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HEARING HEARD IN PUBLIC

Salami, Navid

Registration No: 77085

PROFESSIONAL CONDUCT COMMITTEE

SEPTEMBER 2019

Outcome: Suspension for 10 months (with a review)

Navid SALAMI, a dentist, Tandläkare Malmö 1999, was summoned to appear before the Professional Conduct Committee on 25 September 2019 for an inquiry into the following charge:

Charge

That being a registered dentist:

1. Between 29 November 2007 and 26 January 2008, you provided Patient A (identified in Schedule 1*****) with a metal ceramic bridge using UR2 and UL1 as abutment teeth.

2. You failed to provide an adequate standard of care to Patient A, in relation to bridgework set out in charge 1 above, in that you:

    a) failed to carry out sufficient diagnostic assessments, including:

        (i) taking any or any adequate radiographs as clinically indicated;

        (ii) assessing the periodontal condition of the abutment teeth adequately, or at all.

        (iii) carrying out an adequate clinical examination of the natural crowns of the UR2 and/or UL1.

    b) failed to carry out sufficient treatment planning.

3. In relation to the treatment provided to Patient A under head of charge 1, you failed to obtain informed consent, in that you:

    a) did not provide Patient A with all treatment options;

    b) did not discuss with Patient A the full risks and benefits of the proposed treatment.

4. On 12 February 2013 you failed to provide an adequate standard of care to Patient A, in relation to crownwork at UL2 and/or UL4 with regard to the marginal fit of the crowns.

***Please note schedule 1 is a private document which cannot be disclosed**

and that, in consequence of the matters set out above, your fitness to practise as a dentist is impaired by reason of misconduct.

Mr Salami was not present and was not represented at the hearing on the 23 September 2019. The Chairman made the following statement regarding preliminary matters:

Service

This is a Professional Conduct Committee (PCC) hearing of Mr Salami's case. Mr Salami (the Registrant) is neither present nor represented at the hearing. Mr Milner 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 in accordance with Rules 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules). In so doing, it has taken into account the submissions made by Mr Milner as well as the information before it. The Committee has accepted the advice of the Legal Adviser.

The Committee has received a bundle of documents which contains a copy of the Notification of Hearing dated 22 August 2019, addressed to Mr Salami at his registered address. The Committee is satisfied that the Notification of Hearing contains the prescribed information in accordance with the Rules, including the date, time and venue of the hearing, as well as the charges against Mr Salami. The Royal Mail track and trace receipt states that the document with the same tracking number as that shown on the Notification of Hearing was delivered back to sender (the GDC) on 12 September 2019. The Committee has seen a copy of the envelope with the same tracking number as that shown on the Notification of Hearing with a date stamp of 22 August 2019 by the Royal Mail and second date stamp with "P739 Notice Left" dated 23 August 2019. The Committee is aware that the GDC is only required to demonstrate that the Notification of Hearing has been sent to Mr Salami at his registered address more than 28 days in advance of today's hearing. It is satisfied that this is the case.

In addition, the Committee notes that on 22 August 2019 the GDC sent an email to Mr Salami, enclosing a copy of the Notification of Hearing.

Having regard to all the documents before it, the Committee is satisfied that the requirements of service have been met in accordance with the Rules.

Proceeding in the absence of the Registrant

The Committee went on to consider whether to proceed in the absence of Mr Salami, in accordance with Rule 54. Mr Milner advised the Committee that the hearing of Mr Salami's case was originally listed for August 2018. That hearing did not proceed in view of Mr Salami's application for Voluntary Removal from the Register, which was subsequently refused. In response to questions put to him by the Committee, Mr Milner confirmed that the GDC has received no contact from Mr Salami in relation to these proceedings, his last contact with the GDC being in October 2018. In short, Mr Milner invited the Committee to proceed in the absence of Mr Salami.

The Committee has considered the submissions made by Mr Milner. It has accepted the advice of the Legal Adviser. The Committee has drawn the inference that Mr Salami is aware of these proceedings, in light of the GDC's decision to refuse his application for Voluntary Removal from the Register, and that he has voluntarily absented himself from this hearing. He has not engaged with the GDC for almost a year and there is nothing before the

Committee to suggest that Mr Salami would attend on a future occasion, were the Committee minded to adjourn this hearing. In these circumstances, the Committee has concluded that Mr Salami has voluntarily absented himself from these proceedings.

The Committee has had regard to the issue of fairness to Mr Salami as well as to the GDC in the prosecution of its case. It has also had regard to the fact that the allegations in this case are of some age in that they relate to treatment that took place over ten years ago. In the Committee's view, there is a clear public interest in proceeding with the case. Accordingly, the Committee has determined that it is fair to proceed with the hearing in the absence of Mr Salami. It has drawn no adverse inference by Mr Salami's non-attendance at this hearing.

Rule 57 Application:

Mr Milner, on behalf of the General Dental Council (GDC), made an application under Rule 57 of the GDC (Fitness to Practise) Rules 2006 ('the Rules') for this Committee to admit the witness statement of Patient A dated 11 July 2018, the witness statement of Patient A's subsequent treating dentist, dated 9 July 2018 and the witness statement of Mr Kramer (GDC expert) dated 21 June 2018, as hearsay evidence, in their absences. This means that these witnesses will not be called to give evidence in person or via telephone and their statements will be taken as read by the Committee. The Committee was referred to a letter dated 13 September 2019 from the GDC to Mr Salami which notified him of the GDC's intention to de-warn these witnesses from attending the hearing. Mr Salami was asked to notify the GDC by 20 September 2019 whether he had any objections to this course of action and if so, to provide the GDC with his reasons for requiring the witnesses to attend the hearing. No response was received from Mr Salami.

The Committee was informed that Patient A and Patient A's subsequent treating dentist are available to give evidence via telephone this afternoon and that Mr Kramer is available to give evidence in person on Thursday afternoon and possibly to give answers to written questions at an earlier time.

The Committee has had regard to the submissions made by Mr Milner. It has accepted the advice of the Legal Adviser. In considering this application, the Committee has had regard to the overarching issue of justice and fairness.

The Committee, having read carefully the signed statements of these three witnesses, is of the view that it has no questions to ask of them at this stage of the proceedings. It considers that there would be no unfairness, either to the GDC or to Mr Salami, in admitting the witness statement of Patient A, Patient A's subsequent treating dentist and Mr Kramer, without them having to give evidence either remotely or attending the hearing in person. The Committee has made this decision in the knowledge that should circumstances change, these witnesses are available to give evidence later on in these proceedings.

On 24 September 2019 the Chairman announced the findings of fact to the Counsel for the GDC:

The GDC's Case

"The GDC's case against Mr Salami concerns alleged shortcomings in his treatment of Patient A between 29 November 2007 and 26 January 2008 regarding the provision of a metal ceramic bridge and alleged shortcomings in relation to crownwork at UL2 and/or UL4 on 12 February 2013. In support of its case, the GDC relies on the witness statement of Patient A dated 11 July 2018, the witness statement of Patient A's subsequent treating dentist, dated 9 July 2018 and the witness statement of Mr Kramer (GDC expert) dated 21 June 2018.

Evidence considered and findings of fact

In considering whether the charges have been found proved, the Committee has taken into account all the evidence contained in the GDC's hearing bundle. This includes the statements of the three witnesses referred to above as well as copies of Patient A's dental records. The Committee acceded to the GDC's application under Rule 57 of the Rules to admit these statements as hearsay evidence.

In respect of Patient A, notwithstanding the passage of time between the events in question and the date when her statement was written, it found the content of her statement to be fair and reliable. Further, her account was broadly consistent with the information recorded contemporaneously in her clinical records. Regarding the witness statement of Patient A's subsequent treating dentist, the Committee took the view that parts of his evidence were subjective in nature and reflected his own opinion.

Finally, the Committee considered that Mr Kramer's evidence was generally credible and consistent but noted that his opinion was not based on clear referenced evidence. However, the Committee was assisted by the reasoning within his statement.

The Committee has borne in mind that it has received nothing from Mr Salami as to the matters alleged against him, or indeed any comment from him in respect of the GDC's evidence against him. Although the Committee was provided with some correspondence between Mr Salami and the GDC it was informed that Mr Salami had made no representations in respect of the specific allegations before this Committee.

The Committee has accepted the advice of the Legal Adviser. It has borne in mind that the burden of proof is on the GDC and that it must decide the facts according to the civil standard of proof, namely on the balance of probabilities. Mr Salami need not prove or disprove anything. In accordance with that advice it has considered each charge separately.

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

1.	*Between 29 November 2007 and 26 January 2008, you provided Patient A (identified in Schedule 1) with a metal ceramic bridge using UR2 and UL1 as abutment teeth.* **Found proved** In reaching its decision, the Committee has had regard to the evidence of Patient A, as well as the information contained in her dental records. This evidence confirms that the said treatment was provided by Mr Salami between the dates in question.
2.	*You failed to provide an adequate standard of care to Patient A, in relation to bridgework set out in charge 1 above, in that you:*
2. a)	*failed to carry out sufficient diagnostic assessments, including:*
2. a) (i)	*taking any or any adequate radiographs as clinically indicated;* **Found proved** Mr Kramer's evidence was that an up to date periapical radiograph should have been available for viewing prior to commencing treatment. In his opinion, this would show whether there were any problems or pathology associated with the root and surrounding periodontal bone that either required treatment prior to a

	crown or bridge being provided or would make the tooth unsuitable for this treatment. He could find nothing in the records to show that any such radiographs were obtained prior to the provision of the bridge. The Committee accepts Mr Kramer's evidence on this matter. There is no evidence that radiographs were taken, and it finds that Mr Salami should have taken them for the reasons given by Mr Kramer.
2. a) (ii)	*assessing the periodontal condition of the abutment teeth adequately, or at all.* **Found proved** Mr Kramer was of the opinion that an assessment of the periodontal condition of the teeth should have been made prior to any preparation being carried out. This was to ensure that the periodontal condition was satisfactory prior to the teeth being used as bridge abutments. He explained that the assessments should have included measurement of the periodontal pocket depths around the teeth, any gingival inflammation present and an assessment of any mobility of the teeth. The Committee saw no evidence either in the dental records, or in Patient A's statement, that Mr Salami had undertaken such an assessment. Accordingly, the Committee finds this charge proved.
2. a) (iii)	*carrying out an adequate clinical examination of the natural crowns of the UR2 and/or UL1.* **Found not proved** Mr Kramer was of the opinion that an adequate examination of the natural crowns of the teeth planned for preparation should have been carried out. The Committee is of the opinion that it is unlikely that, in the normal process of preparing the teeth, Mr Salami would not have carried out such an assessment. Accordingly, the Committee finds this charge not proved.
2. b)	*failed to carry out sufficient treatment planning.* **Found not proved** Mr Kramer was critical of Mr Salami for planning a bridge using two less than ideal abutments without further investigating alternative options for treatment. There is evidence in the records that Mr Salami had considered a Maryland bridge and an implant, and Patient A's evidence is that she had tried a partial denture and struggled with it for six months. The Committee is satisfied that there is evidence of treatment planning and considers that the GDC has not discharged its evidential burden in support of this charge. It therefore finds this charge not proved.
3.	*In relation to the treatment provided to Patient A under head of charge 1, you failed to obtain informed consent, in that you:*
3. a)	*did not provide Patient A with all treatment options;* **Found not proved** Mr Kramer set out the options for treatment for Patient A, namely the provision of partial denture, a resin retained bridge, a conventional crown retained bridge, or an implant retained crown. He could find nothing in Patient A's draft statement to show whether any treatment options to replace the missing the UR1 were given to the patient. The Committee takes the view that providing treatment options is an

	ongoing process which may take place over the course of a number of appointments. It has seen from Patient A's dental records, which cover a number of appointments for the period in question, that there is reference to all of the treatment options referred to by Mr Kramer. Further, Patient A refers to there being discussions of treatment options with Mr Salami. Accordingly, the Committee is not satisfied, on the evidence before it, that the GDC has discharged its evidential burden in support of this charge. It therefore finds this charge not proved.
3. b)	*did not discuss with Patient A the full risks and benefits of the proposed treatment.* **Found not proved** Mr Kramer was critical because he considered that Mr Salami should have advised Patient A that UR2 and UL1 were not ideal bridge abutments in view of the risk of fracture associated with them having been root canal treated and following full crown preparation. He considered that the patient should have been given all the reasonable options for treatment together with the risks, benefits and costs of each. In this case, he considered that the patient should have been informed of the probable longevity of the proposed treatment options. Patient A's recollection was that Mr Salami told her that one treatment option to cover the gap was a bridge that involved shaving the teeth down and the bridge should last around 15 to 20 years. Her evidence was that Mr Salami explained to her that "occasionally bridges do fail but he had never had a bridge fail, which made me think that this was a good option." In the light of this evidence, on the balance of probabilities, the Committee is satisfied that discussions took place between Patient A and Mr Salami as to the risks and benefits of the proposed treatment. Accordingly, the Committee finds this charge not proved.
4.	*On 12 February 2013 you failed to provide an adequate standard of care to Patient A, in relation to crownwork at UL2 and/or UL4 with regard to the marginal fit of the crowns.* **Found proved** Mr Kramer's evidence was based on the available radiographs taken by the subsequent treating dentist, just four months after the treatment. In respect of UL2, Mr Kramer opined that "the margin of a crown should fit flush with the prepared underlying tooth in order that the margin should be cleansable. If there was a gap, ledge or overhang at the margin there is an increased risk of plaque accumulation and hence the risk of caries and/or periodontal problems developing as a consequence". His opinion was that the UL4 was also not of a satisfactory standard for the same reasons as given for UL2. The Committee, having seen the available radiographs, agrees with Mr Kramer and finds this charge proved in relation to both teeth.

We move to Stage Two."

On the 25 September 2019 the Chairman announced the determination as follows:

"The Committee has considered the submissions made by Mr Milner under Rule 20 of the Rules following the Committee's announcement of the facts found proved. Mr Milner submitted that the findings of fact amount to misconduct and referred the Committee to the GDC's Standards For Dental Professionals (2005). The GDC's position is that Mr Salami's fitness to practise is currently impaired by reason of his misconduct. In support of that contention, Mr Milner pointed to Mr Salami's failure to provide any evidence of remediation or to engage with the GDC in relation to these proceedings. He also said that Mr Salami's previous fitness to practise history was another aggravating feature in this case. Mr Milner submitted that the appropriate sanction in this case is that of suspension, or alternatively, that of erasure. He said that this was a case where the misconduct was long-lived, with no expressions of remorse or insight into the shortcomings in his treatment of Patient A.

The Committee has accepted the advice of the Legal Adviser.

Misconduct

The facts found proved are that between 29 November 2007 and 26 January 2008 Mr Salami provided Patient A with a metal ceramic bridge using UR2 and UL1 as abutment teeth. The Committee found that Mr Salami failed to provide an adequate standard of care to Patient A, in relation to bridgework in that he failed to carry out sufficient diagnostic assessments in two respects. Firstly, Mr Salami did not take any radiographs as clinically indicated and secondly, he failed to assess the periodontal condition of the abutment teeth adequately or at all.

On 12 February 2013 Mr Salami fitted crowns on UL4 and UL2 for Patient A. The Committee found that Mr Salami failed to provide an adequate standard of care to Patient A, in relation to the crowns to the two teeth with regard to the marginal fit.

The Committee considers that the facts found proved in this case were serious breaches of the standard of clinical care expected of a competent general dental practitioner, as indicated in Mr Kramer's report. In the Committee's judgement, a fundamental requirement before undertaking invasive treatment is that a dentist performs the appropriate clinical assessment. Mr Salami failed in this regard. Furthermore, it is expected that any provision of crowns should be properly assessed, especially the fit of the crowns. Mr Salami failed to do this. The failure to undertake either the appropriate clinical assessments or check for significant defects would, in the Committee's view, amount to a serious falling short of the standards expected of a competent general dental practitioner. Accordingly, the Committee is satisfied that the facts found proved in this case amount to misconduct.

Fitness to Practise history

The Committee has been informed of Mr Salami's fitness to practise history, as set out in the bundle of documents before it. In August 2010 Mr Salami 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 complaint and the provision of an inadequate standard of clinical care. In September 2014 the Investigating Committee (IC) considered allegations in relation to a failure to provide a patient with an adequate standard of care between July 2011 and June 2013. This was in relation to endodontic treatment provided. The IC concluded that there was no real prospect of a finding of current impairment being made by a Professional Conduct Committee (PCC). It considered that it was necessary to issue Mr Salami with a warning, reminding him of the need to ensure that

he maintains and keeps up to date his skills and knowledge of current endodontic dentistry. He was also reminded of the need to maintain accurate and detailed records.

In October 2016 Mr Salami appeared before a PCC in relation to alleged concerns relating to the treatment he provided to a patient between 2010 and 2013. This included a failure to undertake a full assessment of the patient's condition; a failure to identify and/or diagnose the cause of the patient's infection at one tooth and a failure to undertake any or any adequate radiographs on six occasions. There were also failings in Mr Salami's record keeping regarding this patient. The hearing went part heard following the conclusion of the findings of fact in October 2016. The PCC resumed in January 2017 where it found that the facts found proved amounted to misconduct. It recognised that due to Mr Salami's circumstances at that time, he had not had the opportunity to put what he may have learnt into practice. The PCC was therefore unable to assesses adequately the standard of Mr Salami's clinical practice. It determined that Mr Salami's fitness to practise was impaired. However, it considered that Mr Salami had begun the process of remediation and had demonstrated some insight. The PCC directed that Mr Salami's registration be subject to an order of conditions for a period of 18 months, with a review to take place before the expiry of that order.

The PCC reviewed that order on 24 July 2018. Mr Salami was neither present nor represented; the PCC decided to proceed in his absence. There was nothing before the PCC to satisfy it that he had addressed the concerns identified by the PCC at the initial hearing. Further, the PCC had regard to Mr Salami's lack of engagement with the GDC as well as the indication that he wished to seek Voluntary Removal from the Register. It therefore directed that the order of conditions be replaced with one of suspension for a period of 12 months.

The PCC reviewed the order again at a hearing on 2 August 2019. Mr Salami was neither present nor represented; the PCC decided to proceed in his absence. At that hearing the PCC 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 PCC decided to proceed in the absence of Mr Salami. It had regard to Mr Salami's lack of engagement and the absence of any evidence from him as to his reflections on the shortcomings identified by the PCC at the initial hearing. It directed that Mr Salami's registration be suspended for a further period of 12 months.

Current Impairment

The Committee next considered whether Mr Salami's fitness to practise is currently impaired as a result of the finding of misconduct. In so doing, it has 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 considers that the clinical failings in respect of Patient A are capable of being remedied and can be properly addressed by further learning and training. In considering whether the failings have been remedied, it has borne in mind Mr Salami's lack of engagement with the GDC in connection with these proceedings and the absence of any information from him. There is no acceptance of wrong-doing on the part of Mr Salami, any reflections as to how he would deal with things differently, and what changes, if any, he has implemented to his clinical practice so as to ensure that his practice is safe. The Committee

notes that the most recent contact Mr Salami had with the GDC was in October 2018, which was in connection with his application for Voluntary Removal from the Register. There is no reference in Mr Salami's correspondence, to the matters relating to Patient A or any evidence of steps he has taken to improve on the standard of his professional practice following the PCC's findings in 2016/2017. In Mr Salami's correspondence to the GDC he expresses a sense of injustice about being pursued by the GDC. The Committee considers that there is a duty on a registered dentist that he recognises his professional responsibilities in co-operating with their professional regulator in relation to fitness to practise proceedings. In these circumstances, the Committee has concerns about Mr Salami's lack of insight.

Given the absence of any evidence of remediation, or even attempts at remediation, as well as its concerns about Mr Salami's lack of insight, the Committee is concerned about the risk of repetition as to the clinical shortcomings. In the Committee's judgement, these factors are compounded by Mr Salami's fitness to practise history and his lack of engagement in relation to the previous PCC case where shortcomings in his clinical practice were identified, as well as within this case. In the Committee's view, given the risks identified, a finding of current impairment is necessary for the protection of patients.

The Committee has also borne in mind the wider public interest, including the need to declare and uphold proper standards of conduct and behaviour, in order to maintain public confidence in the profession. The Committee has found proved that Mr Salami failed to provide an adequate standard of care to Patient A. It considers that public confidence in the profession would be undermined if a finding of impairment were not made, especially where there is no evidence of remediation.

Having regard to all of these matters, the Committee has determined that Mr Salami's fitness to practise is currently impaired by reason of his misconduct.

Sanction

The Committee has considered what sanction, if any, to impose on Mr Salami's registration. 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 has taken into account the 'Guidance for the Practice Committees including Indicative Sanctions Guidance (effective 1st October 2016, revised 3rd May 2019) (the Guidance). It has considered the range of sanctions available to it, starting with the least serious. The Committee has applied the principle of proportionality, balancing the public interest with Mr Salami's own interests.

The Committee has determined that it would be inappropriate to conclude this case without taking any action in respect of Mr Salami's registration. It reached the same conclusion in respect of a reprimand. In the Committee's judgement, these courses of action would not adequately reflect the serious nature of Mr Salami's misconduct and the ongoing risk to patient safety. Nor would they satisfy the public interest in this case.

The Committee next considered the imposition of conditions on Mr Salami's registration, bearing in mind that any conditions must be proportionate, measurable and workable. The Committee has had regard to the fact that the clinical failings in this case, which concern one patient, are remediable. On the face of it, this is a case where Mr Salami's deficiencies could be addressed by conditions on his registration. However, the Committee has borne in mind the absence of any evidence of corrective steps he has taken, as well as his lack of engagement with the GDC in these proceedings. The Committee has concerns about Mr

Salami's willingness to respond positively to conditional registration, particularly given that he has failed to comply with conditions previously. In all the circumstances, the Committee is not satisfied that conditions will be sufficient for the protection of patients or be in the public interest.

The Committee then went on to consider the sanction of suspension. It considers that a number of the factors set out in paragraph 7.28 of the Guidance (relating to the sanction of suspension) are relevant in this case, including the fact that Mr Salami has not shown any insight into his shortcomings and the risk of repetition. The Committee considers that the findings against Mr Salami, although serious, are not so serious as to warrant the sanction of erasure. This is not a case where there is evidence of a deep-seated personality problem or where Mr Salami's conduct is fundamentally incompatible with him remaining on the Register. Accordingly, the Committee directs that Mr Salami's registration be suspended. It considers that this sanction is necessary and proportionate to the findings made against him. The Committee directs that Mr Salami's registration be suspended for a period of ten months. It considers that Mr Salami will need time to develop insight into his failings and for him to embark on a path of remediation, should he choose to do so. It is satisfied that a period of ten months is appropriate and proportionate. The Committee notes that Mr Salami's registration is currently suspended by virtue of the PCC's direction at the review hearing in August 2019 and that that order will expire around the same time as this order. It may be practical if both cases are reviewed at the same hearing.

A Committee will review Mr Salami's case at a resumed hearing to be held shortly before the end of the period of suspension. That Committee will consider what action it should take in relation to Mr Salami's registration. It may be assisted by evidence of sustained and targeted CPD specifically designed to address the deficiencies in his practice identified in this case. Mr Salami will be informed of the date and time of that resumed hearing.

The Committee now invites submissions from you as to whether Mr Salami's registration should be suspended immediately.

Decision on immediate order

The Committee has considered whether to make an order for the immediate suspension of Mr Salami's registration in accordance with Section 30(1) of the Dentists Act 1984 (as amended).

Mr Milner, 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, given the Committee's findings. This order is required to cover the 28 day appeal period, or on the event that an appeal is lodged, the disposal of that appeal.

The Committee has considered the submissions made by Mr Milner. It has accepted the advice of the Legal Adviser.

The Committee is satisfied that it is necessary for the protection of patients and in the public interest to take action in respect of Mr Salami's registration. It directed that his registration be suspended for a period of 10 months. However, the Committee is aware that Mr Salami's registration is currently suspended by virtue of the PCC's direction of August 2019. It is satisfied that patients are currently protected by the existing suspension order which is not due to expire until August 2020. Further, the Committee is not satisfied that an immediate order is necessary solely on the grounds to protect public confidence in the profession.

Accordingly, the Committee is not satisfied that it is necessary to make an order for the immediate suspension of Mr Salami's registration.

Unless Mr Salami exercises his right of appeal, the substantive order of 10 months' suspension will come into effect 28 days from the date on which notice of this decision is deemed to have been served on him.

That concludes the hearing of Mr Salami's case."