Notice to Dentists Pursuant to Bylaw 20(7) of the Alberta Dental Association and College
Summary of the Decision about Unprofessional Conduct of the ADA&C Hearing Tribunal involving Dr. William Mather.
The Decision involving sanctions, or penalties, will be published upon its written release by the Hearing Tribunal. Dr. Mather has the right to appeal.

ALLEGATION	FINDING OF THE HEARING TRIBUNAL	*HEALTH PROFESSION ACT (s. 1(1)(pp) definition of unprofessional conduct)*
Charge 1A: Failing to obtain informed consent from the parent of A.A. on September 6, 2016 and/or September 7, 2016 for the treatment provided to A.A. on September 7, 2016 including failing to discuss the risks and benefits of treatment and general anaesthesia and/or neurolept anaesthesia including no treatment or anaesthesia and the requirements to prepare a child for undergoing a general anaesthetic and/or neurolept anaesthesia.	**Proven**	1(1)(pp)(ii) contravention of Code of Ethics or Standards of Practice.
Charge 1B: Failing to provide appropriate care in the pre-operative, intraoperative phases (including treatment and general anaesthesia and/or neurolept anaesthesia) and/or post-operative/recovery phases delivered to A.A. on September 7, 2016, including one or more of the following:	**Partially proven**	1(1)(pp)(i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and (ii) contravention of Code of Ethics or Standards of Practice.
i. ensure a history and physical examination was performed or completed including the pre-anaesthetic assessment;	Partially proven	
ii. establish the NPO status of the patient including time of last food and drink;	Proven	
iii. establish the weight of the patient;	Proven	
iv. ensure the anaesthetic gases were turned off before leaving the operatory;	Proven	
v. monitor appropriate, consistent and reliable vital signs during treatment, anaesthesia and post-operatively;	Partially proven	
vi. ensure the personnel was qualified to monitor patients, while Dr. Mather performed the treatment;	Not proven	
vii. follow an explicit protocol for the hand-over of responsibility to recovery room personnel;	Proven	
viii. ensure continuous observation, attendance, assessment and monitoring by competent and qualified recovery room personnel during the recovery phase;	Proven	
ix. leave the patient in the care of a qualified and competent person, after exiting the operatory to attend to another patient;	Proven	
x. properly position the patient in the recovery phase;	Not proven	
xi. maintain the patient's IV during the recovery phase;	Proven	
xii. appropriately supervising personnel providing care and managing the care of A.A. on September 7, 2016.	No finding: overlaps with other allegations	
Charge 1C: Failing to provide appropriate care to and management of A.A. on September 7, 2016 when addressing the overall emergency situation, including one or more of the following:	**Proven**	1(1)(pp)(i) displaying a lack of knowledge of or lack of skill or judgment in the

i. inadequate and timely response to the emergent situation; ii. inadequate resuscitation efforts by Dr. Mather; iii. inadequate resuscitation efforts by the personnel under Dr. Mather's supervision; iv. failing to initiate the 911 call upon the discovery of the non-responsive patient; v. failing to follow PALS protocols in the resuscitation of A.A.; vi. failing to immediately access and implement the emergency resuscitation cart.	Proven Proven Proven Proven Proven Proven	provision of professional services; (ii) contravention of Code of Ethics or Standards of Practice; and (xii) conduct that harms the integrity of the profession.
1D: Failing to report or to appropriately report a Reportable Incident to ADA&C following the professional services provided to A.A. on September 7, 2016, by failing to make a telephone reporting to the ADA&C within one working day of the discovery of the Reportable Incident.	**Admitted by Dr. Mather/proven**	1(1)(pp)(ii) contravention of Code of Ethics or Standards of Practice; and (xii) conduct that harms the integrity of the profession.
2A: Failing to meet your duties and/or responsibilities as a Dental Operator of a Dental Surgical Facility ("DSF"), including failing to ensure one or more of the following: i. the safe and effective care of patients in the DSF is achieved; ii. the clinical status of patients is assessed, monitored and responded to in a timely and appropriate manner; iii. the duties and responsibilities of all personnel are described, understood and documented; iv. complete and current Manuals, appropriate to the DSF are in place; v. arrangements and protocols are in place for the emergency transfer and admission of patients to hospital; vi. appropriate, complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are created and maintained; vii. the time on the Welch Allyn 6200 monitor is set to the correct time.	**Partially proven** Not proven Not proven Proven Proven Proven No finding: overlaps with other allegations No finding: overlaps with other allegations	1(1)(pp)(i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.
2B: Failing to meet your duties as the Dental Operator and/or Qualified Dentist in one or more of the following: i. not organizing, participating and documenting mock drills that involve appropriate personnel for the management of life-threatening emergencies related to procedures performed in the DSF in the time required by the DFA Standards; ii. not ensuring that the recovery room registered nurse has the necessary qualifications, competencies, skills and abilities to appropriately and continuously monitor the patient;	**Partially proven** Proven No finding: overlaps with other allegations	1(1)(pp)(ii) contravention of Code of Ethics or Standards of Practice; and (xii) conduct that harms the integrity of the profession.

iii. not ensuring that delegated functions for administration of medications and anaesthetic, monitoring of vital signs, record keeping, observation of patients and recovering patients are provided only by competent and qualified personnel;	No finding: overlaps with other allegations	
iv. not having appropriate policies and procedures in place to address emergency situations in your dental practice;	No finding: overlaps with other allegations	
v. not appropriately training personnel in the administration of sedation, neurolept anaesthetic and/or general anaesthetic, in the pre-anaesthetic, intra-operative, recovery phase and/or in providing emergency response;	Not proven	
vi. not supervising personnel involved in the administration of sedation, neurolept anaesthetic and/or general anaesthetic generally.	Not proven	
2C: Displaying a lack of knowledge of, or a lack of skill or judgment in the provision of professional services by continuing to provide professional services under sedation, neurolept anaesthesia and/or general anaesthesia in the same afternoon and the days following the emergency of A.A., without meeting with personnel to review the incident and your and their competencies and qualifications, reviewing Standards of Practice, policies and procedures in place or considering if you and/or your personnel were able to continue providing professional services and sedation, neurolept anaesthesia and/or general anaesthesia, safely and competently given the events of A.A.	**Proven**	1(1)(pp)(i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.
3A: Failing to create or maintain appropriate patient records on September 7, 8, and/or 9, 2016 for 8 specific patients	**Admitted by Dr, Mather/proven for the 8 patients**	1(1)(pp)(ii) contravention of Code of Ethics or Standards of Practice.
3B: Failing to appropriately or accurately bill for professional services provided to patients on September 7, 8, and/or 9, 2016 for 3 specific patients	**Admitted by Dr. Mather/proven for the 3 patients**	1(1)(pp)(ii) contravention of Code of Ethics or Standards of Practice.
4A: Failing to comply with undertakings or promises given to the ADA&C identified in the 2013 ADA&C Facility Inspection Report.	**Admitted by Dr. Mather/proven**	1(1)(pp)(ii) contravention of Code of Ethics or Standards of Practice; and (xii) conduct that harms the integrity of the profession.
4B: Representing yourself as a specialist when you are a general dentist.	**Admitted by Dr. Mather/proven**	1(1)(pp)(ii) contravention of Code of Ethics or Standards of
5A: Failing to have appropriate infection prevention and control practices in your dental practice, on or about October 6, 2016.	**Admitted by Dr. Mather/proven**	1(1)(pp)(ii) contravention of Code of Ethics or Standards of Practice.