HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

31 March to 1 April 2025

Name:	FARROKHE, Taghi
Registration number:	71389
Case number:	CAS-203327

General Dental Council:	Tom Stevens, counsel Instructed by Ervin Gjoleka, Capsticks solicitors
Registrant:	Present Represented by Ranald Davidson, counsel Instructed by Stewart Duffy, Weightmans solicitors

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Fitness to Practise Impaired. Reprimand Issued
Duration:	N/A
Immediate order:	N/A

Committee members:	Carson Black (Dentist) (Chair) Louise Fletcher (Dental Care Professional) Jane Jones (Lay)
Legal adviser:	Richard Ferry-Swainson
Committee Secretary:	Gareth Llewellyn

Determination on preliminary matters and facts – 31 March 2025

Mr Farrokhe

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 Ranald Davidson of counsel, instructed by Stewart Duffy of Weightmans solicitors. Tom Stevens of counsel, instructed by Ervin Gjoleka of Capsticks solicitors, appears for the General Dental Council (GDC).

The charge

3. The charge that you face at this hearing reads as follows:

"*That being a registered dentist:*

1. *You failed to provide an adequate standard of care to Patient A (identified in Schedule A), from 6 March 2015 to 2 May 2019, in that:*

a. *you did not adequately diagnose and/or treat peri-implant disease between 6 March 2015 and 2 May 2019;*
b. *prior to fitting an implant-retained bridge on 16 September 2017, you did not:*

i. *adequately assess Patient A's lower arch implants radiographically;*
ii. *adequately assess Patient A's lower arch implants clinically, through visual inspection and probing;*
iii. *adequately diagnose the presence of peri-implant disease at Patient A's implants;*
iv. *adequately plan a fixed implant retained bridge in light of the failing implants present;*
v. *discuss with Patient A the specific risks associated with the treatment proposed.*

2. *By reason of your conduct in Charge 1.b.i and/or 1.b.ii and/or 1.b.v. you did not obtain Patient A's informed consent for the bridge provided.*

3. *During Patient A's appointment on 25 March 2020, after Witness 1 asked you a question you:*

a. *stopped your treatment of Patient A;*
b. *forcefully opened the treatment room door;*
c. *said in a raised voice and in close proximity to witness 1, words to the effect of: "you can leave now, and if you don't get out I'll physically remove you";*
d. *said in a raised voice and in close proximity to witness 1 (in response to witness 1 saying he did not want to leave), words to the effect of: "no, you'll get out now";*
e. *told Patient A that he should leave and that that you would not treat him anymore.*

4. *Your conduct in charge 3.a. and/or 3.b. and/or 3.c. and/or 3.d. and/or 3.e.:*

a. *was unprofessional;*
b. *failed to treat Patient A and/or Witness 1 with dignity and respect.*

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

Background to the case and summary of allegations

4. The allegations giving rise to this hearing arise out of the care and treatment that you provided to a patient, who is referred to as Patient A for the purposes of these proceedings.

5. It is alleged that you failed to provide an adequate standard of care to Patient A in the period of 6 March 2015 to 2 May 2019. This allegation is made in relation to two specific aspects of your care and treatment. First, it is alleged that you did not adequately diagnose and/or treat peri-implant disease. Second, it is alleged that there were a number of deficiencies in your assessment, diagnosis, treatment-planning and patient communication which were evident before you fitted an implant-retained bridge. The GDC further alleges that, as you did not adequately assess Patient A's lower arch implants both radiographically and clinically, and as you did not discuss with the patient the specific risks associated with the treatment proposed, you failed to obtain the patient's informed consent for the implant-retained bridge that you provided.

6. You face further allegations in relation to your conduct at an appointment that patient A attended with you on 25 March 2020. Patient A was accompanied at that appointment by his son, who is referred to as Witness 1. The GDC alleges that you spoke in an unprofessional manner, and that you failed to treat patient A and/or Witness 1 with dignity and respect.

Evidence

7. The Committee has been provided with documentary material in relation to the heads of charge that you face, including:

   - the witness statement, documentary exhibits and patient records of Patient A;
   - the witness statement of Patient A's son, who is referred to for the purposes of these proceedings as Witness 1;
   - the witness statement and documentary exhibits of another treating dentist at a different dental practice, who is referred to as Witness 2;
   - The report of the GDC's expert witness, namely Geoffrey Bateman.

8. The Committee heard no oral evidence at this stage of the hearing.

Determination of admissions

9. At the outset of the hearing, and at the preliminary stage, Mr Davidson tendered admissions on your behalf to all of the heads of charge that you face. Where heads and sub-heads of charge were raised in the alternative, that is to say 'and/or', Mr Davidson stated that the head or sub-head is admitted at its highest, that is to say on the basis of 'and'. The Committee, having accepted the advice of the Legal Adviser, determined and announced that the facts alleged at each of the heads and sub-heads of charge were proven on the basis of your admissions in accordance with Rule 17 (4) of the General Dental Council (Fitness to Practice) Rules 2006 ('the Rules'). For clarity, the Committee's factual findings are set out in the following table:

1.	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A), from 6 March 2015 to 2 May 2019, in that:*
1. (a)	*you did not adequately diagnose and/or treat peri-implant disease between 6 March 2015 and 2 May 2019;* **Admitted and proved**
1. (b)	*prior to fitting an implant-retained bridge on 16 September 2017, you did not:*
1. (b) (i)	*adequately assess Patient A's lower arch implants radiographically;*

	Admitted and proved
1. (b) (ii)	*adequately assess Patient A's lower arch implants clinically, through visual inspection and probing;* **Admitted and proved**
1. (b) (iii)	*adequately diagnose the presence of peri-implant disease at Patient A's implants;* **Admitted and proved**
1. (b) (iv)	*adequately plan a fixed implant retained bridge in light of the failing implants present;* **Admitted and proved**
1. (b) (v)	*discuss with Patient A the specific risks associated with the treatment proposed.* **Admitted and proved**
2.	*By reason of your conduct in Charge 1.b.i and/or 1.b.ii and/or 1.b.v. you did not obtain Patient A's informed consent for the bridge provided.* **Admitted and proved**
3.	*During Patient A's appointment on 25 March 2020, after Witness 1 asked you a question you:*
3. (a)	*stopped your treatment of Patient A;* **Admitted and proved**
3. (b)	*forcefully opened the treatment room door;* **Admitted and proved**
3. (c)	*said in a raised voice and in close proximity to witness 1, words to the effect of: "you can leave now, and if you don't get out I'll physically remove you";* **Admitted and proved**
3. (d)	*said in a raised voice and in close proximity to witness 1 (in response to witness 1 saying he did not want to leave), words to the effect of: "no, you'll get out now";* **Admitted and proved**
3. (e)	*told Patient A that he should leave and that that you would not treat him anymore.* **Admitted and proved**
4.	*Your conduct in charge 3.a. and/or 3.b. and/or 3.c. and/or 3.d. and/or 3.e.:*
4. (a)	*was unprofessional;* **Admitted and proved**

4. (b)	*failed to treat Patient A and/or Witness 1 with dignity and respect.* **Admitted and proved**

10. We move to stage two.

Determination on misconduct, impairment and sanction – 1 April 2025

11. Following the handing down of the Committee's findings of fact on 31 March 2025, the hearing proceeded to stage two; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

12. The Committee has considered all the evidence presented to it, both oral and documentary. It has taken into account the submissions made by Mr Stevens on behalf of the GDC and those made by Mr Davidson on your behalf as summarised below. In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

Evidence at stage two

13. The Committee has been provided with further documentary evidence at this stage of the hearing. This information includes certificates of and reflections upon continuing professional development (CPD) that you have undertaken; personal development plans (PDPs); workplace reporter reports provided in connection with interim conditions to which your registration has been subject, supervisory audits, logs and reflections on your clinical practice; patient survey results; testimonial letters from patients and colleagues; and a reflective statement from you.

14. The Committee heard no oral evidence at this, or indeed the previous, stage of the hearing.

Fitness to practise history

15. Mr Stevens addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Stevens set out your fitness to practise in the following terms, and stated that these matters were not ultimately considered by a Practice Committee. Mr Stevens stated that you received a warning in April 2010 in relation to your advertising practices, that you received advice in September 2019 in relation to your treatment of a patient in 2017; that you received a warning in May 2023 in relation to concerns about your treatment of a number of patients in the period of 2011 to 2017, including record-keeping and diagnostic assessment; and that in May 2024 you received a warning in relation to your care and treatment, and particularly your endodontic practice including consent, arising from events from 2011 to 2014.

Summary of submissions

16. Mr Stevens on behalf of the GDC submitted that the facts that the Committee has found proved amount to misconduct. Mr Stevens submitted that the GDC is neutral as to the question of whether your fitness to practise is currently impaired by reason of misconduct. Mr Stevens submitted that, were the Committee instead to find that your fitness to practise is currently impaired, a sanction of conditions would represent a suitable outcome if public protection risks only are identified. In the alternative, if no such public protection risks are identified and a finding of impairment is required only in the public interest, no higher sanction than that of a reprimand would be appropriate.

17. Mr Davidson on your behalf submitted that he does not seek to argue against a finding of misconduct. Mr Davidson submitted that, were the Committee to determine that the facts that it has found proved do amount to misconduct, the Committee would be entitled to find that your fitness to practise is not currently impaired in relation to either the clinical or behavioural issues summarised above in light of the insight and extensive remediation that you have undertaken. Mr Davidson submitted that, were the Committee to determine that you have not in fact remedied the clinical issues, no higher sanction than that of conditions would be appropriate, or if it were to find that your fitness to practise is impaired in relation to the behavioural matters, a reprimand would be appropriate.

Misconduct

18. The Committee considered whether the facts that it has found constitute misconduct. In considering this and all other matters, the Committee has exercised its own independent judgement.

19. In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the facts that the Committee has found proved. These paragraphs state that as a dentist:

1.2 You must treat every patient with dignity and respect at all times.

1.2.1 You should be aware of how your tone of voice and body language might be perceived.

1.2.3 You must treat patients with kindness and compassion.

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

3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

- *options for treatment, the risks and the potential benefits;*
- *why you think a particular treatment is necessary and appropriate for them;*
- *the consequences, risks and benefits of the treatment you propose;*
- *the likely prognosis;*
- *your recommended option;*
- *the cost of the proposed treatment;*
- *what might happen if the proposed treatment is not carried out; and*
- *whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.*

7.1 You must provide good quality care based on current evidence and authoritative guidance.

9.1 You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.

9.1.1 You must treat all team members, other colleagues and members of the public fairly, with dignity and in line with the law.

20. The Committee's findings relate to the care and treatment that you provided to a patient, who is referred to as Patient A. The Committee has found that you failed to provide an adequate

standard of care to Patient A in the period of 6 March 2015 to 2 May 2019, in that you did not adequately diagnose and treat peri-implant disease, or adequately assess the patient, plan treatment or discuss the risks of the treatment with the patient prior to fitting an implant-retained bridge. The Committee also found that, as you did not adequately assess Patient A's lower arch implants both radiographically and clinically, and as you did not discuss with the patient the specific risks associated with the treatment proposed, you failed to obtain the patient's informed consent for the implant-retained bridge that you provided. The Committee also found that, at an appointment that Patient A attended with you on 25 March 2020 at which he was accompanied by his son, who is referred to as Witness 1, you spoke in an unprofessional manner, and that you failed to treat Patient A and Witness 1 with dignity and respect.

21. In light of the findings of fact that it has made, the Committee has determined that those facts amount to misconduct. The Committee notes that your clinical failings relate to basic and fundamental aspects of the safe practice of dentistry, and consist of acts and omissions that persisted over a considerable period of time. Your clinical failings resulted in actual harm to the patient in question, as well as giving rise to the risk of harm. The Committee has taken note of the opinion of the GDC's expert witness, namely Geoffrey Bateman, that your clinical practice fell far below the reasonable standards of a registered dentist. The Committee considers that your conduct, both clinical and in relation to your conduct and comments towards Patient A and Witness 1, was a serious falling short of the standards reasonably to be expected of a registered dentist. Furthermore, in the Committee's judgement your conduct would be viewed as deplorable by your fellow practitioners.

22. The Committee has therefore determined that the facts that it has found proved amount to misconduct.

Impairment

23. The Committee next considered whether your fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee again exercised its own independent judgement. Throughout its deliberations, the Committee has borne in mind that its overarching objective is to protect the public, which includes the protection of patients and the wider public, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

24. The Committee considers that your clinical failings as summarised above are capable of being remedied, relating as they do to specific and identifiable aspects of practice. The Committee notes that you have undertaken a considerable amount of remediation of your misconduct. The evidence presented to the Committee is that you have carefully reflected upon your clinical failings, have reflected upon and have shown willing to make the necessary improvements in the relevant aspects of your practice, and have provided considerable and persuasive evidence of you having remedied your misconduct. The Committee also notes that there has been no reported repetition of your misconduct, and a considerable number of years have elapsed since the events in question. In the circumstances, the Committee considers that a repeat of your clinical failings is highly unlikely, and that your fitness to practise is not currently impaired on public protection grounds.

25. The Committee also considers that the conduct that it has found in relation to your behavioural conduct is also not such as to impair your fitness to practise. The Committee considers that your actions relate to an isolated single lapse, with no similar incidents having occurred prior to or since the events in question. The Committee also notes that you have undertaken some remediation in relation to these behavioural matters, including further learning about dealing with complaints and managing stress. The Committee has therefore concluded that your fitness to practise is similarly not impaired on public protection grounds in relation to this aspect of your misconduct.

26. However, the Committee considers that a finding of impairment is, nonetheless, required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment were not made given the serious nature of your misconduct. Your misconduct entailed actual harm being caused to the patient in this case, as well as an unwarranted risk of harm, over a sustained and significant period of time. The Committee considers in particular that your failings in relation to informed consent require an appropriate marking for public interest considerations. Accordingly, the Committee has determined that a declaration of impairment is required in the wider public interest.

Sanction

27. The Committee then determined what sanction, if any, is appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have such an effect, but is instead imposed to protect patients and safeguard the wider public interests mentioned above.

28. In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has applied the principle of proportionality, balancing the public interest with your own interests. The Committee has once more exercised its own independent judgement.

29. The Committee has paid careful regard to the mitigating and aggravating factors present in this case.

30. In respect of the mitigating factors that are present, the Committee notes your good conduct since the events giving rise to these proceedings, as well as the remorse, insight and apology that you have evidenced. You have taken steps to remedy your misconduct, and the events giving rise to this case occurred a considerable period of time ago. Whilst your clinical misconduct was sustained over a lengthy period of time, those failings relate to a single patient case, and your behavioural misconduct relates to a single event. The Committee also notes that your conduct resulted in no apparent financial gain.

31. In terms of aggravating factors, the Committee notes that your conduct resulted in actual harm to Patient A, as well as creating the risk of harm. Your clinical misconduct was sustained and repeated over a considerable period of time. The Committee also considers that your failure to obtain informed consent represents a breach of the trust that Patient A placed in you. The Committee has also taken note of your fitness to practise history as summarised above.

32. The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of its findings, the Committee considers that taking no action would not be sufficient in the particular circumstances of this case. In the Committee's judgement public trust and confidence in the profession and in the regulatory process would be significantly undermined if no action were taken.

33. The Committee next considered whether it would be appropriate to conclude the case with a reprimand. After careful consideration the Committee has concluded that it would be appropriate and proportionate to issue a reprimand. The Committee has found that you do not pose a risk to the public, that you have shown remorse for, insight into and remediation of your misconduct, that your conduct was not deliberate, and that your behavioural conduct was isolated. The Committee considers that a reprimand is sufficient to declare and uphold proper professional standards of conduct and behaviour, and to maintain public trust and confidence in the profession in the particular circumstances of this case.

34. The Committee did consider whether a higher sanction such as a period of conditional or suspended registration would be appropriate. It considered that no higher sanction than that of reprimand is needed in order to address the public interest considerations referred to above. Indeed, as the issues that the Committee has identified relate to public interest rather than public protection matters, a higher sanction of conditions or suspension would not be appropriate or proportionate.

35. This reprimand, and a copy of the public determination, will appear alongside your name in the register for a period of 12 months. The reprimand forms part of your fitness to practise history and is disclosable to prospective employers and prospective registrars in other jurisdictions.

Existing interim order

36. In accordance with Rule 21 (3) of the Rules 2006 and section 27B (9) of the Dentists Act 1984 (as amended) the interim order of conditions in place on your registration is hereby revoked.

37. That concludes this case.