PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

29 September – 15 October 2025

Name:	COETSEE, John
Registration number:	72009
Case number:	CAS-202201

General Dental Council:	Mr Scott Smith, Counsel Instructed by Lauren Boddy, Capsticks
Registrant:	Present Represented by Mr Andrew Hockton, Counsel Instructed by Charlotte Ellis, DWF Law

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Reprimand

Committee members:	Carson Black (Chair, Dentist Member) Helen Eatherton (Lay Member) Nosheen Kabal (Dental Care Professional Member)
Legal adviser:	Lucia Whittle-Martin
Committee Secretary:	Jenny Hazell

1 This is a Professional Conduct Committee (PCC) hearing. You were present at this hearing and represented by Mr Hockton, Counsel. Mr Smith, Counsel, appeared as the Case Presenter for the General Dental Council (GDC).

2 The charges being considered by the Committee are as follows:

"*That, being a registered dentist, whilst in practice as a dentist at the Practice (the Practice):*

Patient 2

1. *You failed to provide an adequate standard of care to Patient 2 from 27 July 2021 to 12 October 2021 in that:*

    a. *You did not conduct an adequate assessment of Patient 2 including:*
        i. failing to conduct an adequate clinical examination of Patient 2;
        ii. failing to conduct an adequate radiographic examination of Patient 2;
    b. *You did not discuss, or record discussion of, treatment options, risks or benefits of the proposed treatment with Patient 2;*
    c. *You provided a poor standard of root canal treatment to the LL6;*
    d. *You did not report on the radiographs taken on 27 July 2021 and/or 3 August 2021 and/or 12 October 2021;*
    e. *You did not advise on or consider extraction of a tooth* at the earliest point.*

2. *As a result of 1(b) above (if options, risks and benefits were not discussed with Patient 2) you did not obtain informed consent.*

**LL6*

Patient 3

3. *You failed to provide an adequate standard of care to Patient 3 from 3 August 2021 to 12 October 2021 in that:*

    a. *You did not discuss, or record discussion of, treatment options, risks or benefits of the proposed treatment with Patient 3, including specifically the risk of damage to the patient's bridge/crown;*
    b. *You provided a poor standard of root canal treatment to the UR3;*
    c. *You repeatedly complained about the equipment available at the Practice;*
    d. *You showed anger towards Patient 3 in relation to him being unwilling to pay for the whole laboratory cost for the replacement crown that was required as a result of the crown being fractured during treatment;*
    e. *You did not report on radiographs taken on 3 August 2021 and/or 17 August 2021.*

4. *As a result of 3(a) above (if options, risks and benefits were not discussed with Patient 3) you did not obtain informed consent.*

Dental Nurse 1

5. *On 28 September 2021 you left a used syringe on a tray resulting in a sharps injury to Dental Nurse 1 when she cleared the tray away.*

Communication and interaction with Dental Nurses

6. *Between around July 2021 to November 2021, your communication to and interaction with dental nurses at the Practice was unprofessional and inappropriate, including:*

    a. *Being angry and/or rude towards the dental nurses in respect of equipment at the practice and/or their knowledge of the equipment you were requesting and/or their competence;*
    b. *Complaining about the inadequacy of equipment and materials in the presence of patients;*
    c. *On one occasion removing Dental Nurse 2's chair from the treatment room meaning that she was unable to sit down all day;*
    d. *Throwing clinical items such as pouches or gloves at Dental Nurse 2, or on the floor, in order for her to pick them up;*
    e. *Not allowing Dental Nurse 2 sufficient time to clean the treatment room in-between patients;*
    f. *On or around 3 August 2021, in the presence of Dental Nurse 3 who is originally from Poland, when late for a patient's appointment saying to the patient words to the effect of "I'm sorry I'm late, I don't speak Polish", inferring that Dental Nurse 3's Polish accent was to blame for you being late to the appointment because you had not understood her.*

Consequences

7. *In relation to any or all of Charges 5, 6(d) and 6(e)*
    a. *You did not maintain appropriate standards of practice in relation to*
        i. *The disposal of hazardous clinical waste;*
        ii. *Decontamination;*
        iii. *Cross-infection control.*

    b. *You put patient and dental professional health and safety at risk.*

And that, in consequence of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

Admissions

3 At the outset Mr Hockton, on your behalf, admitted the following charges: 1(d), 3(c), 3(e) and 6(b) insofar as it relates to Patient 3. The Committee determined and announced that the facts alleged at those charges were proven on the basis of your admissions in accordance with Rule 17(4) of the General Dental Council (Fitness to Practise) Rules Order of Council 2006 (the Rules).

The GDC's case

4 On 14 February 2022 the GDC received a complaint from a Case Referrals Adviser from the dental care provider organisation (the Organisation) about your professional practice over a period of several months in 2021. At the material times you were employed as an associate dentist at one of the Practices (the Practice) owned by the Organisation from May 2021 to November 2021. The alleged concerns related to your inappropriate manner towards patients and staff, your inadequate clinical treatment of patients 2 and 3 and your inadequate cross infection control. In due course, the allegations were referred to a PCC.

5 In opening the case for the GDC, Mr Smith submitted that in relation to charge 1(e), the tooth in question was the LL6. Mr Hockton did not take issue with the proposed clarification to this charge and therefore there was no formal application by the GDC to amend this charge.

Evidence

6 The Committee had regard to the GDC's hearing bundle which comprised Patient 2's records, Patient 3's records as well as a number of witness statements along with their associated exhibits. These included:

- Witness statement and exhibits from Patient 3, dated 5 July 2024
- Witness statement and exhibits of Dental Nurse 2 dated 26 August 2024
- Witness statement and exhibits of Dental Nurse 1, dated 24 September 2024
- Witness statement and exhibits of Dental Nurse 3 dated 25 September 2024

7 In addition to the documentary evidence, the Committee heard oral evidence from Patient 3, Dental Nurse 2, Dental Nurse 1 and Dental Nurse 3. The Committee did not receive a witness statement or oral evidence from Patient 2.

8 In respect of Patient 3, the Committee also received additional information in the form of telephone attendance notes dated 5 June 2024 and 11 June 2024 between Capsticks and Patient 3 regarding his draft witness statement dated 11 June 2024, the first two pages of which have been signed by him.

9 The GDC's hearing bundle also contained a copy of your witness statement , together with a copy of your CV. In your statement you set out your responses to each of the allegations. The Committee also had regard to your own oral evidence.

10 The Committee received a report dated 22 August 2024 from Dr Ward (expert, instructed by the GDC) and an expert report dated 22 September from Professor Barker, (expert, instructed on your behalf). The Committee also received a copy of the joint experts' report dated 22 September 2025 in which they set out their opinion in respect of each of the charges.

11 In addition, the Committee was provided with the following guidance: Faculty of General Dental Practice (UK) FGDP Clinical Examinations and Record Keeping Good Practice Guidelines 2016 and the Organisation's Sharps Management and Inoculation Injury Policy dated November 2020.

Findings of Fact

12 The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing written and oral submissions on the alleged facts made by Mr Smith on behalf of the GDC and those made by Mr Hockton on your behalf.

13 The Committee accepted the advice of the Legal Adviser. It has borne in mind that you are of good character in that you have no criminal convictions or previous fitness to practise findings against you.

14 The Committee considered the factual allegations 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 matters are proved on the balance of probabilities.

15 The Committee made the following findings:

Patient 2	
1	*You failed to provide an adequate standard of care to Patient 2 from 27 July 2021 to 12 October 2021 in that:*
1ai	*You did not conduct an adequate assessment of Patient 2 including: failing to conduct an adequate clinical examination of Patient 2* ***Found proved*** The Committee has borne in mind that it has received no evidence from Patient 2. However, it has had regard to Patient 2's contemporaneous records as well as your evidence on this matter. The clinical notes for Patient 2's first appointment with you on 27 July 2021 indicate that root canal treatment (RCT) commenced on LL6 through an existing crown. You recorded in the notes: "*pt nervous la – articaine x 2 46[sic] – access through crown-margins not perfect – found mesial canals – distal found canal – but probably needs a crown length – or extrusion [sic] (not debated with pt). Calcium hydroxide in canals and temp. Will see in 3 weeks to finish and possible cl or extrusion appointment. Will charge full 650 next time for complete rct*." Dr Ward's evidence was that there was no record of pre-operative assessment, diagnosis and discussion of treatment options at the first appointment on 27 July 2021. Dr Ward's opinion was that had an adequate clinical and/or radiographic examination taken place, the void at the crown would have been noticed and that this would have prompted further exploration on that issue before embarking on RCT. Professor Barker's evidence was that whilst the records were brief, it should be noted that Patient 2 was seen specifically on referral from Dentist K for RCT. He opined that if your evidence is accepted, then this would be a reasonable standard of care. The Experts both agree that there is no evidence to support whether an adequate assessment took place in the records. Your position is that you would have followed the Faculty of General Dental Practice Guidelines in relation to the clinical examination although you accepted that you did not take an impression. In your oral evidence you confirmed that you had undertaken an adequate examination, albeit you accepted that your notes of the initial consultation were "somewhat sparse". During the course of being cross-examined by GDC Counsel, you made reference to having had a joint consultation with Dentist E, but when it was drawn to your attention that Dentist E was not Patient 2's dentist and they were treated by another dentist, Dentist K, you then said that you could not remember. The Committee considers that for a clinical examination to be adequate before commencing RCT it would need to provide an adequate assessment of the factors which would impact on subsequent coronal restoration of the tooth as well as providing effective endodontic treatment. In the Committee's judgement, there is no evidence of a clinical or radiographic assessment having taken place prior to treatment on 27 July 2021, which would have been expected.

	The Committee found you appeared to be telling the Committee what you ought to have done and believe you would have done, rather than providing it with evidence of a clear recollection of what you actually did. In this case, the Committee noted that a significant void under the crown was not identified by you until RCT had already commenced, whereas if you had provided an adequate clinical examination, you would have identified the void and could have ensured that caries was removed. The Committee also noted your comment in the records at the end of that appointment that crown lengthening or extrusion of the tooth would probably be required and this should have been identified before treatment commenced. Accordingly, it finds this charge proved.
1aii	*failing to conduct an adequate radiographic examination of Patient 2* ***Found proved*** Both experts agree that there was no pre-operative radiograph taken by you at the appointment on 27 July 2021. There was a previous radiograph taken by another dentist on 5 May 2021 that was available to you but there was no evidence in the records to indicate whether this was reviewed. This radiograph was not included in the bundle. When questioned, your evidence was that you would have reviewed the radiograph from 5 May 2021 although you accepted that you could not recall what that radiograph showed. You accepted that you did not make a record of it in the clinical notes. The Committee has borne in mind the absence of any reporting of the radiograph of 5 May 2021 in your notes of the appointment on 27 July 2021 when you commenced RCT. The Committee considered that had you reviewed the radiograph of 5 May 2021 it was more likely than not that you would have noticed the void at the crown which would have prompted further investigation before embarking on RCT on 27 July 2021. Taking these factors into account, the Committee is satisfied that you failed to conduct an adequate radiographic examination of Patient 2.
1b	*You did not discuss, or record discussion of, treatment options, risks or benefits of the proposed treatment with Patient 2* ***Found proved*** Dr Ward's evidence was that there was no record of the treatment options, risks and benefits having been discussed with Patient 2. She was therefore unable to say whether the discussions took place. Her opinion was that there were two options in the case – either RCT or extraction. She opined that extraction should have been discussed both initially and as the case progressed. Professor Barker's evidence was that there was no evidence of a full record of risks, benefits and options related to the treatment. Your position is that you would have discussed the options with Patient 2, including the option of extracting the tooth, by reference to the radiographs. Your written evidence was that you advised Patient 2 that she had two options – either attempt RCT with the chance that the canals would need to be re-filled or do nothing. On your account, Patient 2 did not wish to have the tooth extracted and opted to have

	RCT. However, there is no reference in the notes or in your witness statement regarding your discussion of the option to extract the tooth. In respect of a question by a member of the Committee regarding "crown lengthening or extrusion", as recorded in your notes, you were unable to say whether that had been discussed with the patient. Given the Committee's finding at 1a(i) and (ii) above, it follows that as you did not conduct an adequate assessment of Patient 2, you could not have a full discussion of the treatment options or risks and benefits as you did not have all the necessary information before you to discuss with Patient 2. The Committee accepts that there is a note of your first appointment with Patient A on 27 July 2021. However, it considers that the note is sparce and does not include a full record of discussion of treatment options, or risks or benefits. Accordingly, the Committee finds this charge proved.
1c	*You provided a poor standard of root canal treatment to the LL6* ***Found proved*** Dr Ward's opinion was that the RCT was not completed to an adequate standard. In the Joint Expert Report she set out her criticisms as follows: • Perforation • Overcut of the access cavity • No Evidence of Working Length determination • Obturation when the correct materials were not present • Seven visits in relation to this treatment and subsequent extraction • No record of irrigant Dr Ward maintained these criticisms throughout save for her withdrawing her criticism on irrigant in light of the fact that rubber dam had been used. Professor Barker's view was that if there was no adequate response to the above then cumulatively this would constitute a poor standard of RCT. The Committee considered each area in turn. *Perforation* Dr Ward drew the Committee's attention to a radiograph taken on 27 July 2021 which she said showed that an endodontic file had perforated the distal wall of the tooth. Professor Barker opined that the radiograph showed an inadequate crown margin and a void between the crown and remaining tooth structure. His view was that "if the file was extruded through an inadequate margin, then this is not a failure" . In oral evidence Dr Ward acknowledged the possibility that the file had passed through a defective margin but said that if caries was present there it would impact on the prognosis of the tooth and that soft dentine should have been removed prior to files being placed in the tooth. The Committee was unable to ascertain from a radiograph whether the file had passed through healthy tooth structure or a defective margin. However it noted the comments of Dr Ward with regard to the need to assess and remove caries prior to commencing endodontic treatment. In particular it was noted that "the first thing is to

remove caries, probably taking the crown off, it might be very apparent that the tooth is not restorable".

In view of the inconclusive nature of the radiograph and the differing opinions of the experts the Committee was not satisfied on the balance of probabilities that a perforation had occurred as alleged. The Committee was clear that the incident would not have occurred if you had addressed the void under the crown prior to commencing RCT.

Overcut of the access cavity

In her written statement Dr Ward referred to an "extensive access cavity overcut mesially" In oral evidence she accepted that the crown masked her view of the access cavity however she drew the committees attention to a dark spot mesial to the root furcation which in her view represented an overcut but that it was a "small point". In oral evidence while Professor Barker seemed to accept that the dark spot on the radiograph may have been caused by you in the course of accessing the canals but was unable to say that it represented an "overcut".

The Committee was unable to glean sufficient information from the radiograph to conclude that there was an overcut and noted Dr Ward's comments that this was a "small point" and that Professor Barker's opinion was as valid as hers.

Accordingly, the Committee was not satisfied on the balance of probabilities that there was an extensive overcut mesially.

No Evidence of Working Length Determination

It is common ground between the parties that no working length radiograph was exposed. In your evidence you accept that you did not take a working length radiograph. While a length of 24mm is noted in the records for all canals there is no indication of how this length was obtained.

In your written statement you refer to an apex locater and that it was "unstable as the back of the tooth was wet" and you "were unable to dry it due to the location of the gum tissue". You further state that "…I took a radiograph to be sure". You also state "the first radiographs I took were not supposed to show lengths but simply to allow orientation". The files visible in these radiographs all appear to be significantly short of the root apices and in her oral evidence Dr Ward stated that these were at best indicators of rough length.

In your oral evidence you stated that you used paper points to confirm length. Professor Barker, in his oral evidence, stated that a paper point can be used as an adjunct when identifying working length and that the apex locater and paper point could have been used later in the treatment if a repair to the marginal defect had successfully controlled the moisture level.

In view of the fact that it is common ground that no working length radiographs were taken and that there was no reference in the records to the apex locater being used and no reference in your written statement to its successful use, the Committee concluded that there is no reliable evidence of working length determination.

Obturation when the correct materials were not available

It is not disputed that the root fillings placed in the canals were significantly short of the apices. You stated in your witness statement that you intended to complete the restoration but that both files and filling material available to you were insufficient.

	You further stated that this was a common occurrence at the practice and that you were frequently left without the necessary equipment such as files of the correct length. You stated in written and oral evidence that you realised before you started that you might only be able to fill short of the apex and that the treatment that day would be an interim solution. You stated that you informed the patient of the situation and that she elected for the canals to be filled rather than temporised. Professor Barker opined that this was a reasonable approach and that the removal of the root filling would not be much more difficult than washing out a temporary dressing. Dr Ward's evidence was that you should have placed a temporary dressing and re-visited the filling at the next appointment. Your position was that you gave options to Patient 2 and she elected to have a permanent filling placed. The GDC alleges that this was not a planned interim solution and that it was in fact a completed restoration. The Committee's attention was drawn to the patient record dated 12 October 2021. In it you describe the situation and that you have told the patient that you did not achieve cone fit and length and that the root filling would need to be replaced at the next visit. The GDC submits that this first reference to the issue suggests that it was not a planned procedure but a post-operative finding. In oral evidence Dr Ward opined that this was a final restoration and that she could not imagine why any patient would elect to have an interim solution of this nature. The Committee preferred the evidence of Dr Ward in this matter as it was unlikely that an informed patient would elect to have a root filling placed in the knowledge that it was an interim solution. *Seven visits in relation to this treatment and subsequent extraction* It is evident from Patient 2's records that she had attended multiple visits, interspersed with emergency appointments and treatment for pain. Ultimately the tooth was extracted by another practitioner at Patient 2's request. *Irrigant* The Committee noted that Dr Ward withdrew her criticism on this matter. *Conclusion* The Committee has found that Patient's 2 tooth was not adequately assessed clinically or radiographically, that treatment was commenced without prior removal of caries and in the presence of a void under the crown. There was no evidence of working length being established and the roots were filled significantly short of the apices using incorrect materials. The treatment was carried out over multiple visits interspersed with emergency appointments to deal with flair ups and pain before the tooth was eventually extracted. In the Committee's view, this amounted to a poor standard of root canal treatment and the charge is found proved.
1d	*You did not report on the radiographs taken on 27 July 2021 and/or 3 August 2021 and/or 12 October 2021* ***Admitted and found proved***
1e	*You did not advise on or consider extraction of a tooth (LL6) at the earliest point* ***Found proved***

	The experts agree that Patient 2 should have been provided with the option of extraction and that this option should have been revisited as the case developed. In response to this charge you state " I did consider an extraction in this case and I did inform Patient 2 that this was one of the options available to her". There was no evidence in the records of extraction ever being discussed with the patient. Your oral evidence on the matter was vague and you stated that you did not have the " philosophical basis to say "this tooth is out". It is far better for the patient to have the option". The Committee noted that the option of extraction was discussed when Patient 2 was seen by other clinicians and ultimately she selected that option. Regardless of this, the Committee was of the view that you did not advise on or consider extraction of the LL6 at the earliest opportunity, that this was a failing on your part and therefore the charge has been found proved.
2	*As a result of 1(b) above (if options, risks and benefits were not discussed with Patient 2) you did not obtain informed consent* ***Found proved*** The Committee has found proved in light of its findings at 1(b) it follows that it is more likely than not that you did not obtain informed consent.
Patient 3	
3	*You failed to provide an adequate standard of care to Patient 3 from 3 August 2021 to 12 October 2021 in that:*
3a	*You did not discuss, or record discussion of, treatment options, risks or benefits of the proposed treatment with Patient 3, including specifically the risk of damage to the patient's bridge/crown* ***Found not proved in relation to discuss*** ***Found proved in relation to record*** The Committee received evidence from Patient 3 in support of this charge. Patient 3 set out in his signed witness statement as to what took place at the initial appointment on 6 April 2021 with Dentist E (his referring dentist). Patient 3's evidence was that Dentist E told him that the lump on his gum was next to his dental bridge on the upper right side of his mouth and that the dentist conducting his RCT would need to be careful not to damage the dental bridge. Patient 3's evidence was that the plan was for him to wait to see a "specialist" at the Practice for RCT. Patient 3 saw you on 3 August 2021. Patient 3's evidence was that during this first appointment you carried out an assessment, which involved an x-ray being taken. On Patient 3's account, you told him "it would be a straightforward RCT" which you would conduct and did not raise any issues about my dental bridge at the time. Patient 3 was clear in his witness statement and in his oral evidence that you did not discuss any risks or benefits of the RCT, including the risk of damage to his dental bridge. In his oral evidence Patient 3 stated that Dentist E had not done so either. It was put to Patient 3 by Mr Hockton that there was a discussion of risks or benefits of RCT with Dentist E. Patient 3 denied this despite being shown the patient's notes of the appointment dated 6 April 2021 with Dentist E which states: *"…. Discussed the risks involved for having RCT, Failure, file fracture, root perforation options of*

	having trx under NHS or HP or seeing specialist given priv pt opted to see specialist privately." Your position is that you discussed the treatment options, risks and benefits with this patient, including the risk of damage to the patient's bridge/crown. You accepted that your notes of your discussions with Patient 3 were a shortened summary and that you did not sufficiently record them. The Committee has concluded that Patient 3's evidence in relation to his appointment with Dentist E is inconsistent with the contemporaneous dental records. Further, it considers that given that Patient 3 had been advised by Dentist E on 6 April 2021 of the possible risk to the bridge and RCT, it seems likely that Patient 3 would have raised this matter with you. Whilst Patient 3 appears to have been inconsistent on this issue, you appear to have been consistent in this in that you referenced your discussion with Patient 3 in the patient's notes. Your note dated 31 August 2021 states "*The one problem is that I did not get him to 'sign away his life' after informing him of the risks."* The Committee concluded that the note provided some support for your contention that you had a discussion with Patient 3 on the risks of the treatment proposed which would have included the risk of damage to the bridge. In these circumstances, the Committee was not satisfied that the GDC has proved this charge to the requisite standard that you did not discuss treatment options, risks or benefits of the proposed treatment with Patient 3, including specifically the risk of damage to the patient's bridge/crown. However, whilst you had referenced discussion of risks in your entry of 31 August 2021, having reviewed the records, the Committee was not satisfied that risks and benefits had been adequately recorded. Accordingly, it finds this charge not proved in relation to discuss and found proved in relation to record.
3b	*You provided a poor standard of root canal treatment to the UR3* ***Found proved.*** Dr Ward's evidence was that she was critical of the standard of RCT you provided to UR3 for the following reasons: there was a fracture of porcelain on access; there was no evidence of the use of rubber dam, irrigant, or an estimate of working length and there was evidence of overfilling of the canal. Dr Ward subsequently withdrew her criticisms in relation to two aspects of the care – the use of the rubber dam and irrigant. However, Dr Ward maintained her criticisms that there was no evidence of a determination of working length and that the canal was overfilled. In her oral evidence Dr Ward explained that the radiograph showed that there was a round puff of sealer right at the apex inside the radiolucency. Dr Ward stated that the GP was visible past the 'puff'. Professor Barker, in his written statement, agreed that the post-operative radiograph revealed extrusion of the Gutta percha (GP) beyond the apex. However, in oral evidence, Professor Barker appeared to change his position and said that what had been thought to be over-extended GP was actually bone. Professor Barker explained

	that the overfill was limited to sealant which was a common occurrence with the material used. Professor Barker opined that whilst the canal was overfilled, it would be wrong to characterise the standard of treatment as 'poor'. Both experts agreed that there was evidence of periapical healing. They also agreed that there was overfill but disagreed as to its extent and nature. The experts agreed that there was no working length radiograph in the bundle for the tooth. In your witness statement you explained that Patient 3 had an extremely long UR3 (31 mm). You explained that you used a file and a radiograph to ascertain the length of the tooth. However, you accepted that you went further than 31 mm, likely opening up the tip of the root. You explained that one of the accessory points of GP went through the tip of the root. You accepted that you had made an error. However, in your oral evidence, you also changed the reference of GP to being sealant. In your written statement you stated that you used a file and a radiograph to ascertain the working length. You later stated in oral evidence that you meant to "confirm" working length. You further stated that the radiograph, which is not available in the bundle, may not have saved properly due to "system errors". In your written statement you stated that you should have used an apex locator and filled canals 1 or 1.5 mm short of the apex. At the outset of your oral evidence, you added the word 'again' to your witness statement. You stated that having used the apex locator, you confirmed the lengths using paper points. The Committee noted that there was no reference to the use of an apex locator in Patient 3's records nor was a working length radiograph recorded or reported on. The Committee found your evidence on this charge to be inconsistent and at times evasive. You amended your statement to include the word 'again' in respect of the apex locator. Further, there is no evidence of a determination of a working length, save for your note of "31+". The Committee considered you failed to obtain an accurate working length. You accepted that you went further than 31mm, and are likely to have opened up the tip of the root. In view of the over-preparation of the tip of the root and the evidence of filling material going beyond the apex, the Committee concluded that notwithstanding the evidence of healing, the RCT was of a poor standard. Accordingly, the Committee finds this charge proved.
3c	*You repeatedly complained about the equipment available at the practice* ***Admitted and found proved***
3d	*You showed anger towards Patient 3 in relation to him being unwilling to pay for the whole laboratory cost for the replacement crown that was required as a result of the crown being fractured during treatment.* ***Found proved*** Patient 3's evidence, as set out in his statement, was that at the appointment on 31 August 2021 you discussed the repair of Patient 3's crown which had fractured on 17 August 2021. His evidence was that prior to this appointment you asked him to

	pay for the laboratory costs. On Patient 3's account, he paid £100 towards the cost of replacing the crown on 14 September 2021. In his witness statement Patient 3 describes you becoming "very irate" because he was not willing to pay the entire laboratory cost. He describes you as being "quite forceful and loud" as you did not see why you should be paying for the replacement of the crown. In his oral evidence Patient 3 maintained that you became irate over the fact that you wanted him to pay for the full crown and the laboratory work and that he refused to pay the full amount. Patient 3 stated that the volume of your voice was a 7 (where 10 is high and 0 is low). Your evidence is that you had explained the risks associated to the replacement crown to Patient 3. Your understanding was that you had agreed with Patient 3 that you would carry out the repair free of charge and that he would pay for the laboratory fee in the event that the crown fractured during treatment. Your evidence was that Patient 3 subsequently resiled from that agreement. You said that "you did not recall being obnoxious or intimidating". When it was put to you that you got angry you said you were not happy about the bridge fracturing. You said that you were "in a hard place at the time". The Committee found Patient 3's evidence to be consistent on this point. Given the circumstances where you thought you had reached an agreement with Patient 3, the Committee has concluded that it was more likely than not that you showed anger to him in relation to him being unwilling to pay for the whole laboratory cost. Accordingly, it finds this charge proved.
3e	*You did not report on radiographs taken on 3 August 2021 and/or 17 August 2021.* ***Admitted and found proved***
4	*As a result of 3(a) above (if options, risks and benefits were not discussed with Patient 3) you did not obtain informed consent* ***Found not proved*** Given that it has found 3(a) above not proved, it follows that this charge is not made out.
Dental Nurse 1	
5	*On 28 September 2021 you left a used syringe on a tray resulting in a sharps injury to Dental Nurse 1 when she cleared the tray away* ***Found proved*** Dental Nurse 1 set out in her witness statement that on 28 September 2021, at the end of the patient's appointment, she began clearing a tray with some equipment on when she sustained a sharps injury. She described in her witness statement how the equipment on the tray had been left there by you and that she did not notice the used naked needle on the tray straight away as it was hidden under a pair of gloves. On Dental Nurse 1's account she was wearing a pair of gloves at the time when the needle went through her gloves and pricked her which caused some bleeding. In her oral evidence Dental Nurse 1 accepted that you never asked her to dispose of the syringe. She further accepted that the incident in question was an accident and that you took it seriously. Your evidence was that you did not leave the syringe for Dental Nurse 1 to dispose of and that you understood that it was your responsibility to dispose of it. You explained that you were in the process of taking the tray to dispose of the syringe yourself but you were delayed in doing so because the patient was asking you a

	number of questions. You explained that you took the incident seriously and that you followed the regular protocol. During the course of being cross-examined on this point you mentioned for the first time that the needle was capped. In response to questions by the Committee you explained that you never placed an uncapped needle on the tray and that the cap must have become dislodged. The Committee did not accept your evidence on this point and preferred the evidence of Dental Nurse 1. It is common ground that you placed the syringe on the tray and that Dental Nurse 1 sustained a sharps injury. It was satisfied that you had a duty to dispose of the used needle safely in accordance with the Organisation's sharps policy. You did not do so. Accordingly, the Committee is satisfied that you left a used syringe on a tray which resulted in a sharps injury to Dental Nurse 1.
<u>Communication and interaction with Dental Nurses</u>	
6	*Between around July 2021 to November 2021, your communication to and interaction with dental nurses at the Practice was unprofessional and inappropriate, including:*
6a	*Being angry and/or rude towards the dental nurses in respect of equipment at the practice and/or their knowledge of the equipment you were requesting and/or their competence;* ***Found proved*** Dental Nurse 2's evidence was that on 15 September 2021 she sent an email to the Practice Manager and the Practice Co-ordinator raising concerns about your behaviour. In that email Dental Nurse 2 refers to you asking for equipment she has never heard of in all of her years of dental nursing and when she asked you about it you shouted a catalogue number at her. In dental Nurse 2's witness statement she states that you would be rude and loud towards her when she was not able to find instruments you asked for which she had not heard of. Dental Nurse 2 described you as acting exasperated with her as if she was incompetent. Dental Nurse 3's evidence was that she found it difficult to work with you because you did not make her feel respected. Her evidence was that when nursing with you during RCT you would ask her for equipment which she had not heard of. On her account, this was because you knew the equipment by a different name which she was not familiar with. In her witness statement Witness 3 stated "When I asked the Registrant what equipment they were asking for he would laugh at me that I did not know what they were talking about". You accepted that your communication with the dental nurses was not always as good as it should have been and that you were sometimes 'short' in your responses to people. You also accept that at times, you allowed your frustration at your working conditions to have impacted on your mood. During the course of your evidence you apologised to the witnesses if your frustration caused them upset. The Committee found the evidence of Dental Nurses 2 and 3 to be reliable on this point. In addition, it has borne in mind that Dental Nurse 2's evidence is supported

	by her contemporaneous complaint to the Practice on 15 September 2021 in relation to this matter. Accordingly, it finds this charge proved.
6b	*Complaining about the inadequacy of equipment and materials in the presence of patients;* ***Admitted and found proved in respect of Patient 3 only*** ***Found proved in the presence of patients*** In relation to patients other than Patient 3, the Committee has had regard to the evidence of Dental Nurse 2. Her evidence was that on dates she could not recall, you complained to patients about the lack of equipment at the Practice. She raised this issue in her email dated 15 September 2021 to the Practice Manager and the Practice Co-ordinator. In that email Dental Nurse 2 refers to "numerous occasions" when you grumbled to the patient that the Organisation did not provide you with the equipment and materials you needed. You admitted this insofar as it took place in the presence of Patient 3. You set out in your witness statement that the Practice was often lacking in equipment that you considered to be important to undertake treatment. You say that this was because it had not been ordered or because colleagues would remove the equipment for their own use. In your oral evidence you explained that you were unable to recall specifically whether you made similar complaints in the presence of other patients. The Committee considered that Dental Nurse 2's evidence on this matter was credible. In addition, Dental Nurse 2's evidence was supported by her contemporaneous complaint to the Practice on 15 September 2021 in relation to this matter. Accordingly, the Committee finds this charge proved.
6c	*On one occasion removing Dental Nurse 2's chair from the treatment room meaning that she was unable to sit down all day* ***Found not proved*** Dental Nurse 2's evidence was that on a date she could not recall you removed her chair from the treatment room which meant that she could not sit down all day. Her evidence was that she had no understanding of why you removed the chair and she said that she did not question it with you at the time because "you were the dentist and she was the dental nurse". You deny this allegation. In your oral evidence you explained that you have no recollection of this event but you accepted that on one occasion you may have moved the chair within the treatment room and may have asked Dental Nurse 2 to stand so she could have a better view of the patient's mouth. Dental Nurse 2 accepted that she did not ask to fetch the chair back in. It follows that there was no evidence that you actively prevented her from being able to sit down all day. The Committee took account of Dental Nurse 2's position as lead nurse and concluded that even if the chair had been removed at some point, this did not preclude her from asking if she could fetch it back into the room. She did not do so. It follows that the Committee was not satisfied on the balance of probabilities that

	you had prevented her from returning the chair to the treatment room and therefore she was not unable to sit down all day. Accordingly, the Committee finds this charge not proved.
6d	*Throwing clinical items such as pouches or gloves at Dental Nurse 2, or on the floor, in order for her to pick them up* ***Found proved*** Dental Nurse 2's evidence was that on more than occasion you would throw things at her or on the floor, such as pouches of clean equipment or gloves, with the expectation that she would pick them up. Her evidence was that these incidents would happen when patients were present. In her oral evidence Dental Nurse 2 described this behaviour happening in front of patients on a frequent basis and she recollected picking up the items. However, she was unable to recollect if you would say something to her when you did this. You deny this allegation. In your witness statement you say that the incident being referred to was a situation where you sensed that Dental Nurse 2 appeared to be "somewhat unhappy" and that in an attempt to lighten the mood you stuffed paper toweling into an unused glove to make a "basketball". You threw the "basketball" in the direction of Dental Nurse 2 for her to catch. Your evidence was that Dental Nurse 2 picked it up and threw it in the bin. You then say that you repeated the exercise using an unused glove which you threw towards the bin but you missed it. Dental Nurse 2 picked it up and threw it away. You go on to explain that you were not making "basketballs" to throw at Dental Nurse 2 or to make her pick them up off the floor. You say that you were just trying to "lighten the mood" in the treatment room but you realise now that Dental Nurse 2 did not find this funny. When your account was put to Dental Nurse 2, her evidence was that she and you would need "to agree to disagree on that". Further, she did not accept the proposition that you were attempting to lighten the mood. By your own account, you repeated the exercise twice and on each occasion, you watched Dental Nurse 2 throw the "basketball" into a bin. The Committee found Dental Nurse 2's evidence was credible on this charge. It notes that Dental Nurse 2 made reference to you throwing "stuff on the floor and at me such as pouches and gloves" Her email of complaint dated 15 September 2021 supports her evidence. It rejected your position that you were attempting to lighten the mood. Accordingly, the Committee finds this charge proved.
6e	*Not allowing Dental Nurse 2 sufficient time to clean the treatment room in between patients.* ***Found proved*** Dental Nurse 2's evidence was that standard infection control procedure is to leave a ten-minute gap between patients' appointments to allow time for the dental nurse to clean the room. She described how you would bring the next patient into the treatment room before she could clean the room. Dental Nurse 2's evidence was that she would feel embarrassed that patients were coming into a dirty treatment room. In her oral evidence Dental Nurse 2 explained that this occurred several times, on

	dates which she could not recall. Dental Nurse 2 accepted that you did not mention this issue to you directly. You accepted that you had been spoken to by management in respect of not allowing sufficient time to clean. The Committee found Dental Nurse 2's evidence was credible on this charge. It notes that Dental Nurse 2 made reference to you bringing the next patient into the treatment room before she had cleaned it properly. Accordingly, the Committee finds this charge proved.
6f	*On or around 3 August 2021, in the presence of Dental Nurse 3, who is originally from Poland, when late for a patient's appointment saying to the patient words to the effect of "I'm sorry I'm late, I don't speak Polish", inferring that Dental Nurse 3's Polish accent was to blame for you being late to the appointment because you had not understood her.* ***Found proved*** In support of this charge the GDC relies on the evidence of Dental Nurse 3. Her evidence was that on 3 August 2021 you were late to a patient's appointment because the previous appointment took longer than anticipated. She explained that she told you that you were running late for the next patient's appointment. Dental Nurse 3's account was that she was present in the room as the dental nurse assisting you that day. Dental Nurse 3's evidence was that when you arrived at the next patient's appointment you said to the patient "*I'm sorry I'm late, I don't speak Polish".* Dental Nurse 3 understood that the comment related to her and the fact that she was Polish and spoke English with a Polish accent. She explained that she understood that the comment related to you not understanding what she told you about the time of the patient because of her Polish accent. Dental Nurse 3's evidence was that you did not say anything further to her to explain what you meant. In her oral evidence Dental Nurse 3 confirmed that either the phrase or words to that effect were used. Your evidence was that you do not recall this episode and explained that had you made such a comment it would have made in gest and would not have been made with any malice. You accepted that you must have said something similar for Dental Nurse 3 to have made a verbal complaint about you to the Practice Co-Ordinator. The Committee considers that Dental Nurse 3's evidence was consistent on this point. It rejected the suggestion that you were trying to be lighthearted in your comment. The Committee considers that you were effectively seeking to blame Dental Nurse 3 for being late for the appointment, which was inappropriate. Accordingly, it finds this charge proved.
<u>Consequences</u>	
7	*In relation to any or all of Charges 5, 6(d) and 6(e)*
7a	*You did not maintain appropriate standards of practice in relation to*
7ai	*The disposal of hazardous clinical waste* ***Found proved in relation to charge 5***

	The Committee has had regard to the Organization's Sharps Management and Inoculation Injury Policy. It considers that the sharps should have been dismantled straight away into the sharps bin. You failed to dispose of the used sharp in accordance with that policy, resulting in injury to Dental Nurse 1. Accordingly, it finds this charge proved in relation to charge 5. ***Found not proved in relation to charge 6(d)*** The Committee is not satisfied on the information before it that the material thrown at Dental Nurse 2 was hazardous clinical waste. ***Found proved in relation to charge 6(e)*** By not allowing Dental Nurse 2 sufficient time to clean the treatment room, there would have been an impact on her ability to remove hazardous clinical waste from the previous appointment.
7aii	*Decontamination* ***Found not proved in relation to charge 5*** This referred to the safe disposal of sharps and not decontamination. ***Found not proved in relation to charge 6(d)*** The Committee is not satisfied on the information before it that the material thrown at Dental Nurse 2 was contaminated. ***Found proved in relation to charge 6(e)*** By not allowing Dental Nurse 2 sufficient time to clean the treatment room, you did not maintain appropriate standards in relation to decontamination.
7aiii	*Cross infection control* ***Found proved in relation to charge 5*** *By not safely disposing of a used needle, in accordance with the Organisation's policy, you exposed colleagues to the risk of cross infection.* ***Found not proved in relation to charge 6(d)*** The Committee is not satisfied on the information before it that the material thrown at Dental Nurse 2 was contaminated. ***Found proved in relation to charge 6(e)*** By not allowing Dental Nurse 2 sufficient time to clean the treatment room, you did not maintain appropriate standards in relation to cross infection control. This clearly posed a risk of transmission of infection.
7b	*You put patient and dental professional health and safety at risk* ***Found proved in relation to charge 5*** You failed to dispose of the used sharp in accordance with that policy, resulting in an injury to Dental Nurse 2. ***Found not proved in relation to charge 6(d)*** The Committee is not satisfied on the information before it that the material thrown at Dental Nurse 2 amounted to a health and safety risk. ***Found proved in relation to charge 6(e)***

	By not allowing Dental Nurse 2 sufficient time to clean the treatment, you did not maintain appropriate standards in relation to cross infection control. This clearly posed risk of transmission of infection to patients as well as dental professionals.

16 The hearing moves to Stage Two.

Decision on fitness to practise

17 Having announced its decision on the facts, the Committee then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your practice is currently impaired.

18 In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Mr Smith on behalf of the GDC and Mr Hockton on your behalf in relation to the matters of misconduct, current impairment and sanction.

19 The Committee accepted the advice of the Legal Adviser, which included reference to relevant case law.

Evidence

20 The Committee had regard to the Defence bundle provided at this stage of the proceedings. This bundle consisted of the following documents:

- A copy of your CV;
- Copies of reports from your former Workplace Supervisor covering the period from March 2023 to 14 May 2025;
- A copy of a report from your current Workplace Supervisor dated 23 September 2025;
- Your personal reflections dated 8 October 2025;
- Continuing Professional Development (CPD) certificates on a range of topics, including root canal treatment and endodontics, radiography, communication and infection control;
- A copy of your reading log and
- Testimonials dated September 2025 – October 2025 from colleagues and patients.

Submissions

21 Mr Smith confirmed that you have no previous fitness to practise history. He addressed the Committee in relation to each of the findings against you, both in relation to your failure to provide an adequate standard of care to Patient 2 and Patient 3, as well as the 'conduct' matters regarding your communications and interactions with dental nurses and your failure to maintain appropriate standards of practice in relation to the disposal of hazardous clinical waste, decontamination and cross-infection control.

22 During the course of his submissions Mr Smith referred to the joint opinion of Dr Ward and Professor Barker in respect of some aspects of the case whereby they opined the care you provided to Patient 2 and Patient 3 fell far below the standard expected of a registered dental professional. He also submitted that each of finding against regarding your failure to obtained informed consent from Patient 2 was serious. Informed consent, by its very nature, was the bedrock of the public interest and was an essential part of the dentist-patient relationship.

23 Mr Smith invited the Committee to consider a number of the GDC's 'Standards for the Dental Team (2013)' which you have breached, as set out in his document. In short, he submitted that the findings against you amount to misconduct.

24 On the matter of current impairment, Mr Smith submitted that the clinical shortcomings are capable of remediation and the Committee must therefore consider whether there is sufficient evidence to demonstrate that the concerns before it have been sufficiently remediated so as to mitigate against any risk of repetition of similar conduct.

25 Mr Smith drew the Committee's attention to the Workplace Supervisor's report and raised the question as to whether your former Workplace Supervisor had seen the clinical notes of your discussions with patients. He submitted that it appeared from several entries in your notes that you were still experiencing problems with over/under-filling the root canals. He cited the example of one entry which states: "*Canals filled. MB gutta percha was a bit long and the patient was informed*." The GDC's position is that some of the entries in your notes do not document whether an accurate working length has been established – an issue which arose in both patients in this case. It was also the GDC's position that some of the radiographs you have reported on recently may show that the root canals have been over-filled. Mr Smith accepted that there is no expert opinion in relation to the radiographs he referred to in the Defence bundle.

26 In short, Mr Smith submitted that the conduct in relation to the clinical matters has not been remediated to a satisfactory standard and your insight is not fully developed.

27 Turning to the 'misconduct' issues relating to your communications with patients, Mr Smith acknowledged the positive testimonials submitted on your behalf by dental colleagues. However, Mr Smith submitted that it might be difficult to come to a conclusion as to how you would behave in the future towards dental colleagues on this information alone.

28 In relation to public interest, Mr Smith submitted that the public would expect a finding of impairment in response to the serious nature of allegations, to restore its confidence in the profession and in order to uphold proper professional standards.

29 Mr Smith submitted that the appropriate sanction in this case is a suspension order for a period of four to six months, with a review to take place before the expiry of the order. He drew the Committee's attention to paragraph 6.28 (under the heading 'Suspension' of the GDC document, 'Guidance for the Practice Committees including Indicative Sanctions Guidance (December 2020)', 'the GDC's Guidance', where it set out the factors that might be present to justify a suspension order. Mr Smith submitted that erasure was not appropriate in this case since the misconduct is at the lower end of the spectrum of seriousness.

30 Mr Hockton submitted that the clinical shortcomings regarding the RCT for Patients 2 and 3 do not go beyond negligent acts. He asked the Committee to bear in mind the evidence it had heard that there are known complications associated with RCT and that it goes wrong on a daily basis. In respect of the other matters concerning your communications with the dental nurse and your behaviour in front of Patient 3 in relation to him being unwilling to pay for the whole laboratory cost for the replacement crown, Mr Hockton submitted that these were isolated incidents of rude/off-hand comments in circumstances where you were frustrated with not always having the correct equipment available to you. However, those matters do not stray into the category of moral opprobrium urged by the GDC. He referred to the fact that the matters set out at charge 6 (relating to your communications with the dental nurses) are lacking in any specific details and took place in circumstances where the dental nurses only worked with you on a couple of occasions.

31 In short, Mr Hockton submitted that each of the matters individually do not reach the threshold of amounting to misconduct. He also submitted that these matters cannot be 'added up' to justify a finding of misconduct.

32 In the event that a finding of misconduct is found, Mr Hockton invited the Committee to conclude that your fitness to practise is not currently impaired. He made a number of points in support of that contention, including that the fact that over four and a half years have elapsed since the events in question took place. The events in question took place over a period of three or four months when you were working at the Practice on a part time basis and where there were problems with the right materials not always being present when carrying out RCT.

33 Mr Hockton made reference to the fact that you have been subject to an interim order of conditions since 2022. This has included a requirement that you have fortnightly one-to-one meetings with your Workplace Supervisor, which include a number of areas relating to the matters identified in this case, including RCT, discussing full risks, options and benefits of proposed treatment and radiographic practice and Health and safety, including decontamination and infection control results.

34 The Committee's attention was drawn to the reports from your former Workplace Supervisor reports covering the period March 2023 to 14 May 2025. These report positively on the progress you have made in the areas of concern identified in this case. Mr Hockton confirmed that your Workplace Supervisor has had the benefit of reviewing your clinical notes and has not raised any concerns. In short, Mr Hockton invited the Committee to conclude that the positive reports provided by your Workplace Supervisor and the supportive testimonials submitted paint a very different picture to that advanced by the GDC of four years ago. Mr Hockton further submitted that you have demonstrated insight into your past shortcomings and you have taken appropriate steps to remediate the clinical and 'conduct' issues in this case. Mr Hockton submitted that a finding of current impairment was not required on public protection grounds.

35 Mr Hockton submitted that as a result, a fair-minded member of the public would not consider that confidence in the profession or the GDC as its regulator would be undermined if a finding of impairment were not made. This was not, Mr Hockton submitted, a case involving dishonesty or sexual misconduct, where the public interest was likely to be engaged.

36 However, Mr Hockton submitted that if the Committee was minded to find current impairment, then concluding this case with a reprimand, which was the lowest sanction, would be appropriate. Mr Hockton submitted that were the Committee to decide to impose conditions on your registration, it should be for no longer than 4 to six months, given that you have already been subject to an interim order of conditions for some four years. Referring to the GDC's submission that an order of suspension would be appropriate, Mr Hockton submitted that this sanction would be excessive.

Committee's decision and reasons on misconduct

37 The Committee has considered whether any or all of the facts found proved amount to misconduct. In so doing, it has had regard to the submissions made by both parties. The Committee has also taken into account the expert opinions of Dr Ward and Professor Barker.

38 The Committee considers that in relation to Charges 1(a)(i) and (ii), your failure to conduct an adequate assessment of Patient 2, including failing to conduct an adequate clinical and radiographic examination, was serious. Both experts agree that if the Committee finds that the radiograph was not reviewed, then this would fall far below the expected standard. The Committee considers that it was essential requirement that you should have carried out an adequate clinical assessment before commencing RCT on 27 July 2021. In light of its findings, and having regard to the experts' joint opinion, the Committee has concluded that each of these findings fell far below the expected standard of care.

39 The Committee has found that you did not discuss, or record discussion of, treatment options, risks or benefits of the proposed treatment with Patient 2. Dr Ward's evidence was that one of those

options should have been extraction. It considers that it would have been essential for you to have had a detailed discussion with Patient 2. You did not do so. Consequently, you did not obtain informed consent from Patient 2 for what was extensive treatment. It has concluded that your failures in these matters are serious and fell far below the expected standard.

40 The Committee has found that you provided a poor standard of RCT to Patient 2's LL6, with particular reference to no evidence of working length determination and the roots were filled significantly short of the apices using incorrect materials. The Committee recognises that there may be complications in carrying out RCT. However, it considers that your failings in this regard were basic and were compounded by you not having adequately assessed Patient 2's tooth clinically or radiographically. It is satisfied that the failings in respect of the RCT fell far below the expected standard.

41 Regarding your failure to report on the radiographs taken on 27 July 2021 and/or 3 August 2021 and/or 12 October 2021, Dr Ward opined that this amounted to a falling far below the expected standard as it is a failure related to Ionising Radiation (Medical Exposure) Amendment Regulations (IRMER) regulations. Professor Barker's evidence was this amounted to a falling below but not far below the expected standard because he did not consider that there to be any evidence that the failure to report on the radiographs caused or potentially caused harm to the patient. The Committee preferred the evidence of Professor Barker because no harm was caused to the patient by not having a report on the notes.

42 The Committee has found you did not advise on or consider extraction of the LL6 at the earliest point. It has concluded that your failure to discuss this option falls far below the expected standard.

43 Turning to Patient 3, the Committee has found that you failed to record discussion of treatment options, risks or benefits of the proposed treatment, including specifically the risk of damage to the patient's bridge/crown. The Committee has concluded that this failure amounts to a falling below, but not far below the expected standard, given your entry in the notes on 31 August 2021.

44 The Committee has found that you provided a poor standard of RCT in respect of Patient 3's UR3. In particular, the Committee had regard to the over-preparation of the tip of the root and the evidence of filling material going beyond the apex. Both experts agreed that there was evidence of periapical healing. Professor Barker's opinion was that given that there is evidence of periapical healing, he considered that this would infer that overall, whilst the canal was over-filled, the standard of care fell below but not far below the expected standard. The Committee agrees with Professor Barker on this point. Despite the over-preparation of the apex and the extrusion of the filling material, the RCT appeared to be achieving the aim of the treatment and in those circumstances, the Committee concluded that the standard of care fell below but not far below the expected standard.

45 In respect of the Committee's finding that you repeatedly complained about the equipment available at the practice it considers that it was inappropriate for you to have made these comments and is not best practice. However, the Committee concluded that this fell below but not far below the expected standard.

46 Regarding you showing anger towards Patient 3 in relation to him being unwilling to pay for the whole laboratory cost for the replacement crown that was required, the Committee considers that it is not acceptable under any circumstances to show anger towards a patient. It heard from Patient 3 that you were "quite forceful and loud" in respect of this matter. The Committee considers that this amounts to a significant departure from expected behaviour and fell far below the standard expected.

47 Turning to your failure to report on the radiographs taken on 3 August 2021 and/or 17 August 2021, Dr Ward opined that this amounted to a falling far below the expected standard as it is a failure relating to IRMER regulations. Professor Barker's evidence was this amounted to a falling below but not far below the expected standard because he did not consider there to be any evidence that the failure to report on the radiographs caused or potentially caused harm to the patient. The Committee preferred the evidence of Professor Barker because no harm was caused to the patient by not having a report on the notes.

48 The Committee has considered the finding that on 28 September 2021 you left a used syringe on a tray resulting in a sharps injury to Dental Nurse 1 when she cleared the tray. Dr Ward's evidence was that if proved, this falls far below the expected standard. You failed to safely dispose of a sharp. Notwithstanding that you followed the right protocols following the incident, it does not resile from the seriousness of your actions in placing the syringe of the tray. The Committee considered this fell far below the standard expected.

49 Regarding your communication and interaction with dental nurses, the Committee has found that you were angry and/or rude towards the dental nurses in respect of equipment at the practice and/or their knowledge of the equipment. The Committee considers that it is important for dental professionals to work part of a team and that a failure to do so compromises patient care. The experts agree that if it is found that the charges are made out, then this fall far below the standard expected. The Committee agrees.

50 The Committee also found that you complained about the inadequacy of equipment and materials in the presence of patients. The Committee considers that it was unprofessional for you to have made these comments in front of patients. The experts agreed that it fell far below the expected standard. The Committee agrees with the experts.

51 The Committee considers that throwing clinical items such as pouches and gloves at Dental Nurse 2 or on the floor in order for her to pick them up was unacceptable behaviour. It was demeaning and resulted in unnecessary work for Dental Nurse 2. However, there was no evidence that the material thrown was contaminated or that it caused harm to Dental Nurse 2. The Committee has concluded that this matter fell below but not far below the standard expected.

52 The Committee heard from Dental Nurse 2 that you brought the next patient into the treatment room before it had been cleaned properly. You would have seen that the treatment room was unclean and that Dental Nurse 2 would have needed more time to clean the treatment room properly. It demonstrated a lack of respect on your part, represented poor teamwork and exposed patients to risk of cross infection. The Committee is satisfied that this matter fell far below the standard expected.

53 In respect of you making a comment on or around 3 August 2021 to a patient in the presence of Dental Nurse 3 words to the effect that "I'm sorry I'm late I don't speak Polish" the Committee heard from Dental Nurse 3 that she was sufficiently upset to make a verbal complaint about you to the Practice Co-Ordinator. However, she accepted this was not something she expected to have reached this level. She stated in her evidence that she now regards it as a trivial episode. The Committee found that this fell below the standard expected but not far below.

54 Finally, in respect of you not maintaining appropriate standards of practice in relation to charges 5 and 6(e), the Committee concluded that this falls far below expected standards because of hazardous waste, decontamination and cross infection control issues.

55 The Committee has had regard to the following principles from 'Standards for the Dental Team (2013)':

1.2.1 You should be aware of how your tone of voice and body language might be perceived.

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

1.5 You must treat patients in a hygienic and safe environment.

2.1 You must communicate effectively with patients - listen to them, give them time to consider information and take their individual views and communication needs into account.

2.3 Give patients the information they need, in a way they can understand, so they can make informed decisions.

3.1.1 You must obtain valid consent before starting any treatment or investigation. This applies whether you are the first member of your team to see the patient or whether you are involved after other team members have already seen them. Do not assume that someone else has obtained the patients consent.

6.1 You must work effectively with your colleagues and contribute to good teamwork.

6.5 You must communicate clearly and effectively with other team members and colleagues in the interests of patients.

7.1 You must provide good quality care based on current evidence and authoritative guidance.

56 The Committee has found that you have failed to adhere to a number of the GDC Standards for the Dental Team. This includes a failure to obtain informed consent in respect of Patient 2, which the Committee considers a serious matter.

57 The Committee concluded that the matters which fell far below the accepted standards, as identified in this determination, are serious and amount to misconduct.

Committee's decision and reasons on impairment

58 The Committee considered whether your misconduct is remediable, whether it had been remedied, and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare proper standards of conduct and behaviour to maintain public confidence in the profession and this regulatory process.

59 The Committee acknowledged that this case involves elements of clinical practice as well as conduct issues. It concluded that both are capable of remediation.

60 The Committee has taken into account the reports covering the period March 2023 to 14 May 2025 from your former Workplace Supervisor regarding your compliance with the interim order of conditions since 2022. This included a requirement that you have fortnightly one-to-one meetings with your Workplace Supervisor, which include a number of areas relating to the matters identified in this case, including RCT, discussing full risks, options and benefits of proposed treatment and radiographic practice and Health and Safety, including decontamination and infection control results. In his last report dated 14 May 2025 your Workplace Supervisor set out the topics of discussion in relation to a wide range of cases which has covered all aspects of your practice. He confirmed that

you have been complying with the terms of your registration, that he has no concerns about your workplace conduct and that he was not aware of any new complaints.

61 The Committee has also had regard to the most recent report dated 23 September 2025 from your new Workplace Supervisor. Overall, they have given you a score of 1 (= good) in respect of all aspects of your treatment, including radiography reporting and treatment options presented to the patient.

62 The Committee has had regard to the evidence that you have undertaken extensive hours of relevant and focused CPD which address the areas concerned in this hearing, including root canal treatment and endodontics, radiography, consent, communication and infection control. It is clear from the reports from your Workplace Supervisors that you have absorbed this into your daily practice.

63 The Committee has considered carefully the question of your insight. It has borne in mind that at the outset of the hearing you admitted some of the charges against you but you denied a number of the other matters, as was your right. During the course of your evidence you accepted some of your shortcomings and you apologised for your actions. The Committee recognised that you have undertaken many CPD courses and there is evidence of your reflection on these. Further, your insight is reflected in your treatment log and in the reports by your Workplace Supervisors.

64 It is clear from the steps you have taken over the last few years since being subject to an interim order of conditions, including your engagement with your Workplace Supervisors, that you have reflected on your practice and have taken practical steps to address the matters that brought you before the PCC. Your reflective statement dated 8 October 2025 sets out what you have learnt in the main areas of radiographic reporting, working length recording, patient choice and team management.

65 Accordingly, the Committee is satisfied that you have demonstrated sufficient insight into the matters that brought you before this Committee.

66 The Committee has also borne in mind the highly supportive testimonials from professional colleagues and patients, some of whom have recommended your services to friends and family. This includes a testimonial from a dental nurse, who has worked with you since July 2023. She states that what stands out most about your work is your ability to clearly explain even the most complex dental procedure in a way that patients can easily understands. She describes having an “excellent working relationship and easy communication” with you.

67 The Committee has paid particular regard to your former Workplace Supervisor last report dated May 2025 in which he states “I have been mentoring John [you] for a few years now and feel that you, the GDC, should make a decision, this has been going on long enough. John is working hard to deliver quality dentistry to his patients, he is very well read, keeping up to date with his dental literature which he brings to his every day practice”.

68 The Committee has given careful consideration to these factors and acknowledges the fact that in the four years since the incidents in question, no concerns have been raised about your clinical treatment or about your conduct. It was of the view that the interim conditions imposed on your practice had been effective and had contributed to your remediation. It also noted that no concerns have been raised with regards to your attitude and communication with patients and dental staff. Your CPD evidences that you continue to strive to improve your clinical practice.

69 Accordingly, the Committee has concluded that the risk of the concerns being repeated is low and therefore you do not currently pose a risk to the public. It has determined that a finding of impairment is not necessary on the ground of public protection.

70 Turning to the public interest, the Committee has concluded that notwithstanding its findings in relation to the shortcomings regarding your treatment of Patients 2 and 3, given the substantial evidence of remediation in respect of the clinical matters, and the fact that there is no evidence of repetition of these matters which took place some four years ago, a finding of current impairment is not necessary in the public interest.

71 The Committee considered that the conduct issues in relation to your communication and interaction with dental nurses and Patient 3 fall at the lower end of the spectrum of seriousness and do not warrant a finding of current impairment on the grounds of the public interest.

72 The Committee considered that issues in relation to you not maintaining appropriate standards of practice regarding the disposal of hazardous clinical waste, decontamination and cross infection control took place over a very short period of time. In relation to you not allowing Dental Nurse 2 sufficient time to clean the treatment room in between patients, you accepted that the Practice Manager spoke to you about this at the time and you then changed your practice. There is no evidence of any repetition of these matters despite you continuing in practice for the ensuing four years.

73 However, the Committee has considered with care your failure to obtain valid consent from Patient 2. As set out in the GDC's Guidance, obtaining valid consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment. Notwithstanding the remediation you have undertaken in this matter, and the insight you have gained, the Committee has concluded that a finding of current impairment in relation to your failure to obtain valid consent, albeit on one occasion, is necessary on the grounds of the public interest. It considers that public confidence in the dental profession would be undermined if a finding of impairment were not made in this case.

74 Accordingly, the Committee has determined that your practice is currently impaired on the ground of public interest.

Committee's decision and reasons on sanction

75 The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interests. It has borne in mind that its finding of current impairment was made solely on the grounds of public interest and that there are no concerns relating to patient safety.

76 In reaching its decision the Committee has taken into account the GDC's Guidance. It has applied the principle of proportionality, balancing the public interest with your own interests.

77 The Committee has considered the mitigating and aggravating factors present in this case.

78 In terms of mitigating factors, the Committee has noted that you have no fitness to practise history, that you have taken steps since the events in question to address the matters in this case and that during the hearing, both through your Counsel, and in your own evidence, you have apologised for your shortcomings.

79 The Committee also noted that this case relates to events that took place over a relatively short period of time (from around July 2021 until around October 2021) at a Practice where you were working a couple of days a month. There is no evidence of any repetition of the matters identified in

this case, some four years ago. The Committee has also had regard to the positive and supportive testimonials submitted on your behalf from professional colleagues and patients.

80 The Committee has concluded that there are no aggravating factors in this case.

81 The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of the findings made against you, with specific reference to the issue of not obtaining consent for Patient 2, the Committee considers that taking no action would be insufficient to maintain public confidence and trust in the profession and in the regulatory process, and would not declare and uphold proper standards of conduct and behaviour to the extent required in this particular case.

82 The Committee next considered whether it would be appropriate to conclude the case with a reprimand. It has borne in mind that the issue of consent, albeit serious, relates to one patient regarding treatment that took place some four years ago. It has had regard to your targeted CPD in this area, your Workplace Supervisors reports, your reflections and supportive testimonials from patients and your dental nurse regarding consent. Having given the matter careful consideration, and bearing in mind its conclusion that the risk of repetition is low, the Committee has determined that a reprimand is the appropriate and proportionate sanction.

83 In all circumstances, the Committee is satisfied that a reprimand is sufficient and proportionate to mark the seriousness of the misconduct. It is satisfied that the majority of the factors set out in paragraph 6.9 of the GDC's Guidance (on a reprimand) are met in this case. A reprimand would, in the Committee's judgement, meet the public interest considerations of trust and confidence in the profession and declaring and upholding of proper professional standards are engaged by this case. The Committee is satisfied that a reasonable and informed observer would, having regard to the Committee's findings of facts, misconduct and impairment, be satisfied that the sanction of a reprimand represents a suitable disposal of this case.

84 The Committee considers that a higher sanction such as conditions or suspension would be disproportionate and unsuited to the public interest purposes that the Committee has identified. Furthermore, the Committee is satisfied that there is no evidence to suggest that you currently pose a risk to the public such that it is necessary to impose any restrictions on your practice.

85 The Committee therefore directs that a reprimand be recorded against your name in the register. The fact of this reprimand, and a copy of this determination, will appear alongside your name in the GDC register for a period of 12 months. The reprimand forms part of your fitness to practise history, and is disclosable to prospective employers and prospective registrars in other jurisdictions.

86 The Committee has been informed that your registration is currently subject to an interim order of conditions. In accordance with Rule 21(3) the interim order is hereby revoked.

87 That concludes this case.