HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

2-4 November 2026

Name:	ABBAS, Fawaz
Registration number:	81570
Case number:	CAS-209135

General Dental Council:	Natasha Tahta of Counsel Instructed by Kingsley Napley
Registrant:	Present Represented by Anthony Haycroft of Counsel Instructed by Weightmans

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Outcome:	Fitness to Practise Not Impaired. Case Concluded

Committee members:	Chris Weigh	(Lay) (Chair)
	James Maughan	(Dentist)
	Joshua Kelly	(DCP)
Legal adviser:	Justin Gau	
Committee Secretary:	Paul Carson	

The Charge (as amended)

CHARGE

ABBAS, Fawaz, a dentist, Statutory Exam 2003, was summoned to appear before the Professional Conduct Committee on 2 November 2026 for an inquiry into the following charge:

"That being registered as a dentist:

1. *You failed to provide an adequate standard of care in that you failed to conduct an adequate basic periodontal examination ("BPE") on:*

    (a) Patient 2, between 20 August 2018 and 4 June 2019;

    (b) Patient 26, between 17 December 2018 and 27 February 2019.

2. *You failed to provide an adequate standard of care to Patient 2 between 18 February 2020 and 15 December 2020, in that you failed to radiographically review the root canal treatment you had provided at the UL2.*

3. *You failed to provide an adequate standard of care to Patient 5 in that:*

    (a) You failed to take a pre-operative radiograph of UR1 on or before 5 November 2019, before preparing the UR1 for a crown;

    (b) you failed to discuss the relevant risks and benefits of providing a crown to the UR1 on or before 5 November 2019;

4. *You failed to obtain informed consent from Patient 5 before preparing UR1 for a crown on 5 November 2019.*

5. WITHDRAWN

6. *You failed to provide an adequate standard of care to Patient 16 in that you failed to take bitewing radiographs on 11 February 2019.*

7. *You failed to provide an adequate standard of care to Patient 17 in that:*

    (a) you provided a poor standard of root canal treatment at the UL4 between 20 June 2019 and 11 July 2019;

    (b) you failed to adequately review the post operative radiograph taken on 11 July 2019.

8. *You failed to provide an adequate standard of care to Patient 21 in that:*

(a) You failed to take a pre-operative radiograph of UR5 on or before 15 October 2019, before preparing the UR5 for a crown;

(b) you failed to discuss the relevant risks and benefits of providing a crown to the UR5 on or before 15 October 2019;

9. You failed to obtain informed consent from Patient 21 before preparing UR5 for a crown on 15 October 2019.

10. You failed to provide an adequate standard of care to Patient 30 in that you failed to take bitewing radiographs on 3 July 2019.

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

Mr Abbas,

1. The allegations against you relate to the adequacy of the standard of care you provided to a number of patients between August 2018 and December 2020, including in relation to periodontal examination, radiographic assessment, root canal treatment, crown preparation, treatment planning and the obtaining of informed consent.

Procedural progress

2. At the outset of the hearing, Ms Tahta, on behalf of the General Dental Council (GDC) applied under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 to amend the charge set out in the notification of hearing by deleting charge 5, which pleaded that: "*You failed to provide an adequate standard of care to Patient 11 in that you failed to carry out adequate treatment planning before providing a crown to the UR5 between 4 July 2019 and 29 July 2019.*"

3. The application was made following the production of a joint expert report from the two expert witnesses instructed in this case, with both reaching an agreed opinion that a reasonable body of dentists would have proceeded in the way alleged and that the corresponding criticism of you cannot therefore be sustained.

4. Mr Haycroft, on your behalf, did not oppose the application.

5. The Committee accepted the advice of the Legal Adviser on its power to amend under Rule 18. Having examined the joint expert report, the Committee was satisfied that it would be appropriate to delete charge 5 and that no injustice or unfairness would be caused in allowing this amendment. Accordingly, the charge set out in the notification of hearing was amended by deleting charge 5.

6. Mr Haycroft proceeded to admit the entirety of the remaining charges on your behalf. He also conceded that these clinical failings fell far below the standard expected of a reasonably competent general dental practitioner, save for charges 1(a), 1(b), 7(a) and 7(b), where there was a conflict of expert opinion as to whether they were far below or only below.

7. The Committee accepted your admissions and therefore found charges 1 to 4 and 6 to 10 proved.

Stage Two

8. As there was no factual dispute to resolve, the Committee proceeded to "Stage Two" of its procedure to determine whether the facts admitted and found proved amount to misconduct and, if so, whether your fitness to practise as a dentist is currently impaired by reason of that misconduct. If the Committee were to find current impairment, it must then decide on what action, if any, to take in respect of your registration.

Factual background

9. Following an NHS investigation during which a number of your patients' clinical records were requested and reviewed, a number of deficiencies were identified in the care you had provided to seven patients between August 2018 and December 2020. Those patients are referred to as Patients 2, 5, 16, 17, 21, 26 and 30 for the purposes of these proceedings.

10. In relation to Patients 2 and 26, you failed to conduct adequate basic periodontal

examinations (BPEs).

11. Patient 2 had an established history of periodontal disease. Although the clinical records demonstrated that you had recognised the patient's periodontal condition and provided treatment, you subsequently failed to undertake adequate BPE assessments over an extended period.

12. You also failed radiographically to review root canal treatment that you had provided to Patient 2 at the UL2.

13. Patient 26 was aged 60 and was a new patient to your practice. Although radiographs had been taken and the records referred to periodontal risk and bone loss, an adequate BPE had not been completed at the initial examination.

14. In relation to Patients 5 and 21 you failed to take pre-operative radiographs before preparing teeth for crowns. In the absence of those radiographs, you were unable to fully assess the proposed treatment and adequately explain the risks and benefits to the patients. In consequence, you failed to obtain their informed consent.

15. In relation to Patients 16 and 30, you failed to take bitewing radiographs when these were clinically indicated.

16. In relation to Patient 17, you provided root canal treatment to the UL4. The treatment resulted in a root filling that was too short in one canal, in that it did not fill the entire root. Although you took a post-operative radiograph, your recorded assessment described the root filling as satisfactory and so did not accurately identify the deficiency.

Expert evidence

17. The Committee considered the written reports and oral evidence of Mr C. Mulcahy BA BDentSci MSc, instructed by the GDC, and Dr D. R. Kramer BDS. LDS RCS. FCGDent., instructed on your behalf, together with their joint expert report.

18. Both experts agreed that the clinical care provided fell below the standard expected of a reasonably competent general dental practitioner in respect of all the admitted charges. They agreed that the deficiencies identified in nine of the thirteen admitted subcharges fell far below the expected standard. They differed in their assessment of the seriousness of the failings concerning charges 1(a), 1(b), 7(a) and 7(b). They were cross-examined on their differences in opinion and also answered questions from the Committee.

19. You did not give oral evidence to the Committee but provided a detailed reflective statement and documentary remediation evidence.

20. The Committee had regard to the submissions made by both Counsel.

21. Ms Tahta submitted that the facts found proved amounted to misconduct. She referred to the number of the clinical failings which occurred over a period of approximately two years. She referred to the agreement between both experts that nine of the admitted subcharges individually fell far below the standard expected of a reasonably competent general dental practitioner. She submitted that misconduct could therefore be established even without resolving the conflict

of expert opinion on the extent to which the remaining four subcharges would fall below that standard.

22. As to impairment, Ms Tahta acknowledged your admissions and the evidence of remediation. She stated that Mr Mulcahy had concluded from your remediation that you have adequately addressed all the areas of clinical deficiency identified in the charges. In those circumstances, she submitted that the GDC is neutral on the question of current impairment and made no submissions in relation to sanction.

23. Mr Haycroft accepted that the facts found proved amounted to misconduct. In respect of charges 1(a), 1(b), 7(a) and 7(b), he invited the Committee to prefer Dr Kramer's evidence that these fell below, rather than far below, the expected standard.

24. Mr Haycroft submitted that your fitness to practise is not currently impaired, whether on public protection or wider public interest grounds. He stated that the clinical failings had occurred during a period when you had moved to a much busier practice where you were under increased time pressures. He submitted that you had reflected upon the difficulties this caused and subsequently made changes to your clinical practice.

25. Mr Haycroft also referred the Committee to the fact that you had made full admissions and that you accept misconduct, which shows insight and cooperation with the regulatory process. He referred to your reflective statement, your apologies and the evidence of the targeted Continuing Professional Development (CPD) activity which you have undertaken. He also referred to your clinical audits and the changes you have introduced to your clinical procedures and record keeping. In addition, he referred the Committee to your voluntary engagement with an experienced dental practice advisor who has acted as your mentor over an extended period. He referred to the mentor's positive assessment of your current clinical standards of practice and the mentor's assessment that there are no public safety concerns.

26. Mr Haycroft also referred to the Committee to the positive testimonials in support of you and to the fact that you are of previous good character with no other fitness to practise history. He referred to the absence of any further concerns since the events referred to in the charges.

27. Mr Haycroft submitted that the risk of repetition is very low and that a finding of current impairment is unnecessary to protect the public or to maintain wider public confidence in the profession. In the alternative, he submitted that nothing higher than a reprimand would be appropriate.

Decision

28. The Committee accepted the advice of the Legal Adviser. The Committee had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026).

Misconduct

29. Misconduct denotes a serious departure from expected professional standards. In

considering whether the facts found proved amount to misconduct, the Committee had particular regard to the following underlying principles from the GDC's *Standards for the Dental Team* (September 2013):

- Standard 2.2.1 – communicating effectively with patients and explaining treatment options;
- Standard 3.1 – obtaining valid consent before treatment;
- Standard 4.1 – maintaining complete, accurate and contemporaneous patient records; and
- Standard 7.1 – providing good-quality care based on current evidence and authoritative guidance.

30. The Committee assessed your failings individually by reference to each charge.

Charges 1(a) and 1(b)

31. Mr Mulcahy's opinion was that your failure to undertake adequate BPEs for Patients 2 and 26 fell far below the expected standard. As to Patient 2, his opinion was that the existing periodontal disease required regular assessment and monitoring. The previous BPE had been taken in January 2017 and the absence of further BPEs meant that there had been no adequate assessment from which the patient's periodontal condition could be reliably recorded and monitored throughout the period referred to in the charge.

32. In relation to Patient 26, Mr Mulcahy's opinion was that the patient was new and that a BPE is a fundamental component of initial periodontal assessment.

33. Dr Kramer agreed that BPEs are an important screening tool. He agreed that they should have been undertaken. However, he distinguished between a failure to undertake a BPE and the complete failure to assess periodontal health. His opinion was that the records of radiographic assessments, clinical observations and the treatment provided show that some assessment of the patients' periodontal conditions would have taken place. He also referred to the absence of evidence of any adverse consequences.

34. Dr Kramer's opinion was therefore that the deficiencies fell below, rather than far below, the expected standard.

35. The Committee preferred the opinion of Mr Mulcahy.

36. In relation to charge 1(a), Patient 2 had an established history of periodontal disease. The Committee accepted Mr Mulcahy's opinion that regular BPE assessments were an important part of monitoring the patient's condition and ensuring that treatment would be effective.

37. Whilst you had identified the patient's periodontal condition and provided treatment, this in itself was not adequate in the Committee's view. The Committee accepted Mr Mulchay's opinion that there remained a need for an adequate, systematic assessment of the patient's periodontal condition. Without undertaking the indicated BPEs no reliable clinical record was made against which any changes in the patient's periodontal condition could be measured and monitored.

38. The Committee considered this to be a significant failing in the care of a patient with established periodontal disease and that your conduct fell far below the standard expected of a reasonably competent general dental practitioner.

39. In relation to charge 1(b), Patient 26 was a new patient to your practice and there was therefore a need for an adequate periodontal assessment to establish and record the patient's presenting periodontal condition and this should have taken the form of a BPE. The patient's age and the available information regarding their periodontal health also increased the importance of undertaking a BPE at the initial appointment.

40. Although radiographs had been taken, these are not a substitute for a BPE, which involves probing pocket depths and recording the findings. Given the fundamental importance of a BPE at an initial examination of an adult patient, the Committee considered your failure to have undertaken a BPE to represent a significant departure from accepted clinical standards and that your conduct therefore fell far below the expected standard.

Charges 2, 3(a), 3(b), 4 and 6

41. The Committee considered each of these charges individually, having regard to the clinical records, the expert reports and the joint expert evidence. Both experts were in agreement that these failings fell far below the standard expected of a reasonably competent general dental practitioner.

42. The Committee accepted that evidence.

Charges 7(a) and 7(b)

43. Both experts agreed that the outcome of the root canal treatment provided to Patient 17 was below the expected standard. A post-operative radiograph showed that the root filling was too short in one root and sealant extruded beyond the apex of the other root. There was some disagreement between the two experts whether this was a tooth with two apices or a convergent apex. Both experts agreed the root filling was not satisfactory. However, the Committee noted that in the clinical records you had described the root filling as being satisfactory. It therefore appears you had not identified the deficiencies in the root filling and in any event had not documented this, neither would you therefore have explained it the patient.

44. Both experts were in agreement that a failed root filling does not in itself necessarily represent a serious clinical failing in the standard of care which had been provided. However, Mr Mulcahy considered that the adequacy of the standard of care must be assessed holistically, including by having regard to whether the deficiency in the root filling had been recognised by you and whether you had documented this in the clinical records and explained it to the patient.

45. Mr Mulcahy's opinion was therefore that the overall standard of care you provided fell far below the expected standard.

46. Whilst Dr Kramer agreed that the clinical outcome of the root filling was imperfect and that the radiographic assessment was inadequate, he considered that the risk of significant harm arising from this was relatively low. He explained that the root

canal treatment was still capable of being clinically successful even with the imperfect root filling and that any subsequent problems could be identified and treated. He therefore considered that the deficiencies in charges 7(a) and 7(b) fell below, but not far below, the expected standard.

47. In relation to charge 7(a), the Committee concluded that the deficiency in the root canal treatment in itself fell below, but not far below, the expected standard. This was consistent with the underlying opinion of both experts.

48. As to charge 7(b), your clinical records described the radiographic findings as showing a "good quality root filling both canals", notwithstanding that the radiograph demonstrated a deficiency in the root filling. In the Committee's judgment, this was a significant failing in the assessment of the treatment outcome. The Committee accepted Mr Mulcahy's evidence that an accurate assessment of the radiograph was necessary not only to assess the clinical outcome of the treatment but also to ensure that the patient could be appropriately informed of the outcome along with any associated risks and the further treatment or monitoring options. By failing adequately to identify and record the deficiency, the patient was not likely to have been provided with the information necessary to make an informed decision about their care.

49. The Committee considered Dr Kramer's evidence that the risk of significant harm might have been relatively low and that further treatment could have been undertaken if subsequent complications arose. In the Committee's view, these factors on which he relied are of secondary significance. They do not adequately address the primary failing to have made the patient aware of the imperfect root filling and the implications this could have for future treatment, Dr Kramer's opinion instead depended upon the possibility of the deficiency being identified at a later stage.

50. Accordingly, the Committee preferred Mr Mulcahy's evidence and concluded that your failure to adequately review the post-operative radiograph fell far below the expected standard.

Charges 8(a), 8(b), 9 and 10

51. The Committee considered each of these charges individually and accepted the agreement between the experts that the deficiencies fell far below the standard expected.

52. Having assessed the seriousness of the individual failings, the Committee concluded that these matters represented clear breaches of the above standards. The Committee concluded that they are serious and that they amount to misconduct.

Impairment

53. The Committee went on to consider whether your fitness to practise is currently impaired by reason of misconduct.

54. It reminded itself that impairment is a current and forward-looking assessment. The Committee considered whether your misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the

wider public interest, which includes the need to uphold and declare appropriate standards of conduct and behaviour.

55. The Committee considered the principles identified in *Cohen v GMC* and the approach to impairment set out in *CHRE v NMC and Grant*.

56. Although there was no evidence before the Committee that the patients concerned had suffered actual harm, the Committee concluded that the clinical deficiencies had the potential to expose them to an unwarranted risk of harm.

57. The Committee therefore considered whether you are liable to put patients at an unwarranted risk of harm again in the future. It was satisfied that the identified deficiencies were purely clinical in nature and therefore capable of being remedied through appropriate training, reflection and changes to your practice.

58. The Committee noted that you had admitted all the charges and accepted that your conduct amounted to misconduct. You also demonstrated a willingness to acknowledge the deficiencies in your practice.

59. The Committee considered your reflective statement to be detailed and comprehensive. It demonstrates that you recognise the nature of your failings and that you have reflected upon their causes. You understand their potential impact upon patients and public confidence in the profession. The Committee also noted your apologies and your self-critical recognition of the need to improve your clinical systems and procedures.

60. It considered your explanation that the deficiencies had occurred following a move from a relatively quiet practice to a much busier working environment. You have recognised the effect of those working arrangements and have taken practical steps to address the underlying difficulties.

61. These steps include undertaking substantial targeted CPD addressing the areas of clinical deficiency; introducing structured clinical templates and improving your record-keeping procedures; and reviewing your approach to treatment planning, radiographic assessments and obtaining of informed consent. You have also undertaken clinical audits and governance reviews to assess and monitor the changes in your practice.

62. In addition, you voluntarily engaged an experienced dental practice adviser as a mentor, who had supported and reviewed your progress over an extended period.

63. The Committee noted the mentor's conclusion that there are no outstanding patient safety concerns and that you are meeting expected clinical standards.

64. The Committee also noted the assessment of Mr Mulcahy, who concluded from your remediation material that you have satisfactorily addressed all the areas of clinical deficiency identified in these proceedings.

65. The Committee also took account of the positive testimonials, which referred to, among other things, your clinical abilities, professionalism and a conscientious approach to patient care.

66. You have no previous fitness to practise history and that there was no evidence before the Committee of subsequent complaints or similar clinical concerns.

67. Having considered the remediation evidence in its entirety, the Committee was satisfied that you demonstrate substantial insight and comprehensive remediation.

68. Accordingly, it concluded that the clinical deficiencies had been adequately remedied and that the risk of repetition is very low.

69. In those circumstances, the Committee determined that a finding of impairment is not necessary for public protection.

70. The Committee considered whether a finding of impairment is nevertheless required to maintain public confidence in the dental profession and to uphold proper professional standards.

71. The Committee considered that the misconduct in this case, although serious, did not fall towards the most serious end of the spectrum of professional wrongdoing. It concerned deficiencies in clinical care rather than deliberate, dishonest or otherwise fundamentally incompatible professional behaviour where a finding of impairment is more likely to be indicated on wider public interest grounds.

72. The Committee also took account of the absence of evidence of actual harm and the passage of time since the events in question. Having regard to all the circumstances, including your insight, reflection and remediation, the Committee determined that public confidence in the profession and the maintenance of proper professional standards would not be undermined by such a finding that your fitness to practise is not currently impaired.

73. Accordingly, the Committee determined that your fitness to practise is not currently impaired by reason of misconduct.

74. That concludes the case.