GENERAL DENTAL COUNCIL

AND

JAMILEH, Yaser

[Registration number: 104915]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council commencing at **10:00 am** on 22 October 2024**.**

The General Dental Council
37 Wimpole Street
London
W1G 8DQ

The heads of charge contained within this sheet are current at the date of publication. They are subject to amendments at any time before or during the hearing. For the final charge, findings of fact and determination against the registrant, please visit the Recent Decisions page at https://www.dentalhearings.org/hearings-and-decisions/decisions after this hearing has finished.

Committee members:	Gill Mullen	Lay	Chair
	Gezala Umar	Dentist	
	Stacey Firby	DCP	
Legal Adviser:	Mark Sullivan		

CHARGE

JAMILEH, Yaser, a dentist, Statutory Exam 2006MDentSci University of Leeds 2002BDS Damascus University 1994 is summoned to appear before the Professional Conduct Committee on 22 October 2024 for an inquiry into the following charge:

The Charge

The hearing will be held to consider the following charge against you:

"That being a registered dentist,

A. You practised as a dentist at the dental practice referred to in Schedule 1[1] below ("the Practice") and treated the patients listed below (and referred to in Schedule 1 below) from August 2016 to January 2021.

Patient 1A

1. You failed to provide an adequate standard of care to Patient 1A, in that:
    a. You did not diagnose and/or treat caries, found at the distal aspect of their LR5, which was evident on a radiograph taken on 12 April 2019;
    b. You did not take a periapical radiograph of their upper right-hand side during an appointment on:
        i. 6 August 2020;
        ii. 14 August 2020;
        iii. 7 September 2020;
    c. You did not discuss the risks associated with crown treatment in advance of placing crowns at Patient 1A's UL5, LL5 and LL7 on 23 November 2020;
    d. You did not provide Patient 1A with the option of having crown treatment on the NHS in advance of placing crowns at their UL5, LL5 and LL7 on 23 November 2020.
2. By reason of your conduct in Charge 1.c. and/or 1.d. you failed to obtain Patient 1A's informed consent for the crown treatment provided on 23 November 2020.
3. Your conduct in Charge 1.d. was:
    a. Lacking in integrity;
    b. Financially motivated;
    c. Dishonest, in that you failed to make Patient 1A aware of a cheaper NHS treatment option that you knew was available to her.

[1] Schedule 1 is a private document that cannot be disclosed.

4. You failed to maintain an adequate standard of record keeping in respect of Patient 1A's appointment on 7 September 2020, in that you inaccurately recorded: *"Diss options, Advantages, Disadvantages and relative prognosis… NHS Private Pt understands"*

5. Your conduct in charge 4. Was:

    a. Misleading;

    b. Lacking in integrity;

    c. Dishonest, in that you knew you had not discussed with Patient 1A the disadvantages of the crowns proposed and/or the fact such crowns could be provided on the NHS.

Patient 1C

6. You failed to provide an adequate standard of care to Patient 1C, in that you did not diagnose and/or treat caries, found at their UL4, which was evident on a radiograph taken on 4 April 2019.

Patient 2A

7. You failed to provide an adequate standard of care to Patient 2A, in that you did not diagnose distal caries found at their UR4, which was evident on a radiograph taken on 17 August 2016.

Patient 2C

8. You failed to provide an adequate standard of care to Patient 2C, in that you did not take a periapical radiograph covering their UR6, in advance of providing root canal treatment on 4 January 2021.

Patient 3A

9. You failed to provide an adequate standard of care to Patient 3A, in that:

    a. You did not provide Patient 3A with any treatment options for their UR4 on 10 August 2017;

    b. You did not tell Patient 3A that their UL6 had an inadequate root filling and/or signs of infection in advance of crowning that tooth on 12 February 2018;

    c. You did not discuss with Patient 3A the risks associated with crowning their UL6 in advance of providing treatment on 12 February 2018;

    d. You did not discuss with Patient 3A, in advance of providing a bridge at their LL5-LL7 on 12 February 2018:

        i. NHS alternatives to the bridge;

        ii. The risks associated with the procedure.

10. By reason of your conduct in Charge 9.a. you failed to obtain Patient 3A's informed consent for not treating their UR4.

11. By reason of your conduct in Charge 9.b. and/or 9.c. you failed to obtain Patient 3A's informed consent for the crown placed at their UL6.

12. By reason of your conduct in Charge 9.d.i. and/or 9.d.ii. you failed to obtain Patient 3A's informed consent for the bridge placed at their LL5-LL7.

13. Your conduct in Charge 9.d.i. was:
    a. Lacking in integrity;
    b. Financially motivated;
    c. Dishonest, in that you failed to provide Patient 3A with a cheaper NHS treatment option that you knew was available to her.

Patient 3B

14. You failed to provide an adequate standard of care to Patient 3B, in that you did not take a periapical radiograph covering their LL6, in advance of providing root canal treatment on 17 November 2020.

Patient 3D

15. You failed to maintain an adequate standard of record keeping in respect of Patient 3D's appointments, in that you did not make any record of their appointment with you, on:
    a. 22 December 2020;
    b. 23 December 2020;
    c. 29 December 2020.

Patient 4C

16. You failed to provide an adequate standard of care to Patient 4C, in that you did not take a periapical radiograph covering their UR4, in advance of providing root canal treatment on 11 January 2021.
17. You failed to maintain an adequate standard of record keeping in respect of Patient 4C's appointment on 2 January 2020, in that you did not record sufficient details of:
    a. Discussing the risks associated with leaving their UR4 and LL6 untreated;
    b. Why Patient 4C did not want to have UR4 and LL6 treated.

Patient 5A

18. You failed to provide an adequate standard of care to Patient 5A, in that you did not remove caries present on the mesial aspect of their UL7, when restoring this tooth on 8 May 2017.
19. You failed to maintain an adequate standard of record keeping in respect of Patient 5A's appointments, in that:
    a. For an appointment on 3 October 2016, you did not record sufficient details of:
        i. Discussing the risks associated with leaving their UR5, UR6, UL6, UL7 and LL5 untreated;
        ii. Why Patient 5A did not want to have UR5, UR6, UL6, UL7 and LL5 treated;
    b. For an appointment on 8 May 2017, you did not record sufficient details of:

a. Discussing the risks associated with leaving their UR5, UR6, UL6 and LL5 untreated;

b. Why Patient 5A agreed to have their UL7 restored but did not want to have UR5, UR6, UL6 and LL5 treated.

Patient 5B

20. You failed to provide an adequate standard of care to Patient 5B, in that you did not take a periapical radiograph covering their UL6, in advance of providing root canal treatment on 5 January 2021.

Patient 5C

21. You failed to provide an adequate standard of care to Patient 5C, in that you did not take a periapical radiograph covering their UL4, in advance of providing root canal treatment on 27 November 2020;

Patient 5D

22. You failed to provide an adequate standard of care to Patient 5D, in that you did not take a periapical radiograph covering their UR7, in advance of providing root canal treatment on 14 December 2020.

Patient 6C

23. You failed to maintain an adequate standard of record keeping in respect of Patient 6C's appointment on 4 March 2020, in that you did not record sufficient details of:

    a. Discussing the risks associated with leaving their UL5 and LL4, LL5, LL6 and LL7 untreated;

    b. Why Patient 6C agreed to have their UR6, LR5 and LR4 restored but did not want to have their UL5 and LL4, LL5, LL6 and LL7 treated.

Patient 6D

24. You failed to maintain an adequate standard of record keeping in respect of Patient 6D's appointment on 31 October 2019, in that you did not record sufficient details of:

    a. Discussing the risks associated with leaving their LR7 and LL5 untreated;

    b. Why Patient 6D agreed to have their LR8, LL7 and LR5 restored but did not want to have their LR7 and LL5 treated.

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