

GENERAL DENTAL COUNCIL

AND

ANDI, Margaret Data Ilanye

[Registration number: 82258]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council, to be held at:

**The General Dental Council
37 Wimpole Street
London
W1G 8DQ**

Commencing at **10:00am** on **23 February 2026**.

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.

Committee members

Clive Powell	Lay	Chair
Suki Sandhar	Dentist	
Caroline Ross	DCP	

Advisers:

Kenneth Hamer	Legal Adviser
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CHARGE

Margaret Data Ilanye ANDI, a dentist, BDS Lond 2003 is summoned to appear before the Professional Conduct Committee on 23 February 2026 for an inquiry into the following charge:

“That being a registered dentist,

A. You practised as a dentist at the dental practice referred to in Schedule 1¹ below (“the Practice”) and treated the patients listed below (and referred to in Schedule 1 below) from October 2019 to March 2022.

Patient 1

1. You failed to maintain an adequate standard of record keeping in respect of Patient 1’s appointments from 12 October 2019 to 9 March 2021, in that you did not make and/or retain any record for appointments that took place on:
 - a. 12 October 2019;
 - b. 26 October 2019;
 - c. 20 December 2019;
 - d. 1 February 2020;
 - e. 27 February 2020;
 - f. 15 September 2020;
 - g. 7 October 2020;
 - h. 9 March 2021.

Patient 2

2. You failed to provide an adequate standard of care to Patient 2 from 17 June 2021 to 30 November 2021, in that:
 - a. On, or around, 17 June 2021 you did not diagnose and/or treat caries found at their:
 - i. UL5;
 - ii. UL6;
 - iii. UR4;
 - iv. UR5;
 - b. On, or around, 27 October 2021 you provided a poor standard of treatment to Patient 2, in that you root filled their LL5 without first removing all of the caries present in that tooth;

¹ The Schedules are private documents and cannot be disclosed.

- c. On, or around, 18 November 2021 you provided a poor standard of treatment to Patient 2, in that you root filled their LL6 without first removing all of the caries present in that tooth;
 - d. You did not discuss with Patient 2 the option of specialist referral for further treatment of their LL6 after you root filled this tooth on 18 November 2021;
 - e. On, or around, 18 November 2021 you did not diagnose and/or treat caries that remained in their LL6, following your root canal treatment ('RCT');
 - f. On, or around, 30 November 2021 you provided a poor standard of treatment to Patient 2, in that, you filled their LL7 without first removing all of the caries present in that tooth.
3. By reason of your conduct in charge 2.a.i. you did not obtain Patient 2's informed consent for not treating caries found at their UL5.
 4. By reason of your conduct in charge 2.a.ii. you did not obtain Patient 2's informed consent for not treating caries found at their UL6.
 5. By reason of your conduct in charge 2.a.iii. you did not obtain Patient 2's informed consent for not treating caries found at their UR4.
 6. By reason of your conduct in charge 2.a.iv. you did not obtain Patient 2's informed consent for not treating caries found at their UR5.
 7. By reason of your conduct in charge 2.d. you did not obtain Patient 2's informed consent for not having further specialist treatment at their LL6.

Patient 4

8. You failed to provide an adequate standard of care to Patient 4 on 14 June 2021 in that:
 - a. You did not take a pre-operative radiograph, of sufficient diagnostic quality, in advance of undertaking RCT at their UR1;
 - b. You did not adequately report on the post operative radiograph taken following RCT;
 - c. You inaccurately informed patient 4 that you could not complete RCT on her UR1 because it was "fully sclerosed", or words to that effect;
 - d. You did not include the option of specialist referral within your letter to Patient 4's dentist, dated 14 June 2021;
 - e. You inaccurately recorded in your letter to Patient 4's dentist, dated 14 June 2021, that their UR1 is "completely sclerosed."
9. By reason of your conduct in charge 8.a. you did not obtain Patient 4's informed consent for the RCT you provided at their UR1.
10. By reason of your conduct in not providing Patient 4 with the option of specialist referral following failed RCT on 14 June 2021, you did not obtain Patient 4's informed consent for not having further specialist treatment at their UR1.
11. By reason of your conduct in not providing Patient 4 with the option of specialist referral following failed RCT you did not obtain Patient 4's informed consent for not having further specialist treatment at their UR1.

12. You failed to maintain an adequate standard of record keeping in respect of Patient 4, in that, you inaccurately recorded, in a record dated 20 May 2021, that you had “Adv patient that they will need to see a specialist when ready” following unsuccessful RCT at their UR1.

13. Your conduct in charge 8.e. was:

- a. Misleading;
- b. Lacked integrity;
- c. Dishonest, in that you knew Patient 4’s UR1 was not fully /completely sclerosed and that the reason for your failed RCT treatment was because your access was in the wrong position.

Patient 5

14. You failed to provide an adequate standard of care to Patient 5 from 20 May 2021 to 14 October 2021, in that:

- a. You did not take a pre-operative radiograph in advance of undertaking RCT at their UL6 on 14 October 2021.

15. By reason of your conduct in charge 14.a. you did not obtain Patient 5’s informed consent for the RCT you provided at their UL6.

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

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