GENERAL DENTAL COUNCIL

AND

COETSEE, John

[Registration number: 72009]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council, commencing at **10:00am** on **14 October 2024.**

Please note that this hearing will be conducted remotely by video conference.

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

Committee members

Debbie Jones	DCP	Chair
Carson Black	Dentist	
Kam Sandhu	Lay	

Advisers:

Alastair McFarlane	Legal Adviser

CHARGE

John COETSEE, a dentist, BDS Queen's University of Belfast 1998 is summoned to appear before the Professional Conduct Committee on 14 October 2024 for an inquiry into the following charge:

"That, being a registered dentist, whilst in practice as a dentist at the Practice (identified in Schedule A below):

Patient 2

1. You failed to provide an adequate standard of care to Patient 2 (identified in Schedule B below), 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.

Patient 3

3. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule B below), 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 (identified in Schedule B below) 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 (identified in Schedule B below) 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 (identified in Schedule B below) 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."