

HEARING HELD IN PUBLIC

Professional Conduct Committee Initial Hearing

5 to 12 January 2026

Name: MANIR, Haroon Mohammed Bin

Registration number: 258226

Case number: CAS-209736-S0M5V1

General Dental Council: Daniel Mansell, counsel
Instructed by Ervin Gjoleka, Capsticks solicitors

Registrant: Present
Not represented

Fitness to practise: Impaired by reason of misconduct

Outcome: Suspended with immediate suspension (with a review)

Duration: Three months

Immediate order: Immediate suspension order

Committee members: Martin Isherwood (Dental Care Professional) (Chair)
Jane Jones (Lay)
Annika Hindocha (Dentist)

Legal adviser: Alice Moller

Committee Secretary: Gareth Llewellyn

Determination on preliminary matters – 5 January 2026

Name: MANIR, Haroon Mohammed Bin

Registration number: 258226

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 not represented. Daniel Mansell 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, as amended, reads as follows:

"That, being registered as a Dentist:

1. *On or around 17 November 2022, you failed to maintain adequate standards of cross-infection control when treating Patient 3 (as identified in Schedule 1 below), in that you used an instrument which had been on the floor in the patient's mouth.*
2. *On 8 November 2023, following a request from the General Dental Council, you inaccurately confirmed your current postal address as [redacted].*
3. *From on or around 19 January 2021 to 31 December 2024, you failed to maintain a correct and up to date address with the General Dental Council.*
4. *Your actions at 2 and/or 3 above were misleading.*
5. *You failed to cooperate with an investigation conducted by the General Dental Council in that you:*
 - a) *From on or around 6 February 2024 to 24 June 2024, did not provide the General Dental Council with patient records for Patient 3;*
 - b) *From on or around 8 November 2023 to 9 April 2024, did not provide the General Dental Council with patient records for Patient 1 and Patient 2 (as identified in Schedule 1 below);*
 - c) *From on or around 6 February 2024 to on or around 9 April 2024, did not provide the General Dental Council with evidence of indemnity;*
 - d) *From on or around on or around 6 February 2024, did not provide the General Dental Council with details of your working arrangements.*

And, by reason of the matters set out above, your fitness to practise as a Dentist is impaired by reason of your misconduct."

Amendment to charge

4. At the outset of the hearing on 5 January 2026 Mr Mansell applied to amend the charge pursuant to Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Mansell invited the Committee to amend sub-head of charge 5 (d) by way of removing duplicated and extraneous text. The sub-head of charge originally read as follows:

5. (d) *From on or around on or around 6 February 2023, did not provide the General Dental Council with details of your working arrangements.*

5. Mr Mansell applied to remove the second appearance of the phrase, 'on or around'. You made no objection to the proposed amendment. The Committee, having accepted the advice of the Legal Adviser, determined to accede to the application on the basis that it was fair and appropriate for the amendment to be made. The schedule of charge was duly amended, and appears above in its amended form.

Further amendment to charge – 7 January 2026

6. The Committee did not sit on 6 January 2026.
7. During the course of the GDC's factual case, Mr Mansell applied to amend heads of charge 5 (a), 5 (c) and 5 (d) in order to correct a date that appeared at each of those heads of charge. Mr Mansell invited the Committee to correct the date of 6 February 2023 so that it would instead read 6 February 2024. You made no objection to the proposed amendment. The Committee, having accepted the advice of the Legal Adviser, determined to accede to the application on the basis that it was fair and appropriate for the amendments to be made. The schedule of charge was duly amended, and appears above in its amended form.

Findings of fact – 9 January 2026

Background to the case and summary of allegations

8. The matters giving rise to this hearing relate to your standards of cross-infection control when treating a patient, to your co-operation with the GDC's investigation into your fitness to practise, and to your compliance with the GDC's requirements for keeping your contact details accurate and up-to-date.
9. The GDC alleges that, on or around 17 November 2022, whilst working as a dentist at a dental practice, you failed to maintain adequate standards of cross-infection control when treating a patient, who is referred to for the purposes of these proceedings as Patient 3, in that you used an instrument which had been on the floor in the patient's mouth.
10. The GDC further alleges that on 8 November 2023, following a request that the GDC had made, you inaccurately confirmed your current postal address as being a dental practice which you had in fact left some time earlier in January 2021. The GDC also contends that, for the four-year period of around 19 January 2021 to 31 December 2024, you failed to maintain a correct and up-to-date address with the GDC. The GDC alleges that such matters amount to misleading conduct.
11. You also face allegations of failing to co-operate with the GDC's investigation. It is alleged that you did not provide the GDC with the records for Patient 3 in the approximate period of 6 February 2024 to 24 June 2024, and did not provide the records for two other patients, who are referred to as Patient 1 and Patient 2, in the approximate period of 8 November 2023 to 9 April 2024. The GDC further alleges that, from around 6 February 2024, you did not provide it with details of your working arrangements and, from that approximate date until around 9 April 2024, you did not provide evidence of your indemnity insurance arrangements.

Evidence

12. 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 3; the witness statements and documentary exhibits of a casework manager at the GDC, who was involved in and has knowledge of the case, and who is referred to for the purposes of these proceedings as Witness A, the witness statement and

documentary exhibits of the practice manager at a dental practice at which you had previously worked, and which you had left in January 2021, who is referred to as Witness B; and the report of the GDC's expert witness, namely Geoffrey Bateman.

13. The Committee heard oral evidence from Patient 3, Witness B, Witness A, Mr Bateman and from you.

Committee's findings of fact

14. The Committee has taken into account all the evidence presented to it, both written and oral. It has considered the submissions made by Mr Mansell on behalf of the GDC and those made by you. The Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).
15. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads and sub-heads of charge against the civil standard of proof, that is to say, the balance of probabilities. The Committee has considered each head and sub-head of charge separately, although some of its findings will be announced together.
16. I will now announce the Committee's findings in relation to each head of charge:

<p>1.</p>	<p><i>On or around 17 November 2022, you failed to maintain adequate standards of cross-infection control when treating Patient 3 (as identified in Schedule 1 below), in that you used an instrument which had been on the floor in the patient's mouth.</i></p> <p>Not proved</p>
	<p>The Committee finds the facts alleged at head of charge 1 not proved.</p> <p>The Committee has had regard to the evidence relevant to this head of charge, which may be summarised as follows.</p> <p>Patient 3's evidence is that he attended an appointment with you on 17 November 2022 for the purposes of fitting a permanent crown. Patient 3 states that, during the course of the appointment, whilst he was in the dental treatment chair, he saw you, out of the corner of his eye, drop a dental instrument, which he believed to be an 'elevator'. Patient 3 stated that he then turned his head around to see that the dental instrument had fallen to the floor, and that he then saw you pick up the dental instrument from the floor and start to use it in his mouth again. Patient 3 further stated that he did not think that the dental nurse who was working with you saw you drop the dental instrument in question. In his oral evidence Patient 3 stated that he may have lost sight of the instrument between it hitting the floor and it entering his mouth, and that he cannot be sure, but assumed, that the instrument that entered his mouth was the same dental instrument that you had dropped.</p> <p>In your oral evidence to the Committee you stated that, whilst you accept that you did drop an instrument, more particularly a dental mirror, but that you did not then put that mirror into the patient's mouth. You stated that you did not bend down to retrieve the mirror, but that you may have looked down at the mirror that you had dropped on to the floor. You stated that you instead kicked the mirror that you had dropped away from you, so that you did not stumble on it. You stated that apologised to the patient for having dropped the mirror. You stated that the dental nurse with whom you were working handed you a new mirror in an efficient</p>



	<p>manner, which was then available for use with the patient. You stated that Patient 3 is simply mistaken in his recollection. You stated that at no point during this appointment did you use an elevator or luxator, and that instead you used a crown removal tool, which has a hook at one end.</p> <p>The expert evidence of Mr Bateman is that, were the Committee to accept Patient 3's account as summarised above, this would amount to a failure to maintain adequate standards of cross-infection control.</p> <p>The Committee finds that the GDC has not demonstrated to the standard required that you used an instrument which had been on the floor in Patient 3's mouth. The Committee considered that there were some inconsistencies when comparing Patient 3's oral evidence with his written evidence. For instance, Patient 3 stated in his written evidence that he had seen you bend down to collect the dropped instrument which you then proceeded to use. However, in his oral evidence Patient 3 stated that he may not have had uninterrupted sight of the event in question, and did not see the event in its entirety. Patient 3 stated in his oral evidence that it had appeared to him at the time that you had used the same instrument that you had dropped, but that he was not able to be certain.</p> <p>The Committee is aware that an honest witness can be mistaken. As Patient 3 himself acknowledged, he was doing his best to give evidence about a matter on the basis of '<i>a memory of a memory</i>'. The Committee noted that Patient 3 made his witness statement on 29 July 2025, which was approximately two-and-a-half years after the events that it describes, and his oral evidence to the Committee was given over three years after those events. The Committee is mindful that the passage of time since the events in question are said to have taken place can make it difficult for events to be recalled precisely. The Committee noted that Patient 3 was willing to state when his recollection may not have been clear or comprehensive.</p> <p>In finding that the GDC has not discharged its burden of proof in respect of this head of charge, the Committee accepted many aspects of the account that you provided, including your evidence that you did not use an elevator dental instrument. It considers that this evidence was plausible, given the nature of the treatment that you were providing to Patient 3 at the appointment in question. The Committee also accepted your evidence that the experienced and capable dental nurse with whom you were working handed you a new dental mirror after you had dropped the previous one. The Committee noted that Patient 3 did not raise the issue of you using a dropped instrument at the time of the appointment. The Committee considers that, had the incident occurred, it is unlikely that the patient, who is a retired clinical dental technician, would have not raised their concerns about the incident with you at the time of the appointment. The Committee further accepts your evidence that you kicked the dropped dental mirror away, representing as it did a trip hazard, and that you did not, and would not have, reused a dropped instrument in the manner alleged.</p> <p>For these reasons, the Committee has concluded that the GDC has not adduced sufficient evidence for the Committee to determine that the facts alleged at this head of charge are proved. Accordingly, the Committee finds the facts alleged at head of charge 1 not proved.</p>
2.	<p><i>On 8 November 2023, following a request from the General Dental Council, you inaccurately confirmed your current postal address as [redacted].</i></p> <p>Proved</p>

	<p>The Committee finds the facts alleged at head of charge 2 proved.</p> <p>The Committee has had regard to the evidence relevant to this head of charge, which may be summarised as follows.</p> <p>The evidence of Witness A, who is a case manager at the GDC, is that the GDC emailed you on 8 November 2023 to seek your confirmation that the address that it held for you, namely that referred to at this head of charge, was correct. The full address was quoted in the GDC's email. On that same day, namely 8 November 2023, you replied by email and stated, '<i>the details you have are correct</i>'. The GDC then sent letters to you at that address on that same day, and sent copies of those letters to you by email.</p> <p>The Committee also had regard to the evidence of Witness B. Witness B was, and remains, the practice manager of the dental practice located at the address referred to at this head of charge, which is the address to which the GDC sent letters to you on 8 November 2023 as referred to in the previous paragraph. Witness B states that, having received a letter addressed to you at that practice, he contacted the GDC on 22 December 2023 to state that you no longer worked at that practice. Witness B subsequently stated that you had not worked at that practice since 19 January 2021. Witness B provided an alternative address for you, stating that he understood that you now worked at, and owned, a dental practice located at that different address.</p> <p>In your oral evidence to the Committee you stated that you recognise that you should have been more diligent, and that you had had nothing to hide. You stated that you were confused, but that you accept that you should have paid more attention to the email to which you replied. You stated that you accept that you sent the email of 8 November 2023 in question, but that you had not read the GDC's email properly.</p> <p>The Committee accepts the evidence of Witness A and Witness B as summarised above. It had sight of the email that you sent on 8 November 2023, and finds that this evidence demonstrates that you did indeed state to the GDC that the address that they quoted to you was correct. The Committee accepts Witness B's evidence that this address was not in fact correct, and indeed had not been correct since the time you left that address nearly three years earlier. The Committee has also taken into account your acknowledgement in evidence that the confirmation that you provided to the GDC on 8 November 2023 was incorrect.</p> <p>Accordingly, the Committee finds the facts alleged at head of charge 2 proved.</p>
<p>3.</p>	<p><i>From on or around 19 January 2021 to 31 December 2024, you failed to maintain a correct and up to date address with the General Dental Council.</i></p> <p>Proved</p>
	<p>The Committee finds the facts alleged at head of charge 3 proved.</p> <p>The Committee has had regard to the evidence relevant to this head of charge, which may be summarised as follows.</p> <p>Witness A's evidence is that, following the GDC being informed by Witness B on 8 November 2023 that you had left the practice address at which the GDC had</p>



	<p>attempted to correspond with you on 19 January 2021, the GDC then attempted to contact you on a number of occasions in connection with the matters referred to at the other heads of charge that you face. This contact included the GDC reminding you of the need for you to keep your address up to date. Witness A's evidence is that you updated your registered address with the GDC on 31 December 2024.</p> <p>In your oral evidence to the Committee you stated that you thought you had maintained a correct and up-to-date address with the GDC, but that with hindsight you realise that you did not in fact do so. You referred to having had your '<i>wires crossed</i>' and that you were mistaken in believing that you were confirming the correct details to the GDC. You further accepted in your oral evidence that you were, as Mr Bateman opines, under a duty to maintain a correct and up-to-date address with the GDC, that you recognise that it is important that a registrant keeps these details up-to-date, and that you failed in this duty.</p> <p>The Committee accepts the evidence of Witness A as summarised above, and also notes that you accepted in your oral evidence and submissions that you did not maintain an up-to-date address with the GDC. The Committee also finds that you were, as Mr Bateman opines, under a duty to maintain a correct and up-to-date address with the GDC. The Committee finds, and notes that you accept, that you failed in this duty.</p> <p>Accordingly, the Committee finds the facts alleged at head of charge 3 proved.</p>
4.	<p><i>Your actions at 2 and/or 3 above were misleading.</i></p> <p>Proved in relation to heads of charge 2 and 3</p>
	<p>The Committee finds the facts alleged at head of charge 4 proved with regard to the proven facts at heads of charge 2 and 3.</p> <p>You stated in your oral evidence that, in respect of head of charge 2, you accept that stating that an address was correct when it was in fact incorrect was misleading, but that you did not act with malice.</p> <p>You also stated in your oral evidence that, in respect of head of charge 3, you accept that not maintaining a correct and up-to-date address with the GDC was misleading, but that again you did not act with malice and the issue was an oversight and a mistake.</p> <p>The Committee considers that, in stating that your address was correct when it was not in fact correct, and in failing to maintain a correct and up-to-date address, the GDC was liable and likely to be misled into believing that you were at a particular address when in fact you were not at that address. The Committee finds that this conduct was, objectively, misleading.</p> <p>Accordingly, the Committee finds the facts alleged at head of charge 4 proved with regard to the proven facts at heads of charge 2 and 3.</p>
5.	<p><i>You failed to cooperate with an investigation conducted by the General Dental Council in that you:</i></p>
5. (a)	<p><i>From on or around 6 February 2024 to 24 June 2024, did not provide the General Dental Council with patient records for Patient 3;</i></p>

	<p>Proved</p>
	<p>The Committee finds the facts alleged at head of charge 5 (a) proved.</p> <p>The Committee has had regard to the evidence relevant to this sub-head of charge, which may be summarised as follows.</p> <p>In her written evidence Witness A states that the GDC wrote to you on 6 February 2024 at the different address that had been provided by Witness B. The letter included a request for the dental records relating to Patient 3, with a deadline for providing the records of 20 February 2024. An email was also sent at this time to you. The Committee noted that subsequent reminders were sent to you by letter on 1 March 2024 and 21 May 2024, by email on 21 February 2024, 1 March 2024, 21 May 2024, 4 June 2024 and 13 June 2024, and by telephone call on 29 February 2024 and 1 March 2024. Witness A's evidence is that you did not provide that information until 24 June 2024.</p> <p>In your oral evidence to the Committee you stated that, in respect of sub-heads of charge 5 (a), 5 (b) and 5 (c), you accept that you did not send the requested information in a timely manner, and that you should have been more prompt and diligent in your dealings with the GDC. You stated that you recognise your mistakes in not doing so, and that you subsequently, albeit belatedly, provided the requested information. You stated that you recognise that registrants have a duty to co-operate with investigations conducted by the GDC, and that it is important that they do so. You stated that you accept that, as you did not comply with the GDC's requirements in a timely manner, you failed in this duty.</p> <p>The Committee finds that this evidence demonstrates that you did not provide the GDC with the patient records for Patient 3 within the time period specified. The Committee then went on to consider whether this amounts to a failure to co-operate with the GDC.</p> <p>The GDC considered the expert evidence of Mr Bateman that you were under a duty to co-operate with the GDC's investigation. This duty derives from standard 9.4 and standard 9.4.1 of the GDC's <i>Standards for the Dental Team</i>, which read:</p> <ul style="list-style-type: none"> • 9.4 '<i>You must co-operate with any relevant formal or informal inquiry and give full and truthful information</i>'. • 9.4.1 '<i>If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association</i>'. <p>The Committee considers that a registrant's duty to co-operate requires providing information in a timely manner. As you did not provide the requested information in a timely manner, the Committee finds that you failed in your duty to co-operate with the GDC.</p> <p>Accordingly, the Committee finds the facts alleged at head of charge 5 (a) proved.</p>
<p>5. (b)</p>	<p><i>From on or around 8 November 2023 to 9 April 2024, did not provide the General Dental Council with patient records for Patient 1 and Patient 2 (as identified in Schedule 1 below);</i></p>

	<p>Proved</p>
	<p>The Committee finds the facts alleged at head of charge 5 (b) proved.</p> <p>The Committee has had regard to the evidence relevant to this sub-head of charge, which may be summarised as follows.</p> <p>In her written evidence Witness A states that the GDC wrote to you on 8 November 2023 at the address that it held for you, as referred to at head of charge 2. This letter included a request for the patient records for two patients, who are referred to as Patient 1 and Patient 2, with a deadline for providing the records of 22 November 2023. An email was also sent to you at that time. A follow-up letter and email dated 27 November 2023 was sent to you on that same date, with the deadline extended to 4 December 2023. Having been informed by Witness B that you were not at that address, the GDC then wrote to you on 29 January 2024 at the different address provided by Witness B, and at your email address. This letter again asked for the requested information, and the extended deadline of 5 February 2024 was given. Witness A states that the GDC did not receive the requested information from you until 9 April 2024, despite numerous attempts to contact you to remind you of the request.</p> <p>Your evidence in respect of this head of charge is referred to above in connection with sub-head of charge 5 (a).</p> <p>The Committee finds that this evidence demonstrates that you did not provide the GDC with the patient records for Patients 1 and 2 within the time period specified. The Committee then went on to consider whether this amounts to a failure to co-operate with the GDC.</p> <p>The GDC again accepts the expert evidence of Mr Bateman that you were under a duty to co-operate with the GDC’s investigation. The Committee again considers that a registrant’s duty to co-operate requires providing information in a timely manner. As you did not provide the requested information in a timely manner, the Committee finds that you failed in your duty to co-operate with the GDC.</p> <p>Accordingly, the Committee finds the facts alleged at head of charge 5 (b) proved.</p>
<p>5. (c)</p>	<p><i>From on or around 6 February 2024 to on or around 9 April 2024, did not provide the General Dental Council with evidence of indemnity;</i></p> <p>Proved</p>
	<p>The Committee finds the facts alleged at head of charge 5 (c) proved.</p> <p>The Committee has had regard to the evidence relevant to this sub-head of charge, which may be summarised as follows.</p> <p>In her written evidence Witness A states that the GDC wrote to you on 6 February 2024 at the different address provided by Witness B. The letter and email included a request for evidence of your indemnity insurance arrangements, with a deadline for providing this information of 20 February 2024. Witness A’s evidence is that you did not provide that information until on or around 10 April 2024, despite numerous attempts to contact you to remind you of the request.</p>

	<p>Your evidence in respect of this head of charge is referred to above in connection with sub-head of charge 5 (a).</p> <p>The Committee finds that this evidence demonstrates that you did not provide the GDC with evidence of your indemnity insurance arrangements within the time period specified. The Committee then went on to consider whether this amounts to a failure to co-operate with the GDC.</p> <p>The GDC again accepts the expert evidence of Mr Bateman that you were under a duty to co-operate with the GDC's investigation. The Committee again considers that a registrant's duty to co-operate requires providing information in a timely manner. As you did not provide the requested information in a timely manner, the Committee finds that you failed in your duty to co-operate with the GDC.</p> <p>Accordingly, the Committee finds the facts alleged at head of charge 5 (c) proved.</p>
<p>5. (d)</p>	<p><i>From on or around 6 February 2024, did not provide the General Dental Council with details of your working arrangements.</i></p> <p>Proved</p>
	<p>The Committee finds the facts alleged at head of charge 5 (d) proved.</p> <p>The Committee has had regard to the evidence relevant to this sub-head of charge, which may be summarised as follows.</p> <p>In her written evidence Witness A states that the GDC wrote to you on 6 February 2024 at the different address provided by Witness B, and also sent an email to you. The letter included a request for details of your working arrangements, with a deadline for providing this information of 20 February 2024. Witness A's evidence is that you have not provided that information, and that no further letters chasing for the information have been sent since August 2025.</p> <p>The Committee finds that this evidence demonstrates that you have not provided the GDC with evidence of your working arrangements. The Committee then went on to consider whether this amounts to a failure to co-operate with the GDC.</p> <p>The GDC again accepts the expert evidence of Mr Bateman that you were under a duty to co-operate with the GDC's investigation. The Committee again considers that a registrant's duty to co-operate requires providing information in a timely manner. As you did not provide the requested information in a timely manner, the Committee finds that you failed in your duty to co-operate with the GDC.</p> <p>Accordingly, the Committee finds the facts alleged at head of charge 5 (d) proved.</p>

17. We move to stage two.

Determination on misconduct, impairment and sanction – 12 January 2026

18. Following the handing down of the Committee's findings of fact on 9 January 2026, the hearing proceeded on that same day to 'stage two'; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

19. The Committee has considered all the evidence presented to it, both oral and written. It has taken into account the submissions made by Mr Mansell on behalf of the GDC and those made by you. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.
20. 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). Although the Committee notes that that guidance was replaced part-way through the hearing on 6 January 2026 by a new guidance document, namely *Fitness to Practise: Guidance for the practice committees* (January 2026), the Committee has adopted the former guidance at this hearing, as it was extant at the start of the hearing.

Evidence at stage two

21. Save for your written submissions as summarised below, the Committee received no further oral or documentary evidence at this stage of the hearing.

Summary of submissions

22. Mr Mansell on behalf of the GDC submitted that the facts that it has found proved amount to misconduct, and that your fitness to practise is currently impaired by reason of that misconduct. Mr Mansell invited the Committee to direct that your name be suspended for a period of either three or six months, depending on whether the Committee identify public protection as well as public interest considerations.
23. You submitted that you accept the Committee's findings of fact in their entirety. You stated that you recognise that you impeded the GDC's ability to communicate with you and to carry out its public protection role. You stated that you appreciate the damaging implications of your serious breach of professional standards, including the risks of undermining public confidence in the profession. You stated that you take responsibility for, and that you regret, your actions. You referred to difficult personal circumstances at the relevant times. You stated that you have reflected on these matters, and that you recognise that you should have acted more promptly in your dealings with the GDC. You outlined the steps that you have taken to avoid a repeat, including ensuring your address is up to date; having a dedicated email address and a consistent process in relation to your contact with the GDC; and being committed to engaging fully and promptly with your regulator. You again expressed your remorse, and that you will continue to develop your insight into your conduct, including taking meaningful steps to avoid a repetition. You also invited the Committee to consider the impact that a direction of suspension would have on you and the patients whom you treat.

Fitness to practise history

24. Mr Mansell addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Mansell stated that you have no previous fitness to practise history with the GDC.

Misconduct

25. The Committee first considered whether the facts that it has found proved at heads of charge 2, 3, 4 and 5 constitute misconduct. In considering this and all other matters, the Committee has exercised its own independent judgement.
26. 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 you must:

9.1 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.

9.4. You must co-operate with any relevant formal or informal inquiry and give full and truthful information.

9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.

27. The Committee's findings at heads of charge 2, 3, 4 and 5 relate to your contact and co-operation with the GDC as part of its investigation into concerns about your fitness to practise.
28. The Committee has found that, on 8 November 2023, following a request that the GDC had made, you inaccurately confirmed your current postal address as being a dental practice which you had in fact left some time earlier in January 2021. The Committee has also found that, for the four-year period of around 19 January 2021 to 31 December 2024, you failed to maintain a correct and up-to-date address with the GDC. The Committee went on to find that such matters amount to misleading conduct.
29. The Committee found that that you did not provide the GDC with the dental records for Patient 3 in the period of 6 February 2024 to 24 June 2024, and did not provide the dental records for two other patients, who are referred to as Patient 1 and Patient 2, in the period of 8 November 2023 to 9 April 2024. The Committee has also found that, from around 6 February 2024, you did not provide it with details of your working arrangements and, from that approximate date until around 9 April 2024, you did not provide evidence of your indemnity insurance arrangements.
30. In light of the findings of fact that it has made, the Committee has determined that the proven facts amount to misconduct. The Committee considers that your conduct was a serious falling short of the standards reasonably to be expected of a registered dentist. The Committee notes that your conduct was sustained and repeated over a considerable period of time. The Committee considers that co-operating with the GDC as regulator is a basic and fundamental tenet of the profession. Your failure to co-operate deprived the GDC of the full, timely and accurate information that it had requested in connection with fitness to practise investigations. This has the potential to place patients at unwarranted risk of harm, as the GDC was not able to conduct timely and fully informed investigations into any concerns raised about your fitness to practise. The Committee also considers that you have undermined trust and confidence in the profession.
31. The Committee has therefore determined that the facts that it has found proved at heads of charge 2, 3, 4 and 5 amount to misconduct.

Impairment

32. 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.

33. As referred to above, the Committee considers that your conduct had the potential to place patients at unwarranted risk of harm, as it deprived the GDC of the full and accurate information upon which its statutory duty to protect the public is contingent. Your acts and omissions frustrated the GDC's proper and timely statutory functions and undermined its overarching objective to protect the public. The Committee considers that your misconduct is remediable, relating as it does to specific and identifiable aspects of your conduct towards the GDC. However, having had careful regard to all of the information placed before it, the Committee considers that you have not produced sufficient evidence to demonstrate that you have remedied your misconduct to the required extent. The Committee has heard that, since the incidents giving rise to these proceedings occurred, you have put in place appropriate and reliable systems in place for corresponding with the GDC. You have also described your reflections upon, and insight into, your misconduct. The Committee also recognises that these proceedings, which have culminated in this hearing, have had a salutary effect on you.
34. The Committee was not satisfied that you have yet embedded the necessary changes in your approach to co-operating with the GDC. The Committee considers that your insight into these matters appears to have arisen at a relatively late stage, and is limited and developing. The Committee was provided with no documentary evidence of any embedding of the improvements to which you have referred in your approach to correspondence with the GDC. In the circumstances, the Committee finds that it cannot be said that a repetition of your misconduct is highly unlikely. The Committee therefore finds that patients are liable to be placed at unwarranted risk of harm, that you are liable to breach a fundamental tenet of the profession, and that the profession is liable in future to be brought into disrepute. It therefore finds that your fitness to practise is impaired.
35. The Committee also considers that a finding of impairment is required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. The Committee considers that your acts and omissions breached a fundamental tenet of the profession, and have brought the reputation of the profession into disrepute. 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 was not made. Accordingly, the Committee finds that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

36. 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.
37. 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.
38. The Committee has paid careful regard to the mitigating and aggravating factors present in this case.
39. In respect of the mitigating factors that are present, the Committee notes the difficult personal circumstances that you experienced at the relevant times, that you are of previous good character, that you have expressed remorse for and some insight into your misconduct, and have referred to having taken some steps to avoid a repeat, and that your acts and omissions were not financially motivated.

40. In terms of aggravating factors, the Committee notes that your misconduct placed patients at the risk of harm, that your misconduct was sustained and repeated, that you breached the trust that the GDC placed in you, and that you wilfully disregarded its role as regulator.
41. 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, or issuing a reprimand, would not be sufficient in the particular circumstances of this case. In the Committee's judgement the public would be placed at unwarranted risk of harm, and public trust and confidence in the profession and in the regulatory process would be significantly undermined, if no action were taken or if a reprimand were issued.
42. The Committee next considered whether it would be appropriate to conclude the case with a direction of conditional registration. The Committee found that it was unable to identify conditions which would be capable of being practicable and with which you would comply, particularly given that its findings relate to a lack of co-operation with the GDC. The Committee therefore considers that conditions cannot adequately protect the public. The Committee also finds that a direction of conditional registration would not be 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.
43. The Committee next considered whether to direct a period of suspended registration. After careful consideration, the Committee has determined that it would be appropriate and proportionate to suspend your registration. The Committee notes that your misconduct was sustained and repeated, that you lack full insight into your acts and omissions, that you are liable to repeat your misconduct, and that the public and the wider public interest would be insufficiently protected by a lesser sanction.
44. The Committee did consider whether the higher, and ultimate, sanction of erasure would be appropriate. It considered that no higher sanction than that of suspension is needed in order to address the public protection and public interest considerations referred to above. The Committee considers that, whilst your misconduct is highly damaging to your fitness to practise, it does not connote a deep-seated and harmful professional attitudinal problem. Accordingly, a direction of erasure would be disproportionate.
45. The Committee has determined that the appropriate and proportionate period of suspended registration is one of three months. The Committee considers that this period of time is commensurate with its findings, is sufficient to meet the public protection and public interest considerations that it has identified, and will also allow you to continue to develop and demonstrate your insight into, and remediation of, your misconduct. The Committee also directs that the suspension be reviewed prior to the end of the period of suspended registration.
46. Although the Committee in no way wishes to find or fetter the next Committee which will review this case, it considers that the future reviewing Committee may be assisted by an updated reflective statement from you, evidence of learning focussed on the Committee's findings, such as continuing professional development (CPD), and documentary evidence of the embedding of the necessary changes in your practice.
47. Whilst the Committee is mindful of the impact that this decision may have on you, it considers that its overarching duty to protect the public and the wider public interest outweighs your own interests in this matter.
48. The Committee now invites submissions as to whether your registration should be made subject to an immediate order of suspension, pending the substantive direction of suspension coming into effect.

Determination on immediate order – 12 January 2026

49. Mr Mansell on behalf of the GDC submitted that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest.
50. You submitted that, whilst you understand the logic of imposing an immediate order of suspension given the Committee's findings, such an order would affect the care and treatment that you are currently providing to patients.
51. The Committee accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee has again had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).
52. In all the circumstances, the Committee considers that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. The Committee has determined that, given the risks to the public and the public interest that it has identified, it would not be appropriate to permit you to practise before the substantive direction of suspension takes effect. The Committee considers that an immediate order for suspension is consistent with the findings that it has set out in its foregoing determination.
53. The effect of the foregoing determination and this immediate order is that your registration will be suspended from the date on which notice of this decision is deemed to have been served upon you. Unless you exercise your right of appeal, the substantive direction of suspension will be recorded in the register 28 days from the date of deemed service. Should you decide to exercise your right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.
54. That concludes this case.