HEARING HEARD IN PUBLIC

SALAMI, Navid

Registration No: 77085

PROFESSIONAL CONDUCT COMMITTEE

OCTOBER 2016 – July 2020*

Most recent outcome: Suspended indefinitely

***See page 24 for the latest determination**

Navid Salami, a dentist, Tandläkare Malmö 1999, was summoned to appear before the Professional Conduct Committee on 17 October 2016 for an inquiry into the following charge:

Charge (as AMENDED on 18, 19 and 20 October 2016)

"That being a Registered Dentist:

1. At all material times you were practising as a dentist at Broadway House Dental Practice, 7a Union Street, Yeovil, Somerset, BA20 1PQ.
2. WITHDRAWN:
    a. WITHDRAWN;
    b. WITHDRAWN;
    c. WITHDRAWN;
    d. WITHDRAWN.
3. On 5 March 2010 you did not provide an adequate standard of care to Patient A in that you:
    a. WITHDRAWN;
    b. failed to identify and/or diagnose the cause of Patient A's infection at LL7 adequately;
    c. WITHDRAWN;
    d. failed to make or failed to advise Patient A to make an appointment for further treatment;
    e. failed to provide adequate and/or definitive treatment of the infection present at LL7.
4. On 16 September 2010 you did not provide an adequate standard of care to Patient A in that you failed to or undertake a full assessment of Patient A's condition including:
    a. a follow up examination of the infection at LL7 recorded on 5 March 2010;
    b. a follow up examination of the abscess and pain in LL and UR recorded on 21 December 2009.

5. On or about 11 November 2010 an inappropriate claim for treatment was submitted in that you: -

   a. claimed for treatment in a higher band than which had been provided;

   b. claimed for treatment that was not completed.

6. WITHDRAWN:

   a. WITHDRAWN;

   b. WITHDRAWN.

7. Between 11 November 2011 and 2 December 2011 you did not provide an adequate standard of care to Patient A in that you provided a crown to UR7 without carrying out an adequate assessment of the tooth including not carrying out any vitality testing.

8. On 6 September 2012 you did not provide an adequate standard of care to Patient A in that you failed to undertake:

   a. WITHDRAWN;

   b. a follow up on the infection at LL7 diagnosed on 5 March 2010;

   c. a scale and polish where the BPE scores indicated that sub-gingival scale was present.

9. On 3 January 2013 you did not provide an adequate standard of care to Patient A when he presented with a complaint of a foul taste and smell in that you:

   a. failed to investigate the source of the foul taste and smell; and

   b. failed to provide appropriate treatment accordingly.

10. On 30 April 2013 you did not provide an adequate standard of care to Patient A in that you:

    a. failed to carry out a full assessment of Patient A's complaint;

    b. failed to identify and/or diagnose and/or treat an oro-antral fistula.

11. You failed to take any or any adequate radiographs as clinically indicated on:

    a. 14 January 2010;

    b. 5 March 2010;

    c. 16 September 2010;

    d. 11 November 2011;

    e. 6 September 2012;

    f. 3 January 2013;

    g. WITHDRAWN.

12. You did not maintain an adequate standard of record keeping in respect of Patient A's appointments including:

    a. On 14 January 2010:

       i. you failed to record an extra oral examination;

ii. you failed to record an examination of the soft tissue(s);

iii. you failed to record an examination of the periodontal condition;

iv. you failed to record a further assessment of the infection previously recorded on 21 December 2009.

b. WITHDRAWN:

i. WITHDRAWN;

ii. WITHDRAWN.

c. On 16 September 2010:

i. WITHDRAWN;

ii. you failed to record a follow up examination of the infection at LL7 recorded on 5 March 2010;

iii. you failed to record a follow up examination of the abscess and pain in LL and UR recorded on 21 December 2009.

13. Your conduct at paragraph 5 above was:

a. Misleading; and/or

b. Dishonest.

And that by reason of the facts alleged above your fitness to practise as a dentist is impaired by reason of your misconduct."

On 21 October 2016, the Chairman made the following statement regarding the finding of facts:

"Mr Salami,

The matters in this case relate to your treatment of one patient, Patient A, whilst you were practising as a dentist at Broadway House Dental Practice in Yeovil, Somerset ('the Practice').

It is alleged by the General Dental Council (GDC) that at a number of your appointments with Patient A, you did not provide him with an adequate standard of care. It is further alleged that you did not maintain an adequate standard of record keeping in respect of Patient A's appointments. There are also allegations of misleading and dishonest conduct on your part, in respect of an NHS claim for treatment.

Preliminary amendments to the charge

At the outset of the hearing, Ms Hewitt, Counsel on behalf of the GDC, made an application to amend the charge against you, under Rule 18 of the GDC (Fitness to Practise) Rules 2006. Ms Hewitt proposed amending head of charge 3b by replacing the word *'pain'* with the word *'infection'* and by deleting the words *'and/or at all'*, which were at the end of that head of charge. In relation to head of charge 8c, Ms Hewitt proposed the deletion of the words *'of LL7'*, which were after the words *'scale and polish'*. In addition, Ms Hewitt told the Committee that the GDC wished to withdraw the following heads of charge: 3c, 6a, 8a, 11g, 12b in its entirety and 12c(i).

Having received advice from the Legal Adviser, the Committee acceded to Ms Hewitt's application. In doing so, it took into account that Mr Hurst, on your behalf, raised no objection. The Committee was satisfied that the proposed amendments could be made without causing any injustice and the charge was amended accordingly.

Admissions

Mr Hurst, Counsel on your behalf, informed the Committee that you admitted the following heads of the amended charge: 1, 3b, 4a, 4b, 5a, 5b, 8b, the remainder of 11 in its entirety and 12a in its entirety.

The Committee noted Mr Hurst's explanation regarding your admission of heads of charge 5a and 5b, which relate to the submission of an inappropriate NHS claim for treatment. Mr Hurst told the Committee that, whilst you accepted that the claim was inappropriate, you maintained that you were not culpable in a manner that was misleading or dishonest.

Factual evidence

The Committee received documentary evidence, which included copies of the clinical records for Patient A at the Practice, as well copies of your NHS claims data for the patient. The Committee was also provided with the clinical records of Mr M H, the dentist who subsequently treated Patient A. Mr M H's witness statement, dated 7 February 2016, was accepted by the Committee as unchallenged evidence. Further, the Committee received the witness statement of Patient A, dated 22 May 2016 and your witness statement, dated 10 October 2016.

The Committee heard oral evidence from Patient A and from you. Patient A told the Committee that he had very little recollection of any of his appointments with you, particularly those before April 2013. Similarly, the Committee found that you only remembered certain isolated aspects of your treatment of Patient A. You did say, however, that seeing Patient A again, during this hearing, refreshed your memory of some of the events under consideration.

Notwithstanding this, the Committee considered that the most reliable evidence in relation to Patient A's appointments with you, was the detail contained in your clinical records. Whilst the Committee took into account your own admission that these records are poor, it found them of some assistance. It also took into account that there had been no suggestion that your clinical records were not accurate. Further, the Committee noted that the quality of your record keeping did improve over the period of time in question.

The Committee also took into account your evidence that Patient A did not routinely attend your practice. It noted that your testimony is corroborated by the list of appointments provided, which suggests that the majority of Patient A's attendances with you were emergency appointments.

Expert evidence

The Committee received a report, dated 2 February 2016 prepared by Mr Anthony Lynn, the expert witness called by the GDC. It also received a report dated 21 September 2016 prepared by Dr Sharon Caro, the expert witness called on your behalf. The Committee was further provided with a 'Joint Statement of Opinion of the Expert Witnesses', dated 17 October 2016. It also heard oral evidence from both experts. The Committee found the evidence of both experts of assistance in reaching its findings.

Further amendments to the charge

During the course of the hearing and following advice from the Legal Adviser on Rule 18, the Committee acceded to further unopposed applications to amend the charge, made by Ms Hewitt on behalf of the GDC. These were as follows:

At the end of the GDC's case, in light of the oral evidence given by Mr Lynn, head of charge 2, in its entirety, was withdrawn, as were heads of charge 3a and 6b.

Further, at the conclusion of all the evidence, the stem of head of charge 5 was amended to reads as follows:

"On or about 11 November 2010 an inappropriate claim for treatment was submitted in that you: -"

The Committee was satisfied that this amendment accurately reflected the evidence it had seen and heard in respect of the claim for treatment. It was accepted by both parties that the documentary evidence showed that '*11 November 2010'* was the material date, as opposed to '*16 September 2010'*, which was the original date in this head of charge. Further, it was your evidence that it was the Practice Manager who submitted the claim for treatment, without your knowledge, although you accepted responsibility as the named dental performer. You confirmed that it was on this basis that you had admitted heads of charge 5a and 5b.

The Committee's findings of fact

The Committee considered all of the evidence presented to it. It took account of the submissions made by Ms Hewitt on behalf of the GDC and those made by Mr Hurst on your behalf. The Committee accepted the advice of the Legal Adviser. It considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities.

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

1.	*At all material times you were practising as a dentist at Broadway House Dental Practice, 7a Union Street, Yeovil, Somerset, BA20 1PQ.* **Admitted and proved.**
2.	*WITHDRAWN.*
2. a)	*WITHDRAWN.*
2. b)	*WITHDRAWN.*
2. c)	*WITHDRAWN;*
2. d)	*WITHDRAWN.*
3.	*On 5 March 2010 you did not provide an adequate standard of care to Patient A in that you:*
3. a)	*WITHDRAWN;*
3. b)	*failed to identify and/or diagnose the cause of Patient A's infection at LL7 adequately;*

	Admitted and proved (as amended).
3. c)	*WITHDRAWN.*
3. d)	*failed to make or failed to advise Patient A to make an appointment for further treatment;* **Not proved.** The Committee was not satisfied that the GDC had discharged its burden of proof in relation to this head of charge. The Committee received no evidence to suggest that you had failed to advise Patient A to return for further treatment. Patient A was clear in his evidence that he could not remember any detail at all about the appointment on 5 March 2010. The only evidence regarding this appointment is contained in your clinical records, where it is noted in relation to the patient's LL7 "*if more c/o xla"*. You stated in evidence that this meant *'if more complaints; extraction'*. The Committee inferred from this note that there was some discussion between you and Patient A about what would happen next in respect of the LL7, which would have necessitated a further appointment. In considering whether you should have in fact made an appointment for Patient A for further treatment, the Committee preferred the evidence of Dr Caro. She told the Committee that, generally, the booking of appointments is "patient-led" and that it would not have been for you to make a further appointment for Patient A in the circumstances.
3. e)	*failed to provide adequate and/or definitive treatment of the infection present at LL7.* **Proved.** You have admitted, and the Committee has found proved that you failed to identify and/or diagnose the cause of the infection present at Patient A's LL7. In the Committee's view, in the absence of any diagnosis, it follows logically that you could not have provided adequate or definitive treatment in the circumstances. In reaching its conclusion, the Committee took into account the agreed opinion of both expert witnesses that your prescription of antibiotics could only be considered an adjunct to treatment and not treatment for the cause of the infection. Both expert witnesses agreed that the provision of antibiotics would "damp down" the infection, but would not necessarily address the underlying cause.
4.	*On 16 September 2010 you did not provide an adequate standard of care to Patient A in that you failed to [or] undertake a full assessment of Patient A's condition including:*
4. a)	*a follow up examination of the infection at LL7 recorded on 5 March 2010;* **Admitted and proved.**
4. b)	*a follow up examination of the abscess and pain in LL and UR recorded on 21 December 2009.* **Admitted and proved.**

5.	*On or about 11 November 2010 an inappropriate claim for treatment was submitted in that you: -*
5. a)	*claimed for treatment in a higher band than which had been provided;* **Admitted, but not proved (as amended).**
5. b)	*claimed for treatment that was not completed.* **Admitted, but not proved (as amended).** The Committee considered heads of charge 5a and 5b separately, but reached the same conclusions in respect of both allegations. The Committee took account of the fact that you had admitted both these heads of charge. However, it determined that it should consider the evidence that supported them. It first had regard to the FP17 claims data for Patient A for this course of treatment. It noted that the date of acceptance was recorded as the 16 September 2016 and the date of completion or last visit was recorded as 11 November 2010. It also noted that the date recorded as the "receipt at DSD" was also 11 November 2010. The charge band was recorded as 'Band 3' and the Units of Dental Activity was recorded as '12'. However, the Committee also had regard to the entry "incomplete treatment charge band" and under this, the entry "1". The Committee considered all the other FP17 claim forms exhibited in the evidence and noted that as they all dealt with claims for completed treatment, the original charge band remained the same and the entry "incomplete treatment charge band" did not appear. The Committee determined that it had to consider whether it could draw an inference from the presence of the entry "incomplete treatment charge band" and the figure "1" below it, that this was the band under which the claim for this incomplete treatment was, in fact, made. The Committee considered the evidence of Mr Lynn and Dr Caro on this point. It noted that Mr Lynn made reference to "incomplete treatment charge band 1", but made no further comment about it. The Committee noted that Dr Caro made no reference to it. The Committee noted your admissions, however, it also had regard to your present circumstances and to the potential difficulties that you have encountered in preparing and presenting your case. It concluded that it could not be satisfied on the evidence before it, that the incomplete treatment claim presented on 11 November 2010 was inappropriate because it could not rule out the possibility that the claim was in fact made under Band 1, not under Band 3. For this reason, despite your admissions, the Committee was not satisfied on the evidence and found these heads of charge not proved.
6.	*WITHDRAWN.*
6. a)	*WITHDRAWN.*
6. b)	*WITHDRAWN.*

7.	*Between 11 November 2011 and 2 December 2011 you did not provide an adequate standard of care to Patient A in that you provided a crown to UR7 without carrying out an adequate assessment of the tooth including not carrying out any vitality testing.* **Proved.** The Committee heard detailed evidence on the issue of vitality testing from both experts and from you. You told the Committee that you had undertaken vitality testing on Patient A's UR7 using cold air. You stated that the tooth had been sensitive. The Committee noted, however, that this head of charge relates to the carrying out of an adequate assessment of the UR7, which includes, but is not limited to, vitality testing. The Committee had regard to the evidence of Mr Lynn, who stated that an adequate assessment of the tooth should have also included: removal of the filling, excavation of any caries and an examination of possible exposure of the pulp. The Committee noted Dr Caro's evidence that she would not necessarily expect vitality testing with cold air to be recorded in the clinical records, if there were no concerns about the tooth's vitality. However, the Committee had regard to the fact that there is no evidence in your clinical records to suggest that you carried out any of the other actions referred to by Mr Lynn, prior to preparing the tooth for a crown. The Committee noted that this was despite the obvious improvement in record keeping around the period in question. In the circumstances, it could see no reason why you would not have recorded undertaking a fuller assessment of the UR7, had you done so. The Committee did not consider vitality testing alone to be sufficient and was therefore satisfied on the balance of probabilities that you did not carry out an adequate assessment.
8.	*On 6 September 2012 you did not provide an adequate standard of care to Patient A in that you failed to undertake:*
8. a)	*WITHDRAWN.*
8. b)	*a follow up on the infection at LL7 diagnosed on 5 March 2010;* **Admitted and proved.**
8. c)	*a scale and polish where the BPE scores indicated that sub-gingival scale was present.* **Not proved (as amended).** The Committee took into account your clinical records and the clinical records for Patient A's subsequent treating dentist, Mr M H. It noted that as of 6 September 2012, Patient A's BPE scores were all 2s. However, at the time of the patient's visit with Mr M H on 24 May 2013 there had been a change in the patient's BPE scores; from 2 to 1 in the upper arch. The Committee noted the evidence of both expert witnesses regarding the variability in practitioners' recording of BPE scores, however, it preferred the evidence of Dr Caro in this regard. She explained that the difference between a score of 1 and 2 relates to the presence of calculus or any other material on the teeth, as opposed to the variations between the scores of 3

	and 4, which relate to the measurement of pocket depths. Dr Caro stated that for a score to change from 2 to 1, as it did in Patient A's upper arch**,** something had to have been removed from those teeth. Taking this evidence into account, the Committee could not be satisfied that you had not undertaken some form of scale and polish for Patient A.
9.	*On 3 January 2013 you did not provide an adequate standard of care to Patient A when he presented with a complaint of a foul taste and smell in that you:*
9. a)	*failed to investigate the source of the foul taste and smell;* **Not proved.**
9. b)	*failed to provide appropriate treatment accordingly.* **Not proved.** The Committee considered heads of charge 9a and 9b separately, but reached the same conclusions in respect of both allegations. In making its decisions, the Committee first considered whether on the date in question, Patient A had in fact presented to you with a complaint of a foul taste and smell. It had regard to Patient A's oral evidence on this matter. He told the Committee that he had suffered from these symptoms for a long time and that the problem *"came and went"*. The Committee noted that Patient A could not actually recall when he raised the problem with you and it was not confident in the reliability of his testimony that he specifically did so on 3 January 2013. The Committee considered your clinical records and noted that in an entry for 6 September 2012, you did make reference to the patient complaining of a bad taste and you gave advice regarding food impaction. There is no mention of the patient reporting a foul taste or smell in your clinical records for 3 January 2013, which in the Committee's view contain more comprehensive notes, and which include the entry *"c/o nil"*. It was satisfied that had the patient complained of these problems you would have made a record. Further, the Committee had regard to the appointments log, which appeared to indicate that this was a planned appointment with Patient A, rather than an emergency. Taking all of this evidence into account, the Committee was not persuaded that Patient A did present with the problems as alleged. It therefore concluded that you could not have failed to investigate or treat appropriately something which had not be brought to your attention.
10.	*On 30 April 2013 you did not provide an adequate standard of care to Patient A in that you:*
10. a)	*failed to carry out a full assessment of Patient A's complaint* **Not proved.**
10. b)	*failed to identify and/or diagnose and/or treat an oro-antral fistula.* **Not proved.**

	The Committee considered heads of charge 10a and 10b separately, but reached the same conclusions in respect of both allegations. In making its decisions, the Committee first considered whether on the date in question, Patient A had informed you that he had experienced problems with movement of air and an inability to create suction in his mouth. The Committee took this approach bearing in mind that both Dr Caro and Mr Lynn stated that they would not be critical of your alternative diagnosis of a dry socket, if Patient A had not reported any symptoms indicating an oro-antral fistula. The Committee considered Patient A's oral evidence on this issue, which appeared to it to be unclear. It noted that Patient A initially said that the movement of air had ceased before he returned to see you at the next appointment and as he had stopped worrying about it, he could not recall whether he then mentioned it to you on 30 April 2013. Then when questioned further, he became uncertain as to whether he did or did not mention the matter to you on that date. The Committee also had regard to the witness statement of Mr M H, Patient A's subsequent treating dentist. It noted that Patient A's primary complaints to Mr M H at their first appointment on 7 May 2013 appeared to be pain and a bad taste at the extraction site of the UR7. Whilst it is said that Patient A reported his problem with maintaining suction, the Committee noted that this was only after Mr M H reported to him the findings of the radiographic examination. On the basis of all of the evidence, the Committee could not be satisfied that Patient A was forthcoming with you on 30 April 2013 with signs or symptoms indicating an oro-antral communication. You could therefore not have failed fully assess a complaint that the patient did not make. Further, taking into account the experts' evidence on this particular matter, the Committee decided that your alternative diagnosis and treatment for dry socket was not inappropriate in the circumstances.
11.	*You failed to take any or any adequate radiographs as clinically indicated on:*
11. a)	*14 January 2010;* **Admitted and proved.**
11. b)	*5 March 2010;* **Admitted and proved.**
11. c)	*16 September 2010;* **Admitted and proved.**
11. d)	*11 November 2011;* **Admitted and proved.**
11. e)	*6 September 2012;*

	Admitted and proved.
11. f)	*3 January 2013;* **Admitted and proved.**
11. g)	*WITHDRAWN.*
12.	*You did not maintain an adequate standard of record keeping in respect of Patient A's appointments including:*
12.a)	*On 14 January 2010:*
12. a) i)	*you failed to record an extra oral examination;* **Admitted and proved**.
12. a) ii)	*you failed to record an examination of the soft tissue(s);* **Admitted and proved.**
12. a) iii)	*you failed to record an examination of the periodontal condition;* **Admitted and proved.**
12. a) iv)	*you failed to record a further assessment of the infection previously recorded on 21 December 2009.* **Admitted and proved.**
12. b) i)	*WITHDRAWN.*
12. b) ii)	*WITHDRAWN.*
12. c) i)	*WITHDRAWN.*
12. c) ii)	*you failed to record a follow up examination of the infection at LL7 recorded on 5 March 2010;* **Proved.**
12. c) iii)	*you failed to record a follow up examination of the abscess and pain in LL and UR recorded on 21 December 2009.* **Proved.** The Committee considered heads of charge 12c(ii) and 12c(iii) separately, but reached the same conclusions in respect of both allegations. The Committee accepted the opinion of Mr Lynn that, given Patient A's dental history, you should have made a record of any follow-up examinations, even if this meant confirming that the positions remained unchanged. There is nothing in the clinical records to suggest that you made any such notes.
13.	*Your conduct at paragraph 5 above was:*
13. a)	*Misleading; and/or*
13. b)	*Dishonest.* Head of charge 13 falls away, in its entirety, in light of the Committee's

	findings at head of charge 5 above.

We move to Stage Two."

On 21 October 2016, the hearing adjourned. It resumed on 5 January 2017.

On 6 January 2017, the Chairman announced the determination as follows:

"Mr Salami,

The Committee's tasks at this stage of the hearing have been to consider whether the facts found proved amount to misconduct and if so, whether your fitness to practise is currently impaired by reason of that misconduct. The Committee took into account that if it found current impairment, it must then decide what sanction, if any, to impose on your registration.

The Committee took into account all of the evidence presented to it, at both the fact-finding stage and this stage. This included a copy of your Remediation Bundle comprising your Personal Development Plan (PDP), evidence of your Continuing Professional Development (CPD) and your written reflections.

The Committee also took into account the submissions made by Ms Hewitt on behalf of the General Dental Council (GDC) and those made by Mr Hurst on your behalf. It accepted the advice of the Legal Adviser.

Facts found proved

The facts in this case concern your treatment of one patient, Patient A, whilst you were practising as a dentist at Broadway House Dental Practice in Yeovil, Somerset ('the Practice'). There were a number of failings in your care of Patient A, many of which you admitted at the outset of this hearing.

It was found that you did not provide an adequate standard of care to Patient A on a number of occasions. On 5 March 2010 you failed to identify and/or diagnose the cause of the patient's infection at LL7 adequately and, consequently, you failed to provide adequate and/or definitive treatment of the infection.

On 16 September 2010 you failed to undertake a full assessment of Patient A's condition including a follow up examination of the infection at LL7 recorded on 5 March 2010, and a follow up examination of the abscess and pain in the Lower Left and Upper Right areas of the mouth, as recorded on 21 December 2009.

Between 11 November 2011 and 2 December 2011 you provided a crown to UR7 without carrying out an adequate assessment of the tooth including not carrying out any vitality testing.

On 6 September 2012 you failed again to undertake a follow up of the infection at LL7 diagnosed on 5 March 2010.

It was further found that on six occasions between 14 January 2010 and 3 January 2013, you failed to take any or any adequate radiographs in respect of Patient A, as clinically indicated. There were also failings in your record keeping for this patient on 14 January 2010 and 16 September 2010.

Misconduct

The Committee considered whether the facts found proved amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the standards expected of a registered dental professional. It had regard to the GDC's publication *'Standards for Dental Professionals (May 2005)'*, which contains the applicable standards at the time of the events in this case. In particular, the Committee noted the following paragraphs:

1 Put patients' interests first and act to protect them.

1.4 Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.

5.3 Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

The Committee took into account that its findings of fact relate to your treatment of one patient. However, it noted that your failings in respect of this single patient persisted over a number of years and covered a range of clinical areas. The Committee considered that, during the course of Patient A's attendance at the Practice, you failed to reflect upon and take appropriate action in relation to his dental health. It found that there was a clear lack of coherent planning on your part in respect of Patient A's treatment, which was evident in your failings in assessment and follow-up examinations.

There were also repeated failings in your radiographic practice and in relation to your record keeping. The Committee agreed that there was some improvement in your clinical note taking over the period in question. However, the Committee regarded your record keeping at the material time to be of a poor standard.

Overall, the Committee considered that your treatment of Patient A lacked many of the features that would normally be expected in patient care and good case management. It was therefore satisfied that misconduct is made out on the facts of this case.

Impairment

The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. In reaching its decision, the Committee exercised its independent judgement. It had regard to the over-arching objective of the GDC, which involves: the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

The Committee also took into account your fitness to practise history, as outlined by Ms Hewitt. It heard that in August 2010 you received a published written warning in relation to allegations involving a single patient. The allegations in question concerned issues of record keeping, dealing with the patient's complaints and the provision of an inadequate standard of clinical care. In September 2014, you received a further warning, which was unpublished. That warning also concerned a single patient and related to issues arising out of the standard of care you were said to have provided to that patient.

The Committee noted that the warnings were both before, and contemporaneous with, the matters involving Patient A. They also raised similar concerns regarding your record keeping and the standard of care you provided to patients. Notwithstanding this background, which

may suggest that Patient A's case was not an isolated incident, the Committee was satisfied that the misconduct it has found is capable of being remedied. It considered that your failings in the aspects of dentistry highlighted in this present case could be properly addressed by further learning and training.

In considering whether your identified failings had in fact been remedied, the Committee had regard to your Remediation Bundle. Whilst the Committee noted that your PDP broadly covered the areas of deficiency in your clinical practice, it considered there to be little evidence of how you have actually used your PDP to address the fundamental issues arising in this case. The Committee found that the majority of your CPD certificates dated back to 2013 and much of this CPD did not appear to have gone beyond the usual core requirements for all dentists. The Committee took into account that you are currently studying a course in Endodontics at the Shiraz University of Medical Sciences in Iran, where you presently reside. The Committee accepts that this course may touch on some of the pertinent areas in this case, but it does not address them directly or completely.

The Committee acknowledged that, given your current circumstances, you may have faced some difficulties in accessing a full range of relevant CPD material. However, this Committee's primary concern is to safeguard the public and the fact remains that the evidence of your remediation to date is somewhat limited in scope and substance.

Furthermore, given the range of your failings in Patient A's case and your fitness to practise history involving similar matters, the Committee considered that it would be difficult for you to fully address your clinical shortcomings by way of theoretical learning alone. In the circumstances, the Committee would have expected to receive evidence of how you have embedded your learning, albeit limited, into your clinical practice. Unfortunately, due to your present circumstances you have not had the opportunity to put what you may have learned into practice and consequently, the Committee has not received any evidence of how you have incorporated your learning into your practice. Therefore, it has been unable to assess adequately the current standard of your clinical practice.

The Committee was satisfied from the evidence, including your reflective writing, that you have some insight into the mistakes you made in Patient A's case. It also took into account the admissions you made at the outset. However, in its view, the Remediation Bundle you have provided demonstrates that the process of your remediation is still in its very early stages. In the absence of sufficient remediation, including verifiable evidence of how your clinical practice has improved in the highlighted areas of concern, the Committee could not be satisfied that you would not repeat your misconduct. It therefore concluded that there is an outstanding risk to the safety of patients and that a finding of impairment is necessary in the circumstances.

The Committee also considered the wider public interest. It accepted that your failings in clinical care alone were not so grave as to warrant action being taken in the wider public interest. However, in the light of your fitness to practise history, your limited remediation and the level of your insight, the Committee decided that public confidence in the dental profession would be undermined if a finding of impairment were not made in the circumstances of this case.

The Committee has determined that your fitness to practise is currently impaired.

Sanction

The Committee considered what sanction, if any, to impose on your registration. It noted that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest.

In reaching its decision, the Committee took into account the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2016)*'. It considered the range of sanctions available to it, starting with the least serious. The Committee applied the principle of proportionality, balancing the public interest with your own interests.

Given your insufficient remediation and its concerns about patient safety and the wider public interest, the Committee decided that it would be wholly inappropriate to conclude this case without taking any action in respect of your registration.

The Committee also concluded that the issue of a reprimand would be inadequate. It considered that the sanction of a reprimand would not afford the necessary public protection. Nor would it uphold public confidence, given the range of your clinical failings, which you have yet to fully address.

The Committee next considered whether to impose conditions on your registration. It took into account that your clinical failings are capable of being remedied, that you have begun the remedial process and that you have demonstrated some insight. In the circumstances, the Committee concluded that it could formulate a set of workable and measurable conditions to address its outstanding concerns. It was satisfied that a period of conditional registration is an appropriate and proportionate response to the matters in this case. It was also satisfied that conditional registration would serve to protect members of the public adequately and would uphold the wider public interest.

The Committee considered that a higher sanction would be disproportionate, in view of the fact that you have embarked on a process of remediation and you have engaged fully with the GDC's regulatory process.

In all the circumstances, the Committee has determined to impose conditions on your registration for a period of 18 months. In deciding on this period, the Committee took into account your particular circumstances in that you are currently resident in Iran. It considered an 18-month timeframe would afford you adequate time to address all of the concerns that have been raised in this case, should you have the opportunity to return to the UK and find employment.

The following conditions are set out as they will appear against your name in the Dentists Register:

1. He must inform the GDC within seven days of his return to the UK. The following conditions can only be fulfilled in the UK and the monitoring of his compliance of these conditions will start from the date of his return.

2. He must work with a Postgraduate Dental Dean/Director (or their nominated deputy), to formulate a Personal Development Plan, specifically designed to address the deficiencies in the following areas of his practice:

    a. Assessment and diagnosis;
    b. Justification, reporting and appropriate use of radiographs;

c. Management of infection;
d. Record keeping/clinical notes.

3. He must forward a copy of his Personal Development Plan to the GDC within two months of the date on which he obtains employment in the UK.

4. He must meet with the Postgraduate Dental Dean/Director (or their nominated deputy), on a regular basis to discuss his progress towards achieving the aims set out in his Personal Development Plan. The frequency of these meetings is to be set by the Postgraduate Dental Dean/Director (or their nominated deputy).

5. He must allow the GDC to exchange information about the standard of his professional performance and his progress towards achieving the aims set out in his Personal Development Plan with the Postgraduate Dental Dean/Director (or their nominated deputy), and any other person involved in his retraining and supervision.

6. At any time he is employed, or providing dental services, which require him to be registered with the GDC; he must place himself and remain under the supervision of a workplace supervisor nominated by himself and agreed by the GDC.

7. He must allow his workplace supervisor to provide reports to the GDC at intervals of not less than three months and the GDC will make these reports available to the Postgraduate Dental Dean/Director (or their nominated deputy) referred to in these conditions.

8. He must keep his professional commitments under review and limit his dental practice in accordance with his workplace supervisor's advice.

9. a. He must carry out audits in the following areas of his practice:

i. Assessment and diagnosis;
ii. Justification, reporting and appropriate use of radiographs;
iii. Prescribing;
iv. Record keeping/clinical notes.

b. He must provide copies of these audits to the GDC on a three-monthly basis.

10. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services (and the Commissioning Body on whose Performers List he is included or Local Health Board, if in Wales Scotland or Northern Ireland).

11. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and any Postgraduate Dental Dean/Director (or their nominated deputy) or workplace supervisor referred to in these conditions.

12. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.

13. He must inform the GDC if he applies for dental employment outside the UK.

14. He must inform within one week the following parties that his registration is subject to the conditions listed at 1 to 13 above:

- Any organisation or person employing or contracting with him to undertake dental work;
- Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application);
- Any prospective employer (at the time of application);
- The Commissioning Body on whose Dental Performers List he is included or seeking inclusion, or Local Health Board, if in Wales, Scotland or Northern Ireland (at the time of application).

15. He must permit the GDC to disclose the above conditions 1 to 14, to any person requesting information about his registration status.

A Committee will review your case at a resumed hearing to be held shortly before the end of the period of conditional registration. That Committee will consider what further action, if any, to take in relation to your registration. You will be informed of the date and time of that resumed hearing, with which you will be expected to engage.

Unless you exercise your right of appeal, your registration will become subject to the aforementioned conditions, 28 days from the date when notice is deemed to have been served upon you.

The Committee now invites submissions from Ms Hewitt and then from Mr Hurst, as to whether the conditions should be imposed on your registration immediately, pending its substantive determination coming into effect."

"Mr Salami,

In deciding whether to impose an immediate order of conditions on your registration, the Committee took into account the submissions of both Ms Hewitt and Mr Hurst that such an order is not necessary in the particular circumstances of this case. The Committee accepted the advice of the Legal Adviser.

The Committee has determined that it is necessary for the protection of the public to impose an immediate order of conditions on your registration. The Committee has found that you are yet to remedy the deficiencies in your clinical practice and it has imposed a substantive order of conditional registration to safeguard the public. Whilst the Committee took into account your present circumstances, given the potential for risk to patients, it considered that it would be inconsistent not to impose an immediate order to ensure the public's protection in the intervening appeal period.

The effect of the foregoing determination and this order is that your registration is subject to the conditions immediately to cover the appeal period. If you do not appeal, the substantive

direction for conditions will take effect 28 days from the date when notice is deemed to have been served upon you and will continue for a period of 18 months.

Should you exercise your right of appeal, this immediate order for conditions will remain in place until the resolution of any appeal.

The interim order currently on your registration is hereby revoked.

That concludes this hearing."

At a review hearing on 24 July 2018 the Chairman announced the determination as follows:

"Service and Proceeding in absence

This is the resumed Professional Conduct Committee (PCC) hearing of Mr Salami's case. Mr Salami is neither present nor represented today. Ms Headley appears on behalf of the General Dental Council (GDC). In the absence of Mr Salami, the Committee first considered whether the Notification of Hearing had been served on him at his registered address in accordance with Rules 28 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules).

The Committee has received a copy of the Notification of Hearing dated 22 June 2018 which was sent to Mr Salami's registered address by special delivery. The Royal Mail track and trace receipt confirms that the item was delivered to that address on 23 June 2018 and was signed for in the name of 'Salami'. The Committee is satisfied that this letter sets out the information required in accordance with Rule 28 and that it was sent to Mr Salami's registered address more than 28 days in advance of today's hearing. The Committee has also seen copies of emails dated 22 June 2018 from the GDC to Mr Salami and to RadcliffesLeBrasseur Solicitors (his last known legal representative), attaching a copy of the Notification of Hearing. The Committee, having heard the submissions made by Ms Headley and accepted the Legal Adviser's advice, is satisfied that the GDC has complied with Rules 28 and 65 and that proper service of the Notification of Hearing has been effective.

The Committee went on to consider whether to proceed in the absence of Mr Salami, in accordance with Rule 54. It has considered the submission made by Ms Headley, on behalf of the General Dental Council, (GDC), that it would be appropriate and fair to proceed with today's hearing in the absence of Mr Salami. She referred to the letter dated 6 July 2018 from RadcliffesLeBrasseur Solicitors which states that Dental Protection had now withdrawn its instructions, given the lack of contact from Mr Salami. The letter states that Mr Salami was known to be under house arrest in Iran. It further advises that they have received no contact from Mr Salami since 23 July 2017, despite repeated attempts to contact him by email. Ms Headley informed the Committee that save for Mr Salami's registered address, the GDC has no other address for Mr Salami. She reminded the Committee that it is in the public interest to review the order before its expiry on 9 August 2018, in accordance with the GDC's statutory provisions, and that a failure to do so would mean that the Committee would lose jurisdiction of the order.

The Committee has accepted the advice of the Legal Adviser. It has borne in mind the email dated 23 July 2017 from Mr Salami in which he advises that he has no fixed address and that he remains under house arrest and is not allowed to leave the country. He also advises the GDC that he has no intention of returning to the UK and requests that the GDC ceases

to contact him. The letter dated 6 July 2018 from RadcliffesLeBrasseur Solicitors effectively confirms Mr Salami's position that he is under house arrest and also advises that he is no longer legally represented. The Committee has concluded that due to Mr Salami's particular circumstances, there is nothing before it today to suggest that he might attend the hearing on a future occasion, were it minded to adjourn. Further, he is no longer legally represented at these proceedings. In addition, the Committee considers that there is a clear public interest in proceeding with the hearing today given that the current order is due to expire in August 2018. Accordingly, the Committee has decided to proceed with today's review hearing in the absence of Mr Salami.

Background

This resumed hearing of Mr Salami's case has been convened pursuant to Section 27C of the Dentists Act 1984 (as amended). His case was considered by the PCC at a hearing that took place between October 2016 and January 2017. Mr Salami attended the hearing and was legally represented. The facts in the case concerned Mr Salami's treatment of one patient, Patient A, whilst he was practising as a dentist at a dental practice in Somerset ('the Practice'). There were a number of failings in Mr Salami's care of Patient A, many of which he admitted at the outset of this hearing.

The PCC found that on 5 March 2010 Mr Salami failed to identify and/or diagnose the cause of Patient A's infection at LL7 adequately and, consequently, he failed to provide adequate and/or definitive treatment of the infection.

On 16 September 2010 Mr Salami failed to undertake a full assessment of Patient A's condition including a follow up examination of the infection at LL7 recorded on 5 March 2010, and a follow up examination of the abscess and pain in the Lower Left and Upper Right areas of the mouth, as recorded on 21 December 2009. Between 11 November 2011 and 2 December 2011 Mr Salami provided a crown to UR7 without carrying out an adequate assessment of the tooth including not carrying out any vitality testing.

On 6 September 2012 Mr Salami failed again to undertake a follow up of the infection at LL7 diagnosed on 5 March 2010.

The PCC further found that on six occasions between 14 January 2010 and 3 January 2013, Mr Salami failed to take any or any adequate radiographs in respect of Patient A, as clinically indicated. There were also failings in his record keeping for this patient on 14 January 2010 and 16 September 2010.

The PCC determined that the facts found proved amounted to misconduct. It considered that the evidence of Mr Salami's remediation to date was "somewhat limited in scope and substance." It noted that due to Mr Salami's present circumstances, he may not have had the opportunity to put into place what he had learnt. In the absence of sufficient remediation, the Committee concluded that there was a risk to the safety of patients. It determined that Mr Salami's fitness to practise was impaired by reason of his misconduct.

The PCC concluded that conditions could be formulated to protect the public and address the discrete areas where deficiencies were found in Mr Salami's practice. In reaching its decision, the PCC had regard to the fact that Mr Salami had embarked on the process of remediation and had engaged fully with the GDC. It therefore determined to impose an order of conditions on Mr Salami's registration for a period of 18 months.

Today's review hearing

This Committee first considered whether Mr Salami's fitness to practise remains impaired by reason of his misconduct.

Ms Headley submitted that Mr Salami's fitness to practise remains impaired. She referred to the information before the Committee which indicates that Mr Salami has remained in Iran under house arrest and therefore he has not been able to comply with the requirements of the conditions on his registration since they can only be fulfilled in the UK. The GDC's position is that this did not amount to a wilful breach of the conditions but rather due to Mr Salami's circumstances, which are beyond his control. Therefore, he has not been able to provide any evidence of remediation or engage with the GDC. She said that the order of conditions is no longer sufficient for the protection of the public and therefore invited the Committee to direct that Mr Salami's registration be suspended.

The Committee has considered carefully the submissions made. It has accepted the advice of the Legal Adviser. It has taken into account Mr Salami's current circumstances which makes it difficult for him to provide any evidence of further remediation than that which he had provided to the PCC in October 2016 to January 2017. The Committee has also had regard to Mr Salami's indication to the GDC in his email dated 23 July 2017 that he wishes to seek voluntary removal from the Register and no longer wishes to engage with the GDC. In the absence of any evidence of further remediation, the Committee cannot be satisfied that Mr Salami has addressed the concerns identified by the PCC nearly two years ago and thus the risk of repetition remains.

Taking all these matters into account, the Committee has concluded that Mr Salami's fitness to practise remains impaired by reason of his misconduct.

The Committee next considered what direction to give, bearing in mind its powers in accordance with Section 27C(2) of the Dentists Act 1984. There is nothing before the Committee today to satisfy it that Mr Salami has the capacity to comply with a further period of conditional registration, given his current circumstances, his lack of engagement with the GDC and the evidence that he no longer wishes to remain on the Register. Taking all these factors into account, the Committee has concluded that conditions are no longer workable, achievable or sufficient for the protection of the public and the wider public interest.

The Committee therefore directs that Mr Salami's registration be made subject to an order of suspension for a period of 12 months. The order of suspension will be reviewed shortly before the end of the 12 month period.

The Committee now invites submissions from Ms Headley as to whether Mr Salami's registration should be suspended immediately, pending the taking effect of its substantive direction of suspension."

"Decision on immediate order

Having directed that Mr Salami's registration be suspended, the Committee has considered whether to impose an order for immediate suspension. Ms Headley, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is otherwise in the public interest. She explained the effects on Mr Salami's registration during the appeal period and before the substantive order of suspension taking effect, were this Committee not to make an immediate order.

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

In accordance with Section 30(1) of the Dentists Act 1984 (as amended), the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to order that Mr Salami's registration be suspended forthwith. In the light of its reasons for directing that the current order of conditions be replaced with one of suspension, the Committee is satisfied that an immediate order of suspension is necessary to guard against the risks identified during the intervening appeal period.

The effect of this direction is that Mr Salami's registration will be suspended immediately.

That concludes today's hearing."

At a review hearing on 2 August 2019 the Chairman announced the determination as follows:

"This is a resumed hearing pursuant to s 27C of the Dentists Act 1984.

On 6 January 2017, the Professional Conduct Committee (PCC) found Mr Salami's fitness to practise to be impaired by reason of misconduct, summarising the background to the case as follows:
The facts in this case concern your treatment of one patient, Patient A, whilst you were practising as a dentist at Broadway House Dental Practice in Yeovil, Somerset ('the Practice'). There were a number of failings in your care of Patient A, many of which you admitted at the outset of this hearing.

It was found that you did not provide an adequate standard of care to Patient A on a number of occasions. On 5 March 2010 you failed to identify and/or diagnose the cause of the patient's infection at LL7 adequately and, consequently, you failed to provide adequate and/or definitive treatment of the infection.

On 16 September 2010 you failed to undertake a full assessment of Patient A's condition including a follow up examination of the infection at LL7 recorded on 5 March 2010, and a follow up examination of the abscess and pain in the Lower Left and Upper Right areas of the mouth, as recorded on 21 December 2009.

Between 11 November 2011 and 2 December 2011 you provided a crown to UR7 without carrying out an adequate assessment of the tooth including not carrying out any vitality testing.

On 6 September 2012 you failed again to undertake a follow up of the infection at LL7 diagnosed on 5 March 2010.

It was further found that on six occasions between 14 January 2010 and 3 January 2013, you failed to take any or any adequate radiographs in respect of Patient A, as clinically indicated. There were also failings in your record keeping for this patient on 14 January 2010 and 16 September 2010.

The PCC directed that Mr Salami's registration be made conditional on his compliance with conditions for a period of 18 months with a review.

The conditions were reviewed on 24 July 2018. Mr Salami was neither present nor represented at that review hearing. He was understood to be under house arrest in Iran. His former solicitors confirmed to the PCC that his last contact with them was on 23 July 2017

and that his dental defence organisation had withdrawn its instruction to them, owing to a lack of contact from him.

The July 2018 PCC found that Mr Salami's fitness to practise continued to be impaired by reason of his misconduct:

> …Mr Salami's current circumstances which makes it difficult for him to provide any evidence of further remediation than that which he had provided to the PCC in October 2016 to January 2017. The Committee has also had regard to Mr Salami's indication to the GDC in his email dated 23 July 2017 that he wishes to seek voluntary removal from the Register and no longer wishes to engage with the GDC. In the absence of any evidence of further remediation, the Committee cannot be satisfied that Mr Salami has addressed the concerns identified by the PCC nearly two years ago and thus the risk of repetition remains.

The July 2018 PCC directed that the conditions be replaced with a period of suspension for 12 months with a review. The PCC also made an order for immediate suspension:

> There is nothing before the Committee today to satisfy it that Mr Salami has the capacity to comply with a further period of conditional registration, given his current circumstances, his lack of engagement with the GDC and the evidence that he no longer wishes to remain on the Register…

It is the role of the Committee today to undertake the review directed by the July 2018 PCC. Mr Salami was neither present nor represented at the hearing. Mr Middleton, for the General Dental Council (GDC), submitted that service of notification of this hearing had been effected on Mr Salami in accordance with the General Dental Council (Fitness to Practise) Rules 2006 (the "Rules") and that the hearing should proceed in his absence.

Service and absence

The notification of hearing dated 25 June 2019 was sent to Mr Salami by Special Delivery to his registered address in the United Kingdom. Royal Mail 'Track and Trace' records that delivery was attempted on 27 June 2019 and that delivery was refused with the item returned to sender. The Committee was satisfied that the notification of hearing contained the required information under Rule 28 of the Rules, including the date, time and venue of the hearing; and that it had been served with more than 28 days' notice in accordance with Rule 65, by virtue of it being sent to his registered address by Special Delivery. The Committee accepted the advice of the Legal Adviser that the Rules do not require proof of delivery for service to be effected.

A copy of the notification of hearing was also sent to Mr Salami on 25 June 2019 using a secure file sharing service. There is no record before the Committee of the notification being downloaded by the recipient.

By email to the GDC sent 10 August 2018 at 21:07, Mr Salami stated that he was a political prisoner in Iran and that he was emailing the GDC from prison under supervision. He stated that he had learned of the suspension of his registration through a friend and he repeated a request for voluntary removal from the Register, on the basis that he is not able to defend the proceedings against him due to his confinement and that he does not intend to return to practise dentistry in the UK again.

By email to the GDC sent 18 September 2018, the majority of which has been redacted from the Committee, Mr Salami stated that he had now returned to Sweden. There is no further

record before the Committee of any communication from Mr Salami. An attendance note prepared by the GDC records the following attempts by the GDC to contact Mr Salami by telephone:

> 27.06.2019 - Call to registrant (Swedish number) to ascertain where he resides and details of his address etc.
>
> Attempted to call 4 times- number showing as invalid. Connected on one occasion but no answer and no option to leave voicemail.
>
> 10.07.2019- Call to Registrant- not connecting 3 times. Connected once but no option to leave message.

The Committee was satisfied that the GDC had made all reasonable efforts to notify Mr Salami of this hearing. The Committee had regard to Mr Salami's circumstances and his email correspondence. On the basis of his most recent email, Mr Salami has voluntarily absented himself from these proceedings. There is no application from him for a postponement and there is nothing to suggest to the Committee that an adjournment would make his attendance at the hearing any more likely in the future. Indeed, it appears from the terms of his correspondence that an adjournment of the hearing would likely be unwanted and stressful for him. The Committee also had regard to the fact that the suspension is due to lapse on 23 August 2019, meaning that there would be insufficient time to serve a new notification of hearing on Mr Salami with 28 days' notice in respect of a relisted hearing. Accordingly, the Committee risks losing jurisdiction if it were to adjourn the hearing today.

Having regard to all the circumstances, including the need for the expeditious disposal of proceedings and the public interest in the case being reviewed today, the Committee was satisfied that it would be fair and in the interests of justice to proceed with the hearing, notwithstanding the absence of Mr Salami.

The resumed hearing

Mr Middleton submitted that Mr Salami's fitness to practise continues to be impaired by reason of his misconduct and invited the Committee to direct that the period of suspension be extended for a further period of 12 months with a review. As to an application for Voluntary Removal, Mr Middleton stated to the Committee that Mr Salami's application had been granted by the registrar on 4 September 2018 on the basis of extenuating circumstances, namely his inability to respond and engage in the proceedings owing to his political imprisonment in Iran. The decision was emailed to Mr Salami the same day by a secure file sharing service and the download receipt indicated that the document had been downloaded in Sweden. Following an enquiry from the GDC Mr Salami then confirmed in his email of 18 September 2018 that he had returned to Sweden. In light of this change of circumstance, the registrar reviewed his decision and refused Voluntary Removal. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016).

The Committee accepted the advice of the Legal Adviser.

In light of Mr Salami's lack of engagement there is no evidence at all from him of any insight, reflection or embedded improvement in practice. The clinical failings identified in these proceedings are remediable, but there continues to be no corresponding evidence of remediation. The Committee is in the same position as that of the July 2018 PCC. There has been no change in circumstances and the risk of repetition remains. Accordingly, the

Committee is satisfied that Mr Salami's fitness to practise continues to be impaired by reason of his misconduct.

The Committee is satisfied that a restriction is necessary on Mr Salami's registration in order to protect the public from the risk of harm. The concerns identified in these proceedings are remediable through a period of conditional registration. However, conditions are only workable with engagement. Mr Salami is not engaging in these proceedings, at least not to any meaningful extent. He has stated that he has no intention of returning to the UK to practise again. The Committee cannot be satisfied that Mr Salami would comply with any conditions on his registration and they are not therefore workable or measurable at this stage.

Accordingly, the suspension of Mr Salami's registration remains necessary and proportionate. The Committee directs that Mr Salami's registration be suspended for a further period of 12 months with a review. Any lesser period would not give Mr Salami sufficient time to demonstrate remediation of all the concerns. Further, a period of 12 months suspension will allow the reviewing Committee to consider the question of indefinite suspension.

Should Mr Salami change his position and wish to engage in these proceedings, the reviewing Committee is likely to be assisted by reflective writing from him, evidence of his Continuing Professional Development activity, a Personal Development Plan addressing the areas of concern identified in these proceedings, evidence of full engagement with the GDC and any evidence of embedded improvement in clinical practice (if he were to practise outside of the UK).

That concludes the hearing today."

At a review hearing on 29 July 2020 the Chairman announced the determination as follows:

"This is a resumed hearing pursuant to section 27C of the Dentists Act 1984 (as amended) ('the Act'). The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Skype in line with the GDC's current practice. Mr Salami is neither present nor represented at this resumed hearing of the Professional Conduct Committee (PCC). Ms Headley is the Case Presenter for the General Dental Council (GDC) who also appears via Skype.

Decision on service of the Notification of Hearing

The Committee considered whether notice of the hearing had been served on Mr Salami in accordance with rules 28 and 65 of the Rules. It received a bundle of documents containing a copy of the Notification of Hearing letter, dated 25 June 2020 including his registered address, and a Royal Mail 'Track and Trace' receipt confirming delivery had been attempted. A copy of the letter was also sent to him by email on the same date.

The Committee was satisfied that the letter contained proper notification of today's review hearing, including its time, date and location (remotely), as well as notification that the Committee had the power to proceed with the hearing in Mr Salami's absence. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Salami in accordance with the Rules.

Decision on proceeding with the hearing in the absence of Mr Salami

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Salami. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision as set out in the case of *R v Jones [2003] 1 AC 1HL*. It remained mindful of the need to be fair to both Mr Salami and the GDC, and it had regard to the public interest in the expeditious review of the suspension order in place on Mr Salami's registration. The Committee took into account that the current order is due to expire on 23 August 2020.

The Committee noted from the Notification of Hearing letter of 25 June 2020 that Mr Salami was asked to confirm by 01 July 2020, whether he would be attending today's hearing and/or whether he would be represented. The Committee noted the GDC sent a further email to Mr Salami on 21 July 2020. The information before the Committee indicates that there has been no response from Mr Salami. Mr Salami has not provided a reason for his non-attendance, nor has he requested an adjournment. The Committee therefore concluded that Mr Salami had voluntarily absented himself from today's proceedings. The Committee noted there was no information before it to indicate that an adjournment was likely to secure his attendance on a future date. The Committee also noted that Mr Salami did not attend and was not represented at his review hearings on 24 July 2018 and 02 August 2019.

In all the circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr Salami and/or any representative on his behalf.

Background matters

At the initial PCC hearing which began in January 2017 and went part heard until January 2017, the allegations which Mr Salami faced and which the Committee subsequently found proved, related Mr Salami's failure to provide an adequate standard of care to Patient A on a number of occasions. Mr Salami attend that hearing and was legally represented. The initial PCC decided that Mr Salami's remediation was still in its early stages and in the absence of sufficient remediation, including verifiable evidence of how his clinical practice had improved in the highlighted areas of concern, the Committee could not be satisfied that Mr Salami would not repeat his misconduct. It therefore concluded that there was an outstanding risk to the safety of patients and that a finding of impairment is necessary in the circumstances. The Committee determined that Mr Salami's fitness to practise was impaired by reason of his misconduct. It directed that an order of conditions was appropriate and proportionate for a period of 18 months with a review prior to the expiry of the order.

First PCC review – 24 July 2018

The order was reviewed by the PCC on 24 July 2018. The Committee determined to revoke the order of conditions and impose an order of suspension for a further period of twelve months. Mr Salami had not been able to comply with the requirements of the conditions on his registration since he remained in Iran under house arrest. Therefore, Mr Salami had not been able to provide any evidence of remediation or engage with the GDC and that the order of conditions was no longer sufficient. The Committee also had regard to Mr Salami's indication that he wished to seek Voluntary Removal from the Register.

Second PCC review – 02 August 2019

A second review hearing was held on 02 August 2019. At that hearing the Committee was advised that Mr Salami had notified the GDC in September 2018 that he was now residing in Sweden. Save for this information, there was no other record of any communication from Mr Salami. The Committee considered that there was no evidence provided by Mr Salami to sufficiently satisfy it that he had addressed all of the concerns identified by the PCC at the initial hearing and at the review hearing. The Committee directed that Mr Salami's fitness to practise continued to be impaired and the order of suspension was extended for a further period of twelve months. The Committee considered that the reviewing Committee may find it helpful to have sight of the following:

"Should Mr Salami change his position and wish to engage in these proceedings, the reviewing Committee is likely to be assisted by reflective writing from him, evidence of his Continuing Professional Development activity, a Personal Development Plan addressing the areas of concern identified in these proceedings, evidence of full engagement with the GDC and any evidence of embedded improvement in clinical practice (if he were to practise outside of the UK)."

Today's review

In comprehensively reviewing Mr Salami's case today, the Committee considered all the documentation before it. It took account of the submissions made by Ms Headley on behalf of the GDC and accepted the advice of the Legal Adviser. No material or written submissions were received from, or on behalf of, Mr Salami.

Ms Headley submitted that to date, there is no evidence that Mr Salami has remedied any of the failings identified by the previous Committees. In relation to the matters before the Committee today, she stated that in the circumstances, the GDC invited the Committee to find that Mr Salami's fitness to practise remains impaired. Ms Headley further invited the Committee, if it found current impairment, to indefinitely suspend Mr Salami's registration.

The Committee first considered whether Mr Salami's fitness to practise is still impaired. It bore in mind that at a review hearing the onus is on a registrant to demonstrate that their fitness to practise is no longer impaired. There is no evidence before this Committee that Mr Salami has addressed his past misconduct or provided any information as recommended to him by the reviewing PCC on 02 August 2019. In addition, he has not provided any information to demonstrate any evidence of insight or remediation. In these circumstances, the Committee considers that there remains a risk that Mr Salami could repeat the misconduct identified and thus he remains a risk to the public. It also notes that Mr Salami has not engaged with the GDC in relation to these proceedings over a protracted period of time, despite repeated attempts by the GDC to secure his involvement. Accordingly, the Committee has determined that Mr Salami's fitness to practise remains impaired.

The Committee next considered what direction, if any, to make. It has had regard to the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (Effective October 2016, revised May 2019).

The Committee has borne in mind the principle of proportionality, balancing the public interest against Mr Salami's own interests. The public interest includes the protection of the public, the maintenance of public confidence in the profession, and declaring and upholding proper 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 or to terminate it with immediate effect. Given Mr Salami's lack of engagement with the GDC and the absence of any remediation or insight, the Committee has concluded that it would not be appropriate to terminate the current order or to allow it to lapse.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee is aware that in order for conditions to be appropriate and workable there would need to be some measure of positive engagement from Mr Salami. To date, he has not engaged with the GDC or provided any evidence of remediation, despite being given ample opportunity to do so. Furthermore, Mr Salami has indicated that he no longer wishes to practice. In these circumstances, the Committee has concluded that replacing the suspension order with a conditions of practice order would not be workable or appropriate.

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 Salami's lack of engagement with the GDC over a sustained period of time. Mr Salami has chosen not to attend any of the hearings since the initial hearing to provide any evidence of his remediation. In these circumstances, the Committee has concluded that a further time limited period of suspension is unlikely to achieve his engagement or delivery of material requested to assist any future Committee. In these circumstances an indefinite period of suspension is the appropriate and proportionate outcome and is required in order to maintain public confidence in the profession. It therefore directs that Mr Salami's registration be suspended indefinitely.

The effect of the foregoing direction is that, unless Mr Salami exercises his right of appeal, his registration will be suspended indefinitely from the date on which the direction takes effect; he will not be able to seek a review until at least two years have elapsed from that date

That concludes this hearing."