HEARING HEARD IN PUBLIC

ABBASI, Hossein

Registration No: 78936

PROFESSIONAL CONDUCT COMMITTEE

NOVEMBER 2022

Outcome: Erased with Immediate Suspension

ABBASI Hossein, a dentist, Tannlege Oslo 1997, was summoned to appear before the Professional Conduct Committee on 02 November 2022 for an inquiry into the following charge:

Charge

"That, being a registered dentist:

1. Between January 2018 and December 2018 you were in general dental practice at Practice 1 working under the provisions of the NHS and private contract.

Patient B

2. On 17 October 2018, in relation to Patient B:
   (a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;
   (b) you failed to adequately report on bitewing radiographs including;
      (i) bone loss;
      (ii) interdental calculus;
      (iii) caries at UR7.
   (c) you failed to adequately discuss, or record discussion, concerning Patient B's:
      (i) periodontal condition;
      (ii) treatment needs and options including under the NHS.
3. On 21 November 2018, in relation to Patient B:
   (a) you failed to adequately report on a periapical radiograph including;
      (i) bone loss;
      (ii) interdental calculus;
   (b) you failed to adequately discuss, or record discussion, concerning Patient B's:
      (i) periodontal condition;
      (ii) treatment needs and options including under the NHS.

Patient C

4. On 3 August 2018, in relation to Patient C:

   (a) you failed to adequately record Patient C's presenting symptoms;

   (b) you failed to adequately record your clinical findings and/or diagnosis;

   (c) you failed to adequately report on a periapical radiograph erroneously dated 14 August 2018, including:

      (i) a deficient distal margin at LR5

      (ii) a root filling beyond the apex at LR5.

   (d) you failed to ensure adequate anaesthesia for the complete extraction of LR6;

   (e) you failed to treat Patient C with kindness and compassion by the manner in which you spoke to her;

   (f) you failed to ensure you had consent for the continuation of the extraction of the LR6;

   (g) you failed to make or record arrangements for a review and/or referral for the retained root at LR6;

   (h) you inappropriately recorded in Patient C's records that you had a negative impression of the Practice Manager and that, "THEY HAVE A PLAN TO MAKE PROBLEMS FOR ME."

5. On 3 August 2018 you failed to treat the Practice Manager with respect in that you raised your voice and behaved towards her in an aggressive manner.

Patient D

6. On 3 August 2018, in relation to Patient D:

   (a) you declined to see Patient D without any, or any adequate, enquiry of her dental needs;

   (b) you failed to treat Patient D with kindness and compassion by the manner in which you spoke to her;

   (c) you failed to offer to refer the patient to the Community Dental Service;

   (d) you inappropriately recorded in Patient D's records that the Manager/Receptionist had involved herself "IN THE PROBLEM" and that, "LATER COMING TO ME AND TREATEN THAT YOU SHOULD HAVE SEEN THE PAT. ACCORDING TO THE GDC REG. AND THAT SHE REPORT ME TO THE GDC".

Patient E

7. On 6 July 2018, in relation to Patient E:

   (a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;

   (b) you failed to adequately report on a bitewing radiograph of the right side.

(c) you failed to take or record a justification for not taking a bitewing radiograph of the left side.

8. On 26 September 2018, in relation to Patient E:

(a) you failed to update or record updating Patient E's medical history;

(b) you failed to adequately record Patient E's presenting symptoms;

(c) you failed to discuss or adequately record discussion of treatment options, including risks and benefits, in respect of the LR6;

(d) you inappropriately commenced treatment without discussing with Patient E that not all the necessary materials or equipment were available;

(e) you failed to use rubber dam;

(f) you failed to treat Patient E with kindness and compassion by the manner in which you interacted with her.

Patient F

9. On 17 July 2018, in relation to Patient F:

(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessment;

(b) you failed to adequately record a treatment plan or discussion of treatment options in respect of the patient's periodontal condition;

(c) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of retained roots at UL3, and/or UL4 and/or LL5;

(d) you failed to take or record a justification for not taking bitewing radiographs.

10. On 18 July 2018, in relation to Patient F:

(a) you failed to adequately record a treatment plan or discussion of treatment options in respect of the Patient F's periodontal condition;

(b) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of retained roots at UL3 and/or UL4;

Patient I

11. On 10 July 2018, in relation to Patient I:

(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;

(b) you failed to adequately record Patient I's presenting complaint;

(c) you failed to adequately report on a periapical radiograph including caries at UL6;

(d) you failed to record a Basic Periodontal Examination;

(e) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of caries at UL3, and/or UL 4 and/or UL6.

Patient J

12. On 11 July 2018, in relation to Patient J:

(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;

(b) you failed to record a Basic Periodontal Examination;

(c) you failed to adequately report on radiographs including:

(i) the broken down UL4;

(ii) caries at UL6 and/or UL7.

(d) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of:

(i) the broken down UL4;

(ii) caries at UL6 and/or UL7.

13. On 17 July 2018, in relation to Patient J:

(a) you failed to record a medical history update;

(b) you failed to adequately record a diagnosis and/or discussion of treatment options, including risks and benefits, in respect of caries at UL6, and /or UL7.

14. On 31 July 2018 you failed to record a medical history update for Patient J.

15. On 28 August 2018, in relation to Patient J:

(a) you failed to adequately record clinical findings and/or diagnosis in respect of UL7;

(b) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of the UL7.

Patient L

16. On 27 February 2018, in relation to Patient L:

(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;

(b) you failed to adequately record a treatment plan or discussion of treatment options in respect of the patient's periodontal condition.

17. On 21 March 2018 you provided root canal treatment to Patient L's UR6 and:

(a) you failed to adequately report on intra-operative working length radiographs;

(b) you failed to record if a post-operative radiograph was taken;

(c) you failed to use, or record the use, of rubber dam.

18. On 3 April 2018, in relation to Patient L:

(a) you failed to record updating the patient's medical history;

(b) you failed to record the status of the UR5;

(c) you failed to adequately record details concerning the crown fit at UR6;

(d) you failed to adequately record a justification for treatment at UL6.

19. On 9 October 2018, in relation to Patient L:

(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;

(b) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of the UL6;

(c) you failed to adequately report on a radiograph including a deficient coronal restoration at UL6.

20. At about 23.45 on 11 April 2021 you sent a WhatsApp message to Colleague A who you knew, or suspected, was a potential witness for the General Dental Council ('GDC').

21. You wrote words to the effect that you had heard she did not want to give a witness statement and that you had sent her apology letter to the GDC and you warned her to be careful and remember what she had written to you a couple of months ago.

22. Your conduct as set out above at 21 was:

(a) inappropriate;

(b) liable to intimidate;

(c) intended to intimidate.

23. The GDC wrote to you and asked you to supply information in relation to your working arrangements and proof of indemnity on:

(a) 15 October 2021;

(b) 3 November 2021.

24. You failed to co-operate promptly, or at all, with the above requests.

And that, by reason of the facts alleged, your fitness to practice is impaired by reason of your Misconduct."

Mr Abbasi was not present and was not represented. On 2 November 2022 the Chairman made a statement regarding the preliminary applications. On 9 November 2022 the Chairman announced the findings of fact to the Counsel for the GDC:

"This is a Professional Conduct Committee (PCC) hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely

via Microsoft Teams in line with current General Dental Council (GDC) practice. Mr Hossein Abbasi was not present at the hearing and unrepresented. Ms Lydia Barnfather, Case Presenter, appeared on behalf of the GDC.

Preliminary matters

On 2 November 2022, the Chair made a statement regarding the following preliminary applications:

Decision on service of Notice of Hearing

The Committee was informed at the start of this hearing that Mr Abbasi was neither present nor represented at today's hearing.

In his absence, the Committee first considered whether the Notice of Hearing ('the Notice') had been served on Mr Abbasi in accordance with Rules 13 and 65 of the *'General Dental Council (Fitness to Practise) Rules Order of Council 2006'* ('the Rules').

The Committee had regard to the indexed hearing bundle of 352 pages, which contained a copy of the Notice, dated 14 September 2022. The Notice was sent to Mr Abbasi's registered address by Special Delivery on 14 September 2022, in accordance with Section 50A of the *'Dentists Act 1984' (as amended)* ('the Act') and via email on the same date.

The Committee was satisfied that the Notice contained proper and correct information relating to today's hearing. This included the time, date and that it is being conducted remotely via Microsoft Teams, as well as notification that the Committee has the power to proceed with the hearing in Mr Abbasi's absence.

The Committee was provided with information that demonstrated that the Notice had been returned to sender. However, it noted that it is a requirement of the Rules that the Notice is served, not received.

In light of the information available, the Committee was satisfied that Mr Abbasi has been served with proper notification of this hearing, at least 28 days before its commencement, in accordance with the Rules.

Decision on whether to proceed in the absence of Mr Abbasi

The Committee next considered whether to exercise its discretion to proceed with the hearing in the absence of Mr Abbasi and any representative on his behalf. The Committee was mindful that its decision to proceed in the absence of Mr Abbasi must be handled with the utmost care and caution. The Legal Adviser reminded the Committee of the requirement to be fair to both parties, as well as considering the public interest in the expeditious disposal of this case.

Ms Barnfather, on behalf of the GDC, informed the Committee that Mr Abbasi was been aware of the GDC investigation for a considerable time and has previously failed to cooperate with requests from the GDC for information. She stated that Mr Abbasi had previously been legally represented. His representatives had notified the GDC on 28 January 2022 that Mr Abbasi stopped practising in January 2021, did not pay his annual retention fee, and intended to come off the GDC register. This was

confirmed by Mr Abbasi in an email in April 2022. Since then, Mr Abbasi has not responded to any information sent by the GDC to his registered address or by email.

The Committee noted that no application for an adjournment had been made by Mr Abbasi and, in the light of his non-engagement since April 2022, there was no information before the Committee that adjourning would secure his attendance at a later date. On the basis of the information before it, the Committee concluded that Mr Abbasi had voluntarily absented himself from today's hearing.

The Committee also bore in mind that there are a number of witnesses who have been warned to attend and that adjourning the matter may cause inconvenience to the witnesses and any further delay may have an adverse effect on their memories of the events.

In all these circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr Abbasi".

Finding of facts

On 9 November 2022, the Chair announced the finding of facts:

Background

Mr Abbasi qualified in 1997 from the University of Oslo and registered with the GDC in 2001. Between January 2018 and December 2018, he was working at a dental practice, 'Practice 1', under the provisions of the NHS and privately. Practice 1 was not a happy environment allegedly in part because of Mr Abbasi's behaviour towards both colleagues and patients.

The allegations concern the care and treatment of eight patients including the failure to treat three of those patients with kindness and respect. Additionally, it is alleged that Mr Abbasi treated a fellow member of staff in a way that was unprofessional and aggressive and, following his referral to the GDC, he went on to try and intimidate a second member of staff so as to influence her evidence before this tribunal. Lastly, he faces allegations of non-co-operation with the GDC and specifically the failure to provide information requested regarding his indemnity and employment status.

Evidence

The Committee had regard to a number of documents, including the GDC hearing bundle, referred to as Exhibit 1. This bundle included, but was not limited to, the following documents:

- Patient records;
- Witness statements; and
- Expert witness reports, dated 14 July 2021 and 20 July 2021.

Witnesses

In addition to their written statements, the Committee heard the testimony of the following witnesses:

- Ms Jane Ford – Expert Witness

- Witness 1 – Operations Manager
- Witness 2 – Practice Manager
- Colleague A – Dental nurse

Committee's findings

The Committee considered all the evidence presented to it and accepted the advice of the Legal Adviser. It 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 facts are proved on the balance of probabilities.

The Committee's findings in relation to each head of charge are as follows:

1.	*Between January 2018 and December 2018 you were in general dental practice at Practice 1 working under the provisions of the NHS and private contract.* **FOUND PROVED** The Committee accepted that Mr Abbasi had worked at Practice 1 at the relevant time.
2.	*On 17 October 2018, in relation to Patient B:* *(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments* **FOUND PROVED** The Committee took into account that Patient B attended Practice 1 in connection with two upper teeth on the right and left which were said to have been causing him pain. His initial examination was undertaken by Mr Abbasi as an NHS patient on 17 October 2018. Mr Abbasi recorded a Basic Periodontal Examination (BPE) and took bitewing radiographs. An extraction was performed, and Patient B was advised to see the hygienist. The Committee accepted Ms Ford's evidence that following the examination, it was the responsibility of Mr Abbasi to report in the dental records an assessment of what has been identified. She stated that this would include reference to a number of factors, including caries. Ms Ford stated that a failure to do so would fall far below the expected standards of record keeping, as risk assessments are used to inform prevention regimes and recall intervals to lessen the chance of new disease occurring. In not doing so, a patient is placed at a potentially increased risk of disease. The Committee was satisfied that Mr Abbasi had a duty to record his findings in the patient dental records. The Committee noted that any reference to risk of caries, oral cancer and periodontal disease in Patient B's dental records is absent. Accordingly, the Committee concluded that Mr Abbasi had failed to

adequately record risk assessments for caries and oral cancer and periodontal disease and found **charge 2(a) proved**.

(b) you failed to adequately report on bitewing radiographs including;

(i) bone loss;

(ii) interdental calculus;

(iii) caries at UR7.

FOUND PROVED

The Committee had regard to the bitewing radiograph taken by Mr Abbasi at Patient B's appointment.

In her written statement, Ms Ford opined, *"On reviewing the radiographs, I agree there is deep caries at UL5, there is also interdental calculus visible and significant bone loss, which are not reported upon. The BW* [bitewing] *at the right side shows deep caries at UR7, interdental calculus and significant bone loss, these have not been reported upon."*

In her oral evidence, Ms Ford told the Committee that it is a requirement of all dentists to make a full report of the clinical evaluation undertaken after assessing a radiograph, particularly as a dose of radiation has been received by a patient. She stated that it is mandatory for all radiographs to be graded as part of an ongoing quality assurance programme, and that a failure to do so falls below the expected standard of record keeping. The Committee accepted Ms Ford's evidence that Mr Abbasi had a duty to record the findings of his evaluation of the bitewing in the patient dental records.

The Committee noted that in Patient B's dental records, Mr Abbasi has failed to adequately report on bone loss and interdental calculus and caries at UR7.

Accordingly, the Committee concluded that Mr Abbasi had failed to adequately report on the bitewing radiographs and found **charge 2(b)(i) – (iii) proved**.

(c) you failed to adequately discuss, or record discussion, concerning Patient B's:

(i) periodontal condition;

(ii) treatment needs and options including under the NHS.

FOUND PROVED

In Patient B's witness statement, he recalled, *"[Mr Abbasi] did not inform me that I required any further treatment [following the extraction], he only told me to see the hygienist. I assumed he was*

	asking me to see the hygienist as he thought that my teeth needed to be cleaned… I do not recall [Mr Abbasi] explaining why I was being referred to the hygienist…" The Committee was satisfied that the subsequent BPE scores of 2/3 recorded by the hygienist after Patient B's referral, the full mouth scaling also carried out by the hygienist, and the bone loss identified by Ms Ford on the bitewings taken by Mr Abbasi were evidence that Patient B more than likely had periodontal disease. Ms Ford was of the opinion that there was a responsibility on Mr Abbasi to have had a discussion with Patient B regarding his periodontal condition. There is no reference in Patient B's records about any discussion. The Committee concluded that simply referring Patient B to the hygienist was insufficient in the circumstances. Patient B's witness statement also confirmed that Mr Abbasi did not offer any alternative options or whether the hygienist appointment would be under the NHS. Patient B stated that he noted a sign in the Practice that showed a hygienist appointment cost £55, and he believes this is what he was charged. Again, there is no reference in Patient B's dental records regarding any treatment needs or options available, whether as a private or NHS patient. In the light of the evidence available, the Committee concluded that it was more likely than not that Mr Abbasi had failed to adequately discuss Patient B's periodontal condition and any subsequent treatment options. Accordingly, the Committee found **charge 2(i) and (ii) proved,** in relation to having failed to discuss. In having failed to do so, the Committee did not consider there was a responsibility to record any discussion.
3.	*On 21 November 2018, in relation to Patient B:* *(a) you failed to adequately report on a periapical radiograph including;* *(i) bone loss;* *(ii) interdental calculus;* **FOUND PROVED** Patient B felt what he described as a *"splinter"* and pain at the extraction site, so returned to see Mr Abbasi on 21 November 2018. In Patient B's records, Mr Abbasi noted two x-rays had been taken (however, only one has been provided to the Committee). In her expert report, Ms Ford stated that there was evidence of bone loss associated with poor periodontal health. She confirmed that interdental calculus is also present in the radiograph.

In the light of its findings in respect of charge 2(a), the Committee was satisfied that Mr Abbasi had a responsibility to report his findings following an assessment of all radiographs.

The Committee noted that any reference to an assessment of the radiograph on 21 November 2018 is absent from Patient B's records.

Accordingly, the Committee concluded that Mr Abbasi had failed to adequately record bone loss and interdental calculus and found **charge 3(a)(i) and (ii) proved**.

(b) you failed to adequately discuss, or record discussion, concerning Patient B's:

(i) periodontal condition;

(ii) treatment needs and options including under the NHS.

FOUND PROVED, in relation to charge 3(b)(i)

FOUND NOT PROVED, in relation to charge 3(b)(ii)

The Committee noted that by 21 November 2018, Patient B was already under the care of the hygienist. It is clear from the hygienist's notes that Patient B had undergone treatment as a result of poor periodontal health.

Patient B attended his appointment on 21 November 2018 as he was experiencing pain and that Mr Abbasi had undertaken an examination. During this examination, it would have been a requirement of Mr Abbasi to discuss Patient B's periodontal health, despite having been seen by the hygienist 18 days prior. As per charge 2(c), Mr Abbasi has recorded a BPE was performed, but has not recorded any scores.

On the balance of probabilities, the Committee was satisfied that a discussion regarding Patient B's periodontal health was required but that it is more likely than not that the discussion did not take place.

In this regard, the Committee concluded that Mr Abbasi had failed to discuss Patient B's periodontal condition and finds **charge 3(b)(i) proved**.

However, as it is unclear in the absence of any notes regarding Patient B's periodontal condition when he attended on 21 November 2018, the Committee was unable to confirm whether any further treatment was required. Patient B had presented at the appointment having experienced pain in the extraction site and sensitivity.

In his witness statement, Patient B stated that Mr Abbasi had informed him that the discomfort he was experiencing was because of gum recession and that if he had "*rockstar*" money, Patient B could have this treated.

The dental records indicated that Mr Abbasi provided Patient B with

	information about receding gums and that he advised the use of sensitive toothpaste as well as providing regular floss advice at the appointment. The Committee interpreted this as management for Patient B's pain at that appointment. In her expert opinion, Ms Ford confirmed that she considered Mr Abbasi was required to discuss treatment options with Patient B. Whilst the Committee accepted Ms Ford's evidence on this point, the Committee was not satisfied that the GDC had sufficiently proved that further treatment was required in the circumstances. As the requirement for further treatment has not been established, the Committee was not satisfied that Mr Abbasi was under a duty to discuss this with Patient B or record any discussion. Accordingly, the Committee conclude that the GDC had not discharged its burden of proof by sufficiently demonstrating that further treatment was required and find **charge 3(b)(ii) not proved.**
4.	*On 3 August 2018, in relation to Patient C:* *(a) you failed to adequately record Patient C's presenting symptoms;* **FOUND PROVED** On 3 August 2018, Patient C attended for an appointment with Mr Abbasi. The Committee heard from witnesses that Patient C had presented to the Practice in pain and that an abscess was the likely cause. Mr Abbasi has mentioned in Patient C's records that the patient was in pain but there is no mention of the presenting symptoms. As with its findings in relation to charge 2(a), the Committee accepted Ms Ford's opinion that it was a requirement of Mr Abbasi to make a note of the presenting symptoms. As there is an absence of this in Patient C's notes, the Committee concluded that Mr Abbasi had failed to do so. Accordingly, the Committee finds **charge 4(a) proved.** --- *(b) you failed to adequately record your clinical findings and/or diagnosis;* **FOUND PROVED** Having considered Patient C's notes, it was clear that Patient C had presented in pain, that a radiograph was taken and an extraction of LR 6 was performed. As per its earlier findings, an assessment of the radiograph was required. However, Mr Abbasi has not recorded in the notes any assessment in relation to his clinical findings or any diagnosis, and any reference to the reason for the extraction is absent. Therefore, the Committee concluded that Mr Abbasi had failed to

adequately record is clinical findings and a diagnosis

Accordingly, the Committee found **charge 4(b) proved, on both grounds.**

(c) you failed to adequately report on a periapical radiograph erroneously dated 14 August 2018, including:

(i) a deficient distal margin at LR5

(ii) a root filling beyond the apex at LR5.

FOUND PROVED

The Committee had regard to the periapical radiograph and noted the evidence of Ms Ford. She stated that although the radiograph was taken to assess the LR6, it was clear from the radiograph images that there was a deficient distal margin in relation to LR5. This, she stated, should have been reported by Mr Abbasi in Patient C's notes as it may have indications for the health and prognosis of the tooth.

The Committee accepted Ms Ford's evidence that it was also apparent from the image, that the root filling at LR5 extended beyond the apex and this this was apparent enough that Mr Abbasi should have made a note of this when reporting on his assessment of the radiograph.

As with its earlier findings, the Committee was satisfied that it was the responsibility of Mr Abbasi to have reported in Patient C's notes these clinical findings having assessed the radiograph.

Having considered Patient C's notes, and noting the absence of any such information, the Committee concluded that Mr Abbasi had failed to adequately report a deficient distal margin at LR5 and a root filling beyond the apex at LR5.

Accordingly, the Committee found **charge 4(c)(i) and (ii) proved.**

(d) you failed to ensure adequate anaesthesia for the complete extraction of LR6;

FOUND PROVED

In coming to its decision, the Committee had regard to the witness statement of Ms 3 who recalled that Patient C had a painful abscess and was unaware what treatment she was supposed to be having as Mr Abbasi had not adequately communicated this to Patient C. Ms 3 reported that having administered a dose of anaesthetic, Mr Abbasi attempted to extract the tooth and ignored Patient C's questions about what was going on. Ms 3 stated that she did not think Mr Abbasi had checked with Patient C whether her mouth was sufficiently numb before attempting the extraction. MS 3 recalled Mr Abbasi administering more than three doses of anaesthetic, but not which

anaesthetic was administered, and did not recall Mr Abbasi checking the area for numbness before continuing with the extraction.

The Committee also heard from Colleague A that during Patient C's appointment, she had heard Patient C scream which she described as a "*roar*". She told the Committee that she had entered Mr Abbasi's surgery and offered her assistance as Patient C was "*hysterical, crying and hyperventilating."* Colleague A explained that she had enquired with Patient C whether her lip and tongue were numb, to which she is said to have replied her lip was not really and that she had "*felt the whole thing*".

The Committee noted that during the incident, none of the staff present had described Mr Abbasi checking with Patient C whether her mouth was numb. The Committee considered Ms Ford's evidence that there were a number of ways to make this enquiry, including asking questions of the patient or testing the area by carefully probing and patient confirmation.

When Patient C screamed, the Committee noted that he did not make enquiries as to the reason she was screaming; this could have been for a number of reasons, including fear of the procedure or of the experience in general, as well as physical pain. The Committee was satisfied that a verbal communication between the dentist and patient was the expected minimal requirement for checking whether enough anaesthesia had been administered.

The Committee noted that three separate witnesses had been present and recalled that Patient C was evidently in pain. The witnesses stated that the sound of Patient C's scream, described as a "*roar*", was unusual for the Practice and this had prompted them to attend the patient. None of the witnesses attested to Mr Abbasi making enquiries with Patient C regarding the source or level of the pain before continuing with the extraction.

In her statement, Colleague A stated that she witnessed Mr Abbasi push on the socket with an elevator after Patient C had explained that she was happy for Mr Abbasi to look inside her mouth but to not do anything without first telling her. The Committee was satisfied that, based on the situation that had presented itself at that time, pushing the socket with the elevator alone was not considered a sufficient test for whether anaesthesia had been achieved.

On the balance of probabilities, the Committee concluded that Mr Abbasi had not ensured that adequate anaesthesia had been administered.

Accordingly, the Committee found **charge 4(d) proved.**

(e) you failed to treat Patient C with kindness and compassion by

the manner in which you spoke to her;

FOUND PROVED

The Committee had regard to the witness statements of Ms 3 and Colleague A. In her statement, Ms 3 explained that when Mr Abbasi began the extraction, Patient C started crying and screaming and telling him to stop as she could feel pain. She recalled Patient C moving around in the chair, saying, "*please stop*". Ms 3 remembered Mr Abbasi responding to Patient C by saying words to the effect of, "*it's fine, stay still*" and continuing with the procedure even though Patient C was clearly feeling pain.

In her witness statement, Colleague A stated that despite Patient C's obvious distress, Mr Abbasi had been dismissive of her and without making enquiries as to the reason, he had told Patient C *"If you can feel it I can give more anaesthetic, but if you are just scared that's a different thing, you just need to be brave."*

The Committee found the recollections of the witnesses to be credible and reliable. Colleague A's oral evidence was consistent with her written statement.

Having accepted the witnesses' accounts of the incident, the Committee acknowledged that the use of language used and the dismissive attitude of Mr Abbasi towards Patient C when she was evidently in distress, was likely to have exacerbated the situation.

As a dental professional, the Committee acknowledged that every patient must be treated with dignity and respect at all times, in accordance with Standard 1.2.

Therefore, the Committee concluded that Mr Abbasi had failed in his duty to treat Patient C with kindness and compassion.

Accordingly, the Committee found **charge 4(e) proved.**

(f) you failed to ensure you had consent for the continuation of the extraction of the LR6;

FOUND NOT PROVED

Again, the Committee took into account the witness statement of Ms 3 and Colleague A. Ms 3 recalled Patient C telling Mr Abbasi that, part-way through the extraction, she would allow him to look in her mouth but to not do anything without telling her first. Ms 3 stated that he was then observed pushing on the socket with the elevator.

Colleague A thought that Mr Abbasi had gained consent from Patient C before continuing with the extraction. Although she did not recall Mr Abbasi discussing with Patient C about measuring the level of pain she was experiencing, she believed that he had spoken with Patient C and

obtained permission to look inside her mouth and told Patient C he was going to press the area.

After the agreement to have a look, it was observed by both witnesses that Mr Abbasi had responded by pushing the socket with the elevator, causing Patient C to turn her head away and to cry.

Due to the witnesses' varying recollections that some discussion was had with Patient C, the Committee concluded that the GDC had not provided enough evidence to demonstrate that during Mr Abbasi's discussion with the patient that he had not obtained consent to continue with the extraction.

Accordingly, the Committee found **charge 4(f) not proved**.

(g) you failed to make or record arrangements for a review and/or referral for the retained root at LR6;

FOUND PROVED

The Committee took into account that due to the persistent pain Patient C was experiencing during the extraction of the LR6 and the absence of Mr Abbasi recording complete extraction of the LR6 in the dental records, that on the balance of probabilities Mr Abbasi was aware that the LR6 had not been fully removed. The incomplete removal of the LR6 was also confirmed by Ms 3's witness statement, who stated, *"As far as I am aware, the patient left the Practice with her treatment incomplete."* This was also confirmed by a subsequent dentist who wrote in Patient C's notes on 3 August 2018 that the patient "…*would need XLA* [extraction under local anaesthetic] *of distal root."*

Having not completed the treatment, the Committee accepted Ms Ford's evidence that there was a requirement for Mr Abbasi to document in Patient C's notes that part of the LR6 had been retained. She also stated that the tooth would have required review and arrangements for this should have been made.

As there is an absence of these arrangements, and no evidence of a referral, in Patient C's notes, the Committee concluded that Mr Abbasi had failed to do so.

Accordingly, the Committee found **charge 4(g) proved.**

(h) you inappropriately recorded in Patient C's records that you had a negative impression of the Practice Manager and that, "THEY HAVE A PLAN TO MAKE PROBLEMS FOR ME."

FOUND PROVED

The Committee had regard to Patient C's records and accepted that Mr Abbasi had made an entry on 3 August 2018, under the heading

	"Clinical notes" which included the above statement. The Committee was satisfied that this entry did not relate to Patient C's treatment or presenting problems. Ms Ford confirmed in her evidence that this entry had no place being in a patient's records, as Mr Abbasi was referring to a professional dispute between himself and other members of staff at the Practice. Therefore, the Committee concluded that this should not be recorded in Patient C's dental records and was clearly inappropriate. Accordingly, the Committee found **charge 4(h) proved.**
5.	*On 3 August 2018 you failed to treat the Practice Manager with respect in that you raised your voice and behaved towards her in an aggressive manner.* **FOUND PROVED** The Committee took into account the written statements and oral evidence of Witness 2 ('the Practice Manager') and Colleague A. The Committee also had regard to the documentary evidence, including a number of contemporaneous reports of the alleged incident. The Practice Manager told the Committee that she had only recently taken up this position at the time of Patient C's appointment. She left the Practice after three days, citing that a contributory factor to her decision to leave was Mr Abbasi's behaviour on 3 August 2018. Following the incident with Patient C, the Practice Manager stated that after she had enquired with Mr Abbasi whether enough anaesthetic had been used, he "became very angry; I had never seen a dentist behave like this." She stated that Mr Abbasi proceeded to shout at her and provided the example: *"I have been trained for 20 years and you dare come in and tell me what to do when you know nothing".* In her oral evidence, the Practice Manager told the Committee that Mr Abbasi was swearing and "*waving his arms around*", and that, had she been any closer to him at the that point, she may have been hit. She recalled him acting aggressively and that, despite her personal feelings, other people *"may have felt intimidated because he was horrible".* In her oral evidence, Colleague A stated that she did not consider the incident to be *"particularly aggressive"* whilst she was present, but she confirmed that she had left the interaction before it had concluded. This was also confirmed by the Practice Manager who explained that it had escalated after Colleague A had left. Colleague A told the Committee that Mr Abbasi's manner was abrupt and rude. The Practice Manager immediately informed her manager what had happened with Mr Abbasi, and she was advised to complete a statement regarding the incident on 3 August 2018. In the statement, dated 3 August 2018, the Practice Manager had reported the incident much as she had described it in her GDC witness statement and in her

	oral evidence. The Committee found the witnesses to be credible and reliable, noting that the written statements and oral evidence of the witnesses, as well as the contemporaneous documentary evidence provided, corroborated the Practice Manager's recollection of the incident. In the light of the evidence provided, the Committee was satisfied that Mr Abbasi had shouted at the Practice Manager, used profanities, and had gesticulated in an aggressive manner. Accordingly, the Committee concluded that Mr Abbasi had failed to treat the Practice Manager with respect and found **charge 5 proved.**
6.	*On 3 August 2018, in relation to Patient D:* *(a) you declined to see Patient D without any, or any adequate, enquiry of her dental needs;* **FOUND PROVED** On 3 August 2018, Patient D had an appointment scheduled with Mr Abbasi. Patient D was concerned about a lump under her gum which was causing her discomfort. She had not attended the Practice before, although members of her family had. Prior to booking her appointment, the receptionist had confirmed Patient D could be seen notwithstanding that she could not transfer out of her wheelchair. In coming to its decision, the Committee had regard to the witness statements of Patient D and Witness 1. In her witness statement, Patient D stated that when she arrived at the Practice, she was seen into the surgery by a dental nurse. She stated that Mr Abbasi spoke to her "*rudely from across the room*", telling her he could not see her because she was in her wheelchair, and she would have to attend the community dentist. Patient D stated that Mr Abbasi did not make any enquiries as to her dental needs. Patient D's recollection of events was consistent with the complaint email she sent regarding the appointment two days later on 5 August 2018. Witness 1 confirmed that she saw Patient D was very upset and asked her what had happened. She was told by Patient D that Mr Abbasi would not see her unless she was out of her wheelchair. The Committee noted that Mr Abbasi did not make any reference to Patient D's dental needs in her notes. In light of the information before it, the Committee was satisfied on the balance of probabilities that Mr Abbasi did not make any enquiry as to Patient D's dental needs before informing her he would not see her. Accordingly, the Committee found **charge 6(a) proved.**

(b) you failed to treat Patient D with kindness and compassion by the manner in which you spoke to her;

FOUND PROVED

The Committee accepted that all dental professionals must treat every patient with dignity and respect, according to Standard 1.2. This was consistent with Ms Ford's opinion that to do otherwise falls far below the expected standard of a dental professional.

The Committee has accepted Patient D's written statement who described Mr Abbasi as having a *"rude attitude"* which left her upset and distressed. Her account was recorded in an email of complaint sent to the Practice two days after the incident took place.

This evidence was consistent with Witness 1's account, who stated that Mr Abbasi had shouted at and "*been rude*" to Patient D, prompting her to speak with him about the incident.

In the light of this evidence, the Committee was satisfied that Mr Abbasi did have a responsibility to treat Patient D with kindness and compassion and he had failed in his duty to do so.

Accordingly, the Committee found **charge 6(b) proved.**

(c) you failed to offer to refer the patient to the Community Dental Service;

FOUND PROVED

The Committee had regard to Patient D's notes, in which Mr Abbasi has recorded, *"[Informed] that it is more convenient that [Patient D] contact a community dentist. [Patient D] accepted and told me that the receptionist should have the sense to infom me about that…"* [sic]

It is not clear from the records that Mr Abbasi made a referral or, at the very least, explained to Patient D how she could refer herself for the service.

Ms Ford informed the Committee that if Mr Abbasi had made a clinical decision that Patient D could not be seen by him due to the physical restrictions of the surgery, he had a responsibility to provide sufficient information to enable Patient D to be seen by a dentist. By failing to offer any care or advice beyond advising an appointment with another dentist, Ms Ford stated that Mr Abbasi's conduct fell far below the expected standards.

Having accepted Patient D's statement that Mr Abbasi did not provide further advice or make a referral, particularly as this was not recorded in her notes, the Committee concluded that Mr Abbasi had failed to offer to make a referral to the community dentist on Patient D's behalf.

	Accordingly, the Committee found **charge 6(c) proved.** *(d) you inappropriately recorded in Patient D's records that the Manager/Receptionist had involved herself "IN THE PROBLEM" and that, "LATER COMING TO ME AND TREATEN THAT YOU SHOULD HAVE SEEN THE PAT. ACCORDING TO THE GDC REG. AND THAT SHE REPORT ME TO THE GDC".* **FOUND PROVED** As with its earlier findings in relation to charge 4(h), the Committee was satisfied that the entry was not related to Patient D's treatment or care. Therefore, the Committee concluded that Mr Abbasi's entry had no place being recorded in Patient D's dental records and was clearly inappropriate. Accordingly, the Committee found **charge 6(d) proved.**
7.	*On 6 July 2018, in relation to Patient E:* *(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;* **FOUND PROVED** On 6 July 2018 Patient E attended for a general check-up. There was discussion about an extraction of the LR6 which was causing pain. Patient E was reluctant to reattend for treatment with Mr Abbasi but did so on 13 September 2018 as the tooth continued to cause pain. On 13 September 2018. Patient E saw another dentist who advised root canal treatment or extraction of the tooth. She opted for root canal treatment which was then scheduled to commence on 26 September 2018. As per its earlier findings in relation to charge 2(a), the Committee was satisfied that Mr Abbasi had failed in his duty to record the risk assessments as there was no reference to the risk of caries, oral cancer and periodontal disease in Patient E's dental records. Accordingly, the Committee found **charge 7(a) proved.** *(b) you failed to adequately report on a bitewing radiograph of the right side.* **FOUND PROVED** The Committee had regard to Patient E's dental records; a radiograph from July 2018 has not been provided to the Committee. Without having the radiograph image to examine, the Committee was unable to determine whether it was the left or right side that had been taken. In the absence of that information, the Committee relied on Patient E's notes.

	Neither the GDC or Ms Ford have been able to confirm whether the radiograph was of the left or right side, however it was accepted that a bitewing radiograph was taken at the appointment due to the reference made to "*1 BW. Quality grade 1"* in Patient E's notes. In the absence of any further information pertaining to the bitewing, the Committee was satisfied, as per its earlier findings, that there was a responsibility for Mr Abbasi to report his findings from the bitewing radiograph and he had failed to do so. Accordingly, the Committee found **charge 7(b) proved.** --- *(c) you failed to take or record a justification for not taking a bitewing radiograph of the left side.* **FOUND NOT PROVED** Having already noted that the Committee had not been provided with the radiograph taken at the 6 July 2018 appointment, there is nothing before the Committee to show whether Mr Abbasi had taken a radiograph of the left or right side. In the absence of any information confirming which side was taken, the Committee could not find that Mr Abbasi had failed to take, or failed to record a justification, for not taking a left side radiograph. Accordingly, the Committee found **charge 7(c) not proved**.
8.	*On 26 September 2018, in relation to Patient E:* *(a) you failed to update or record updating Patient E's medical history;* **FOUND PROVED** The Committee noted that Patient E had attended on 26 September 2018, accompanied by her sister for support, and saw Mr Abbasi for her scheduled root canal treatment. The Committee took into account that Mr Abbasi had taken Patient E's medical history at her initial appointment in July 2018. Ms Ford informed the Committee that there is nothing in the notes recorded for the 26 September 2018 appointment that indicates that Mr Abbasi has taken an updated medical history. A number of weeks has passed since the initial details were taken and Patient E had been seen by a different dentist before the scheduled root canal treatment. Ms Ford stated that she would have expected Mr Abbasi to have updated Patient E's details in these circumstances. In her witness statement, Patient E confirmed that although Mr Abbasi had taken her medical history in July, he had not asked her for updated

information at the September appointment.

The Committee accepted that there is an absence of any information pertaining to Patient E's medical history in the notes he has recorded for the root canal treatment appointment.

Having accepted Ms Ford's evidence that Mr Abbasi had a duty to update, and in the absence of any reference in her records, the Committee accepted that Mr Abbasi had failed to update Patient E's medical history on 26 September 2018.

Accordingly, the Committee found **charge 8(a) proved**.

(b) you failed to adequately record Patient E's presenting symptoms;

FOUND PROVED

The Committee noted that in Patient E's witness statement she had been complaining of pain in her "*lower right tooth, second from the back*" on 13 September 2018. It is not clear from her statement whether she was still experiencing pain 13 days later when she attended her appointment with Mr Abbasi.

The Committee consulted the notes that Mr Abbasi recorded at the appointment and noted that he had not mentioned anywhere in the notes whether Patient E had still been experiencing pain. Moreover, there was no reference at all to Patient E's presenting symptoms before commencing the root canal treatment.

The Committee accepted the opinion of Ms Ford who stated that before commencing treatment, Mr Abbasi should have confirmed the accuracy of the diagnosis made by the previous dentist on 13 September 2018. This could be achieved by establishing a number of factors, including whether Patient E was still experiencing pain and any other presenting symptoms. She confirmed that it would be the responsibility of the treating dentist to record this information in their notes.

As there is an absence of this information in Patient E's notes for the 26 September 2018 appointment, the Committee was satisfied that Mr Abbasi had failed to adequately record her presenting symptoms.

Accordingly, the Committee found **charge 8(b) proved.**

(c) you failed to discuss or adequately record discussion of treatment options, including risks and benefits, in respect of the LR6;

FOUND PROVED

In her written statement, Patient E confirmed that when she entered Mr Abbasi's surgery on 26 September 2018 for her root canal treatment,

he did not have any discussion with her regarding the treatment. She stated that he told her to lay on the bed and that anything else that was discussed was addressed to her sister. She confirmed in her written statement that Mr Abbasi did not discuss treatment options or risk and benefits relating to the LR6. Patient E's sister did not recall in her statement that any other discussion took place before the treatment commenced.

The Committee had regard to Patient E's notes and was satisfied that there is an absence of information pertaining to treatment options, including risks and benefits, for the 26 September 2018 appointment.

Having already accepted Ms Ford's evidence that it is the treating dentist's responsibility to update a patient's notes, and taking into account Patient E's evidence that no discussion took place, the Committee was satisfied that Mr Abbasi did not discuss treatment options with Patient E.

Accordingly, the Committee found **charge 8(c) proved**, in respect of failing to discuss treatment options.

(d) you inappropriately commenced treatment without discussing with Patient E that not all the necessary materials or equipment were available;

FOUND NOT PROVED

Patient E and her sister both recalled in their written statement that once the treatment had commenced, a discussion was had between Mr Abbasi and the dental nurse regarding not having the required equipment. Both witnesses recalled that the dental nurse had informed Mr Abbasi that either tools or equipment were unavailable, and he had "*rudely*" told the dental nurse to go and check again.

The witnesses described the dental nurse returning and confirming that the equipment was not available.

In Patient E's notes, Mr Abbasi has recorded *"…it is risky to increase WL without Glider…we have not any glider in the practice'.*

In her expert report, Ms Ford stated *"… I believe the Registrant is referring to either dental chelating agent (a paste used to soften calcification and aid in cleansing the root canal system) or rotary endodontic files when he notes 'glider', these would aid filing further down a tight root canal."* She confirmed in her oral evidence that the product referred to as 'glider' by Mr Abbasi is not used as standard by all dentists and she personally does not.

The Committee considered that both witnesses recalled Mr Abbasi telling the dental nurse to "*go and look again*", or words to that effect, which implied that he was of the belief that the item was stocked by the

Practice and that, at the time he commenced the treatment, he believed it was available. Further, the Committee considered that as it is not an item that is always used, Mr Abbasi may not have realised it was required until he began the procedure.

In any event, the Committee was satisfied that the GDC had not sufficiently persuaded it that there was a requirement for Mr Abbasi to have had a discussion with this patient regarding the availability of tools or equipment, prior to commencing this treatment, particularly with a material that is not considered essential by all dentists.

Accordingly, the found that Mr Abbasi was not required to discuss the availability of tools and equipment with Patient E before commencing this treatment and found **charge 8(d) not proved**.

(e) you failed to use rubber dam;

FOUND PROVED

In her witness statement, Patient E confirmed that Mr Abbasi did not use a rubber dam during the course of her treatment.

Ms Ford explained to the Committee that it was standard practice for a rubber dam to be used, primarily for patient protection, and particularly when sodium hypochlorite is used as an irrigant. She stated that if there was justification not to use a rubber dam, this should be detailed in the patient's notes, including the reason.

Having looked at the notes, Ms Ford stated that Mr Abbasi should have used a rubber dam as he irrigated the canals with sodium hypochlorite and that in not doing so, he failed to adequately protect Patient E.

In the absence of any notes confirming a justification for not using a rubber dam, and in the light of Patient E's confirmation that a rubber dam was not used, the Committee concluded that Mr Abbasi had failed in his duty to adequately protect Patient E by using the correct equipment.

Accordingly, the Committee found **charge 8(e) proved.**

(f) you failed to treat Patient E with kindness and compassion by the manner in which you interacted with her.

FOUND PROVED

In her witness statement, Patient E confirmed that Mr Abbasi had only spoken to her when she entered his surgery, with an abrupt instruction to *"lay on the bed so I can do the treatment*", or words to that effect. Similarly, in Patient E's sister's statement, she recalled Mr Abbasi pointing to the dental chair and stating something to the effect of *"sit".* Both witnesses recalled that Mr Abbasi had been abrupt in his manner

	and that communications were directed to Patient E's sister, and not to Patient E. It was noted that Mr Abbasi referred to Patient E as *"she"* or *"her"* throughout the appointment. It was recorded in Patient E's notes that *"Patient is phobic, could not co-op."* This is disputed by Patient E, who stated, *"I can see from my records that* [Mr Abbasi] *has recorded that I am phobic and would not cooperate at the appointment. I would not say this was the case, I cooperated very well and I am not phobic of dentists, only injections."* Overall, the witness statements described Mr Abbasi as dismissive of Patient E's nervousness and rude and abrupt in his manner, issuing instructions rather than discussing the treatment with Patient E. The Committee accepted that Mr Abbasi did not reassure Patient E at any point and did not address her concerns. On the balance of probabilities, the Committee was persuaded that Mr Abbasi had failed to treat Patient E with kindness and compassion. Accordingly, the Committee found **charge 8(f) proved.**
9.	*On 17 July 2018, in relation to Patient F:* *(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessment;* **FOUND PROVED** As per its earlier findings in relation to charge 2(a), the Committee was satisfied that Mr Abbasi had failed in his duty to record the risk assessments as any reference to risk of caries, oral cancer and periodontal disease in Patient F's dental records is absent. Accordingly, the Committee found **charge 9(a) proved.** --- *(b) you failed to adequately record a treatment plan or discussion of treatment options in respect of the patient's periodontal condition;* **FOUND PROVED** The Committee considered Patient F's records and noted that Mr Abbasi has recorded that a BPE was undertaken with scores of 1 and 2. The Committee was therefore aware that there was a periodontal treatment need for Patient F with a possible referral to the hygienist required. There is no record of a prescription in Patient F's notes and Mr Abbasi has not written in the dental notes how the periodontal treatment is going to be managed as he has also not recorded a treatment plan. There is also an absence of the discussion in Patient F's dental notes of treatment options in respect of the patient's periodontal condition

and having already found this a requirement in its consideration of earlier charges, the Committee found it unlikely that this discussion took place.

Accordingly, the Committee found **charge 9(b) proved.**

(c) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of retained roots at UL3, and/or UL4 and/or LL5;

FOUND PROVED

As with its findings in relation to charge 9(b), the Committee noted there was an absence in Patient F's notes concerning a treatment plan or discussion of treatment options, relating to the retained roots. The Committee bore in mind that Mr Abbasi has recorded a baseline chart, but no further information regarding the retained roots.

Ms Ford informed the Committee that retained roots are at risk of infection so there is a duty on dentists to record a plan for the roots in the patient's records, even if the plan was to leave the roots in situ.

It appears from the evidence presented in Patient F's notes that some discussion had taken place between Patient F and Mr Abbasi in relation to the teeth in question. Mr Abbasi recorded, *"*[Patient] *wants to leave the rest roots."* There is an absence in the notes of the risks involved and further management options.

In this regard, the Committee concluded that Mr Abbasi had not adequately recorded a treatment plan or treatment options and, as per its earlier findings, had failed in his duty to do so.

Accordingly, the Committee found **charge 9(c) proved**, in respect of failing to record.

(d) you failed to take or record a justification for not taking bitewing radiographs.

FOUND PROVED

The Committee noted that there is an absence of a bitewing radiograph for Patient F at the initial appointment. At the initial appointment, where the notes record an extensive examination had been performed, the Committee accepted that it would be usual practice for radiographs to be taken to establish the health of the teeth for the patient's records.

The Committee bore in mind that it is not an absolute requirement for radiographs to be taken at all initial patient appointments.

Having considered Patient F's records, the Committee noted that there are a number of posterior teeth missing, which may have been a justification for Mr Abbasi not requiring a radiograph. It could be said

	that as there were a number of teeth missing, the surface of the remaining teeth was visible and therefore did not require further radiographic examination. However, had this been the case, the Committee accepted Ms Ford's evidence that the reason for not doing so should always be recorded in the patient's notes. Therefore, the Committee was satisfied that Mr Abbasi had failed to record a justification for not taking bitewing radiographs. Accordingly, the Committee found **charge 9(d) proved**.
10.	*On 18 July 2018, in relation to Patient F:* *(a) you failed to adequately record a treatment plan or discussion of treatment options in respect of the Patient F's periodontal condition;* **FOUND NOT PROVED** The Committee bore in mind that the appointment on 18 July 2018 was a treatment appointment to extract LL7. Patient F had attended the previous day for the initial appointment and examination so all discussion regarding treatment and options should have taken place before the treatment appointment. Having already found in charge 9(b) that Mr Abbasi had failed to record treatment options, the Committee was not persuaded that he was required to do so the following day at the treatment appointment. Therefore, it found that Mr Abbasi was not under any duty to record a treatment plan or any discussion about treatment options on 18 July 2018. Accordingly, the Committee found **charge 10(a) not proved**. --- *(b) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of retained roots at UL3 and/or UL4;* **FOUND NOT PROVED** In light of its findings in relation to charge 9(c), the Committee concluded that Mr Abbasi was not additionally under a duty to record a treatment plan or treatment options on 18 July 2018. Accordingly, the Committee found **charge 10(b) not proved.**
11	*On 10 July 2018, in relation to Patient I:* *(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;* **FOUND PROVED** As per its earlier findings in relation to charge 2(a), the Committee was

satisfied that Mr Abbasi had failed in his duty to record the risk assessments as any reference to risk of caries, oral cancer and periodontal disease in Patient I's dental records is absent.

Accordingly, the Committee found **charge 11(a) proved.**

(b) you failed to adequately record Patient I's presenting complaint;

FOUND PROVED

In Patient I's records, Mr Abbasi has identified the cavitation of the patient's teeth, but he has not recorded whether he presented with any symptoms.

Ms Ford stated that it would be expected that even if no symptoms were present, this would be recorded in the notes.

The Committee bore in mind that, at a later appointment with Patient I, treatment was required on those teeth but at this appointment, no information was recorded.

In the absence of any information relating to Patient I's presenting symptoms, the Committee concluded that Mr Abbasi had failed to adequately record the presenting symptoms, or lack thereof.

Accordingly, the Committee found **charge 11(b) proved**.

(c) you failed to adequately report on a periapical radiograph including caries at UL6;

FOUND PROVED

The Committee had regard to the radiograph image and noted that it is apparent that there is caries present at UL6.

In the absence of any reference to the radiograph, or any assessment of what was observed, in Patient I's records, and in the light of its earlier findings demonstrating a requirement to do so, the Committee concluded that Mr Abbasi had failed to adequately report on the radiograph.

Accordingly, the Committee found **charge 11(c) proved**.

(d) you failed to record a Basic Periodontal Examination;

FOUND PROVED

The Committee acknowledged that Mr Abbasi had recorded that a BPE had been undertaken but has not provided any scores.

Despite having recorded that BPE was undertaken, the Committee determined that Mr Abbasi had failed to record the outcome of the

	BPE. Accordingly, the Committee found **charge 11(d) proved**. *(e) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of caries at UL3, and/or UL4 and/or UL6.* **FOUND PROVED, IN RESPECT OF UL6** Focusing on the notes for 10 July 2018, the Committee accepted that Mr Abbasi has recorded that cavities were present and further investigation would be undertaken in relation to UL3 and UL4. The Committee considered that it was evident from these entries that some discussion had taken place. Ms Ford stated in her evidence that it was apparent from the periapical radiograph that there is extensive caries at UL4 and deep caries at UL3. The Committee bore in mind that if another dentist were to have seen Patient I on a subsequent date, there would be limited information regarding the presentation of the teeth, but that there would be an indication that further examination was required. Although the Committee accepted that Mr Abbasi could have provided more information in relation to UL3 and UL4, it was satisfied that as he had not established a treatment plan or treatment options as a result of his incomplete investigations of the teeth, he had not failed in his duty to record this information. In relation to UL6, the Committee was unable to find any reference to any discussion that had taken place. Ms Ford informed the Committee that the periapical radiograph that was taken on 19 July 2018 shows mesial caries at UL6, but there is no reference to this by Mr Abbasi in Patient I's notes. However, the Committee was satisfied that Mr Abbasi had failed to record the caries at UL6 and what treatment was required in relation to this tooth. In the light of this, the Committee accepted Ms Ford evidence that Mr Abbasi had a requirement to record that information and in the absence of it, he had failed to do so. Accordingly, the Committee found **charge 11(e) proved**, in respect of UL6.
12.	*On 11 July 2018, in relation to Patient J:* *(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;*

FOUND PROVED

As per its earlier findings in relation to charge 2(a), the Committee was satisfied that Mr Abbasi had failed in his duty to record the risk assessments as any reference to risk of caries, oral cancer and periodontal disease in Patient J's dental records is absent.

Accordingly, the Committee found **charge 12(a) proved.**

(b) you failed to record a Basic Periodontal Examination;

FOUND PROVED

In light of its findings in relation to charge 11(d), the Committee determined that Mr Abbasi had failed to record the outcome of the BPE.

Accordingly, the Committee found **charge 12(b) proved**.

(c) you failed to adequately report on radiographs including:

(i) the broken down UL4;

(ii) caries at UL6 and/or UL7.

FOUND PROVED, in relation to 12(c)(i) and (ii), in respect of UL6
The Committee acknowledged that there is a report on the quality of the radiograph, but no clinical report on UL4, UL6, or UL7.

Ms Ford referred the Committee to the periapical radiograph which she stated showed that the UL4 was broken down, evident by its shorter appearance. The Committee agreed with Ms Ford's opinion on this matter. It also agreed with Ms Ford's opinion that there is caries present on UL6.

Ms Ford also directed the Committee to UL7, which she stated showed that there is caries on the mesial part of the tooth. However, the Committee determined that it was inconclusive from the image and therefore did not accept Ms Ford's evidence in relation to UL7.

In the absence of any reference to the presentation of UL4 or UL6 in Patient J's notes, the Committee concluded that Mr Abbasi had failed to adequately report on the radiographs in respect of those teeth.

Accordingly, the Committee **found charge 12(c)(i) and (ii),** in respect of UL6**, proved.**

(d) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of:

(i) the broken down UL4;

	(ii) caries at UL6 and/or UL7. **FOUND PROVED, in relation to 12(d)(i) and (ii), in respect of UL6** As the Committee found 12(c)(ii) not proved in relation to UL7, this falls away in relation to UL7. The Committee considered Patient J's notes and acknowledged that Mr Abbasi had recorded that a crown had been advised for UL4 and the next appointment would involve filling UL3. The Committee did not consider this to be an adequate recording of a discussion as there is limited detail relating to the types of treatments offered, the risk or the benefits, or the treatment plan decided upon. Whilst the Committee was content that a discussion had taken place, the record of the discussion relating to UL4 was not adequate in the circumstances. In relation to UL6, the Committee noted that Mr Abbasi has recorded that he intends to fill the tooth but there is an absence of information pertaining to what options were made available to Patient J, including the type of filling material, the risk and benefits of each option, and limited information relating to caries management. Therefore, the Committee was satisfied that Mr Abbasi had failed to adequately record the treatment plan or treatment options for UL4 and UL6. Accordingly, the Committee found **charge 12(d)(i) and (ii),** in relation to UL6, **proved.**
13.	*On 17 July 2018, in relation to Patient J:* *(a) you failed to record a medical history update;* **FOUND PROVED** In coming to its decision, the Committee bore in mind its earlier findings in respect of charge 8(a). The Committee was satisfied that Mr Abbasi had a responsibility to update Patient J's medical history at the appointment. Therefore, the Committee was satisfied that Mr Abbasi had failed to update Patient J's medical history. Accordingly, the Committee found **charge 13(a) proved**. *(b) you failed to adequately record a diagnosis and/or discussion of treatment options, including risks and benefits, in respect of caries at UL6, and /or UL7.* **FOUND PROVED** As the Committee found 12(c)(ii) not proved in relation to UL7, this falls away in relation to UL7. The Committee could see from Patient J's records that Mr Abbasi

	completed an amalgam filling on UL6. The Committee had previously found that caries was present in UL6, as per charge 12(c)(ii). It is reasonable to assume that this tooth was restored by Mr Abbasi for the management of caries. There was no reference to caries in Patient J's notes, nor a diagnosis justifying the restoration. There is nothing further in the records to indicate what types of filling material were discussed, and the risks and benefits of each type. In the absence of this information, and the absence of any recorded diagnosis, the Committee was satisfied that Mr Abbasi had failed in his duty to record a diagnosis and any treatment options available. Accordingly, the Committee found **charge 13(b) proved**, in relation to UL6.
14.	*On 31 July 2018 you failed to record a medical history update for Patient J.* **FOUND PROVED** As with its earlier findings, the Committee was satisfied that Mr Abbasi was required to record an update of Patient J's medical history at this treatment appointment and had failed to do so. Accordingly, the Committee found **charge 14 proved**.
15.	*On 28 August 2018, in relation to Patient J:* *(a) you failed to adequately record clinical findings and/or diagnosis in respect of UL7;* **FOUND PROVED** Patient J's dental records show that Mr Abbasi restored the UL7 on 17 July 2018 by way of the entry, *"(UL7 OP Amalgam)".* Mr Abbasi had recorded in Patient J's dental notes on 28 August 2018 *"CO: lost filling 27BO, AM".* The Committee understood these entries to mean that the occlusal/palatal surfaces of the UL7 were restored by Mr Abbasi with an amalgam filling on 17 July 2018. The filling failed and Mr Abbasi restored the buccal/occlusal surfaces of the UL7 with amalgam on 28 August 2018. There is no other information provided in the notes to describe the clinical presentation of the UL7 on 28 August 2018, other than the entry of the lost filling. Ms Ford stated that this level of information was required for an appointment where a patient had attended as a result of a previous treatment being unsuccessful. She told the Committee that "*lost filling*" is not a diagnosis in itself but, although brief, it would be considered to be a clinical finding. In the absence of any further information, though, she submitted that it is an inadequate recording. Having accepted Ms Ford's evidence on this matter, and in the

	absence of any further information in Patient J's notes, the Committee concluded that Mr Abbasi had failed to adequately record his clinical findings or a diagnosis relating to UL7. Accordingly, the Committee found **charge 15(a) proved**. --- *(b) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of the UL7.* **FOUND PROVED** The Committee acknowledged that Mr Abbasi has recorded what treatment he had undertaken and, whilst it is limited in detail, it could be considered to be evidence of a treatment plan. In light of its earlier findings, the Committee was satisfied that in the absence of any notes pertaining to the discussions had in relation to a treatment plan or options, Mr Abbasi had failed to adequately record treatment options. Accordingly, the Committee found **charge 15(b) proved**.
16.	*On 27 February 2018, in relation to Patient L:* *(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;* **FOUND PROVED** Patient L was seen by Mr Abbasi on four dates: 27 February, 21 March, 3 April and 9 October 2018. As per its earlier findings in relation to charge 2(a), the Committee was satisfied that Mr Abbasi had failed in his duty to record the risk assessments as any reference to risk of caries, oral cancer and periodontal disease in Patient L's dental records is absent. Accordingly, the Committee found **charge 16(a) proved.** --- *(b) you failed to adequately record a treatment plan* **FOUND PROVED** Again, the Committee had regard to Patient L's notes and whilst it is clear that a BPE was undertaken, and scores of 1 and 2 were recorded, there is no further information consistent with a treatment plan. It was evident from the scores that further treatment was required but in the absence of that information, the Committee concluded that Mr Abbasi had failed to adequately record a treatment plan. Accordingly, the Committee found **charge 16(b) proved.**
17.	*On 21 March 2018 you provided root canal treatment to Patient L's*

UR6 and:

(a) you failed to adequately report on intra-operative working length radiographs;

FOUND PROVED

Patient L attended on 21 March 2018 to undergo root canal treatment at UR6.

The Committee had regard to Patient L's notes and the periapical radiographs provided. Ms Ford explained to the Committee that the periapical radiographs included an intra-operative working length radiograph, which showed that Mr Abbasi had used single GP (gutta-percha) points to aid in determining the required root filling length. It was clear to the Committee that the length of these GP points in the UR6, in relation to the tooth root canals, had not been reported on by Mr Abbasi in Patient L's notes.

As with its earlier findings, the Committee was satisfied that this was a requirement and in the absence of this information, Mr Abbasi had failed to adequately report on the radiographs.

Accordingly, the Committee found **charge 17(a) proved**.

(b) you failed to record if a post-operative radiograph was taken;

FOUND PROVED

Again, the Committee has accepted Ms Ford's evidence that there is a requirement to take and report on post-operative radiographs in patients' notes. In this instance it is unclear as there is no mention in the records that a post-operative radiograph was taken.

Accordingly, the Committee found **charge 17(b) proved**.

(c) you failed to use, or record the use, of rubber dam.

FOUND PROVED

As with charge 8(e), the Committee concluded that there was a requirement to use a rubber dam in order to adequately protect the patient. Having already concluded that there must be some justification for not using a rubber dam, and therefore a requirement to record the reason, the Committee accepted Ms Ford's evidence that use of a rubber dam is standard practice.

In the absence of any record establishing why a rubber dam had not been used, the Committee was satisfied that Mr Abbasi had failed to use one.

Accordingly, the Committee found **charge 17(c) proved**.

18.	*On 3 April 2018, in relation to Patient L:* *(a) you failed to record updating the patient's medical history;* **FOUND PROVED** As with its earlier findings, the Committee concluded that despite having attended on previous occasions, it was a requirement of Mr Abbasi to record an update of Patient L's medical history. In the absence of any information in the records, the Committee concluded that Mr Abbasi had failed to do so. Accordingly, the Committee found **charge 18(a) proved.** --- *(b) you failed to record the status of the UR5;* **FOUND PROVED** The Committee took into account that Patient L had recently been seen by another dentist and at that appointment, had been prescribed antibiotics. Mr Ford told the Committee that there was a requirement for Mr Abbasi to have recorded the status of UR5 in the patient's notes. These notes should have recorded a full review of the tooth, including the clinical presentation, as well as any diagnosis, and any treatment plan. The Committee accepted Ms Ford's evidence that there was a requirement to record the status of UR5. As there is an absence of this information in Patient L's notes, the Committee was satisfied that Mr Abbasi had failed to record the status of UR5. Accordingly, the Committee found **charge 18(b) proved**. --- *(c) you failed to adequately record details concerning the crown fit at UR6;* **FOUND PROVED** In her evidence, Ms Ford referred the Committee to the absence of information pertaining to the marginal fit of the crown, which she stated is a requirement at this type of appointment. It is clear from the evidence that a crown was fitted on 3 April 2018 but there is an omission of information regarding the fit in the patient's notes. Ms Ford also informed the Committee that there is no information in the dental records made by Mr Abbasi on the type of cement used or whether the occlusion was checked, which should have been provided at the crown fit stage. Having accepted Ms Ford's evidence, the

	Committee concluded that Mr Abbasi had failed to adequately record details concerning the crown fit at UR6. Accordingly, the Committee found **charge 18(c) proved.** --- *(d) you failed to adequately record a justification for treatment at UL6.* **FOUND PROVED** The Committee had regard to Patient L's notes and it was apparent that the amalgam filling is mentioned for the first time on 3 April 2018. Beyond this note, there is no further information relating to a diagnosis or a treatment plan. The Committee has already accepted the evidence of Ms Ford that this is a requirement. In the absence of any information relating to the health of the tooth, the clinical presentation, the history, or the treatment options available, the committee was satisfied that Mr Abbasi had failed in his duty to adequately record a justification for the filling at UL6. Accordingly, the Committee found **charge 18(d) proved.**
19.	*On 9 October 2018, in relation to Patient L:* *(a) you failed to adequately record caries and/or oral cancer and/or periodontal disease risk assessments;* **FOUND PROVED** As per its earlier findings in relation to charge 2(a), the Committee was satisfied that Mr Abbasi had failed in his duty to record the risk assessments as any reference to risk of caries, oral cancer and periodontal disease in Patient L's dental records is absent. Accordingly, the Committee found **charge 19(a) proved**. --- *(b) you failed to adequately record a treatment plan or discussion of treatment options, including risks and benefits, in respect of the UL6;* **FOUND PROVED, in respect of not recorded treatment options** The Committee noted that Patient L had attended with a broken filling on UL6 and Mr Abbasi took a periapical radiograph. It took into account that the tooth had been apparently asymptomatic for some time, but that Patient L had consented to restorative treatment, electing for a crown. Although lacking in detail, the Committee accepted that this could be considered to be a treatment plan. In the light of this evidence, the Committee was satisfied that some discussion must have taken place but there is nothing recorded in Patient L's notes to this effect.

	However, in the absence of that information, the Committee concluded that Mr Abbasi had failed to adequately record the discussion relating to treatment options for UL6. Accordingly, the Committee found **charge 19(b) proved**. --- *(c) you failed to adequately report on a radiograph including a deficient coronal restoration at UL6.* **FOUND PROVED** In coming to its decision, the Committee had regard to the periapical radiograph taken on and dated 9 October 2018. Ms Ford stated that the cavity present on UL6, which was visible on the radiograph, had not been reported on in the patient's notes. The Committee observed that Mr Abbasi had reported "*lost filling*" in the notes but there is no further information. As the Committee has already accepted that having taken a radiograph there is a duty for Mr Abbasi to report on his findings, and in the absence of this information, the Committee concluded that he had failed to adequately report on the radiograph on this occasion. Accordingly, the Committee found **charge 19(c) proved.**
20.	*At about 23.45 on 11 April 2021 you sent a WhatsApp message to Colleague A who you knew, or suspected, was a potential witness for the General Dental Council ('GDC').* **FOUND PROVED** The Committee was not provided with a copy of the message as Colleague A stated that she deleted the message so that she did not have to look at it again as she was annoyed that the message had been sent. The Committee was satisfied with Colleague A's explanation for deleting the message and concluded that due to the alleged content of the message, it was plausible that she did not want to see it again, having made her angry when she had first read it. Ms Rochelle Williams, solicitor, stated that numerous efforts, which Colleague A had reasonably complied with, were made to retrieve the deleted message from Colleague A's phone but that these had all been unsuccessful. The Committee noted that Colleague A's witness statement and oral evidence were consistent and therefore likely to be reliable. It took into account that Colleague A had no reason to fabricate the content of the message or that it had been sent by Mr Abbasi. Colleague A had described feeling *"verbally attacked"* and *"threatened"* by the message and deleted the message, blocking Mr Abbasi's

	number in the process. On the balance of probabilities, the Committee was satisfied that Colleague A had received a WhatsApp message from Mr Abbasi on 11 April 2021. It was clear to the Committee from the contents of the message that, at that stage, Mr Abbasi knew or suspected that Colleague A was a potential witness in respect of the allegations that the GDC was investigating. Accordingly, the Committee found **charge 20 proved**.
21.	*You wrote words to the effect that you had heard she did not want to give a witness statement and that you had sent her apology letter to the GDC and you warned her to be careful and remember what she had written to you a couple of months ago.* **FOUND PROVED** The Committee heard from Colleague A that she had sent a WhatsApp message to previous Practice colleagues, including Mr Abbasi, apologising for things that had happened during her time as Practice Manager. This was not available to the Committee. She also sent a text message in 2019 to Mr Abbasi regarding the way she had treated him when they had worked together at the Practice, remembering that she included words to the effect of, *"Sorry if I was disrespectful".* A copy of the text that was sent was provided by Mr Abbasi in his defence bundle, submitted by his previous representatives. Under Committee questions, Colleague A was candid about the way she had spoken to Mr Abbasi and stated that she felt compelled to apologise for this when she left the Practice as Practice Manager, as she wanted to leave on good terms. Colleague A considered this to be what Mr Abbasi was referring to in his April 2021 message. The Committee found Colleague A to be a credible witness who had made it clear that she was unable to remember the exact wording of the WhatsApp message but was clear about how she had felt when she received the message and why she had responded by deleting the message. On balance of probabilities, the Committee concluded that Mr Abbasi had sent Colleague A a WhatsApp message warning her to be careful about giving evidence to the GDC and therefore found **charge 21 proved**.
22.	*Your conduct as set out above at 21 was:* *(a) inappropriate;*

	(b) liable to intimidate; *(c) intended to intimidate.* **FOUND PROVED** Ms Ford referred the Committee to Standard 6.1.2, which states, *"You must treat colleagues fairly and with respect, in all situations and all forms of interaction and communication. You must not bully, harass, or unfairly discriminate against them."* The Committee was satisfied that it was clearly inappropriate for Mr Abbasi to contact Colleague A following the GDC's request for her to make a witness statement regarding an investigation into his conduct. This, it noted, may interfere with Colleague A's duty to comply with her regulator. The language that appeared to have been used had the clear purpose of affecting Colleague A's willingness to cooperate with an investigation and may have the potential to intimidate her. The Committee considered the reason for Mr Abbasi having sent the message and what he may have meant by referring Colleague A to "*remember what you had said previously*". The Committee accepted that a reasonable inference could be made that Mr Abbasi was referring to Colleague A's own conduct – admitting she had been disrespectful towards him – as a way of deflecting the blame onto her with the result of her reconsidering her intention to provide a witness statement for the GDC in this investigation. In sending the message, the Committee was satisfied that Mr Abbasi must have known that this would be the effect of his message on Colleague A. The Committee acknowledged that Colleague A stated that she felt verbally attacked, threatened, angry and upset by the message. With this in mind, the Committee concluded that Colleague A had been intimated by the message. She had taken the message as a warning that there may be repercussions if she provided a witness statement to the GDC. In the light of the evidence before it, the Committee determined that the aim of the message was an intention to make Colleague A not give a witness statement to the GDC and had used her own apology to Mr Abbasi as leverage against her, therefore aiming to influence her decision in his favour. Therefore, the Committee concluded that Mr Abbasi's message was inappropriate, was liable to intimidate Colleague A and had the intention of intimidating Colleague A. Accordingly, the Committee found **charge 22(a), (b), and (c) proved**.
23.	*The GDC wrote to you and asked you to supply information in relation to your working arrangements and proof of indemnity on:*

	(a) 15 October 2021; *(b) 3 November 2021.* **FOUND PROVED** Having been provided with copies of the letters sent to Mr Abbasi, both by post and by email, the Committee concluded that the GDC had asked for information pertaining to his working arrangements and proof of indemnity. Accordingly, the Committee found **charge 23(a) and (b) proved**.
24.	*You failed to co-operate promptly, or at all, with the above requests.* **FOUND PROVED** The Committee took into account that it appeared that both letters, sent by post, to Mr Abbasi at his registered address had been 'returned to sender', with a note stating the recipient had "*gone away*". The Committee had also been provided with evidence that copies of the letters had been sent to Mr Abbasi's last known email address, from which he had contacted the GDC in April 2022. The Committee bore in mind that for Mr Abbasi to respond to the letters, he must have first received them. In this regard, the Committee concluded on the balance of probabilities that even if Mr Abbasi had not received the letters by post, it was more likely than not that he had received copies of the letters by email. Mr Abbasi has not responded to the requests from the GDC from October 2021. He sent one email, dated 1 April 2022, to his case worker at the GDC stating, *"I have been retired and stopped working as a dentist since December of 2020 and no longer GDC member."* The Committee was therefore satisfied that he has failed to co-operate at all with the above requests. Accordingly, the Committee found **charge 24 proved**.

We now move to Stage 2."

On 11 November 2022 the Chairman announced the determination as follows:

"The Committee has considered all the evidence presented to it. It has taken into account the submissions made by Ms Barnfather on behalf of the General Dental Council (GDC). As set out previously, Mr Abbasi was not in attendance at the hearing and was not represented in his absence. The GDC received submissions from Mr Abbasi's previous legal representatives in February 2021 which included testimonials and statements from previous work colleagues. The Committee has not received any further submissions, representations, or evidence from him.

In its deliberations the Committee has had regard to the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2016,

updated December 2020). The Committee has accepted the advice of the Legal Adviser.

Fitness to practise history

Ms Barnfather addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Ms Barnfather stated that Mr Abbasi was issued with a warning by the GDC's Investigating Committee on 9 May 2016 regarding failures to maintain adequate cross infection controls. Ms Barnfather stated that Mr Abbasi has no other fitness to practise history.

Misconduct

The Committee first considered whether the facts that it has found proved constitute misconduct. Ms Barnfather submits that those facts amount to misconduct. In considering this matter, the Committee has exercised its own independent judgement.

The Committee's findings relate to a number of identified failings in Mr Abbasi's clinical care and treatment of 8 patients, over a period of time. They predominantly fall into two categories - poor standard of clinical treatment and record keeping, and poor attitude and behaviour.

Poor standard of clinical care and record keeping

In considering the gravity of Mr Abbasi's clinical failures, the Committee took into account the opinion of the expert witness in this case, Ms Ford for the GDC. In her report and oral evidence, Ms Ford is of the view that most of the charges found proved constitutes failings far below an acceptable standard and that taken together Mr Abbasi's conduct fell far below the standards expected of a reasonably competent dentist.

The Committee notes that there are a number of clinical failings, in particular these include:

- Failures to adequately to carry out and record caries, oral cancer or periodontal disease risk assessments
- Failures to record presenting symptoms
- Failures to update or record updating medical histories
- Failures to report on radiographic findings
- Failures to carry out Basic Periodontal Examinations (BPEs)
- Failures to record discussion of treatment options
- Failure to provide appropriate patient referral when needed.

Mr Abbasi's failings in direct patient care related to basic and fundamental aspects of clinical care and are wide-ranging. The Committee considers that there were multiple patients where risk assessments were not carried out and recorded by Mr Abbasi. His record keeping failures are serious matters in themselves. The inappropriate entries regarding interactions with colleagues both a failure of standards of record keeping and a lack of respect towards work colleagues. The Committee also

considers that these clinical failings are collectively, serious enough to amount to misconduct.

The Committee also noted the following failures in respect of the standard of treatment that individually fell far below the standards expected:

- Failure to use rubber dam
- Poor record keeping in relation to radiographic practice
- Failure to diagnose caries

There are clear regulations in radiographic practice. The Committee also considers that Mr Abbasi's poor radiographic practice posed risks to patients, both in terms of their dental health and could cause confusion for a future clinician and lead a patient to have additional exposure to radiation.

The Committee considers that when carrying out root canal treatment, using a rubber dam is a routine aspect of dental practice, and that failing to do so could have serious implications for patient safety. The Committee considers that using a rubber dam is a routine aspect of dental practice.

In respect of failing to diagnose caries, the Committee considers that this had the potential to cause pain and infection for the patient. It could also lead to patients having to seek subsequent dental treatment with additional financial costs. The Committee considers that not diagnosing caries is a fundamental and serious failing. The Committee noted in the GDC expert report, that by failing to do so this increases the risk of disease going undetected, and this also individually fell far below the standards expected.

In its deliberations the Committee has had regard to the following paragraphs of the GDC's Standards for the Dental Team (September 2013). Mr Abbasi's conduct in providing a poor standard of clinical care and record keeping breached the following paragraphs;

1.1 Listen to your patients.

1.2.4 You should manage patients' dental pain and anxiety appropriately.

1.5.1 You must find out about the laws and regulations which apply to your clinical practice, your premises and your obligations as an employer and you must follow them at all times. This will include (but is not limited to) legislation relating to:

• […]

• radiography

• […]

1.7 You must put patients' interests before your own or those of any colleague, business or organisation.

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

• options for treatment, the risks and the potential benefits appropriate for them;[…]

• the consequences, risks and benefits of the treatment you propose;[…]

4.1 Make and keep contemporaneous, complete and accurate patient records.

4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients. Radiographs, consent forms, photographs, models, audio or visual recordings of consultations laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

4.1.2 You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.

4.1.3 You must understand and meet your responsibilities in relation to patient information in line with current legislation. You must follow appropriate national advice on retaining, storing and disposing of patient records.

4.1.4 You must ensure that all documentation that records your work, including patient records, is clear, legible, accurate, and can be readily understood by others. You must also record the name or initials of the treating clinician.

The Committee appreciated that the above breaches do not automatically result in a finding of misconduct. However, the Committee was in no doubt that all of the facts found proved are serious and amount to misconduct. The Committee was satisfied that the clinical failings were widespread, repeated, serious, and had the potential to cause patient harm. The failures concern basic and fundamental obligations of a competent dentist. The Committee considers that all of the failings identified above, taken cumulatively, fell far below the expected standards and amount to misconduct.

Behavioural and attitudinal failings.

The Committee found a number of heads of charge proved in relation to Mr Abbasi's behaviour and attitude towards patients and colleagues. In particular, the Committee found proved that Mr Abbasi failed to treat Patient D and E with kindness and compassion. The Committee considers that Mr Abbasi's poor chair side manner and abrupt demeanour towards patients, one of which was a patient who was a wheelchair user, was a clear example of a lack of kindness and compassion. His conduct undermines the credibility of the dental team particularly for patients who were present at that time. The Committee considers that Mr Abbasi's lack of compassion towards patients is a serious failing. It is a fundamental requirement that all dental professionals treat patients with compassion and respect. Mr Abbasi on several occasions failed to engage the patient in discussion about options for their care, which is a fundamental to good consultation practice.

In addition, Mr Abbasi's conduct in refusing to treat the patient in the wheelchair in a rude manner and in the workplace, is likely to undermine the profession in the public's mind. It also has the potential to undermine confidence in the dental team.

The Committee considers that Mr Abbasi's conduct in these matters is contrary to the core care principles of a dental professional.

In addition, the Committee found proved that Mr Abbasi has failed to treat the Practice Manager with respect, in that he had behaved towards her in an aggressive manner and some of which was in front of a patient. The Committee noted that some incidents of mistreating colleagues occurred in front of patients, which could compromise patient care, as well as undermine the credibility of the clinical team in the minds of the patients. The Committee also found proved that Mr Abbasi had sent a WhatsApp message to a colleague, whom he knew to be a potential witness for the GDC. The Committee found proved that his conduct was inappropriate, liable to intimidate and was intended to intimidate.

The Committee also found proved that Mr Abbasi has failed to co-operate promptly, or at all with the GDC requests to supply information in relation to his working arrangements and proof of indemnity insurance. Mr Abbasi was asked on more than one occasion to provide this information, and failed to do so. It is fundamental principle of the dental profession to comply with the requirements of his regulator in order to maintain standards and patient safety. The Committee is satisfied Mr Abbasi's failure to comply with his regulatory body also demonstrates an attitudinal deficiency towards the profession and towards patient safety. Mr Abbasi's conduct constitutes a blatant and wilful disregard for the systems regulating the profession.

In having regard to the GDC's Standards for the Dental Team (September 2013), Mr Abbasi's poor behaviour and attitude breached the following paragraphs;

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

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

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

1.2.2 You should take patients' preferences into account and be sensitive to their individual needs and values.

1.2.3 You must treat patients with kindness and compassion.

1.2.4 You should manage patients' dental pain and anxiety appropriately.

1.3.2 You must make sure you do not bring the profession into disrepute.

1.6.3 You must consider patients' disabilities and make reasonable adjustments to allow them to receive care which meets their needs. If you cannot make reasonable adjustments to treat a patient safely, you should consider referring them to a colleague.

2.1 Communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.

2.1.1 You must treat patients as individuals. You should take their specific communication needs and preferences into account where possible and respect any cultural values and differences.

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

• explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and

• give full information on the treatment you propose and the possible costs.

2.2.2 You should encourage patients to ask questions about their options or any aspect of their treatment.

2.3.11 You should provide patients with clear information about any referral arrangements related to their treatment.

6.1 You must work effectively with your colleagues and contribute to good teamwork.

6.1.1 You should ensure that any team you are involved in works together to provide appropriate dental care for your patients.

6.1.2 You must treat colleagues fairly and with respect, in all situations and all forms of interaction and communication. You must not bully, harass, or unfairly discriminate against them.

9.4 You must cooperate with any relevant formal or informal enquiry 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.

The Committee noted that Mr Abbasi's actions were a serious departure from, and a clear breach of, the recognised standards and they brought the profession into disrepute. The Committee was satisfied that his behaviour would be considered deplorable by fellow dental professionals and the public alike. The Committee therefore concluded that Mr Abbasi's behaviour had fallen far short of the standards of conduct that were proper in these circumstances and amounted to misconduct.

Impairment

The Committee then went on to consider whether Mr Abbasi's fitness to practise is currently impaired by reason of misconduct. In doing so, the Committee has again exercised its independent judgement. Ms Barnfather submitted that Mr Abbasi's fitness to practise is impaired. Throughout its deliberations, the Committee has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, 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.

The Committee considers that, whilst Mr Abbasi's clinical acts and omissions might be capable of being remedied, relating as they do to identifiable, basic and fundamental aspects of practice, Mr Abbasi has not shown any meaningful insight into his misconduct. The Committee has not been provided with any information to suggest that Mr Abbasi has taken steps to remedy the clinical failings that the Committee has identified, or indeed that he has any inclination of doing so in the future. The clinical shortcomings are serious, wide-ranging and fundamental, and suggest that patients would be put at risk of harm were there to be a repeat of such acts and omissions. Such a repeat cannot in the Committee's judgment be said to be highly unlikely on account of the lack of insight and remediation put forward by Mr Abbasi.

The Committee is mindful that the misconduct that it has found, both in respect of Mr Abbasi's attitude towards colleagues, patients and his regulatory body might be more difficult for him to remedy, as it is suggestive of a professional attitudinal problem. In any event, the Committee has not been provided with evidence of any meaningful insight into, or remediation of, the conduct that it has found.

The Committee noted the emails between Mr Abbasi and the practice owner in addition to the two written statements of two other members of staff at the practice, which indicate there was a poor working environment. The Committee accepts that there may have been a poor working environment. The Committee accepts this may have resulted in a breakdown in communication and caused possible tension between work colleagues. The Committee also noted the three positive and general testimonials from colleagues about Mr Abbasi.

However, the Committee does not consider that this information provides an explanation to the misconduct found, nor any evidence of Mr Abbasi's insight and remediation.

The Committee has not been provided with any information from Mr Abbasi, such as a reflective statement or targeted Continuing Professional Development (CPD) to suggest that he recognises the gravamen of his conduct, including its serious consequences for patients as well as for the trust between practitioners and patients, and the standing and reputation of the profession. Mr Abbasi has failed to express remorse for his harmful conduct. The Committee has similarly not been provided with any information from him that he recognises the seriousness of his clinical deficiencies and behaviour, and also the consequences of his failure to ensure that he complied with his regulatory body.

In the Committee's judgment his conduct is damaging to Mr Abbasi's fitness to practise. His lack of insight into, and remediation of, such serious conduct means that Mr Abbasi continues to pose an unwarranted risk of harm to the safety and wellbeing of the public.

The Committee is also in no doubt that the especially serious nature of its factual findings, justifies a finding of impairment in the public interest. Mr Abbasi's conduct has breached fundamental tenets of the profession and has brought the reputation of the profession into disrepute. The Committee considers that the public's trust and confidence in the profession, and in the regulatory process, would be seriously

undermined if a finding of impairment were not made in the particular circumstances of this case. A finding of impairment is especially mandated in order to maintain the public's trust and confidence in the profession, and to declare and uphold proper standards of conduct and behaviour, given that these fundamentally important public interest considerations have been so undermined by Mr Abbasi's conduct.

The Committee has concluded that Mr Abbasi's fitness to practise is currently impaired by reason of the misconduct.

Sanction

The Committee then determined what sanction, if any, would be 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 punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interests referred to above. The Committee has heard that Ms Barnfather on behalf of the GDC invites the Committee to erase Mr Abbasi's name from the register.

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 Mr Abbasi's own interests.

The Committee has considered the aggravating and mitigating factors present in this case.

In terms of mitigating factors, the Committee notes the negative working environment of the dental practice.

In relation to aggravating factors, Mr Abbasi placed patients at risk of harm. There were repeated incidents of poor behaviour and conduct. Mr Abbasi has shown no remorse and nor engaged in these proceedings. There was no evidence of remediation. His conduct amounted to a breach of trust between him, his colleagues and the GDC. He demonstrated a disregard for his regulator. Mr Abbasi has also, as set out above, demonstrated that he lacks meaningful insight into his misconduct.

The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of the findings made, the Committee has determined that it would be wholly inappropriate and disproportionate to conclude this case with no action or with a reprimand. The Committee's findings of repeated, serious misconduct mean that taking no action, or issuing a reprimand, would be entirely insufficient to protect the public, maintain public confidence and trust in the profession and in the regulatory process, and would not declare and uphold proper standards of conduct and behaviour.

The Committee next considered whether a period of conditional registration would be appropriate. In the Committee's judgment a period of conditional registration would similarly not be sufficient, appropriate or proportionate in light of the public protection and public interest considerations that the Committee has identified. Conditions would not be workable, as Mr Abbasi is not engaging in these proceedings and the Committee would therefore not be able to be satisfied that he would comply with

conditions even if such an outcome was proportionate. The Committee has also made multiple findings of serious misconduct, which does not lend itself to being addressed by way of conditions. In any event, the Committee considers that a period of conditional registration would not be sufficient to declare and uphold proper professional standards of conduct and behaviour, nor maintain trust and confidence in the profession.

The Committee therefore went on to consider whether to suspend Mr Abbasi's registration. The Committee concluded that a period of suspension would not be sufficient to meet the public protection and public interest considerations of this case. Mr Abbasi's repeated misconduct is of a particularly serious kind, relating as it does to a fundamental breach of trust and respect between him and patients, as well as between him and his colleagues, and his regulatory body. There remains a risk of patient harm on account of Mr Abbasi's lack of insight and remediation. The Committee is satisfied that there is evidence of harmful professional attitudinal problems. Mr Abbasi has not provided information to suggest that he recognises the damage that his misconduct has caused to the public or to the wider public interest. He failed to provide care and compassion towards his patients. This represents conduct which is fundamentally incompatible with registration, and the conduct and behaviour is so serious that no lesser sanction than that of erasure is appropriate. The Committee recognises that erasure from the register may cause hardship to Mr Abbasi but considers that his interests are outweighed by the need to protect the public and the public interest. Therefore, the ultimate sanction of erasure is required to protect the public, to declare and uphold proper standards of conduct and behaviour, and maintain public trust and confidence in the profession and in the regulatory process.

The Committee therefore directs that Mr Abbasi's name be erased from the register.

Existing interim order

In accordance with Rule 21 (3) of the General Dental Council (Fitness to Practise) Rules 2006 and section 27B (9) of the Dentists Act 1984 (as amended) the interim order of suspension in place on Mr Abbasi's registration is hereby revoked."

Decision on Immediate order

"Having directed that Mr Abbasi's name be erased from the register, the Committee invited submissions as to whether it should impose an order for his immediate suspension in accordance with section 30 (1) of the Dentists Act 1984 (as amended). The Committee has once more had regard to the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2016, updated December 2020).

Ms Barnfather on behalf of the GDC submitted that an immediate order is necessary to protect the public and is also in the public interest. The Committee has accepted the advice of the Legal Adviser.

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 that it has identified, it would not be appropriate to permit Mr Abbasi to practise before the substantive direction of erasure takes effect. The Committee considers that an immediate order of suspension is consistent with the findings that it has set out in its main determination.

The effect of the foregoing determination and this immediate order is that Mr Abbasi's registration will be suspended from the date on which notice of this decision is deemed served upon him. Unless he exercises his right of appeal, the substantive direction of erasure will be recorded in the dentists' register 28 days from the date of deemed service. Should Mr Abbasi so decide to exercise his right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

That concludes this case".