further evidence provided at this stage. The further evidence received comprised a 'Stage 2' bundle submitted on your behalf, which contained audits of your record keeping, evidence of your Continuing Professional Development (CPD), your personal reflective statement and other reflections, a copy of your Personal Development Plan (PDP), reports from your Workplace Supervisor appointed under your interim conditions, and testimonials. The Committee received separately further evidence of your reflective writing and additional evidence of CPD.

50. The evidence also provided by the GDC at this stage was a copy of a GDC Case Examiners decision letter dated 27 August 2025 issuing you with a published warning. The letter states that the warning is to be displayed against your name in the GDC online register for a period of 12 months.

Summary of the submissions made by the parties

51. The Committee heard submissions on misconduct, deficient professional performance, and impairment from Ms Tahta on behalf of the GDC, and from Mr Cridland on your behalf. Ms Tahta also made submissions on the issue of sanction.

52. In accordance with Rule 20(1)(a) of the *GDC (Fitness to Practise) Rules 2006*, Ms Tahta first addressed the Committee on your fitness to practise history. In doing so, she referred the Committee to the GDC Case Examiners decision letter of 27 August 2025 issuing you with a published warning. Ms Tahta told the Committee that the warning, which is still current, was issued in response to a complaint made by a patient regarding treatment that you provided to them in early 2023. Ms Tahta outlined the details within the warning, and she asked the Committee to note that a number of the issues raised in relation to your treatment of that patient are similar to those found proved in this case.

53. In relation to this case before the Committee, it was the GDC's submission that the facts found proved amount to both misconduct and deficient professional performance. Further, it was the GDC's submission that your fitness to practise is currently impaired on both statutory grounds, despite the considerable evidence of your attempts to remediate the concerns raised.

54. With reference to relevant case law, Ms Tahta submitted that the failings found proved must be sufficiently serious to amount to misconduct. She stated that 'misconduct' is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. She stated that the standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances.

55. Ms Tahta referred the Committee to a number of the GDC *'Standards for the Dental Team' (September 2013)* ('the GDC Standards') that the Council considered to be relevant in this case, namely: Standards 3.1, 4.1, 7.1, 9.1 and 9.4. Ms Tahta submitted that the Committee should also consider the expert opinion provided at this hearing in relation to how far below the standard of a reasonably competent practitioner your conduct fell.

56. Specifically in relation to deficient professional performance, Ms Tahta referred the Committee to the multiple record keeping failings admitted and found proved at head of charge 17. She outlined the legal test for deficient professional performance, as set out in case law. Ms Tahta submitted that the Committee would need to be satisfied that the clinical records in relation to head of charge 17 represented a fair sample of your work. Furthermore, the Committee would need to be satisfied that the standard of record keeping reflected in those records was unacceptably low. It was Ms Tahta's submission that the clinical records in relation to head of charge 17 do represent a fair sample, given that those records were obtained following an

audit of your practice. She stated that a significant number of patients are included in the sample, namely Patients 1 to 28, and that the Committee also had before it the clinical records for Patients A to H which, she said, demonstrate the same failings.

57. Ms Tahta went on to address the issue of current impairment. She reminded the Committee that its findings not only relate to clinical matters, but also to your notification failures to NHS England regarding your interim conditions. She asked the Committee to consider what those failures demonstrate about your attitude, including towards your regulator.

58. It was Ms Tahta's submission that despite the evidence of your remediation, it was clear that you did not fully recognise your failings during the course of this hearing. She also submitted that, even though you have had an interim conditions of practice order in place on your registration from September 2022, the patient complaint, which is the subject of your published warning, related to treatment you provided in early 2023. Ms Tahta therefore submitted that it was clear that there had been no change in your practice in the months between September 2022 and early 2023.

59. Ms Tahta submitted that the Committee could not be satisfied that you have, at this stage, fully remediated, that you do not pose a risk to the public and that you are safe to practice without restriction. Therefore, a finding of impairment is required to protect the public. Ms Tahta submitted that a finding of impairment is also required on wider public interest grounds, in light of the facts found proved, the GDC's view on misconduct and deficient professional performance, and given that you are currently subject to a published warning. She submitted that in view of these factors, to not find current impairment would fail to uphold proper professional standards and undermine public confidence in the dental profession.

60. In relation to sanction, it was Ms Tahta's submission that the only appropriate and proportionate sanction would be a conditions of practice order for a period of between 9 and 12 months, with a review. She stated that a lesser sanction would be insufficient to protect the public and the wider public interest. Ms Tahta submitted that 9 to 12 months of conditional registration was the shortest period practicable to enable you to provide further evidence to demonstrate full insight and remediation. She also submitted that it would not be appropriate, if public safety is one of the grounds on which impairment is found, for the Committee to take into account that you have been under interim conditions for over three years. Ms Tahta submitted that the Committee should focus on what is required for you to remediate.

61. In addressing the Committee on misconduct and deficient professional performance, Mr Cridland also referred to relevant case law. He submitted that misconduct must be serious and that more than mere negligence is required for such a finding. He further submitted that the Committee should avoid any temptation to *"dress up"* misconduct as deficient professional performance and vice versa. He stated that they are distinct concepts.

62. In relation to the facts found proved, Mr Cridland submitted that the clinical findings can be split broadly into two categories, namely record keeping and radiography. He submitted that this categorisation was accepted by the expert witness for the GDC, Mr Pal, in his oral evidence. It was Mr Cridland's submission that, save for those matters found proved at head

of charge 11b and 11c relating to the commencement of RCT on the wrong tooth of a patient, the clinical findings do not amount to misconduct, when this case is viewed fairly. However, Mr Cridland stated that it was accepted by you that the clinical matters found proved, save for those at heads of charge 11b and 11c, do amount to deficient professional performance.

63. Mr Cridland referred to the transcript of Mr Pal's oral evidence under cross-examination and asked the Committee to take into account Mr Pal's opinion that in general, allegations of record keeping are going to be less serious than deficiencies in care. Further, that Mr Pal agreed in respect of your record keeping that "*…the overall standard of the records … are within the range that would be seen in general practice*". Mr Cridland submitted that this was important evidence from the GDC's expert in relation to categorising the deficiencies found proved in relation to your record keeping.

64. In respect of the facts found proved at heads of charge 11b and 11c, concerning the commencement of treatment on a wrong tooth, Mr Cridland told the Committee that you had reflected on those findings and that you recognise they are serious. Mr Cridland submitted that you did not seek to suggest that those matters do not amount to misconduct.

65. With regard to the Committee's findings at heads of charge 22, 23 and 24, relating to your failure to inform NHS England about your interim conditions, Mr Cridland submitted that those issues are of a different nature, in that they are not clinical matters, although they are related to your practice as a dentist. It was Mr Cridland's submission that the facts found proved at heads of charge 22, 23 and 24 do not amount to misconduct. In relation to your initial failure to inform NHS England that interim conditions had been imposed on your registration, Mr Cridland submitted that, although regrettable, such a genuine oversight, as the Committee found to be the case, does not cross the threshold for a finding of misconduct. In respect of your subsequent failure to inform NHS England that your interim conditions had been amended, Mr Cridland highlighted the Committee's finding that you genuinely believed that Witness 1 had sent an email to NHS England on your behalf notifying them of the revision, although you fully accept that it was your responsibility to personally inform NHS England. However, with you genuinely having relied on Witness 1 and genuinely believing that she had informed NHS England, Ms Cridland submitted that this matter cannot amount to misconduct.

66. In relation to the clinical failings found proved, Mr Cridland submitted that you have undertaken effective remediation, such that the Committee could be satisfied that your fitness to practise is not currently impaired. He submitted that this a case in which your interim conditions of practice have created a positive framework and have facilitated you in your efforts to improve your professional practice.

67. Mr Cridland took the Committee through the evidence of your remediation. He referred to your record keeping audits carried out every two months and your Workplace Supervisor's reports prepared on a monthly basis. It was Mr Cridland's submission that your record keeping has been demonstrated to be of a good standard, and your remediation has encompassed the record keeping criticisms raised in head of charge 17. In relation to the workplace supervision reports, Mr Cridland stated that these are all satisfactory and that they provide a reassuring

picture. He stated that you have been working under the interim conditions for over three years and the process of your workplace supervision has not flagged up any further concerns.

68. Mr Cridland also invited the Committee to consider your reflections, including on your workplace supervision, as well as your CPD activity. He submitted that you have clearly reflected on the issues in this case and you have worked hard and assiduously to address them with targeted CPD. He said that this demonstrates an appropriate level of insight and understanding on your part. Mr Cridland asked the Committee to consider in detail your written reflections and he emphasised aspects of them that he regarded as relevant to the assessment of your insight.

69. Mr Cridland told the Committee that you have been profoundly affected by the fitness to practise process, including your experience at this hearing. He submitted that the Committee could be satisfied that you have a good level of insight and that you now approach matters with new recognition of the need to practice to an appropriate standard and to comply with your regulatory requirements. He invited the Committee to find that your fitness to practise is not currently impaired.

The Committee's decisions – 24 July 2026

70. The Committee considered all the evidence before it. It took account of the submissions made by Ms Tahta on behalf of the GDC and those made by Mr Cridland on your behalf.

71. The Committee accepted the advice of the Legal Adviser in relation to the applicable legal principles and guidance, and the approach it should take to its decision-making. The Committee accepted the Legal Adviser's advice that misconduct and deficient professional performance are distinct concepts, as indicated by the relevant case law, and as such, the same allegations cannot amount to both misconduct and deficient professional performance. This was unchallenged by the representatives.

72. The Committee reminded itself that its decisions were for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings.

73. The Committee also took into account that this hearing commenced in September 2025, which was before the GDC issued its revised *'Guidance for the practice committees'* (effective from 6 January 2026). In view of this, the Committee considered and applied the guidance that was in place at the time this hearing began, namely the *'Guidance for Practice Committees including Indicative Sanctions Guidance'* (effective from October 2016 and last revised in December 2020) ('the ISG Guidance), as well as the GDC Conditions Bank (May 2014).

Decision on misconduct

74. The Committee first considered whether the facts found proved in this case amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the standards expected of a dental professional. The Committee noted the submissions made by the GDC in relation to the GDC Standards that it considered relevant.

However, in the Committee's view, having considered its findings, it decided that the following GDC Standards are the most applicable:

3.1 Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.

4.1 Make and keep contemporaneous, complete and accurate patient records.

7.1 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.

75. The Committee considered its findings, taking into account the above GDC Standards and the expert opinion it received from both Mr Pal and Mr Dhami, the expert witness called on your behalf. The Committee noted that in a number of respects the experts differed in their opinions as to how far the proven conduct fell below the expected standard. However, the Committee remained mindful that its conclusions were a matter for its independent judgement, having considered the evidence.

76. The Committee first considered your failure to obtain informed consent from a patient on account of having provided a filling that was not clinically indicated (heads of charge 1 and 3). Whilst the Committee took into account the importance of ensuring that any consent gained from a patient is informed, it bore in mind that this was a single failure that was not repeated in any of the other findings made in this case. The Committee also considered, that although the filling was not clinically indicated, no particular harm was caused to the patient from what was a single surface filling placed on one tooth. In these circumstances, the Committee concluded that neither the failing in informed consent nor the provision of the filling was sufficiently serious to amount to misconduct.

77. However, the Committee did find misconduct in respect of your failings in radiographic reporting (heads of charge 2, 13 and 20). This included your inaccurate report on the radiograph on which you based your decision to provide the filling that was not clinically indicated. In the two other instances you failed to make any radiographic records. The Committee considered these repeated failings in radiographic reporting represented a pattern of conduct that fell far below the standard expected. The Committee had regard to the risk posed to patients from not recording radiographs or making inaccurate reports, including in relation to the safe continuity of care.

78. The Committee concluded that in one instance, you failed to record the findings from a radiograph because it was more likely than not that you had not assessed it. The Committee found proved that you failed to record that the radiograph taken on 11 December 2018 showed widening of the periodontal ligament in the distal root of the patient's LL6. As a result, you failed to offer the patient RCT before providing a crown (head of charge 21). In deciding that your failure to offer RCT was a serious failing, the Committee took into account Mr Pal's opinion

that *"A reasonably competent dentist on seeing such a feature and contemplating a crown would suggest a RCT to the tooth before the crown is provided. Not doing so carries the risk of future pain and infection to the tooth".* The Committee took into account that the patient subsequently lost the tooth. In all the circumstances, the Committee was satisfied that its finding at head of charge 21 amounts to misconduct.

79. The Committee next considered your failure to take bitewing radiographs of a patient between 19 March 2020 and 22 October 2021 (head of charge 4). Whilst the Committee noted that this failing related to the care of one patient, the failure persisted over a significant period of time. Caries was detected on an OPG radiograph, and as highlighted by Mr Pal, this patient's caries risk profile meant that, in the absence of bitewing radiographs, there was a possibility that other carious lesions were missed, particularly any early or interdental caries. The Committee was therefore satisfied that your failing to take bitewing radiographs on this occasion was sufficiently serious to amount to misconduct.

80. The Committee went on to consider its findings regarding your treatment of a wrong tooth (heads of charge 11b and 11c). It took into account that this incident related to a single tooth. However, given that the wrong treatment was provided and also to a poor standard, the Committee was satisfied that these were serious findings that amount to misconduct. Both experts opined that, if found proved, this incident and the resulting poor standard of treatment were matters that fell far below what was expected**.** The Committee also noted that a finding of misconduct in relation to heads of charge 11b and 11c was not contested on your behalf.

81. In relation to the instance where you failed to record the treatment you provided to a patient (head of charge 12), the Committee considered this to be a serious omission. In its view, not to make any record of treatment at all was conduct that represented a significant departure from the standard expected of a reasonably competent dentist. The GDC Standards make clear that you must make and keep contemporaneous, complete and accurate patient records. Record keeping is important for the safe continuity of care of patients. Therefore, whilst this was a single instance of poor record keeping, the Committee was satisfied that it was sufficiently serious to amount to misconduct.

82. You also failed to diagnose caries in one patient (head of charge 15b). This failing related to a single tooth over a relatively short period of time and the failing is not repeated in any of the other findings. Taking this into account, the Committee concluded that whilst this was a falling below what was required, this failing was not so serious as to amount to misconduct.

83. The Committee next considered your other record keeping failures in this case (as set out at head of charge 17). In doing so, it had regard to Mr Pal's evidence regarding the categorisation of your record keeping in general. However, the matters found proved at head of charge 17 are not in relation to general record keeping. The majority of the Committee's findings at head of charge 17 highlight specific instances when you failed to record or record accurately important information in respect of the oral health of patients, in particular failing to record details of extra-oral examinations, the clinical appearance of caries, BPEs and recording inaccurate mouth cancer risk. These failings in record keeping were repeated on multiple occasions in relation to multiple patients. Record keeping is a basic and fundamental aspect

of clinical practice, and as previously noted, is essential for the safe continuity of care of patients. The Committee had regard to the potential risk for harm in the absence of complete and accurate clinical records, particularly in relation to the risk of mouth cancer. The Committee was satisfied that your poor record keeping at head of charge 17, with the exception of the matters found proved at head of charge 17p, represented a pattern of conduct that fell far below what was expected in the circumstances.

84. In relation to head of charge 17p, the Committee recognised that those record keeping failings related to you not having recorded any dietary advice given in relation to five patients. Whilst the Committee considered that this is information that you should have recorded to ensure that the patients' clinical records were complete, it took into account the absence of the potential for harm from not having made entries regarding any dietary advice. Therefore, the Committee concluded that the five instances concerned were not sufficiently serious to amount to misconduct.

85. Lastly, the Committee considered the non-clinical conduct it found proved (heads of charge 22, 23 and 24a). This was your misleading conduct in not initially informing NHS England of your interim conditions and when they were subsequently amended. The Committee concluded in its findings on the facts that your initial notification failure was a genuine oversight borne out of your confusion over terminology used in the conditions. Further, that your second notification failure occurred because you genuinely believed that NHS England had been informed on your behalf by Witness 1. In these circumstances, the Committee decided that neither failing crossed the threshold for a finding of misconduct.

86. Having considered all matters, the Committee was satisfied that the facts found proved at heads of charge 2, 4, 11b and 11c, 12 13, 17 (with the exception of 17p) 20 and 21 amount to misconduct.

Decision on deficient professional performance

87. In accordance with the legal advice it accepted, the Committee only considered those heads of charge that did not amount to misconduct in reaching its decision on deficient professional performance. These were its findings at heads of charge 1, 3 15b and 17p, 22, 23 and 24a namely:

- Your failure to obtain informed consent for a filling that was not clinically indicated, relating to one patient (heads of charge 1 and 3).
- Your failure to diagnose caries in one patient (head of charge 15b).
- Your failure to record any dietary advice given in respect of five patients (head of charge 17p)
- Your failure to inform NHS England about your interim conditions of practice order and the later amendment thereto (heads of charge 22, 23 and 24a).

88. It was the view of the Committee that none of these instances represented a fair sample of your work. In reaching its decision, the Committee took into account that your failure to record any dietary advice related to five patients, but this was five out of the over 30 patients considered in this case.

89. Accordingly, the Committee determined that deficient professional performance is not made out on the facts of this case.

90. The Committee therefore considered the issue of current impairment only in relation to the misconduct found.

91. For the reasons already given at paragraphs 76, 82, 84 and 85 above, the Committee determined that heads of charge 1, 3, 15b, 17p, 22, 23 and 24a did not constitute either misconduct or deficient professional performance.

Decision on current impairment by reason of misconduct

92. The Committee considered whether your fitness to practise is currently impaired by reason of your misconduct. It bore in mind the overarching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

93. The Committee considered that the failings that led to your misconduct are remediable. Whilst the identified deficiencies were serious and related to your care and treatment of a number of patients, the concerns are all clinical in nature which, in the Committee's view, are capable of being remedied by learning and professional development. The Committee took into account that the misconduct found does not include any attitudinal concerns, which might make remediation more difficult.

94. In considering whether your failings have in fact been remedied, the Committee had regard to the evidence of the steps you have taken to address the issues raised in this case. The Committee considered your personal reflective statement and had regard to the evidence of your CPD activity.

95. The Committee found that your personal reflections on this case, as a whole, were thorough and demonstrated an understanding of where things had gone wrong in your clinical practice during the period in question and how you might act differently in the future. The Committee also noted your apology for your failings, and it considered that you demonstrated genuine contrition for your clinical shortcomings. You stated that *"I remain deeply upset, embarrassed, and genuinely remorseful for my actions. This experience has had a profound impact on me, and I have reflected extensively on the seriousness of my conduct and the importance of maintaining the highest professional standards at all times, both inside and outside of my professional role".* The Committee considered from the evidence of your CPD that you have

made considerable attempts to remediate your failings. It found that your CPD had been appropriately targeted to the concerns in this case, and it noted that your learning has taken place over a period of time.

96. However, the Committee remained concerned about the extent of your reflections on your CPD itself. Whilst it considered that you have shown partial insight in understanding what it is you need to do to address the deficiencies identified in your clinical practice, it found that there is limited evidence that your learning has been embedded. It was the view of the Committee, when considering your reflections on your CPD, that there was insufficient evidence in this regard to reassure it that you had fully engaged with your learning. In the Committee's view, it is difficult to embed CPD in the absence of adequate reflection. The Committee also took into account your PDP. Whilst the Committee noted that there were some aspects within it that represented a plan for personal development, it found that a considerable proportion of the document comprised a respective log of CPD that you have already completed.

97. The Committee also had concerns about the sufficiency of information in the workplace supervision reports provided. Whilst it took into account that no further concerns have been raised by your Workplace Supervisor, it found that the reports focused on matters outside of this Committee's remit. Further, in relation to the record keeping audits provided, the Committee noted that a number of these are not signed or quality assured. It also noted that there was little evidence of your reflection on the audits in the context of your current practice.

98. In considering its concerns about whether your learning has been sufficiently embedded, the Committee took into account the issue of the published warning you received in respect of treatment that you provided to a patient from March to May 2023. This was six months into your practice under interim conditions when, as highlighted in the warning, concerns were still being raised including in relation to your radiographic practice and record keeping.

99. The Committee took into account that the misconduct in this case before it persisted over a protracted period time, with some of the failings occurring on multiple occasions. It was its conclusion, having considered all the evidence, that it could not be satisfied, at this stage, that it was highly unlikely that your failings would be repeated. In its view, the risk of repetition is ongoing, and as such, a finding of impairment is necessary for the protection of the public.

100. The Committee also determined that a finding of impairment is required in the wider public interest. It considered that a reasonable and informed member of the public would expect such a finding, given the gravity of your misconduct and the Committee's concerns about your developing insight and remediation. The Committee also remained mindful that you are currently subject to a published warning relating to some similar concerns. It was the view of the Committee that public confidence in the dental profession would be undermined if a finding of impairment were not made in all the circumstances of this case. It also considered the need to uphold proper professional standards.

101. The Committee therefore determined that your fitness to practise is currently impaired by reason of your misconduct on both public protection and wider public interest grounds.

Decision on sanction

102. Having found your fitness to practise to be impaired, the Committee considered what sanction, if any, to impose on your registration. It took into account that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest. The Committee had regard to the ISG Guidance applicable to these proceedings. It applied the principle of proportionality, balancing the public interest with your own interests.

103. The Committee noted that it was open to it to conclude this case without taking any action in relation to your registration. However, it decided that such an outcome would be wholly inappropriate, given the identified risk of repetition and the wider public interest concerns. The Committee concluded that taking no further action would not serve to protect the public nor would it uphold the wider public interest.

104. In deciding on the appropriate sanction, the Committee considered the issue of mitigating and aggravating factors. In mitigation, it considered that the following to be applicable in this case:

- Evidence of remorse shown, some insight and apology given.
- Evidence of steps taken to avoid repetition.
- No financial gain on your part.
- The time elapsed since your misconduct.

105. The Committee also identified the following aggravating factors:

- Actual harm or risk of harm to a patient.
- That your misconduct was sustained over a period in excess of five years.

106. In respect of your published warning, the Committee took into account that this was issued in relation to events that occurred around the same time as some of the matters in this case. Therefore, the Committee did not categorise it as a *"previous warning"* within the context of the aggravating factors set out paragraph 5.18 of the ISG Guidance.

107. In considering sanction, the Committee also took into account that it had before it a number of positive testimonials, including one from your Workplace Supervisor.

108. The Committee first considered whether the sanction of reprimand was appropriate and proportionate. However, having had regard to the relevant guidance at paragraphs 6.7 to 6.9 of the ISG Guidance, the Committee concluded that a reprimand would not be sufficient in all the circumstances. In the Committee's judgement, the misconduct in this case is not at the lower end of the spectrum. Furthermore, the Committee took into account that a reprimand imposes no restriction on a registrant's registration and should therefore, only

be issued where no risk is posed to patients or the public and the registrant can continue practising without restriction. Having noted these factors, the Committee decided that a reprimand would not protect the public or maintain public confidence in the dental profession.

109. The Committee next considered whether to impose a conditions of practice order on your registration. In doing so, it had regard to its view that the clinical failings highlighted in this case are remediable. It also took into account that you have demonstrated a level of insight into the failings, have reflected on them and have made considerable efforts in remediation. The Committee was satisfied, considering the nature of the identified deficiencies, that it could formulate a set of workable conditions which would protect the public and the wider public interest. It was also satisfied, on the basis of the evidence before it, that you would comply with any conditions imposed.

110. In deciding whether conditions of practice would be an appropriate and proportionate outcome, the Committee considered the sanction of suspension. In doing so, it had regard to the factors for imposing a suspension order, as set out at paragraph 6.28 of the ISG Guidance. The Committee took into account that, whilst it has identified a risk of repetition, you have demonstrated some insight into your misconduct and shown genuine contrition. Also, there are no concerns about any attitudinal failings. In these circumstances, the Committee was satisfied that a lesser sanction than suspension would sufficiently protect the public and the wider public interest. The Committee therefore concluded that the suspension of your registration would be disproportionate.

111. Accordingly, the Committee determined to impose a conditions of practice order on your registration. The conditions will be imposed for a period of 12 months. The Committee considered that a 12-month period would give you with sufficient opportunity to provide evidence of how you have embedded your remediation into your clinical practice. The Committee was also satisfied that a 12-month period is appropriate and proportionate to protect the public and the wider public interest.

112. The following conditions will appear alongside your name in the GDC Register:

1. You must work with a Postgraduate Dental Dean/Director (or a nominated deputy), to formulate a Personal Development Plan (PDP), specifically designed to address the deficiencies in the following areas of your practice:

    - Record keeping, including in relation to recording:
        - details of extra-oral examinations;
        - the clinical appearance of caries;
        - accurate mouth cancer risk; and
        - BPE scores.
    - Prescribing radiographs.
    - Radiographic reporting.

2. You must forward a copy of your PDP to the GDC within three months of the date on which these conditions become effective.

3. You must meet with the Postgraduate Dental Dean/Director (or a nominated deputy), on a regular basis to discuss your progress towards achieving the aims set out in your PDP. The frequency of your meetings is to be set by the Postgraduate Dental Dean/Director (or a nominated deputy).

4. You must allow the GDC to exchange information about the standard of your professional performance and your progress towards achieving the aims set out in your PDP with the Postgraduate Dental Dean/Director (or a nominated deputy), and any other person involved in your retraining and supervision.

5. You must notify the GDC promptly of any professional appointment you accept and provide the contact details of your employer or any organisation for which you are contracted to provide dental services and the Commissioning Body on whose Dental Performers List you are included [or Local Health Board if in Wales, Scotland or Northern Ireland].

6. You must allow the GDC to exchange information with your employer or any organisation for which you are contracted to provide dental services, and any Postgraduate Dental Dean/Director, Reporter, Workplace Supervisor or Educational Supervisor referred to in these conditions.

7. At any time you are providing dental services, which require you to be registered with the GDC, you must agree to the appointment of a Reporter nominated by you and approved by the GDC. The Reporter shall be a GDC registrant and shall not be the same person as any Workplace Supervisor referred to in these conditions.

8. You must allow the Reporter to provide reports to the GDC at intervals of not more than three months and the GDC will make these reports available to any Postgraduate Dental Dean/Director, Workplace Supervisor or Educational Supervisor referred to in these conditions.

9. You must inform the GDC of any formal disciplinary proceedings taken against you, from the date of this determination.

10. You must inform the GDC if you apply for dental employment outside the UK.

11. At any time you are employed, or providing dental services, which require you to be registered with the GDC; you must place yourself and remain under the supervision* of a Workplace Supervisor nominated by you, and agreed by the GDC.

12. You must allow your Workplace Supervisor to provide completed and signed reports to the GDC at intervals of not more than two months and the GDC will make these reports available to any Postgraduate Dean/Director or Educational Supervisor referred to in these conditions.

13. You shall carry out an audit, every month, in relation to the following areas of your practice:

    - Record keeping, including in relation to recording:
        - details of extra-oral examinations;
        - the clinical appearance of caries;
        - accurate mouth cancer risk; and
        - BPE scores.
    - Prescribing radiographs.
    - Radiographic reporting.

    Each audit should include a sample of at least 20 patients. The audits must be signed by your Workplace Supervisor and be evidenced as quality assured.

14. You must provide copies of the audits referred to in Condition 13 above to the GDC every two months or, alternatively, confirm that there have been no such cases.

15. You must inform, within seven days, the following parties that your registration is subject to the conditions, listed at 1 to 14 above:

    - Any organisation or person employing or contracting with you to undertake dental work.
    - Any locum agency or out-of-hours service you are registered with or apply to be registered with (at the time of application).
    - Any prospective employer (at the time of application).
    - The Commissioning Body on whose Dental Performers List you are included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application).

16. You must permit the GDC to disclose the above conditions, 1 to 15, to any person requesting information about your registration status.

***Supervised:**

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

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

113. The Committee directs that there should be a review of this conditions of practice order at a resumed hearing to be held shortly before the end of the 12-month period. The Committee at the resumed hearing will consider what action to take in respect of your registration at that time. You will be informed of the date and time of that hearing in due course.

114. Unless you exercise your right of appeal, your registration will be made subject to the above conditions for a period of 12 months, starting 28 days from the date that notice of this Committee's direction is deemed to have been served upon you.

115. The Committee now invites submissions from Ms Tahta and from Mr Cridland, as to whether an immediate order of conditions should be imposed on your registration to cover the 28-day appeal period, pending the taking effect of its substantive direction for conditions.

Decision on an immediate order – 24 July 2026

116. The Committee has made a substantive determination in this case regarding your fitness to practise, therefore the interim order currently in place on your registration in relation to this matter is hereby revoked.

117. In considering whether to impose an immediate order of conditions on your registration, the Committee took account of Ms Tahta's application that such an order should be imposed. She submitted that, given the Committee's findings in its substantive determination, an immediate order is necessary to protect the public. She stated that in the absence of an immediate order, you would be free to practise unrestricted for the next 28 days, or for longer in the event of an appeal. Ms Tahta further submitted that an immediate order is required to maintain public confidence in the dental profession.

118. Mr Cridland stated that, given the terms of the Committee's substantive determination, he had no submissions to make in relation to an immediate order. He stated that the matter was for the Committee's discretion.

119. The Committee accepted the advice of the Legal Adviser, who confirmed the factors it should take into account in reaching its decision, as set out at paragraphs 6.35 to 6.38 of the ISG Guidance.

120. In all the circumstances, having considered its substantive determination, the Committee was satisfied that the imposition of an immediate order of conditions on your registration is necessary for the protection of the public and is otherwise in the public interest.

121. The Committee has identified a risk of repetition in this case, on account of the developing nature of your insight and remediation. It noted from the ISG Guidance that an immediate order might be considered appropriate where a registrant's behaviour is considered to pose a risk to the public. The Committee was therefore satisfied that in this case an immediate order is necessary on public protection grounds.

122. The Committee was also satisfied, taking into account its substantive findings, that

immediate action in respect of your registration is required to maintain public confidence in the dental profession and to uphold proper professional standards.

123. The effect of the foregoing substantive determination and this order is that your registration will be made immediately subject to the conditions set out above to cover the appeal period. Unless you exercise your right of appeal, the substantive order of conditions will take effect 28 days from the date of deemed service and will continue for a period of 12 months.

124. Should you exercise your right of appeal, this immediate order will remain in place until the resolution of the appeal.

125. That concludes this determination.