

**GENERAL DENTAL COUNCIL**

**AND**

**AYDON, Ashley Alexander**

**[Registration number: 216684]**

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**NOTICE OF INQUIRY**

**SUBSTANTIVE HEARING**

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Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council commencing at **09:30 am**.

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

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

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**Committee members:** Gaon Hart Lay Chair  
Sarah Benton Dentist  
Christopher Parker

**Legal Adviser:** Julien Weinberg

## CHARGE

AYDON, Ashley Aexandre, a dentist, National Certificate NEBDN 2011 is summoned to appear before the Professional Conduct Committee on 7 April 2026 for an inquiry into the following charge:

### The Charge

The hearing will be held to consider the following charge against you:

“That being a registered Dental Care Professional, whilst employed as a Practice Manager at Practice A<sup>1</sup> (as identified in Schedule A):

1. Between July 2021 and 27 January 2022, you failed to ensure Practice A’s fire logbook was fully completed.
2. You failed to ensure all cupboards and/or drawers within Practice A were adequately cleaned, on or around 12 January 2022.
3. By 12 January 2022, you failed to ensure:
  - (a) all staff at Practice A were familiar with BUPA’s ‘Winter COVID SOP’;
  - (b) BUPA’s ‘Winter COVID SOP’ was being fully implemented;
  - (c) Practice A had in place a written complaints procedure, that all staff members were aware of;
  - (d) Practice A had a written complaints procedure on display in the Practice;
  - (e) all clinical staff at Practice A were familiar with BUPA’s ‘Wrong Site, Wrong Patient’ SOP;
  - (f) Practice A’s ‘sharps safety’ posters were up-to-date;
4. By 27 January 2022, you failed to ensure:
  - (a) Practice A’s safeguarding chart was up-to-date;
  - (b) Practice A had in place an effective system for the management of referrals.
5. Between 20 September 2019 and 31 January 2022, you failed to ensure Practice A had adequate systems in place to ensure decontamination validation tests (Helix tests) were:
  - (a) performed sufficiently regularly;
  - (b) recorded appropriately.
6. You failed to ensure equipment at Practice A was appropriately maintained and/or fit for use, in that:

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<sup>1</sup> Schedule A is a private document that cannot be disclosed.

- (a) between July 2021 and 27 January 2022, you failed to ensure damaged x-ray equipment, found in surgery 4 of Practice A, had been appropriately repaired;
  - (b) you did not ensure compressor checks were conducted and/or recorded from 1 to 12 January 2022;
  - (c) by 12 January 2022, you did not ensure Practice A had a working illuminated magnifier;
  - (d) by 27 January 2022, you did not ensure all hand pieces had been serviced.
7. You failed to ensure medicines in Practice A were being appropriately managed, resulting in:
- (a) expired adrenaline (found by witness LK on 12 January 2022) not being removed from an emergency drugs kit;
  - (b) expired local anesthetic cartridges (found by witness LK on 12 January 2022) not being removed from surgery 2, in Practice A;
  - (c) the fridge temperature checklist for Practice A, not being completed at any time, between 1 and 12 January 2022;
  - (d) local anaesthetic cartridges, (found in surgery 1 of Practice A, by Witness 2, on 27 January 2022), not being stored in blister packs until the point of use.
8. You failed to ensure staff at Practice A were appropriately trained and/or competent to fulfil the rolls assigned to them, in that:
- (a) you did not ensure Witness 3 was:
    - (i) fully aware of her duties and responsibilities as Practice A's Infection Prevention and Control (IPC) Lead;
    - (ii) sufficiently trained and/or competent to safely fulfil the role of IPC Lead;
  - (b) you did not ensure Witness 4 was:
    - (i) sufficiently trained and/or competent to safely fulfil the role of Fire Marshall at Practice A;
    - (ii) provided with any appropriate training, after she told you she was uncomfortable completing fire safety checks and filling put the fire logbook;
    - (iii) provided with any training on COVID pre-treating protocols;
  - (c) you did not ensure Witness 5 was provided with appropriate training, in advance of becoming Practice A's Practice Coordinator.

9. By 27 January 2022, you failed to adequately respond to all of the areas of concern highlighted by witness 1 following their visit to Practice A on 12 January 2022.
10. Your conduct in some or all of Charges 1 to 9 above put patient safety at risk.
11. From 25 April 2023 to 18 October 2023, you failed to cooperate with an investigation conducted by the General Dental Council (GDC), in that you did not return a completed 'consent for health assessment' form to the GDC.

AND that by reason of the matters alleged above your fitness to practise is impaired

by reasons of misconduct”.