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HEARING HEARD IN PUBLIC

ABBOUD, Nazih

Registration No: 84533

PROFESSIONAL CONDUCT COMMITTEE

NOVEMBER 2017 – NOVEMBER 2019

Most recent outcome: Suspended indefinitely*

* See page 20 for the latest determination

Nazih ABBOUD, a dentist, Registered under s16(2A) Dentists Act 1984, was summoned to appear before the Professional Conduct Committee on 30 October 2017 for an inquiry into the following charge:

Charge

"That, being a registered dentist:

1. At all material times you were a United Kingdom registered Dentist at the Burgess Road Dental Surgery, 314 Burgess Road, Southampton, SO16 3BJ.

Standard of care

2. On 05 March 2015 you failed to provide an adequate standard of care to Patient BD in that you failed to:
   a. Establish a diagnosis for the swelling in the UL2 region;
   b. Take bitewing radiographs to assess for caries.
3. Between 04 June 2015 and 09 July 2015 you failed to provide an adequate standard of care to Patient CH in that you extracted or arranged for the extraction of UR2, UR1, UL5 and / or UL7, when this was not clinically indicated.
4. Between 03 March 2015 and 17 March 2015 you failed to provide an adequate standard of care to Patient EB in that you failed to take bitewing radiographs to assess for caries.
5. Between 10 February 2014 and 24 March 2015 you failed to provide an adequate standard of care to Patient HK in that you failed to:
   a. Take an adequate radiograph of the LL7 prior to commencing RCT on 08 July 2014;
   b. Take an adequate radiograph of the final root filling between 25 July 2014 and 01 October 2014;
   c. Take an updated medical history;
   d. Use a rubber dam when carrying out RCT to the LL7;
   e. Use gutta percha to fill the canals, when carrying out RCT to the LL7.

6. Between 19 November 2014 and 15 September 2015 you failed to provide an adequate standard of care to Patient PL in that you failed to take intra-oral radiographs to assess for caries.

7. Between 31 January 2014 and 07 July 2015 you failed to provide an adequate standard of care to Patient SS in that you failed to monitor teeth UR8, UR7, UL7 and UL8 which had been placed 'under watch'.

8. Between 26 March 2015 and 04 June 2015 you failed to provide an adequate standard of care to Patient JK in that you failed to provide additional fluoride to the patient, to manage the caries risk.

Standard of radiographic practice

9. You failed to maintain an adequate standard of radiographic practice in respect of Patient CH in that you failed to report on the radiographs taken on 25 June 2015.

10. You failed to maintain an adequate standard of radiographic practice for Patient RGL in that you failed to report on the periapical radiograph taken on 09 July 2015.

Standard of record keeping

11. On 05 March 2015 you failed to maintain an adequate standard of record keeping in respect of Patient BD in that you failed to:

    a. Record a diagnosis for the swelling in the UL2 region;

    b. Record the fitting of a veneer to the UL2.

12. Between 04 June 2015 and 09 July 2015 you failed to maintain an adequate standard of record keeping for Patient CH in that you failed to:

    a. Make an adequate record of the medical history;

    b. Make an adequate record of the dental charting between 18 June 2015 and 09 July 2015;

    c. Record the clinical findings on 18 June 2015 which led to the need to extract teeth;

    d. Record the clinical findings which led to the need for a filling in the LL4 on 18 June 2015;

    e. Make an adequate record of extractions having been carried out in the upper jaw, either by you or another, between 25 June 2015 and 09 July 2015;

    f. Record that you had taken radiographs on 25 June 2015;

    g. Record the clinical findings which led to the need for antibiotics being prescribed on 02 July 2015.

13. Between 03 March 2015 and 17 March 2015 you failed to maintain an adequate standard of record keeping for Patient EB in that you failed to record your reasoning for not taking radiographs, when they were otherwise required.

14. Between 10 February 2014 and 24 March 2015 you failed to maintain an adequate standard of record keeping for Patient HK in that you failed to record an updated medical history.

15. Between 15 September 2015 and 05 October 2016 you failed to maintain an adequate standard of record keeping for Patient LB in that you failed to record dental charting.

16. On 19 February 2015 you failed to maintain an adequate standard of record keeping for Patient PL in that you failed to record the need for a new denture.

17. Between 09 July 2015 and 27 September 2015 you failed to maintain an adequate standard of record keeping for Patient RGL in that you failed to;

    a. Make an accurate record of the dental charting;

    b. Make an adequate record of the indication for prescribing antibiotics on 09 July 2015.

18. Between 24 September 2015 and 01 October 2015 you failed to maintain an adequate standard of record keeping for Patient YG in that you failed to record the shade of the denture requested.

19. On 19 May 2015 you failed to maintain an adequate standard of record keeping for Patient JK in that you failed to record any difficulties in taking an impression for a denture.

Other

20. You failed to respond professionally to Patient EB's complaint of 20 March 2015.

21. You submitted an inappropriate claim for treatment for Patient MB, by claiming for Band 3 treatment carried out between 17 June 2014 and 31 March 2015, when treatment appropriate to Band 3 had not been carried out.

22. Your conduct in respect of charge 21 above was:

    a. Misleading; and/or

    b. Dishonest.

And by virtue of the above, your fitness to practise is impaired by reason of your misconduct and / or deficient professional performance."

As Mr ABBOUD did not attend and was not represented at the hearing, the Chairman made the following statement regarding proof of service. He addressed this to the Counsel for the GDC.

"Service and proceeding in the absence of Mr Abboud

Mr Abboud was neither present nor represented at this hearing. In his absence, the Committee first considered whether notice of the hearing had been served on him in accordance with rule 13 of the *General Dental Council (Fitness to Practise) Rules Order of Council* 2006 (the rules).

The Committee saw a copy of the notification of hearing letter dated 20 September 2017 which was sent to Mr Abboud's registered address in Spain. The Committee was satisfied that the notice contained proper notification of today's hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the hearing in Mr Abboud's absence.

The Committee was satisfied that reasonable efforts had been made to serve notice upon Mr Abboud in accordance with the Rules.

The Committee then went on to consider whether to exercise its discretion under rule 54 to proceed with the hearing in Mr Abboud's absence. The Committee was mindful that this was a discretion that must be exercised with the utmost care and caution.

The Committee considered carefully the submissions made by Ms Whyment, on behalf of the General Dental Council (GDC), and had regard to the issue of fairness to both parties, as well as the public interest in the expeditious consideration of this case.

There is no application for an adjournment from Mr Abboud, furthermore, the Committee noted an email dated 10 August 2017 from Mr Abboud to the General Dental Council (GDC) in which he stated that he has no intention to work anymore. He has not engaged with the GDC since that time and has given no indication that he will engage in the future.

In all the circumstances the Committee did not consider that an adjournment was likely to secure Mr Abboud's attendance at a relisted hearing on a future date. It considered that the allegations, which include a dishonesty element, are of a serious nature. The Committee took the view that there is a public interest in the expeditious disposal of this hearing.

In accordance with Rule 54, the Committee determined that it was fair and appropriate to proceed with this hearing notwithstanding Mr Abboud's absence.

Decision on application to have witness statements admitted into evidence

Following her opening submissions, Ms Whyment applied under rule 57 of the rules to have the witness statements in support of the GDC case admitted into evidence.

The Committee was informed that Mr Abboud was given prior notice of the GDC's decision not to call the witnesses to be present at this hearing. He has therefore had the opportunity to object to the admission of the statements and has not done so.

The Committee takes the view that the evidence, taken as a whole, is crucial to the case. The witnesses were prepared to attend. However a pragmatic view was taken not to call them in the light of Mr Abboud's non-attendance.

Taking into account all of the above factors, together with the fact that the witnesses are available by phone should they be needed, the Committee was content to accept the statements into evidence.

Determination of no case to answer

At the conclusion of the GDC's case Ms Whyment accepted that in light of concessions made by Dr Pal in his oral evidence there is no case for Mr Abboud to answer in relation to heads of charge 5a, 5c, 7, 11b, 12a, 14, 15, 17a and 19. The Committee agreed that the available evidence in support of the charges was such that there was no real prospect of finding the heads of charge referred to above, proved. The Committee therefore determined that there was no case to answer in respect of these charges."

On 1 November 2017 the Chairman made the following statement regarding the finding of facts:

"The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser.

Background to the case and summary of allegations

The allegations in this case relate to inadequate standards of care, inadequate radiographic practice, and inadequate record keeping, in respect of a number of patients. It is also alleged

that Mr Abboud failed to respond appropriately to a patient complaint, submitted an inappropriate claim for treatment and engaged in misleading and/or dishonest conduct.

Evidence

The Committee had regard to the report and oral evidence of the GDC's expert witness, Dr Abhijit Pal.

The Committee has been provided with documentary material in relation to the heads of charge that you face, including patient records and witness statements and documentary exhibits of a number of staff members from NHS England that were involved in their investigation into these matters by that body.

Committee's findings of fact

The Committee has taken into account all the evidence presented to it, both written and oral, and has considered the submissions made by Ms Whyment on behalf of the GDC.

The Committee has applied the civil standard of proof, namely the balance of probabilities, and has been reminded that the burden of proof lies with the GDC. The Committee has considered each head of charge separately.

I will now announce the Committee's findings in relation to each head of charge:

1.	Proved.
	<u>Standard of care</u>
2.(a)	Proved. Mr Abboud made a note of the swelling in Patient BD's UL2 region in the patient records. He took a periapical radiograph and noted 'NAD root filled' in relation to it. There is no diagnosis noted. Dr Pal stated that the failure to establish or record a diagnosis fell far below the standard of care expected. The Committee concurs. It is satisfied that Mr Abboud should have established a diagnosis. In failing to do so he did not provide an adequate standard of care.
2.(b)	Proved. Dr Pal stated in his report that bitewing radiographs are the most reasonable way to diagnose caries between teeth. He asserted that it was necessary as part of a full mouth examination, to carry out bitewing radiographs to assess for caries. This was not done. In his view it therefore fell short of the standards as set out within the FGDP (Faculty of General Dental Practitioners) publication *Selection Criteria in Dental Radiography*. The Committee concurs. If Patient BD had recently had radiographs taken by another dentist, it would have been reasonable not to take them. However, Mr Abboud has not recorded such a situation nor any other reason for his failure to take bitewings.
3.	Not proved. The Committee has been referred to two radiographs purported to be of Patient CH's mouth. The radiographs formed the basis of Dr Pal's opinion

	that the extraction of these teeth was not clinically indicated. The Committee is aware that the radiographs for this patient have been mislaid in the past, as set out in the Clinical Review Report of the NHS BSA Clinical Adviser, dated 25 May 2016. The radiograph envelope was available to the Clinical Adviser, but not the radiographs themselves. In the Committee's view the radiograph on page 29 of the hearing bundle may not belong to the patient. This is because the UL4 is present on it despite constituting part of the denture to be provided to the patient, and not being due for extraction. Furthermore, the radiographs do not correspond with the laboratory ticket request for a denture for the patient. The Committee could not be satisfied on a balance of probabilities that the radiographs belong to the patient. It therefore did not go on to determine the remainder of the allegation as it is predicated upon the radiographs belonging to the patient.
4.	Proved. The notes of a meeting between Dr Abboud and staff at NHS England, which took place on 17 December 2015, indicate that he accepted he did not take bitewing radiographs. He stated that Patient EB's thyroid problem was the reason why he chose not to take radiographs. Dr Pal stated in his report that bitewing radiographs are the most reasonable way to diagnose caries between teeth. He asserted that it was necessary as part of a full mouth examination, to carry out bitewing radiographs to assess for caries. This was not done. In his view it therefore fell short of the standards as set out within the FGDP (Faculty of General Dental Practitioners) publication *Selection Criteria in Dental Radiography*. He also expressed the view that radiographs are not contraindicated in instances of thyroid problems. The Committee concurs on both points.
5.(a)	No case to answer.
5.(b)	Proved. There is no evidence of any radiographs having been taken between those dates. Dr Pal expressed the view that a failure to take a radiograph following the root filling of the tooth and before placing the inlay, fell far below the standard expected. The Committee concurs.
5.(c)	No case to answer.
5.(d)	Proved. There is no record of a rubber dam having been used. The Committee therefore infers that none was used. Dr Pal expressed the view that if no rubber dam was used, this fell far below the standard expected. The Committee concurs.
5.(e)	Proved. There is no record of gutta percha having been used. The Committee

	therefore infers that none was used. Dr Pal expressed the view that a failure to use gutta percha fell far below the standard expected. The Committee concurs.
6.	Proved. The Committee has seen that there are some undated radiographs available for Patient PL. However, the records relating to the period 19 November 2014 to 15 September 2015 show that the UL5 is not present. Yet it is present on the undated radiographs. The Committee has determined that the undated radiographs must therefore predate the period 19 November 2014 to 15 September 2015 The Committee has looked through the records and is satisfied that for the relevant period, there were no intraoral radiographs taken. The patient had posterior teeth present with contact points. The Committee concurs with Dr Pal that a failure to take radiographs during the relevant period fell far below acceptable standards.
7.	No case to answer.
8.	Proved. Patient JK was a young patient with poor dentition. He had caries on his lower anterior teeth with other teeth missing. A lower partial denture was planned by Mr Abboud. There is no evidence of additional fluoride in the form of either mouthwash, varnish or toothpaste being prescribed. The Committee concurs with Dr Pal that in such a young patient with active caries present, a failure to prescribe fluoride treatment fell far below the standard.
	<u>Standard of radiographic practice</u>
9.	Not proved. The Committee notes the Clinical Review Report of the NHS Clinical Adviser, dated 25 May 2016, in which reference is made to an envelope bearing the name of Patient CH and the date 25 June 2015. The Committee determined at head of charge 3 above, that the radiographs ascribed to the patient and seen by Dr Pal may not actually relate to the patient. The Committee has seen nothing within the patient records to indicate that a radiograph was taken on 25 June 2015. The envelope seen by the Clinical Adviser may have had the incorrect name accidentally entered on it or may have been completed in anticipation of radiographs being taken that never actually were taken. The Committee cannot be satisfied to the requisite standard, that radiographs were taken on that date. It therefore finds this head of charge not proved.
10.	Proved. Mr Abboud took a radiograph on 9 July 2015, but merely noted in the patient

	records that it had been taken. He made no report on it. The Committee concurs with the evidence of Dr Pal that this falls far below the appropriate standards.
	<u>Standard of record keeping</u>
11.(a)	Not proved. The Committee determined at head of charge 2a above, that Mr Abboud did not make a diagnosis. It therefore cannot make a finding that there was a failure to record something that did not occur. Such a finding would be inconsistent.
11.(b)	No case to answer.
12.(a)	No case to answer.
12.(b)	Proved. The Committee has had regard to the clinical records of Patient CH. It noted that there is a written note of the teeth present in the mouth that needed extracting. However, there is no completed charting. The Committee concurs with the opinion of Dr Pal that Mr Abboud's failure to make an adequate record of the dental charting fell far below the appropriate standards.
12.(c)	Proved. The Committee has seen no record of the clinical findings of Mr Abboud that led to the need for extraction of the teeth. The Committee concurs with the opinion of Dr Pal that Mr Abboud's failure to make a record of the clinical findings leading to the need for extraction of the teeth fell far below acceptable standards.
12.(d)	Proved. The Committee has seen no record of the clinical findings leading to the need for a filling in the LL4. The Committee concurs with the expert opinion of Dr Pal that Mr Abboud's failure to make a record of the clinical findings leading to the need for a filling in the LL4 fell far below the standard.
12.(e)	Proved. The Committee has seen no record of the extractions having been carried out in the upper jaw by Mr Abboud or another practitioner. The records indicate that a denture was fitted to replace the extracted teeth. The Committee is therefore satisfied that the extractions were carried out. The Committee concurs with the expert opinion of Dr Pal that Mr Abboud's failure to make a record of the extractions having been carried out in the upper jaw by him or another practitioner fell far below the appropriate standard.

12.(f)	Not proved. The Committee was not satisfied that radiographs were taken on 25 June 2015 (see findings at heads of charge 3 and 9 above). As a consequence there cannot have been a recording failure on the part of Mr Abboud.
12.(g)	Proved. The Committee has seen no record of the clinical findings which led to the need for antibiotics to be prescribed. It notes Mr Abboud made a record that the patient was complaining of pain. This does not, however, amount to a clinical finding that justifies prescribing antibiotics. The Committee concurs with the expert opinion of Dr Pal that Mr Abboud's failure to make a record of the clinical findings which led to the need for antibiotics to be prescribed fell far below the standard.
13.	Proved. Mr Abboud accepts that he did not take bitewing radiographs. He stated in correspondence to the patient, that at he took no radiographs as a result of the patient's thyroid condition. However, it is clear from the clinical records that no reason is noted. The Committee accepts the view of the expert witness that a thyroid issue is not a contraindication. It also accepts his view that Mr Abboud should have made a note of his reason for not taking a radiograph. The Committee finds that this failure fell far below the appropriate standard.
14.	No case to answer.
15.	No case to answer.
16.	Proved. The records for Patient PL indicate that a new denture was required on the date in question. However, the Committee understands the head of charge to mean that Mr Abboud did not record the reasons for a new denture being required six months after the provision of a previous denture. No reason is recorded. The Committee concurs with Dr Pal that there was a duty on Mr Abboud to make such a record and his failure to do so fell below appropriate standards.
17.(a)	No case to answer.
17.(b)	Proved. The Committee has seen no adequate record of the indications for the Metronidazole that Mr Abboud prescribed. It noted that Periodontitis is recorded as present, however this does not amount to an indication for a prescription of antibiotics. The Committee concurs with the expert opinion of Dr Pal that Mr Abboud's failure to make a record of the indications for the antibiotics prescribed fell far below the standard.
18.	Proved.

	The Committee has seen no record of the shade of the denture requested in either the clinical notes or the lab docket. The Committee concurs with the expert opinion of Dr Pal that Mr Abboud's failure to make a record of the shade prescribed fell far below the standard. The denture was to be a partial denture. It was necessary to record a shade so as to ensure that the denture provided matched the remaining teeth in the patient's mouth. It was also important for the continuity of the clinical records.
19.	No case to answer.
	<u>Other</u>
20.	Proved. The Committee has considered the letter sent by Mr Abboud to Patient EB in response to her complaint. In it he attempted to address the clinical issues but did not attempt to resolve them satisfactorily. Some aspects of his letter struck the Committee as confrontational and accusatory. Mr Abboud stated within it that Patient EB insisted on having private treatment on the NHS. The Committee, having seen the patient's complaint, is not of the view that the patient insisted on the treatment Mr Abboud alludes to. In his letter Mr Abboud also stated, 'I'm seeing every month about 300-400 patients, over 99% of them are happy, still we can't make everybody happy especially new patients, we are trying our best to make them happy, but they are more relaxed at the second exam.' In the Committee's judgement this was an inappropriate comment that failed to recognise the reasons Patient EB gave for her dissatisfaction. The Committee also notes and concurs with the comments of the Dental Practise Adviser and Clinical Commissioning Lead at NHS England South (Wessex) that the response was written in poor English. The Committee agreed with Dr Pal that Mr Abboud's response was not in accordance with *Standards for the Dental Team* section 5.3, and therefore he had failed to respond to the complaint professionally.
21.	Not proved. The Committee has looked at the clinical records and appointment book evidence. There is no record indicating Mr Abboud provided Patient MB with any treatment between 17 June 2014 and 31 March 2015. However, the Committee has seen evidence that a claim was submitted under his performer number for band three treatment for that period. In an email dated 7 June 2016, from Mr Abboud to NHS England, he denied having submitted any UDAs (units of dental activity) and stated that all the claims were submitted by the practice principal. The practice principal was the last dentist to treat the patient at the practice. In his oral evidence Dr Pal conceded that someone else at the practice could have submitted the claim in issue under Mr Abboud's performer number. The claim was generated some twelve months after Mr Abboud last saw the

	patient. Taking all of the available evidence into consideration, in the Committee's view, it is more likely than not that the practice systems generated the claim rather than Mr Abboud. It therefore is not satisfied that he knew about the claim.
22.(a)	Not proved. As head of charge 21 above was found not proved, this head of charge therefore falls.
22.(b)	Not proved. As head of charge 21 above was found not proved, this head of charge therefore falls.

We move to Stage Two."

On 2 November 2017 the Chairman announced the determination as follows:

"The Committee took into account the submissions made at this second stage of the proceedings. It accepted the advice of the Legal Adviser.

FACTUAL BACKGROUND

The Committee has determined that Mr Abboud failed to provide an adequate standard of care, radiographic practice and record keeping in relation to a number of patients over the period 2014 to 2015. His failings included not establishing a diagnosis in relation to a swelling in a patients UL2 region. In relation to other patients he failed to take radiographs to assess for caries. He did not use a rubber dam and he failed to use gutta percha during root canal treatment. Mr Abboud also failed to provide additional fluoride to a 21 year old patient to manage their high caries risk. In respect of radiographic practice, he failed to report on radiographs. In respect of record keeping, he failed to make an adequate record of dental charting, clinical findings leading to a need to extract teeth, clinical findings leading to a need for a filling, extractions having been carried out by him or another practitioner and clinical findings leading to the need for antibiotics being prescribed. He also did not record his reasoning for not taking radiographs that were otherwise required for a patient, as well as not recording the reason a patient required a new denture, having been provided with one six months earlier. He also failed to record the shade of denture requested for a patient.

In addition, when a patient made a complaint, he failed to respond professionally.

MISCONDUCT

The Committee first considered whether any of the facts it found proved against Mr Abboud amounted to misconduct. It bore in mind that misconduct is a word of general effect involving some act or omission which falls short of what would be proper in the circumstances, and in order to make such a finding the falling short must be serious. The Committee also bore in mind that misconduct is matter for its own judgement.

The Committee had regard to the following sections of *Standards for the Dental Team* (2013):

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their

situation. You may need to balance their oral health needs with their desired outcomes.

If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.

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:

- the disposal of clinical and other hazardous waste
- radiography
- health and safety
- decontamination
- medical devices.

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.

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.

4.1.4 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.

5.2.1 You should not react defensively to complaints. You should listen carefully to patients who complain and involve them fully in the complaints process. You should find out what outcome patients want from their complaint.

5.3.2 You should deal with complaints in a calm and constructive way and in line with the complaints procedure.

5.3.3 You should aim to resolve complaints as efficiently, effectively and politely as possible.

7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.

7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

Mr Abboud' s failures were wide ranging and related to nine patients. The Committee was particularly concerned about the number of breaches over a lengthy period. His conduct was sustained and repeated.

Mr Abboud's actions and omissions as set out above were serious and fell far short of the standards expected of a reasonably competent dentist. The Committee is in no doubt that they would be deemed deplorable by his fellow professionals and therefore amount to misconduct.

DEFICIENT PROFESSIONAL PERFORMANCE

Ms Whyment on behalf of the GDC submitted that misconduct alone is alleged against Mr Abboud on the grounds that he knew the standards to which he was subject at the time and did not comply with them. The Committee therefore considered misconduct only and did not go on to consider the questions of impairment on the grounds of deficient professional performance.

IMPAIRMENT

The Committee next considered whether Mr Abboud's fitness to practise is currently impaired by reason of his misconduct.

The Committee first looked at whether his misconduct was remediable. It took the view that it was capable of remedy demonstrated by appropriate Continuing Professional Development (CPD) courses, evidence of reflection and evidence of insight.

Mr Abboud has not engaged with the GDC in relation to this hearing beyond his email of 10 August 2017 in which he confirmed that he was content to receive documents by email and that he had no intention to work anymore. The Committee has therefore seen no remediation documentation addressing the areas of concern in this case. Furthermore, it has seen no evidence that demonstrates Mr Abboud has reflected on his misconduct nor that he has any insight.

Mr Abboud's misconduct served to put patients at risk of significant harm. The Committee was particularly concerned about his record keeping failures, his failure to make a diagnosis, his failings in radiographic practice and his failure to prescribe fluoride to a young person with poor oral health. Patients could have suffered real harm as a result of his misconduct. The lack of evidence that he has engaged in reflection and has developed insight raises the prospect of a real risk of repetition of his past misconduct. There is no evidence that he has changed or has any intention to change his practice. Any repetition would have the potential to put patients at risk of harm.

The Committee also considered the matter of the public interest. In doing so, it paid particular regard to Mr Abboud's inappropriate handling of a complaint from one of his patients. He failed to apologise to the patient and instead sought to place blame on her. In his response there was no indication that he had reflected on what he may have done wrong and there was no evidence of an ability to acknowledge or recognise his deficiencies. Furthermore, there was no evidence of steps taken by him to address the matters raised.

The Committee took the view that such conduct taken together with his clinical and record keeping failings, was liable to bring the reputation of the profession into disrepute.

One of this Committee's functions is to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession and in the regulatory process. Were the Committee not persuaded of Mr Abboud's current impairment on the basis of a real risk of repetition, it took the view that in light of his wide ranging failings this was a case which would nevertheless merit a finding of current impairment on public interest grounds alone so as to maintain public confidence in the profession.

SANCTION

The Committee next considered what sanction, if any, to impose upon Mr Abboud's registration. It bore in mind that the purpose of a sanction is not to be punitive, but rather to protect patients and the wider public interest, which includes:

- protecting patients, colleagues and the wider public from the risk of harm;
- maintaining public confidence in the dental profession;
- upholding the reputation of the dental professions; and
- declaring and upholding appropriate standards of conduct and competence among dental professionals.

It noted that Mr Abboud has no previous Fitness to Practise history.

In considering sanction, the Committee took into account the *Indicative Sanctions Guidance for the Practice Committees* (October 2016). It applied the principle of proportionality and balanced the public interest against Mr Abboud's own interests.

The Committee had regard to the mitigation in Mr Abboud's favour; namely his lack of a history before the GDC. It balanced this consideration with the aggravating factors, which include the fact that his misconduct was sustained over a lengthy period of time, it was repeated, there is a lack of evidence of insight, no remediation material has been provided to the Committee, and he has not adequately engaged with the regulatory process.

The Committee considered whether it would be sufficient to conclude the case with no further action. However, it determined that in the light of the serious findings it had made, concluding the case with no further action would not be an appropriate or proportionate response.

It next considered whether to issue Mr Abboud with a reprimand. It determined that a reprimand would neither serve to safeguard patients, nor uphold public confidence in the profession given the identified risk of repetition of his misconduct.

It next considered whether conditions of practice could be formulated that would address Mr Abboud's impairment. It was satisfied that conditions would ordinarily be workable in a case such as this, involving as it does, primarily clinical findings. However, Mr Abboud's non-engagement and lack of insight render conditions unworkable. Furthermore, there is evidence that he has not complied with conditions that were imposed upon him in the past by NHS England in relation to the Performers List. Mr Abboud has also stated that he has no intention to practise in future.

The Committee next considered whether to suspend Mr Abboud's registration for a period of time. It noted the GDC's submission that suspension would be the appropriate sanction in this case.

The Committee noted paragraph 7.28 within the *Indicative Sanctions Guidance,* which sets out the factors indicative of a suspension order:

7.28 Suspension is appropriate for more serious cases and may be appropriate when all or some of the following factors are present (this list is not exhaustive):

- *there is evidence of repetition of the behaviour;*
- *the registrant has not shown insight and/or poses a significant risk of repeating the behaviour;*
- *patients' interests would be insufficiently protected by a lesser sanction;*
- *public confidence in the profession would be insufficiently protected by a lesser sanction;*

- *there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).*

The Committee considered the matter very carefully and decided that the factors set out in paragraph 7.28 are engaged in this case. The Committee determined that Mr Abboud's misconduct was sufficiently serious as to merit the imposition of suspension for a period of 12 months. It took the view that erasure would be disproportionate in that a suspension order would adequately protect the public and meet the wider public interest considerations.

The order will be reviewed shortly before the end of the period.

When this matter falls to be reviewed, the reviewing Committee may be assisted by evidence of Mr Abboud's insight and learning in relation to the failings identified and his full engagement with the GDC process.

IMMEDIATE ORDER

The Committee considered the submissions made by Ms Whyment. It accepted the advice of the Legal Adviser.

In her submissions Ms Whyment noted the appeal period prior to the substantive sanction taking effect, during which Mr Abboud could potentially practise should no immediate order be made. She invited the Committee to impose an immediate order of suspension on Mr Abboud's registration for the protection of the public and otherwise in the public interest.

The Committee determined that an immediate order is necessary in this case for the protection of the public and is otherwise in the wider public interest for the same reasons as given for the substantive order. If Mr Abboud were able to practise unrestricted at this time, he would pose a risk to patients and in the light of the Committee's reasons for its substantive decision, public confidence in the profession would be undermined.

The effect of the foregoing determination and this order is that Mr Abboud's registration will be made subject to an order of suspension with immediate effect. If he chooses to appeal the substantive decision, this immediate order of suspension will remain in place until the resolution of that appeal. If no appeal is pursued, the immediate order will remain in place for 28 days, following which the substantive order will take effect.

The interim order currently in place is hereby revoked."

At a review hearing on 21 November 2018 the Chairman announced the determination as follows:

"Mr Abboud was not present nor represented at this hearing, Mr Kasir Ahmed represented the General Dental Council (GDC).

Service of Notice of Hearing

In his absence, the Committee first considered whether the notice of this hearing had been served in accordance with rules 28 and 65 of *the General Dental Council (Fitness to Practise) Rules Order of Council 2006* (the rules). It accepted the advice of the Legal Adviser.

The Committee saw a copy of the notification of hearing letter dated 18 October 2018

which was sent to Mr Abboud's registered address in Spain by recorded delivery. The Royal Mail track and trace receipt shows that it attempted to deliver the item. The Committee was satisfied that the notice contained proper notification of today's hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the hearing in Mr Abboud's absence. The Committee was satisfied that reasonable efforts had been made to serve notice upon Mr Abboud in accordance with the Rules and that due service has been effected.

Proceeding in the absence of Mr Abboud

The Committee then considered whether to exercise its discretion under rule 54 to proceed in the absence of Mr Abboud. The Committee bore in mind that it must exercise its discretion to proceed with the utmost care and caution. It has also borne in mind the overall fairness of the proceedings to both parties, as well as the public interest in the timely review of this case.

The Committee heard the submissions made by Mr Ahmed on behalf of the General Dental Council (GDC). It accepted the advice of the Legal Adviser.

The Committee noted that there had been no correspondence from Mr Abboud in regards to this hearing. He has not informed the Council of any change of address. Mr Abboud had not requested that this hearing be adjourned. The Committee noted that Mr Abboud had not engaged with the GDC and has given no indication that he will engage in the future. In all the circumstances the Committee did not consider that an adjournment was likely to secure Mr Abboud's attendance at a relisted hearing on a future date. The Committee took the view that there is a public interest in the expeditious disposal of this hearing. The present order is due to expire on 4 December 2018. In accordance with Rule 54, the Committee determined that it was fair and appropriate to proceed with this hearing notwithstanding Mr Abboud's absence.

Background

This is the first review of a suspension order that was first imposed on Mr Abboud's registration for a period of 12 months by the Professional Conduct Committee (PCC) in November 2017. Mr Abboud did not attend that hearing. At that hearing the PCC found:

Mr Abboud had failed to provide an adequate standard of care, radiographic practice and record keeping in relation to a nine patients over the period of 2014 to 2015. His failings included not establishing a diagnosis in relation to a swelling in a patients UL2 region. In relation to other patients he failed to take radiographs to assess for caries. He did not use a rubber dam and he failed to use gutta percha during root canal treatment. Mr Abboud also failed to provide additional fluoride to a 21 year old patient to manage their high caries risk. In respect of radiographic practice, he failed to report on radiographs. In respect of record keeping, he failed to make an adequate record of dental charting, clinical findings leading to a need to extract teeth, clinical findings leading to a need for a filling, extractions having been carried out by him or another practitioner and clinical findings leading to the need for antibiotics being prescribed. He also did not record his reasoning for not taking radiographs that were otherwise required for a patient, as well as not recording the reason a patient required a new denture, having been provided with one six months earlier. He also failed to record the shade of a denture requested for a patient. In addition, when a patient made a complaint, he failed to respond professionally.

The PCC considered Mr Abboud's misconduct and determined the following:

Mr Abboud' s failures were wide ranging and related to nine patients. The Committee was particularly concerned about the number of breaches over a lengthy period. His conduct was sustained and repeated. Mr Abboud's actions and omissions as set out above were serious and fell far short of the standards expected of a reasonably competent dentist. The Committee is in no doubt that they would be deemed deplorable by his fellow professionals and therefore amount to misconduct.

Having found there was misconduct the PCC considered whether Mr Abboud's fitness to practise was impaired and determined the following:

Mr Abboud has not engaged with the GDC in relation to this hearing beyond his email of 10 August 2017 in which he confirmed that he was content to receive documents by email and that he had no intention to work anymore. The Committee has therefore seen no remediation documentation addressing the areas of concern in this case. Furthermore, it has seen no evidence that demonstrates Mr Abboud has reflected on his misconduct nor that he has any insight.

Mr Abboud's misconduct served to put patients at risk of significant harm. The Committee was particularly concerned about his record keeping failures, his failure to make a diagnosis, his failings in radiographic practice and his failure to prescribe fluoride to a young person with poor oral health. Patients could have suffered real harm as a result of his misconduct.

The lack of evidence that he has engaged in reflection and has developed insight raises the prospect of a real risk of repetition of his past misconduct. There is no evidence that he has changed or has any intention to change his practice. Any repetition would have the potential to put patients at risk of harm.

The Committee also considered the matter of the public interest. In doing so, it paid particular regard to Mr Abboud's inappropriate handling of a complaint from one of his patients. He failed to apologise to the patient and instead sought to place blame on her. In his response there was no indication that he had reflected on what he may have done wrong and there was no evidence of an ability to acknowledge or recognise his deficiencies.

Furthermore, there was no evidence of steps taken by him to address the matters raised.

The Committee took the view that such conduct taken together with his clinical and record keeping failings, was liable to bring the reputation of the profession into disrepute.

One of this Committee's functions is to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession and in the regulatory process. Were the Committee not persuaded of Mr Abboud's current impairment on the basis of a real risk of repetition, it took the view that in light of his wide ranging failings this was a case which would nevertheless merit a finding of current impairment on public interest grounds alone so as to maintain public confidence in the profession.

Having found Mr Abboud's fitness to practise impaired the PCC considered the matter of sanction and determined the following:

…The Committee next considered whether to suspend Mr Abboud's registration for a period of time. It noted the GDC's submission that suspension would be the appropriate sanction in this case.

The Committee noted paragraph 7.28 within the Indicative Sanctions Guidance, which sets out the factors indicative of a suspension order:

7.28 Suspension is appropriate for more serious cases and may be appropriate when all or some of the following factors are present (this list is not exhaustive):

- *there is evidence of repetition of the behaviour;*
- *the registrant has not shown insight and/or poses a significant risk of repeating the behaviour;*
- *patients' interests would be insufficiently protected by a lesser sanction;*
- *public confidence in the profession would be insufficiently protected by a lesser sanction;*
- *there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).*

The Committee considered the matter very carefully and decided that the factors set out in paragraph 7.28 are engaged in this case. The Committee determined that Mr Abboud's misconduct was sufficiently serious as to merit the imposition of suspension for a period of 12 months. It took the view that erasure would be disproportionate in that a suspension order would adequately protect the public and meet the wider public interest considerations.

Today's Review

Today Mr Ahmed referred the Committee to the documentation before it and outlined the background of the case. He informed the panel that Mr Abboud has not submitted any CPD or followed the recommendations made by the PCC panel in November 2017. Mr Ahmed submitted that given Mr Abboud's non-engagement and the lack of information as to his current intentions regarding his profession there remains a risk of repetition of the misconduct found in 2017. He submitted that Mr Abboud's fitness to practise remains impaired.

Mr Ahmed referred the Committee to the available sanctions and invited the Committee to consider all the circumstances of this case when reaching any decision. He submitted that in all the circumstances of this case the appropriate sanction is that of extending the suspension order for a further period of 12 months.

The Committee accepted the advice of the Legal Adviser.

Decision of review

The Committee has considered whether Mr Abboud's fitness to practise remains impaired. In doing so, the Committee has exercised its independent judgement. Throughout its deliberations, it 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 the declaring and upholding of proper standards of conduct and behaviour.

The Committee was of the view that the misconduct identified was remediable, but there was no evidence that Mr Abboud had taken any steps to address the identified misconduct. Mr

Abboud has not engaged with his regulatory body. The Committee therefore considers that Mr Abboud continues to present a risk to patients and his fitness to practise remains impaired. The Committee also considers that a finding of impairment is also required for wider public interest reasons, namely to declare and uphold proper professional standards of conduct and behaviour and to maintain public trust and confidence in the profession.

Sanction

The Committee then considered what, if any, sanction to impose in this case.

The Committee noted its powers under section 27C(1) the Dentists Act 1984 (the Act). The Committee had the power to extend the current suspension order for a maximum period of 12 months. Alternatively it could revoke the suspension order or replace the order with a conditions of practice order for up to 3 years.

The Committee was aware that it should have regard to the principle of proportionality, balancing the public interest against Mr Abboud's own interests. The public interest includes the protection of the public, the maintenance of public confidence in the profession, and declaring and upholding standards of conduct and performance within the profession.

The Committee first considered whether it would be appropriate to allow the current order to lapse at its expiry on 4 December 2018 or to revoke it with immediate effect. The Committee considered that given all of the information before it, and for all the reasons outlined above, it would not be appropriate to revoke the current order or to allow it to lapse, as this would not protect the public nor would it be in the public interest.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee was mindful that any conditions imposed must be proportionate, measurable and workable. The Committee was aware that in order for conditions to be appropriate and workable there would need to be some measure of positive engagement from Mr Abboud, which is noticeably absent in this case. Furthermore, there is evidence that he has not complied with conditions that were imposed upon him in the past by NHS England in relation to the Performers List. Mr Abboud has also stated that he has no intention to practise in future. Given the above, the Committee concluded that replacing the suspension order with a conditions of practice order would not be workable or appropriate at this stage.

The Committee concluded that in all the circumstances of this case a further period of suspension on Mr Abboud's registration would protect the public, uphold the public interest and give Mr Abboud a further opportunity to address the identified deficiencies and shortcomings in his practice and re-engage in the GDC process. The Committee concluded that for these reasons the appropriate order is that of a 12 month suspension, with a review.

The Committee therefore directs that Mr Abboud's registration be suspended for a further period of 12 months pursuant to Section 27C(1)(b) of the Act. Section 33(3) of the Act comes into operation to cover any period between the expiry of the current suspension and the date when the direction ordered by this Committee comes into force.

The reviewing Committee would be assisted by evidence from Mr Abboud of:

- His attendance at the next review hearing;
- Relevant CPD he has achieved or intends to undertake;
- Reflective account demonstrating insight and learnings in relation to the identified failings.

That concludes this hearing."

At a review hearing on 11 November 2019 the Chairman announced the determination as follows:

"This is a Professional Conduct Committee (PCC) review hearing of Mr Abboud's case, listed for 11 November 2019, which is being held in accordance with Section 27C of the Dentists Act 1984 (the Act). Mr Abboud is neither present nor represented at the hearing. In his absence, the Committee first considered whether the Notice of Hearing had been served on Mr Abboud in accordance with Rule 28 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules) and Sections 50A(2) of the Act. The Committee has accepted the Legal Adviser's advice.

The Committee has seen a copy of the Notice of Hearing dated 18 September 2019, addressed to Mr Abboud at his registered address, which is in Spain. The Committee is satisfied that the Notice of Hearing contains the information required by Rule 28, including the date, time and venue of today's review hearing. The information from Royal Mail indicates that the Notice of Hearing was sent on 18 September 2019 by international delivery, but it was unable to deliver the item as it was "not possible to identify the delivery address". However, the Committee is aware that the GDC is only required to demonstrate that it has sent the Notice of Hearing to the Registrant and not to demonstrate that the item has arrived. The Committee is satisfied that the Notice of Hearing has been sent to Mr Abboud more than 28 days in advance of today's hearing, in accordance with Rule 28. In addition, the Committee has seen a copy of an email dated 18 September 2019 from the GDC to Mr Abboud, attaching a copy of the Notice of Hearing and the bundle. Having regard to all the documents before it the Committee is satisfied that the GDC has complied with the requirements of service in accordance with the Rules and the Act.

Proceeding in the absence of Mr Abboud

The Committee went on to consider whether to proceed in the absence of Mr Abboud and the GDC and on the basis of the papers, in accordance with Rule 54. The GDC, in its written submissions, refer to the further efforts it made on 30 September 2019 and 14 October 2019 to contact Mr Abboud via email to confirm his correct address for sending correspondence and to ask him to notify the GDC whether or not he would like to attend the hearing remotely, either via telephone or Skype. The Notice of Hearing dated 18 September 2019 advised Mr Abboud that should the GDC not hear from the Registrant by 25 September 2019, the GDC intended for the hearing to be held on the papers. The GDC has received no response from Mr Abboud.

The Committee has considered the submissions made by the GDC. It notes the absence of any response from Mr Abboud in respect of the Notice of Hearing or indeed with the GDC generally. There is nothing before the Committee to suggest that Mr Abboud will engage with the GDC at a later stage. In these circumstances, the Committee has concluded that Mr Abboud has voluntarily absented himself from today's hearing. The Committee did not consider than an adjournment would secure his engagement in the future. In addition, the Committee considers that there is a clear public interest in reviewing the order today, given that it is due to expire on or around 4 December 2019. Accordingly, the Committee has determined that it is fair to proceed with today's review hearing on the basis of the papers and in the absence of both parties.

Background

Mr Abboud's case was first considered by the PCC at a hearing in October 2017 – November 2017. He was neither present nor represented at that hearing. The PCC determined that it was fair and appropriate to proceed with that hearing in his absence.

The PCC reached a number of findings against Mr Abboud. It found that Mr Abboud had failed to provide an adequate standard of care, radiographic practice and record keeping in relation to a number of patients over the period of 2014 to 2015. His failings included not establishing a diagnosis in relation to a swelling in a patients UL2 region. He also failed to take radiographs to assess for caries. He did not use a rubber dam and he failed to use gutta percha during root canal treatment. Mr Abboud also failed to provide additional fluoride to a 21 year old patient to manage their high caries risk. In respect of radiographic practice, he failed to report on radiographs. The PCC also found shortcomings in Mr Abboud's record keeping, including a failure to make an adequate record of dental charting and his clinical findings leading to the need for antibiotics being prescribed. In addition, when a patient made a complaint, he failed to respond professionally, submitted an inappropriate claim for treatment and engaged in misleading and/or dishonest conduct.

The PCC considered that Mr Abboud' s failures were wide ranging, relating to nine patients, and his conduct was sustained and repeated. It determined that the facts found proved amounted to misconduct.

In considering current impairment at that time, the PCC was of the view that the failings in Mr Abboud's practice were capable of being remedied. However, the PCC had no evidence of remediation to satisfy itself that Mr Abboud had addressed the wide ranging concerns in this case. In the PCC's judgement, there was also a lack of evidence that Mr Abboud had engaged in reflection and developed insight into the issues raised. The PCC considered that there was a real risk of repetition of his past misconduct.

The PCC also had regard to Mr Abboud's inappropriate handling of a complaint from one of his patients in which he failed to apologise to the patient and instead sought to place blame on her. The PCC took the view that this conduct, together with his clinical and record keeping failings, were liable to bring the reputation of the profession into disrepute. Accordingly, the PCC determined that Mr Abboud's fitness to practise was currently impaired.

In terms of sanction, the PCC determined that Mr Abboud's misconduct was sufficiently serious as to merit the imposition of suspension for a period of 12 months. It took the view that erasure would be disproportionate in that a suspension order would adequately protect the public and meet the wider public interest considerations. It indicated that the order be reviewed before the end of 12 months. It further indicated that the reviewing Committee may be assisted by evidence of Mr Abboud's insight and learning in relation to the failings identified, as well as his engagement with the GDC. The PCC further directed an immediate order on Mr Abboud's registration.

The first review hearing of the order took place on 21 November 2018. Mr Abboud was neither present nor represented. The PCC decided to proceed with the hearing in Mr Abboud's absence. The PCC bore in mind the absence of any evidence from Mr Abboud that he had taken any steps to address the identified misconduct. Further, Mr Abboud had not engaged with the GDC. In the PCC's judgement, Mr Abboud continued to present a risk to patients. It determined that his fitness to practise remained impaired and considered that this finding was also required in the wider public interest reasons, namely, to declare and

uphold proper professional standards of conduct and behaviour and to maintain public trust and confidence in the profession.

The PCC directed that Mr Abboud's registration be suspended for a further period of 12 months. In indicated that the Committee reviewing the order would be assisted by evidence from Mr Abboud of:

- His attendance at the next review hearing;
- Relevant CPD he has achieved or intends to undertake;
- Reflective account demonstrating insight and learnings in relation to the identified failings.

Today's review

At today's hearing this Committee has comprehensively reviewed the current order. In so doing, the Committee has had regard to the GDC bundle. This contains copies of letters and emails from the GDC's Case Review Team to Mr Abboud, reminding him of the recommendations made by the PCC and a date by which he was required to provide the evidence. There has been no response from Mr Abboud , despite repeated attempts to seek his engagement, and therefore there is no evidence of any insight, reflection or remediation of the failings identified by the previous Committee.

The GDC's position is that Mr Abboud's fitness to practise remains impaired. In support of that contention, it refers to Mr Abboud's lack of engagement with the GDC and the absence of any evidence of remediation or insight, or of any response to the recommendations made by the PCC. The GDC also highlights Mr Abboud's lack of engagement with the GDC since before the initial PCC hearing in November 2017. On 10 August 2017 Mr Abboud informed the GDC that he had no intention to work anymore.

In terms of sanction, the GDC says that it has concerns with regard to the imposition of an order of conditions on Mr Abboud's registration, given his lack of engagement with the GDC and assertion that he is not going to work anymore. In respect of an extension of the suspension order for a further period, the GDC's position is that given Mr Abboud's lack of engagement with the GDC and the absence of any evidence of insight or remediation from him, nothing would be gained by a further review. It submits that it would be open to this Committee to consider imposing an indefinite suspension on Mr Abboud's registration. The GDC refer to the dates when Mr Abboud's registration was first suspended and then further suspended. It therefore says that the provisions of 27C(1)(d)(i) and (ii) of the Act have been met, given that he will have been suspended for two years from the date in which the direction is likely to take effect.

The Committee considered carefully the submissions made. Throughout its deliberations, it 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 has accepted the advice of the Legal Adviser.

The Committee has been referred to the case of *Abrahaem v General Medical Council [2008] EWHC 183 (Admin)* where it was held at paragraph 23 that "there is a persuasive burden on the practitioner at a review to demonstrate that he or she has fully acknowledged why past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments."

There is no evidence before this Committee that Mr Abboud has addressed any of the deficiencies identified by the PCC at the initial hearing in October- November 2017 or at the review hearing in November 2018, despite being given the opportunity to do so. Further, Mr Abboud's engagement with the GDC throughout the two years when his registration has been suspended has been extremely limited, save for him notifying the GDC on 10 August 2017 that he had no intention to work anymore. In the absence of any evidence to show any material change in circumstances since the last hearing, the Committee considers that Mr Abboud remains a risk to the public. Accordingly, it has determined that his fitness to practise remains impaired.

The Committee next considered what direction to give. In so doing, it has had regard to the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (October 2016, updated May 2019). It has had regard to the GDC's written submissions.

In the Committee's judgement, Mr Abboud has not demonstrated any commitment to remediate his deficiencies or engage with the GDC, despite being given the opportunity to do so. In these circumstances, the Committee concluded that terminating the current suspension order would not be appropriate or sufficient for the protection of the public.

The Committee considered whether to replace the current suspension order with one of conditions. In so doing, it had regard to the absence of any evidence of remediation from Mr Abboud and his extremely limited engagement with his regulator over the last two years, with no indication that he would engage in the future. In these circumstances, the Committee is not satisfied that conditions are appropriate, workable or sufficient for the protection of the public.

The Committee then went on to consider whether to direct that the current period of suspension be extended for a further period. It has borne in mind Mr Abboud's continuing lack of engagement with the GDC over a long period of time, despite being given the opportunity to do so, as well as the absence of any insight or remediation. Indeed, Mr Abboud's decision not to participate at any of these proceedings over the last two years has exacerbated the situation. In these circumstances, the Committee has concluded that a further period of suspension of 12 months would serve no useful purpose and not be in Mr Abboud's interests. Accordingly, the Committee directs that Mr Abboud's registration be suspended indefinitely. It is satisfied that this is the proportionate and appropriate outcome. It is further satisfied that the provisions of Sections 27C(1)(d)(i) and (ii) of the Act are met.

The effect of the foregoing direction is that, unless Mr Abboud exercises his right of appeal, his registration will be suspended indefinitely from the date on which the direction takes effect. The intervening period between the current order expiring and the new order coming into effect will be covered by the extension of the current order of suspension.

That concludes this case for today."