Notice to **DENTISTS**

IN ACCORDANCE WITH BYLAW 20(7) OF THE ALBERTA DENTAL ASSOCIATION AND COLLEGE

BRIEF SUMMARY OF FACTS

The patient was a four-year-old girl who, on September 7, 2016, attended with her father at Dr. William Mather's office for an initial consultation. Later that morning, Dr. Mather performed dental surgery on her under general anesthetic. At the conclusion of the surgery, Dr. Mather left the patient in the care of a registered nurse, during which time the patient went into respiratory and cardiac arrest. A phone call was made to Emergency Medical Services (EMS) at 12:30:08 p.m., as recorded by Alberta Health Services. After EMS arrived at Dr. Mather's practice, they noted that the patient had carotid pulses present at 12:39:30 p.m. The patient was transferred by EMS to the Stollery Children's Hospital where she was diagnosed with severe anoxic brain injury. She suffered serious and irreversible neurological damage.

Following the incident, Dr. Mather continued to administer anaesthesia to children and adults, until September 9, 2016 when the Alberta Dental Association and College (ADA&C) restricted Dr. Mather's practice permit pursuant to section 65(1) of the *Health Professions Act* from administering sedation or general anaesthesia to patients eight years of age and under. A further restriction was placed on Dr. Mather's practice permit on September 26, 2016 pursuant to section 65(1) of the *Health Professions Act* (HPA) to restrict him from administering sedation or general anaesthesia to any patient.

On September 9, 2016, the Complaints Director of the ADA&C initiated a complaint and began an investigation into this incident. Upon the investigation concluding, this matter was referred to a hearing under section 66(3)(a) of the *Health Professions Act* to consider a number of charges alleging unprofessional conduct on the part of Dr. Mather.

UNPROFESSIONAL CONDUCT BY DR. MATHER

On February 12, 2018, a Hearing Tribunal of the ADA&C found Dr. Mather guilty of unprofessional conduct and a further date was set for sanctioning. A Hearing Tribunal are the decision makers at a hearing and are comprised of a member of the public appointed by the Government of Alberta and three dentists registered in Alberta.

A summary of the charges against Dr. Mather, the findings of the Hearing Tribunal, admissions by Dr. Mather and the relevant sections of the *Health Professions Act* are set out below. The term "CoE" means the Alberta Dental Association and College Code of Ethics, "HPA" means the *Health Professions Act* and "SOP" means Standard of Practice.

ALLEGATION (NOTICE OF HEARING)	FINDING OF THE HEARING TRIBUNAL	HEALTH PROFESSION ACT (s. 1(1)(pp) definition of unprofessional Conduct
1A: Failing to obtain informed consent from the parent of the patient on September 6, 2016 and/or September 7, 2016 for the treatment provided to the patient 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 CoE or SOP.
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 the patient 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 CoE or SOP.
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 the patient on September 7, 2016.	No finding: overlaps with other allegations	
1C: Failing to provide appropriate care to and management of the patient 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 provision of professional services; (ii) contravention of CoE or SOP and (xii) conduct that harms the integrity of the profession.
i. inadequate and timely response to the emergent situation;	Proven	
ii. inadequate resuscitation efforts by Dr. Mather;	Proven	
iii. inadequate resuscitation efforts by the personnel under Dr. Mather's supervision;	Proven	
iv. failing to initiate the 911 call upon the discovery of the non-responsive patient;	Proven	
v. failing to follow PALS protocols in the resuscitation of the patient;	Proven	
vi. failing to immediately access and implement the emergency resuscitation cart.	Proven	
1D: Failing to report or to appropriately report a Reportable Incident to ADA&C following the professional services provided to the patient on September 7, 2016, by failing to make a telephone report 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 CoE or SOP; 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:	**Partially proven**	1(1)(pp)(i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.
i. the safe and effective care of patients in the DSF is achieved;	Not proven	
ii. the clinical status of patients is assessed, monitored and responded to in a timely and appropriate manner;	Not proven	
iii. the duties and responsibilities of all personnel are described, understood and documented;	Proven	
iv. complete and current Manuals, appropriate to the DSF are in place;	Proven	
v. arrangements and protocols are in place for the emergency transfer and admission of patients to hospital;	Proven	
vi. appropriate, complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are created and maintained;	No finding: overlaps with other allegations	
vii. the time on the Welch Allyn 6200 monitor is set to the correct time;	No finding: overlaps with other allegations	

ALLEGATION (NOTICE OF HEARING)	FINDING OF THE HEARING TRIBUNAL	HEALTH PROFESSION ACT (s. 1(1)(pp) definition of unprofessional Conduct
2B: Failing to meet your duties as the Dental Operator and/or Qualified Dentist in one or more of the following:	**Partially proven**	1(1)(pp)(ii) contravention of CoE or SOP; and (xii) conduct that harms the integrity of the profession.
viii. 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;	Proven	
ix. not ensuring that the recovery room registered nurse has the necessary qualifications, competencies, skills and abilities to appropriately and continuously monitor the patient;	No finding: overlaps with other allegations	
x. 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	
xi. not having appropriate policies and procedures in place to address emergency situations in your dental practice;	No finding: overlaps with other allegations	
xii. 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	
xiii. 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 the patient, 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 the patient.	**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 CoE or SOP.
3B: Failing to appropriately or accurately bill for professional services provided to patients 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 CoE or SOP.
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 CoE or SOP; 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 CoE or SOP.
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 CoE or SOP.

PENALTY

The Hearing Tribunal accepted the Joint Submission on Penalty and issued the following orders against Dr. Mather:

1. Dr. Mather is ineligible for registration with the ADA&C;
2. Dr. Mather undertook, which the Hearing Tribunal confirmed, that he will not apply to register or apply for reinstatement as a dentist in Alberta; and
3. Dr. Mather must pay the costs of the investigation and hearing in the amount of $330,000 due immediately.

The Joint Submission set out that if Dr. Mather had not already retired, the ADA&C would have sought cancellation of his permit and registrations as a dentist.

The Hearing Tribunal also noted that had a Joint Submission not been submitted and accepted, it would have considered imposing substantial fines as a reflection of its denunciation of Dr. Mather's conduct and a sign to the public that the ADA&C sees his conduct as falling within the most severe forms of unprofessional conduct.