

PUBLIC HEARING

Professional Conduct Committee Initial Hearing

29 September – 3 October 2025

Name: PAKENIENE, Vitalija Irena

Registration number: 175264

Case number: CAS-209693-Y1N8G7

General Dental Council: Mr Tom Stevens, Counsel.
Instructed by Terry Symon, IHLPS

Registrant: Not Present
Unrepresented

Fitness to practise: Impaired by reason of misconduct

Outcome: Conditions imposed (with a review)

Duration: 18 months

Immediate order: Immediate conditions of practice order

Committee members: Matt King (Dentist) (Chair)
Jodie Mahoney (Dental Care Professional)
Victoria Buller (Lay)

Legal adviser: Tanveer Rakhim

Committee Secretary: Andrew Keeling

CHARGE

Vitalija Irena PAKENIENE, a dentist, D Stom Kaunas 1984, is summoned to appear before the Professional Conduct Committee on 29 September 2025, for an inquiry into the following charge:

“That being a registered dentist,

1. *You failed to provide an adequate standard of care to Patient A from 9 July 2022 to 23 August 2022, in that:*
 - a. *You did not discuss, adequately/ or at all, the risks associated with extracting Patient A’s LR6, in advance of doing so;*
2. *By reason of your conduct in charge 1.a. you did not obtain Patient A’s informed consent for the extraction of their LR6 on 18 August 2022.*
3. *You failed to maintain an adequate standard of record keeping in respect of Patient A’s appointments from 9 July 2022 to 23 August 2022, in that:*
 - a. *Your record of 9 July 2022 does not record:*
 - i. *any discussion with Patient A, about the proposed placement of an implant, following the extraction of her LR6;*
 - ii. *adequate details of the findings of your clinical examination;*
 - b. *Your record of 18 August 2022 does not record:*
 - i. *that you cut your finger during the appointment;*
 - ii. *that Patient A’s LR6 root fractured during your attempted extraction;*
 - iii. *what discussion you had with Patient A about how successful the attempted extraction was;*
 - c. *Your record of 18 August 2022 inaccurately records that:*
 - i. *“roots extracted uneventfully with roots intact”;*
 - ii. *you discussed the risks of:*
 - a. *an oro-antral fistula;*
 - b. *fractured tuberosity;*
 - c. *MRONJ;*
 - d. *Radio necrosis of the jaw;*
 - iii. *you discussed the risks of the extraction being unsuccessful;*
 - d. *You did not record any notes of your appointment with Patient A on 20 August 2022;*
 - e. *Your record of 23 August 2022 does not record:*
 - i. *Patient A’s presenting condition;*

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against Mrs Pakeniene that her fitness to practise is impaired by reason of misconduct.
2. Mrs Pakeniene was not present or represented at the hearing. Mr Tom Stevens, Counsel, appeared on behalf of the General Dental Council (GDC).
3. The hearing was held remotely on Microsoft Teams.

Preliminary Matter

4. At the outset of the hearing, the Committee first considered whether notice of the hearing had been served on Mrs Pakeniene in accordance with the General Dental Council (Fitness to Practise) Rules 2006 (the Rules) and whether to proceed with the hearing in Mrs Pakeniene's absence. The Committee heard submissions from Mr Stevens and accepted the advice of the Legal Adviser.

Decision on Service of the Notice of Hearing (29 September 2025)

5. The Committee received from the GDC a hearing bundle, titled '*Service Bundle*', of 14 pages, which contained a copy of the Notice of Hearing ('the notice'), dated 28 August 2025, thereby complying with the 28-day notice period. The notice was sent to Mrs Pakeniene's registered address by Special Delivery, first class post and secure email.
6. The Committee was satisfied that the notice sent to Mrs Pakeniene contained proper notification of today's hearing. This included the hearing's time, date and that it will be taking place remotely on Microsoft Teams, and the other prescribed information including notification that the Committee had the power to proceed with the hearing in Mrs Pakeniene's absence.
7. On the basis of the information provided, the Committee was satisfied that the notice of the hearing had been served on Mrs Pakeniene in accordance with Rules 13 and 65.

Decision on Proceeding in the Registrant's Absence (29 September 2025)

8. The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mrs Pakeniene. The Committee approached the issue of proceeding in absence with the utmost care and caution. It took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones (Anthony)* [2002] UKHL 5 and *GMC v Adeogba & Visvardis* [2016] EWCA Civ 162. It remained mindful of the need to be fair to both Mrs Pakeniene and the GDC, taking into account the public interest and Mrs Pakeniene's own interests.
9. The Committee noted that the GDC had taken all possible steps to notify Mrs Pakeniene of the hearing. The Committee noted Mrs Pakeniene's email to the GDC,

dated 22 September 2025, in which she stated that, '*Please be aware that I will not be participating in the hearing...*'. The Committee concluded therefore that it was clear that Mrs Pakeniene was aware of the hearing and had chosen not to attend. There was no application for a postponement from Mrs Pakeniene. The Committee determined, therefore, that it should proceed in her absence having regard to the public interest in the fair and expeditious disposal of cases. It concluded that no useful purpose would be served by postponing this hearing as it was unlikely that Mrs Pakeniene would attend any future hearing.

10. In those circumstances, the Committee determined that it was fair and appropriate to proceed with the hearing in the absence of Mrs Pakeniene.

Background

11. The allegations in this case stemmed from Mrs Pakeniene's treatment of a single patient, Patient A, between 9 July 2022 and 23 August 2022.
12. Mrs Pakeniene first saw Patient A at an appointment on 9 July 2022 to discuss the extraction of her LR6 and to replace it with an implant and crown.
13. Patient A next saw Mrs Pakeniene at an appointment on 18 August 2022 to extract the LR6. It was alleged by the GDC that this extraction was not uneventful as the root had fractured during its removal and Mrs Pakeniene had cut her finger on an instrument during the extraction. On 20 August 2022, Patient A returned to see Mrs Pakeniene as she was still experiencing pain. According to the witness statement provided by Patient A to the GDC, Mrs Pakeniene took an x-ray and informed her that there was part of a white filling inside the extraction area. However, Mrs Pakeniene reassured her that the filling should not cause her any pain and that everything was okay as there was no inflammation in the area.
14. On 21 August 2022, Patient A stated that she went to see another dentist, who took an x-ray of the affected area and informed her that the root of her extracted tooth was visible on the x-ray.
15. Patient A returned to see Mrs Pakeniene in the morning of 23 August 2022 as she remained in pain. Patient A stated that Mrs Pakeniene had informed her that she could not help her further and recommended that she see a Maxillofacial Surgeon. Patient A went to see a Maxillofacial Surgeon in the afternoon to treat the pain and remove the remaining root.
16. Patient A subsequently made a complaint to the GDC about the treatment she had received from Mrs Pakeniene, stating that she had been unprofessional.
17. The allegations against Mrs Pakeniene include matters in respect of consent, record-keeping (written records and radiographic reporting) and dishonesty. It is alleged that Mrs Pakeniene did not discuss adequately or at all the risks associated with the

extraction, and therefore did not obtain Patient A’s informed consent. In respect of record keeping, it is alleged that Mrs Pakeniene did not record vital information in respect of the appointments and included information in the records that was inaccurate. It is further alleged that Mrs Pakeniene’s conduct was misleading, lacking in integrity and dishonest when making those records, in that she knew that they did not accurately record what had taken place at Patient A’s appointments.

Evidence

- 18. By way of factual evidence from the GDC, this included Patient A’s dental records and a signed witness statement from Patient A, dated 26 June 2025, with exhibited documents. These exhibits included a transcript, translated into English, of an audio recording taken by Patient A during her appointments with Patient A on 18, 20 and 23 August 2022. Patient A stated that Mrs Pakeniene was unaware that she was recording the appointments.
- 19. The Committee also received an expert report, dated 10 July 2025, from Dr David Igoe. Dr Igoe also gave oral evidence at the hearing.
- 20. As part of Mrs Pakeniene’s case, the Committee received a copy of a witness statement, dated 18 July 2025, from the Practice Manager at the practice and associated exhibits, including an Accident Record dated 18 August 2022.

The Committee’s Findings of Fact

- 21. The Committee has considered all the oral and documentary evidence presented to it. It took account of the submissions made by Mr Stevens, on behalf of the GDC. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head 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, whether the alleged matters are found proved on the balance of probabilities.
- 22. The Committee’s findings in relation to each head of charge are as follows:

1	<p>You failed to provide an adequate standard of care to Patient A from 9 July 2022 to 23 August 2022, in that:</p>
	<p style="padding-left: 40px;">a. You did not discuss, adequately/ or at all, the risks associated with extracting Patient A’s LR6, in advance of doing so;</p> <p>Found Proved</p> <p>In her witness statement, Patient A stated that during the appointment on 9 July 2023 Mrs Pakeniene did not discuss the risks with her in respect of her planned extraction:</p>



'However, we did not discuss the risks of an unsuccessful extraction. I cannot remember other risks were discussed with me, and I gave verbal consent to have treatment. I think I might have signed something too.'

Furthermore, at the second appointment on 18 August 2022 when the extraction took place, Patient A stated that, *'The Registrant did not discuss the risks involved with treatment, she only said that if I experienced strong pain then I would need to take medication'*.

Mrs Pakeniene was served a copy of the bundle of documents for this hearing, which included the unchallenged transcript of the appointments on 18, 20 and 23 August 2022. There was a translation of the conversation reflected in the transcript, which was undertaken by a qualified interpreter, who provided a letter-headed certification of the accuracy of the translation. The Committee noted that there is no evidence in the transcript that Mrs Pakeniene discussed the risks with Patient A.

The Committee had sight of Patient A's dental records and noted the Tooth Removal consent form signed by Patient A on 18 August 2022. However, the Committee noted that some of the risks listed on that consent form were not relevant to Patient A's treatment.

The Committee considered that it was likely, therefore, that Mrs Pakeniene had provided Patient A with a templated consent form and had not adapted it by removing the risks not associated with the extraction of the LR6.

The Committee also noted from the entry in the records of the appointment on 18 August 2022 that some of the risks listed were not applicable to the extraction of the LR6. This also suggested that Mrs Pakeniene had used a template entry in the records and had not removed the information that was not relevant.

Taking all of this into consideration, the Committee determined that it was more likely than not that some form of discussion of the risks had taken place with Patient A. This is supported by the consent form, dated 18 August 2022, signed by Patient A on the day the extraction took place. However, the Committee determined that, based on Patient A's unchallenged evidence and as neither the templated consent form nor the records were suitably amended to show only the risks associated with Patient

	<p>A's specific treatment, this did not constitute an adequate discussion.</p> <p>Accordingly, the Committee found this head of charge proved.</p>
2.	<p>By reason of your conduct in charge 1.a. you did not obtain Patient A's informed consent for the extraction of their LR6 on 18 August 2022.</p> <p>Found Proved</p> <p>Following on from its findings at head of charge 1, the Committee determined that as Mrs Pakeniene had not adequately discussed the risks associated with the extraction, she did not obtain Patient A's informed consent.</p> <p>Accordingly, the Committee found this head of charge proved.</p>
3.	<p>You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 9 July 2022 to 23 August 2022, in that:</p> <p>a. Your record of 9 July 2022 does not record:</p> <p>i. any discussion with Patient A, about the proposed placement of an implant, following the extraction of her LR6;</p> <p>Found Proved</p> <p>The Committee noted from Patient A's witness statement that the appointment on 9 July 2022 was <i>'an implant appointment'</i> and that she went on to discuss with Mrs Pakeniene the type of implant that was to be used and whether the implant treatment would have any risks or side effects. The Committee also noted the treatment plan, dated 9 July 2022 and signed by Patient A, which detailed the cost of the implant treatment.</p> <p>The Committee therefore was satisfied that it was more likely than not that a discussion about implant treatment had taken place on 9 July 2022.</p> <p>However, the Committee noted from the entry in the records for this date that details of this discussion was not included.</p> <p>Accordingly, the Committee found this head of charge proved.</p>

	<p>ii. adequate details of the findings of your clinical examination;</p> <p>Found Not Proved</p> <p>The Committee noted that its findings on this head of charge would rely on whether it agreed with the GDC that this appointment related to a clinical examination rather than an appointment in respect of Patient A's LR6.</p> <p>The Committee noted that it was clear from Patient A's witness statement that she attended this appointment as she was experiencing pain in her LR6 and that this needed to be extracted: <i>'The Registrant said that I needed to extract my lower right tooth 46 because it was painful'</i>.</p> <p>It further noted from Patient A's witness statement that, according to Mrs Pakeniene's treatment plan, a clinical examination was due to take place at a later date: <i>'The treatment plan was to have a consultation, extraction, implant and then a check-up'</i> (Committee's emphasis).</p> <p>The Committee concluded therefore, that it was more likely than not that the appointment on 9 July 2022 related solely to Patient A's LR6, where she was experiencing pain. Mrs Pakeniene had also planned an extraction and a replacement implant, as shown by the treatment plan.</p> <p>The Committee determined that the GDC had not provided sufficient evidence to show, on the balance of probabilities, that this appointment involved a clinical examination.</p> <p>The Committee also noted that in his expert report in relation to record keeping, Dr Igoe stated that:</p> <p><i>'If the Committee find that Patient [A] attended only for the removal of her LR6 then I would not be critical.'</i></p> <p>For these reasons, the Committee found this head of charge not proved.</p>
	<p>b. Your record of 18 August 2022 does not record:</p>
	<p>i. that you cut your finger during the appointment;</p> <p>Found Proved</p>



The Committee first sought to establish whether there was sufficient evidence that Mrs Pakeniene had cut her finger during the appointment on 18 August 2022.

The Committee noted the following from Patient A 's witness statement:

'However, I know the Registrant applied a lot of pressure and then she cut her finger through the gloves that she was wearing. ...When the Registrant changed her glove I saw blood on her finger...'

The Committee also noted the transcript of the appointment in which Mrs Pakeniene states that she injured her hand. Furthermore, the Committee had sight of the 'Accident Record' document, dated 18 August 2022, which was signed by Mrs Pakeniene, and stated that she, 'sustained a minor laceration'.

For these reasons, the Committee was satisfied that Mrs Pakeniene had cut her finger during the appointment.

The Committee then reviewed the dental records for the appointment, and noted that there is no mention of this incident. The Committee also noted that Dr Igoe stated in his expert report that Mrs Pakeniene should have recorded this in the records.

Accordingly, the Committee found this head of charge proved.

- ii. that Patient A's LR6 root fractured during your attempted extraction;

Found Proved

As in the previous head of charge, the Committee first sought to establish whether there was sufficient evidence that Patient A's LR6 root had fractured during the attempted extraction.

The Committee noted from Patient A's witness statement that she stated, 'My tooth came out in pieces...' and that Mrs Pakeniene had told her, '...one root came out in one piece and that the second root came out in pieces'.

The Committee further noted from the transcript of the appointment that Mrs Pakeniene had said, 'One root came out easily; the other crumbled'.

The Committee was therefore satisfied that the LR6 root had fractured during the extraction.

The Committee then reviewed the dental records for the appointment, and noted that there is no mention of this.

The Committee also noted that in his oral evidence, Dr Igoe stated that if the root fractured during the extraction, this should have been recorded in the notes.

Accordingly, the Committee found this head of charge proved.

- iii. what discussion you had with Patient A about how successful the attempted extraction was;

Found Not Proved

When considering this head of charge, the Committee noted from the records that Mrs Pakeniene had stated, *'Forceps placed & crown + roots extracted uneventfully with roots intact'*.

The Committee also noted from the transcript of the appointment that Mrs Pakeniene had believed at the time that everything had been removed.

Patient A's witness statement also stated that Mrs Pakeniene had said, *'that everything had been extracted'* and *'...that she had done the treatment'*.

The Committee concluded that it was likely that Mrs Pakeniene had believed at the time that the extraction had been a success and the whole tooth had been extracted.

In light of this, the Committee determined that there was no failure on Mrs Pakeniene to record a discussion with Patient A about the problems with the extraction in circumstances where she believed that it had been completed successfully.

Furthermore, the Committee noted that it was accepted by Dr Igoe in oral evidence that Mrs Pakeniene may not necessarily have known that it was an incomplete extraction.

For these reasons, the Committee determined that this head of charge was not proved.

- c. Your record of 18 August 2022 inaccurately records that:



	<p>i. “roots extracted uneventfully with roots intact”;</p> <p>Found Proved</p> <p>The Committee has found above in its reasons for head of charge 3(b)(ii) that there was sufficient evidence to show that Patient A’s LR6 root had fractured during the extraction. Therefore, it was inaccurate to state the roots were intact.</p> <p>The Committee has also found in its reasons at head of charge 3(b) (i) that Mrs Pakeniene had cut her finger during the extraction, and therefore it was inaccurate to describe the extraction as uneventful.</p> <p>Accordingly, the Committee found this head of charge proved.</p>
	<p>ii. you discussed the risks of:</p> <ul style="list-style-type: none">a. an oro-antral fistula;b. fractured tuberosity;c. MRONJ;d. Radio necrosis of the jaw; <p>Found Proved</p> <p>The Committee noted and accepted Dr Igoe’s evidence in his expert report that the risks outlined in this head of charge were not relevant to Patient A’s extraction and appeared to be ‘<i>pre-written</i>’ and not ‘<i>tailored to this appointment</i>’. Dr Igoe concludes, therefore, that the notes did not accurately reflect what had occurred and the Committee agreed.</p> <p>Accordingly, the Committee found this head of charge proved.</p>
	<p>iii. you discussed the risks of the extraction being unsuccessful;</p> <p>Found Proved</p> <p>The Committee noted from Patient A’s witness statement and the transcript of the appointment that Mrs Pakeniene did not discuss the risks with her of the extraction being unsuccessful.</p> <p>The Committee determined, therefore, that this entry in the records was inaccurate.</p> <p>Accordingly, the Committee found this head of charge proved.</p>



d. You did not record any notes of your appointment with Patient A on 20 August 2022;

Found Proved

The Committee first sought to establish whether there was a sufficient evidence that an appointment took place on 20 August 2022.

The Committee noted from Patient A's witness statement that she gives a detailed explanation of what occurred during this appointment, in that she presented with pain and an x-ray was taken, which is included in the records and dated 20 August 2022. The Committee also noted that there is a transcript of the appointment.

The Committee was satisfied that an appointment did take place on 20 August 2022, however, there are no notes of that appointment in Patient A's records.

Accordingly, the Committee found this head of charge proved.

	<p>e. Your record of 23 August 2022 does not record:</p> <ul style="list-style-type: none"> i. Patient A's presenting condition; ii. the findings of your clinical examination; iii. what treatment options were discussed and/or offered to Patient A; iv. that a radiographic examination conducted on 20 August 2022 had revealed the presence of a retained root at Patient A LR6; v. why Patient A was to be referred for further treatment. <p>Found Proved</p> <p>The Committee had sight of the record for the appointment of 23 August 2022 and noted that it only states, <i>'Pt is referred to Dr... to finish the extraction of LR6'</i>.</p> <p>The Committee noted Dr Igoe's expert evidence that the matters particularised should have been included in the record for this appointment. The Committee accepted this evidence and noted that there was a duty on Mrs Pakeniene to include this information when she made the referral to the subsequent treating dentist.</p> <p>Accordingly, the Committee found this head of charge proved in its entirety.</p>
<p>4.</p>	<p>You failed to maintain an adequate standard of record keeping in relation to radiographs, in respect of Patient A's appointments from 18 August 2022 to 20 August 2022, in that:</p> <p>a. You did not record that a radiograph was taken on:</p> <ul style="list-style-type: none"> i. 18 August 2022; <p>Found Proved</p> <p>The Committee noted from Patient A's witness statement that Mrs Pakeniene took a panoramic x-ray at the appointment on 18 August 2022. This is also referenced in the transcript for the appointment.</p> <p>The Committee also noted from Dr Igoe's expert report that it is his understanding that a copy of this x-ray is included in the records, albeit it is undated, as it was a pre-operative radiograph and it shows the LR6 in situ.</p>



The Committee further noted from the records that there is no reference to this radiograph and Mrs Pakeniene was under a duty to record it under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

Accordingly, the Committee found this head of charge proved.

ii. 20 August 2022.

Found Proved

When considering this head of charge, the Committee noted that it contained a typographical error in that the date states 20 August 2020, when the evidence in the case suggests it should read 20 August 2022.

The Committee noted that under Rule 18 it has the power to amend a head of charge at any stage before making its findings of fact, provided that it can do so without injustice, and the parties must be given the opportunity to make representations.

Mr Stevens was subsequently invited to make written submissions on the proposed amendment. He submitted that it is a clerical error and therefore the proposal was entirely appropriate and supported by the GDC.

The Committee noted that the error in the date was a clerical slip, the amendment required was minor, there was no prejudice caused to Mrs Pakeniene and it made no difference to the evidence or submissions.

The Committee determined therefore that head of charge 4(a)(ii) should be amended to read 20 August 2022.

The Committee noted from Patient A's witness statement that Mrs Pakeniene took a panoramic x-ray at the appointment on 20 August 2022. This is also referenced in the transcript for the appointment.

The Committee also had sight of a radiograph, dated 20 August 2022, in Patient A's records, but there is no record of this radiograph as Mrs Pakeniene was required to do under (IR(ME)R).

Accordingly, the Committee found this head of charge proved.



	<p>b. You did not report on a radiograph taken on:</p> <ul style="list-style-type: none"> i. 18 August 2022; ii. 20 August 2022. <p>Found Proved</p> <p>As the Committee has found above, Mrs Pakeniene did not report on the radiographs taken on 18 and 22 August 2022 as there was no record of them in the notes.</p> <p>The Committee noted from Dr Igoe’s report that Mrs Pakeniene was under a duty to report on them as required under IRMER.</p> <p>Accordingly, the Committee found these heads of charge proved.</p>
<p>5.</p>	<p>By reason of your conduct in charge 3.b.i. and/or 3.c.i. and/or 3.c.ii.a. and/or 3.c.ii.b. and/or 3.c.ii.c. and/or 3.c.ii.d. and/or 3.c.iii was:</p> <ul style="list-style-type: none"> a. misleading; <p>Found Proved</p> <p>The Committee has found proved that Mrs Pakeniene had failed to maintain an adequate standard of record keeping by not including information that should have been recorded and inaccurately recording information.</p> <p>The Committee concluded that in doing so Mrs Pakeniene would have misled the reader into believing that the information contained in the records was correct, when this was not the case.</p> <p>Accordingly, the Committee found this head of charge proved.</p> <ul style="list-style-type: none"> b. lacking in integrity; <p>Found Proved</p> <p>When considering whether Mrs Pakeniene’s actions amounted to a lack of integrity, the Committee noted the definition of integrity as explained in the case of <i>Wingate v Solicitors Regulation Authority [2018] EWCA Civ 366</i>. It noted that <i>Wingate</i> refers to the ethical standards that a dental</p>



professional should adhere to and the higher standards expected from professional persons.

The Committee noted that Mrs Pakeniene was under a duty to ensure that her patients' records were complete and accurate (GDC Standard 4.1 – *'You must make and keep contemporaneous, complete and accurate patient records.'*)

The Committee determined that, in omitting and inaccurately recording information in Patient A's records, Mrs Pakeniene had breached this duty and that this amounted to conduct that lacked integrity.

Accordingly, the Committee found this head of charge proved.

- c. dishonest – in that you knew your record did not accurately reflect what occurred during the appointment.

Found Not Proved

When considering this charge, the Committee referred to the test set out in the case of *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] UKSC 67. It first considered the actual state of Mrs Pakeniene's knowledge or belief as to the facts at the time. The Committee then considered whether her conduct would be viewed as dishonest by the objective standards of ordinary and decent people.

The Committee first considered head of charge 3(b)(i) and whether Mrs Pakeniene was dishonest in not recording in Patient A's records that she had cut her finger during the appointment on 18 August 2022.

The Committee considered Mrs Pakeniene's knowledge or belief as to the facts at the time. It was clear to the Committee that Mrs Pakeniene was aware that she had cut her finger as the transcript of the appointment states that she injured her hand.

Furthermore, the *'Accident Record'* document, dated 18 August 2022, which was signed by Mrs Pakeniene, stated that:

'Dr V Pakeniene sustained minor laceration, a scratch which was washed and covered with a plaster. There was no contact with a patient. No further treatment or assessment was needed.'



The Committee also noted from the practice manager's witness statement that Mrs Pakeniene followed the practice's Needlestick Policy.

For these reasons, the Committee concluded that it was likely that Mrs Pakeniene had believed at the time that she had followed the correct procedures when she had cut her finger and that no further action was required. The Accident Report refers to it being a *'minor laceration'* and *'a scratch'*, which was *'covered with a plaster'* and that *'no further treatment or assessment was needed'*. The report also stated that there was no contact with Patient A.

The Committee also noted that Mrs Pakeniene did not attempt to cover up the incident. This was clear from the fact she completed the Accident Report and from the transcript which shows that she had explained to Patient A that she had cut her finger.

The Committee determined therefore that it was more likely than not that Patient A believed that the incident had been sufficiently dealt with and would not require documenting in Patient A's records.

The Committee then went on to determine whether Mrs Pakeniene's conduct would be viewed as dishonest by the objective standards of ordinary and decent people.

The Committee determined that in circumstances where Mrs Pakeniene had believed that the incident had sufficiently been dealt with by completion of the Accident Report and adhering to the Needlestick Policy, her conduct would not be viewed as dishonest by the objective standards of ordinary and decent people.

The Committee then went to consider heads of charge 3(c)(i), 3(c)(ii)(a), 3(c)(ii)(b), 3(c)(ii)(c), 3(c)(ii)(d) and 3(c)(iii).

In considering Mrs Pakeniene's knowledge or belief as the facts at the time, the Committee had regard to its findings at head of charge 3(b)(iii) that it was likely that Mrs Pakeniene had believed at the time that the extraction had been a success and the whole tooth had been extracted.



This is shown by the entry in Patient A's records, '*Forceps placed & crown + roots extracted uneventfully with roots intact*', the transcript of the appointment and Patient A's witness statement.

Furthermore, it was accepted by Dr Igoe in oral evidence that Mrs Pakeniene may not necessarily have known that it was an incomplete extraction.

The Committee determined therefore that it was more likely than not that Patient A believed at the time that the extraction had been successful and therefore stated '*roots extracted uneventfully with roots intact*' (head of charge 3(c)(i)).

In these circumstances, the Committee determined that her conduct would not be viewed as dishonest by the objective standards of ordinary and decent people.

The Committee then went on to consider the inaccurate information in the records as outlined at heads of charge 3(c)(ii)(a) to (d), 3(c)(ii)(b), and 3(c)(iii).

The Committee noted that it is clear from the evidence in the records that when Mrs Pakeniene completed the templated records in Patient A's case she showed a lack of concern about the content and meaning. The Committee determined, however, that this was due to her being inattentive, casual and careless with her record keeping rather than having any intention to be misleading or dishonest. The Committee noted that the irrelevant information included in the records about the risks of extraction would not have had a significant impact on Patient A's subsequent care and pointed more to carelessness than anything else.

The Committee also noted that Dr Igoe stated in his expert report that these entries in the records appeared to be '*pre-written*' and not '*tailored to this appointment*'.

In these circumstances, the Committee determined that although Mrs Pakeniene's conduct would likely be viewed as careless and inattentive, it would not be viewed as dishonest by the objective standards of ordinary and decent people.

Stage 2

23. Having announced its decision at Stage 1, the Committee then went on to consider whether the facts found proved amounted to misconduct and, if so, whether Mrs Pakeniene's fitness to practise is currently impaired by reason of her misconduct, and if so, what sanction, if any, should be imposed. In accordance with Rule 20 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), the Committee heard submissions from Mr Stevens, on behalf of the GDC, in relation to the matters of misconduct, impairment and sanction.

Submissions

24. Mr Stevens, on behalf of the GDC, first addressed the Committee on Mrs Pakeniene's fitness to practise history, as required under Rule 20(1)(a). He submitted that in June 2015 a PCC had found proved allegations in respect of clinical care and record keeping regarding Mrs Pakeniene's treatment of a patient between June 2011 and May 2013. However, no finding of misconduct was made by the PCC. He submitted that the concerns were thematically similar to the findings in this case, albeit he acknowledged that they occurred some time ago. He submitted that it was a matter for the Committee as to the significance of Mrs Pakeniene's fitness to practise history.

25. Mr Stevens then addressed the Committee on the matter of misconduct. Firstly, he acknowledged that the complexion of the case had changed following the Committee's finding that Mrs Pakeniene's conduct was not dishonest. However, notwithstanding this, he submitted that the allegations found proved comfortably passed the threshold for misconduct.

26. Mr Stevens submitted that Mrs Pakeniene's failure to obtain informed consent from Patient A was in itself serious enough to justify a finding of misconduct. However, he submitted that the Committee had also found proved that there were significant failings in record keeping, which Dr Igoe concluded fell far below the standard expected of dental practitioners. Furthermore, he submitted that the Committee has concluded that these failings in record keeping amounted to misleading conduct and conduct which lacked integrity. He submitted that these combined failings in consent and record keeping should lead to a finding of misconduct.

27. Mr Stevens next addressed the Committee on the matter of impairment. He acknowledged that the failings found proved were distinct clinical matters that were capable of remedy. However, he submitted that there has been a lack of meaningful engagement by Mrs Pakeniene in this process. He submitted that there has been a marked absence of any evidence of remediation, including any written reflections or Continuing Professional Development (CPD) training courses undertaken. He submitted that Mrs Pakeniene lacked insight into her failings and there was a risk of repetition. He submitted, therefore, that a finding of impairment was required on public protection grounds.

28. Mr Stevens also submitted that a finding of impairment was required on public interest grounds. He submitted that such a finding was required to uphold public confidence in the profession and to declare and maintain proper professional standards.
29. In respect of sanction, Mr Stevens submitted that in the particular circumstances of this case the most appropriate sanction would be a short period of suspension.

Committee's Decision

30. The Committee has borne in mind that its decisions on misconduct, impairment and sanction were matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's *Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020)* (the 'GDC's Guidance'). The Committee also received advice from the Legal Adviser which it accepted and had regard to the relevant case law. The Committee first considered whether the facts found proved amounted to misconduct.

Misconduct

31. The Committee had regard to the GDC's *Standards for the Dental Team (2013)* (the GDC Standards) and determined that Mrs Pakeniene had breached the following sections in particular:
- 1.3 *You must be honest and act with integrity.*
 - 1.3.2 *You must make sure you do not bring the profession into disrepute.*
 - 3.1 *You must obtain valid consent before the starting treatment, explaining all the relevant options and the possible costs.*
 - 4.1 *You must make and keep contemporaneous, complete and accurate patient records.*
32. The Committee found proved that Mrs Pakeniene made a significant number of inaccurate entries in Patient A's records by either omitting vital information, in particular that she had cut her finger during the extraction procedure, or including irrelevant information. In one instance, the Committee noted that no records were made at all for one of Patient A's appointments. The Committee found that Mrs Pakeniene was careless and inappropriate in her use of templated records as they were not tailored to the specific treatment she provided to Patient A. Mrs Pakeniene did also not adhere to the Ionising Radiation (Medical Exposure) Regulations when reporting on radiographs and did not include sufficient information in the records when referring Patient A to another dentist. The Committee found her conduct in respect of her record keeping to be misleading and lacking in integrity. The Committee further noted and accepted the

conclusion in Dr Igoe's expert report that her failings in record keeping fell far below the standards expected.

33. In respect of Mrs Pakeniene's failure to obtain Patient A's informed consent for the extraction procedure, the Committee was mindful of the relevant paragraphs in the GDC's Guidance on consent. In particular, it noted that, *'The issue of informed or valid consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment or investigation. Failure to obtain consent is a serious matter...'*
34. For these reasons, the Committee was satisfied that Mrs Pakeniene's failings in this case were serious and amounted to misconduct.

Impairment

35. The Committee then considered whether Mrs Pakeniene's fitness to practise is currently impaired by reason of her misconduct.
36. The Committee first noted Mrs Pakeniene's fitness to practise history as outlined by Mr Stevens in his submissions. It acknowledged that the findings made were ten years ago and that no misconduct was found. However, the Committee was mindful that the findings in that case were thematically similar to the matters found proved in this case, namely clinical care and record keeping.
37. The Committee was of the view that Mrs Pakeniene's failings were capable of being remedied as they involved discrete areas of her clinical practice, consent and record keeping. However, the Committee has been provided with no evidence from Mrs Pakeniene that these failings have been remedied despite the fact that the matters in this case occurred over three years ago. The Committee noted that although Mrs Pakeniene has corresponded with the GDC, there has been no meaningful engagement from her in respect of this process. She has not provided any written reflections on her misconduct evidencing her insight, including acknowledgement of her failings or any corrective steps she has undertaken to ensure they would not be repeated. She has also not provided any evidence demonstrating her awareness of the impact of her misconduct on Patient A, the public or the dental profession as a whole. Furthermore, Mrs Pakeniene has not provided any evidence of CPD training courses she may have undertaken. Therefore, in the absence of any remediation evidence, the Committee concluded that she lacked insight into her misconduct and it was likely that it would be repeated.
38. Accordingly, the Committee determined that a finding of impairment is necessary in the interests of public protection.
39. The Committee also determined that a finding of impairment is necessary in the wider public interest to maintain public confidence and uphold proper standards of conduct and competence among dental professionals. The Committee has found proved

serious failings in respect of the consent process and record keeping, including conduct which was misleading and lacked integrity. The Committee concluded that a reasonable and informed member of the public, fully aware of the facts of the case, would lose confidence in the profession and the dental regulator if a finding of impairment were not made in the circumstances of this case.

40. The Committee therefore determined that Mrs Pakeneiene's fitness to practise is also currently impaired on the ground of public interest.

Sanction

41. The Committee next considered what sanction, if any, to impose on Mrs Pakeniene's registration. It recognised that the purpose of a sanction was not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing Mrs Pakeniene's interests with the public interest. It also took into account the *GDC's Guidance*.

42. The Committee considered the mitigating and aggravating factors in this case as outlined in the *GDC's Guidance* at paragraphs 5.17 and 5.18.

43. The mitigating factors in this case include:

- There has been no evidence of further wrongdoing since the incident in 2022;
- A positive written endorsement about Mrs Pakeniene's competence from her Practice Manager, who has known her since 2008.

44. The aggravating factors in this case include:

- Misconduct repeated over a period of time – the Committee noted that the misconduct took place over several appointments with Patient A;
- Previous adverse findings;
- No insight.

45. Taking all these factors into account, the Committee considered the available sanctions, starting with the least restrictive. The Committee noted that it was open to it to conclude this case without taking any action in relation to Mrs Pakeniene's registration. However, it concluded that taking no action would not be appropriate or proportionate, given the seriousness of its findings and the identified concerns about public protection and the public interest.

46. The Committee next considered whether to issue Mrs Pakeniene with a reprimand. It had regard to paragraph 6.7 of the *GDC's Guidance* which states:

“A reprimand is the lowest sanction which can be applied and may therefore be appropriate where the misconduct ... is at the lower end of the spectrum. A reprimand does not impose requirements on a registrant's practice and should

therefore only be used in cases where he or she is fit to continue practising without restrictions. A reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice.”

47. The Committee concluded that Mrs Pakeniene’s failings in respect of consent and record keeping, including conduct which was misleading and lacked integrity, was serious and could not be considered to be at the lower end of the spectrum. Furthermore, Mrs Pakeniene has shown no insight into her misconduct and there is a likelihood of repetition of the concerns, which would pose a risk to patients. Accordingly, the Committee determined that issuing a reprimand would not be sufficient to protect the public or the public interest considerations.
48. The Committee went on to consider whether to impose conditions on Mrs Pakeniene’s registration. It noted in the GDC’s Guidance that conditions may be appropriate when *‘there are discrete aspects of the Registrant’s practice that are problematic’*. The Committee noted that the failings in this case involved Mrs Pakeniene’s record keeping and the consent process when undertaking a tooth extraction. The Committee noted that the failings involved a single patient and there was no evidence that Patient A suffered any harm as a result of the treatment. Furthermore, no concerns have been raised about Mrs Pakeniene’s practical skills as a dentist and neither have there been similar concerns raised since the index matters three years ago. The Committee was satisfied, therefore, that in the particular circumstances of this case targeted conditions could be imposed to sufficiently protect the public and the public interest considerations.
49. In respect of whether Mrs Pakeniene would comply with a conditions of practice order, the Committee acknowledged that there has been no meaningful engagement with the process by Mrs Pakeniene and she has not attended this hearing. However, the Committee noted that there has not been a total lack of engagement as there has been some correspondence between Mrs Pakeniene and the GDC. In this regard, the Committee noted Mrs Pakeniene’s email to the GDC, dated 22 September 2025, in which she stated that she was happy to accept the Committee’s decision on her case. The Committee was also mindful to impose the least restrictive sanction on Mrs Pakeniene’s registration, which was sufficient to protect the public and the public interest, and that the purpose of the sanction was not to be punitive.
50. Taking all of this into account, the Committee was satisfied that conditional registration would be appropriate, proportionate, and sufficient to protect the public. These conditions would include a requirement for Mrs Pakeniene to undertake a self-audit every three months on the matters of informed consent and her accurate use of templates in clinical records. She would also be required to work with a Postgraduate Dental Dean/Director (or a nominated deputy) to formulate a Personal Development Plan to address the failings in this case and to submit to the GDC a written reflective piece to demonstrate her insight and remediation journey.

51. In concluding that a period of conditional registration would be the most appropriate sanction, the Committee had regard to the GDC's Guidance at paragraph 6.28 which deals with the sanction of suspension. Having had regard to the relevant factors in that paragraph, the Committee concluded that the matters in this case had not reached the threshold of seriousness for the suspension of Mrs Pakeniene's registration. It also considered that a suspension would be disproportionate, given that the failings involved discrete clinical matters which could be suitably addressed by targeted conditions and which would protect the public.
52. In all the circumstances, the Committee has determined to impose conditions on Mrs Pakeniene's registration for a period of 18 months.
53. In deciding on this 18-month period, the Committee considered that this would be sufficient time for Mrs Pakeniene to demonstrate that she has developed insight into her failings and undertake suitable and sufficient remediation work, which has been fully embedded in her practice. The Committee is satisfied that this is the appropriate and proportionate period.
54. The conditions that will appear against Mrs Pakeniene's name in the Dentists' Register are as follows:
1. *You must work with a Postgraduate Dental Dean/Director (or a nominated deputy), to formulate a Personal Development Plan, specifically designed to address the deficiencies in the following areas of your practice:*
 - *Record keeping, in respect of informed consent, radiographic recording and reporting, and the correct use of templates;*
 - *Clinical incident reporting involving patients, in respect of the accurate detailing of them in the clinical notes and the Accident Book;*
 - *Referrals, in respect of the information that should be provided in the clinical notes when referring a patient for further dental treatment;*
 2. *You must forward a copy of your Personal Development Plan 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 Personal Development Plan. 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 Personal Development Plan 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.*
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 or reporter 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.*
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 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. a. *You shall carry out an audit of the following:*
 - *Informed consent provided to patients in respect of tooth extractions – involving any consent form for extraction and the patients' records;*
 - *Your accurate use of templates in clinical records using a sample size of 20 patients every three months.*
- b. *You must provide a copy of this audit to the GDC every three months or, alternatively, confirm that there have been no such cases.*
12. *You must maintain a log of all radiographs taken and your recording and reporting of them in accordance with the Ionising Radiation (Medical Exposure) Regulations.*
13. *You must provide a copy of this log to the GDC every three months or, alternatively, confirm that there have been no such cases.*
14. *You must provide to the GDC a written reflective piece to demonstrate your development of insight into your misconduct and your remediation journey. This must be provided to the GDC no later than 28 days before the next PCC review hearing.*
15. *You must inform within one week 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 his registration status.

55. The Committee also directs that there be a review of Mrs Pakeniene's case. This means that a Committee will review her case at a hearing to be held shortly before the end of this period of conditional registration. That Committee will consider what action to take in relation to her registration. Mrs Pakeniene will be informed of the date and time of that hearing, with which she will be expected to engage.
56. Unless Mrs Pakeniene exercises her right of appeal, the above conditions will take effect 28 days from the date when notice is deemed to have been served upon her. However, the Committee now invites submissions as to whether an immediate order of conditions should be imposed on Mrs Pakeniene's registration to cover the appeal period, pending the substantive direction for conditions taking effect.

Decision on Immediate Order (3 October 2025)

57. The Committee has considered whether to make an immediate order of conditions on Mrs Pakeniene's registration in accordance with Section 30 of the Dentists Act 1984 (as amended).
58. Mr Stevens, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is in the public interest ground following the findings of the Committee that Mrs Pakeniene's fitness to practise is currently impaired on both of those grounds.
59. The Committee has considered the submission made. It has accepted the advice of the Legal Adviser.
60. The Committee is satisfied that an immediate order of conditions is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of conditions in Mrs Pakeniene's case including the risk of repetition, it is necessary to direct that an immediate order of conditions be imposed on both of these grounds. The Committee considered that, given its findings, if an immediate order was not made in

the circumstances, there would be a risk to public safety and public confidence in the profession would be undermined.

61. The effect of the foregoing determination and this order is that Mrs Pakeniene's registration will be subject to the aforementioned conditions immediately from the date on which notice is deemed to have been served upon her. Unless she exercises her right of appeal, the substantive direction for conditional registration as already announced, will take effect 28 days from the date of deemed service, and continue for a period of 18 months. In the event that she exercises her right of appeal, this immediate order will remain in place until resolution of the appeal.

62. That concludes this hearing.