IN THE MATTER OF A HEARING BY A PANEL OF THE INQUIRY COMMITTEE OF THE BRITISH COLUMBIA COLLEGE OF ORAL HEALTH PROFESSIONALS PURSUANT TO THE *HEALTH PROFESSIONS ACT*, RSBC 1996 c. 183

BETWEEN:

THE BRITISH COLUMBIA COLLEGE OF ORAL HEALTH PROFESSIONALS

AND:

DR. KYLE NAWROT

DECISION OF THE INQUIRY COMMITTEE

Hearing Date:	April 17, 2025 (by videoconference)
Inquiry Committee Panel:	Dr. Jonathan Adams, Chair Thelma O'Grady Charanpreet Dhami
Counsel for the BCCOHP:	Michael Shirreff and Jennifer Falzon
Counsel for Dr. Nawrot	Brent Parker
Independent Counsel for the Panel:	Amy M. Nathanson

A. INTRODUCTION

1. A panel of the Inquiry Committee of the College of Oral Health Professionals of British Columbia (the **College**) conducted a hearing pursuant to s. 35 of the *Health Professions Act* (the **HPA**) to consider whether it is necessary to take extraordinary action against Dr. Nawrot (the **Registrant**) to protect the public pending the resolution of two complaints.

2. The hearing took place by videoconference on April 17, 2025. The Registrant was represented by counsel.

3. For the reasons set out below, the Panel has determined that an order under s. 35 of the *HPA* imposing conditions on the Registrant's practice is necessary to protect the public.

B. FACTUAL BACKGROUND

4. The Registrant has been licenced by the BCCOHP since August 1, 1998. He owns and practices at Lifetime Dental, a clinic in Abbotsford British Columbia.

The Complaints

5. This hearing relates to two complaints, both from individuals formerly employed at Lifetime Dental.

The [redacted] Complaint

6. The first complaint was sent to the College on August 21, 2024, from [redacted], a former receptionist at Lifetime Dental (the "[redacted] **Complaint**").

7. The [redacted] Complaint included the following allegations: billing under another dentist's ID numbers; billing for treatments not actually performed; billing policy holders who were not seen as patients; billing a deceased patient; performing fillings instead of sealants contrary to treatment planning; and "shady billings" including billing insurers directly to determine coverage instead of sending pre-determinations.

8. The College advised [redacted] that it would be difficult for the Registrant to respond to her complaint without particulars of the alleged misconduct, including names and dates. On October 3, 2024, [redacted] provided some additional information to the College, including the following:

   (a) The Registrant billed patients for work on December 31, 2023, but the clinic was closed that day;

   (b) [redacted] provided specific dates that the Registrant did his own billing, including on Sundays when he saw emergency patients and on long weekends while he was suspended he had another dentist come in, but he did the billing;

   (c) On September 30, 2023, the Registrant billed units of scaling for [redacted] but he did not perform the scaling and no hygienist was in the office that day; he also billed for treatment of [redacted] when he did not treat her (she is a young child and had been uncooperative); and

(d) In September 2023 the Registrant billed for root canals for [redacted] using [redacted] ID but [redacted] did not recall [redacted] being in the office that day or recall root canals being performed.

The [redacted] Complaint

9. On December 5, 2024, the College received a complaint from [redacted], a dentist who had been employed by the Registrant at Lifetime Dental. On December 6, 2025, [redacted] sent the College two additional allegations regarding the Registrant (collectively, the [redacted] **Complaint**).

10. The [redacted] Complaint set out the following allegations:

(a) On August 25, 2024, the Registrant interfered with her treatment of four patients;

(b) The Registrant used uncertified dental assistants for tasks requiring certification;

(c) Lack of transparency regarding his recent suspension;

(d) The patient records she received after she left Lifetime Dental appeared to have been altered because she noticed that her clinical notes for three patients were missing; and

(e) "Potential overbilling" -many billing decisions were made directly by the Registrant and she observed bills being altered or additional items being added.

11. On February 12, 2025, [redacted] Complaint and the [redacted] Complaint (collectively, the **Complaints**) were referred to the Inquiry Committee and it directed that an own-motion investigation under s. 33(4) of the *HPA* be commenced.

12. On February 19, 2025, two College inspectors attended Lifetime Dental to hand-deliver letters regarding the Complaints. Each letter contained a copy of the complaint, requested a written response from the Registrant and confirmed that the inspectors were present to obtain copies of patient charts relating to the Complaints (six relating to the [redacted] Complaint and four relating to the [redacted] Complaint).

13. The Registrant was not at Lifetime Dental when the College inspectors arrived, but a staff member advised she had spoken to him, and he would be in shortly. Staff later advised that the Registrant would not be coming in, but advised that they were copying the patient records and would email them to the College that afternoon.

14. From February 20, 2024 to March 5, 2024, the College made numerous attempts to obtain the patient records from the Registrant, including through telephone calls, letters, emails and inspectors attending Lifetime Dental. During this time, clinic staff provided various reasons for the delay, including staff unfamiliarity with the clinic's software, files being too large to email, staff illnesses [redacted]

15. The Registrant's production of patient records was intermittent and protracted: three records were produced on February 21, 2025, two partial records were produced on February 25, 2025, and one record was produced on March 5, 2025.

16. On March 5, 2024, the College sent a letter to the Registrant confirming that patient records were still outstanding and advising that if he did not provide a written response to the Complaints by March 12, 2025, his failure to respond and failure to cooperate would be referred to a panel of the Inquiry Committee for direction.

17. The Registrant did not provide the remaining patient records or respond to the Complaints, and the matter was referred to the Inquiry Committee. On March 26, 2025, the Inquiry Committee directed that if the Registrant did not respond within five days, the College should proceed with a citation and seek an order under s. 35 of the *HPA*.

18. The Registrant did not respond to the College, and on April 2, 2025, the College provided him with notice that it would be proceeding with a hearing under s. 35 of the *HPA* and that the hearing would take place on April 17, 2025.

The Registrant's Discipline History

19. The Registrant has a lengthy discipline history. The College provided a 17-page summary of his discipline history, which includes approximately 42 complaints, four citations, two consent orders and numerous agreements to remedial actions under sections 36 and 37.1 of the *HPA*.

20. The complaints against the Registrant have related to numerous areas of practice, including informed consent, excessive, unnecessary and sub-standard treatment, diagnosis and treatment planning, record keeping and billing. The remedial actions have included remedial coursework on topics such as record keeping and ethics, regular chart

audits (from 2007 to 2012) and a mandatory mentorship covering issues of endodontics, diagnosis and treatment planning and clinical treatment.

21. The Registrant has been fined, and suspended from practice twice, once in February 2020 for nine months and once in October 2023 for 12 months. This most recent suspension overlaps with the Complaints, both of which contain allegations that the Registrant was practicing during his suspension.

22. Throughout, there has been a pattern of the Registrant failing to respond to the College in a timely or responsive manner.

The Adjournment Request

23. By email dated April 14, 2025, counsel for the Registrant sought a brief adjournment of the hearing to allow him to fully prepare response materials. Counsel advised that he had provided the College the remaining patient records that morning and submitted that to the extent the urgency in proceeding with the hearing related to the Registrant's failure to provide these records to the College, this was no longer an issue.

24. The College opposed the adjournment request, noting both the urgency inherent in a s. 35 hearing and the fact that counsel for the Registrant had previously confirmed his availability and had advised the College that he required its submissions by April 9, 2025, or he anticipated seeking an adjournment. The College provided its submissions and supporting affidavit to the Registrant's counsel on April 9, 2025, as requested.

25. On April 15, 2025, the Panel advised the parties that it was denying the adjournment request and provided its written reasons to the parties on April 17, 2025.

C. LAW

26. Section 35 of the *HPA* gives the Inquiry Committee the power to take action to protect the public pending completion of an investigation or a hearing of the Discipline Committee.

27. Section 35 provides:

> **Extraordinary action to protect public**
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> 35. (1) If the inquiry committee considers the action necessary to protect the public during the investigation of a registrant or pending a hearing of the discipline committee, it may, by order,
>
> (a) impose limits or conditions on the practice of the designated health profession by the registrant, or
>
> (b) suspend the registration of the registrant.
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> (2) An order of the inquiry committee under subsection (1) must
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> (a) be in writing,
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> (b) include reasons for the order,
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> (c) be delivered to the complainant, if any, and to the registrant, and
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> (d) advise the registrant of the registrant's right to appeal the order to the Supreme Court.
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> (3) A decision under subsection (1) is not effective until the earlier of
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> (a) the time the registrant receives the notice under subsection (2), and
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> (b) 3 days after the notice is mailed to the registrant at the last address for the registrant recorded in the register of the college.
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> (4) If the inquiry committee determines that action taken under subsection (1) is no longer necessary to protect the public, it must cancel the limits, conditions or suspension and must notify the registrant in writing of the cancellation as soon as possible.
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> (5) A registrant against whom action has been taken under subsection (1) may appeal the decision to the Supreme Court and, for those purposes, the provisions of section 40 respecting an appeal from a decision of the discipline committee apply to an appeal under this section.

28. Section 35(1) allows the Inquiry Committee, if it considers the action necessary to protect the public, to either impose conditions on a registrant's practice or to suspend a registrant's registration.

29. The parties agreed that leading authority in B.C. with respect to section 35 hearings is *Scott v. College of Massage Therapists*, 2016 BCCA 180 (***Scott***).

30. In *Scott*, the Court summarized the two-step test for determining whether extraordinary action under s. 35 of the *HPA* is required:

    (i) whether there is a *prima facie* case supporting the allegations against the registrant; and

    (ii) whether the public requires protection through an interim order.

31. The two questions in this test are distinct: the first goes to whether there is a *prima facie* case against the individual and the second requires a determination of whether the allegations and evidence "justify action necessary to protect the public:" *Klop v. College of Naturopathic Physicians of British Columbia*, 2023 BCCA 125 at para 14 (***Klop***).

32. Additional guidelines for s. 35 orders are set out in *Scott* and *Klop v. College of Naturopathic Physicians of British Columbia*, 2022 BCSC:

    (a) When determining whether a *prima facie* case exists, the inquiry committee is not making any findings of fact regarding the complaints. The inquiry committee must make a "provisional assessment of the facts" and consider "the reliability of the evidence, its internal and external consistency, the plausibility of the complaint and motivation" to determine whether the complaint is "manifestly unfounded or manifestly exaggerated."

    (b) When determining whether there is a real risk to the public if an interim order is not granted, the seriousness of the risk is determined by considering the seriousness of the allegations, the nature of the evidence and the likelihood the conduct will be repeated if no order is made.

    (c) It is not sufficient for the inquiry committee to consider an interim order to be merely desirable; there must be a real risk to patients, colleagues or the public if an order is not made. The risk cannot be speculative**.**

    (d) The inquiry committee must consider the impact of an order on the registrant and balance the need for an order against the consequences to the registrant. The inquiry committee must also be satisfied that the consequences of the order are not disproportionate to the risk it is seeking to protect the public from.

    (e) The standard of proof falls between "the assertion of an unsubstantiated allegations and high standard which is required with respect to the evidence considered at the full hearing of the merits..."

    (f) If the inquiry committee finds that an interim order is necessary, it should not automatically order an interim suspension. Rather, it should first consider whether interim conditions would be sufficient and proportionate.

33. The parties also agreed that orders under s. 35 of the *HPA* are extraordinary and should be used sparingly. In *Kalia v. Real Estate Council of Alberta*, 2021, ABQB 950 (***Kalia***), the court described a suspension under the equivalent provision in the *Real Estate Act*, as a "draconian power" because it denies an individual the ability to practice their profession before a finding of misconduct.

34. The Panel is entitled to consider the Registrant's discipline history on this application. Section 39.2 of the *HPA* provides (in part):

> 39.2(1) Before taking any action respecting a registrant under the following provisions, the registrar, inquiry committee or discipline committee may consider any action previously taken under Part 3 respecting the registrant:
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> …
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> (b) in the case of the inquiry committee, section 33 or sections 35 to 37.1

D. ANALYSIS AND FINDINGS

Position of the College

35. The College's position was that due to the serious nature of the alleged misconduct and the Registrant's discipline history, it is necessary for the protection of the public that the Registrant be suspended pending the resolution of the Complaints.

36. The College submitted that the Complaints contain credible allegations of misconduct that are set out in writing, provide details including names and dates, are from credible sources (both of whom worked closely with the Registrant) and were not made for any improper motive.

37. As a result, the College submitted that the Complaints are not "trivial or clearly misconceived" and there is a *prima facie* case supporting the Complaints.

38. In terms of whether the public requires protection, the College submitted that the allegations in the Complaints are serious, and that there is an urgent risk to the public if an interim order is not made. The College submitted that while the allegations in the Complaints do not relate to technical proficiency, they do relate to core, foundational professional obligations and raise concerns about the Registrant's ethics.

39. The College highlighted the Registrant's discipline history, which it characterized as "lengthy and serious" and submitted that the Panel should consider the risks to be inferred from his discipline history. The College also submitted that it does not appear that the extensive disciplinary measures against the Registrant have impacted his practice, and since some of the same issues from the Registrant's discipline history are repeated in the Complaints there is a clear risk of repeated misconduct.

40. The College submitted that the Registrant's history of failing to respond to the College is an important issue. The College emphasized that the Registrant providing the remaining patient records to the College on the eve of this hearing does satisfy his obligation to promptly respond to requests from the College and noted that he still has not provided a response to the Complaints. The College submitted that the Registrant's delay in providing patient records was intentional avoidance of his professional obligation to cooperate with the College.

41. The College confirmed that it is not appropriate to make a finding on ungovernability at a s. 35 hearing and that whether the Registrant is ungovernable is not the issue before the Panel. However, it submitted that the factors used to determine ungovernability appear to be met and the Registrant has shown he is ungovernable through his discipline history, and his ongoing failure to cooperate with the College.

42. The College submitted that these indicia of ungovernability combined with the allegations in the Complaints present a real risk of harm to the public in the absence of an interim order under s. 35 of the *HPA* and that the Registrant should be suspended.

Position of the Registrant

43. The Registrant's position was that there is no immediate or demonstrable risk to the public that would justify the extraordinary measure of suspending his registration under s. 35 of the *HPA* pending a determination of the Complaints.

Prima Facie Case

44. First, the Registrant submitted that there is no *prima facie* case against him arising out of the Complaints.

45. The Registrant highlighted that a registrant may provide evidence to establish that the allegations are manifestly unfounded or exaggerated (*Scott*, para 81) and that the Panel is entitled to make a provisional assessment of the facts and consider the reliability of the evidence, its internal and external consistency, the plausibility of the Complaints and motivation (*Scott*, para 88).

46. The Registrant submitted that the plausibility of the Complaints should be assessed in light of [redacted] and [redacted] motivations. The Registrant pointed to the fact that the Registrant terminated [redacted] employment at Lifetime Dental and that she had also complained about the Registrant's treatment of her during her employment.

47. The Registrant also suggested that [redacted] may have retaliatory motivations, referring to email correspondence where she expressed frustration at delays in being paid, and the one-star review of Lifetime Dental she posted advising that she had left the clinic because she had not been paid. The Registrant also suggested that [redacted] stood to gain financially if he were suspended because she had solicited his patients.

48. The Registrant argued that some of the allegations in the Complaints do not have sufficient detail to allow him to meaningfully respond, and as a matter of fairness, the Panel should not consider these allegations. He specifically referred to the "broad" allegations of altering records in the [redacted] Complaint and the allegation of "potential overbilling" in the [redacted] Complaint.

49. The Registrant also submitted that the evidence demonstrated that the allegations were manifestly unfounded and went through the various allegations in detail. For example, he submitted that the allegation in the [redacted] Complaint that he billed [redacted] for treatment after he passed away is manifestly unfounded. The Registrant referred to [redacted] chart which records July 14, 2022, as the last treatment date and [redacted] obituary which indicates that he passed away on December 12, 2022 (months later).

50. The Registrant also submitted that the allegation that he billed for treatment of [redacted] in September 2023, without actually providing treatment was manifestly unfounded. He referred to [redacted] chart which records a referral to a paediatric dentist, and a letter

dated October 30, 2023, from Abbotsford Children's Dentistry thanking the Registrant for his referral.

51. With respect to the allegation in the [redacted] Complaint that he interfered with [redacted] treatment of her patients and practiced while he was suspended, the Registrant submitted that since the patients' charts record [redacted] as the treatment provider and include treatment chits in her handwriting, this allegation is manifestly unfounded. The Registrant also submitted that the allegation that he had not been transparent about his suspension was not credible, referring to an email to [redacted] where he references the fact that he was not currently practicing.

52. The Registrant argued that even if the Panel does not accept that all of the allegations in the Complaints are manifestly unfounded, the fact that some are unfounded should raise significant doubts regarding the remaining allegations.

Protection of the Public

53. The Registrant submitted that the College had not established or articulated any real, specific, imminent risk to patients or the public if an interim order is not granted. He highlighted that under the *Scott* test, the risk must be real, not theoretical, and it is not enough for an order to merely be desirable.

54. The Registrant submitted that the College has not established the necessity for an interim order. He acknowledged that the allegations in the Complaints are serious, but submitted that they are largely administrative issues, not allegations of substandard care, and that this type of misconduct does not pose a serious risk that would justify an extraordinary order under s. 35 of the *HPA*.

55. The Registrant also submitted that there is no urgency; the events underlying the Complaints date back to 2024, and if there was any urgent risk, the College could have brought this application earlier.

56. In response to the College's submissions regarding his discipline history and his failure to respond to the College, the Registrant submitted that a s. 35 hearing is not the forum to determine ungovernability.

57. Nevertheless, the Registrant denied that he is ungovernable. He set out the extraordinary personal circumstances he has faced over the last decade, [redacted] In terms of his recent delay in disclosing patient records, the Registrant submitted this was not willful, it was the result of personal hardship [redacted] and technical limitations. He also suggested that the time it took him to produce the patient files was reasonable.

58. Finally, the Registrant highlighted the serious implications for him if the interim suspension sought by the College was granted, including loss of income, damage to his reputation, and professional implications such as continuity of care for patients.

The Panel's Findings

59. The applicable two-stage test for determining whether the Panel should make an order under s. 35 of the *HPA* is: (1) whether there is a *prima facie* case supporting the allegations; and (2) whether the public requires protection through an interim order.

Prima Facie Case

60. In determining whether there is a *prima facie* case supporting the Complaints, the Panel must determine whether the allegations are credible and not manifestly unfounded.

61. While the Registrant is entitled to provide evidence to establish that the allegations are manifestly unfounded, the Panel is not required to hear evidence as to whether the substantive allegations are or are not well-founded (see *Scott*, para 79).

62. The Panel is also mindful of the fact that a s. 35 hearing is not intended to be a "mini-trial" of the various allegations in the Complaints. While the Registrant made submissions about the various allegations, the Panel will only address some of the allegations in these reasons.

63. The Panel finds that there is *prima facie* case supporting the Complaints.

The [redacted] Complaint

64. The Panel finds that the [redacted] Complaint contains credible allegations of misconduct that are not manifestly unfounded.

65. The Panel finds the allegation that the Registrant billed insurers directly rather using predeterminations is credible. In response to this allegation the Registrant set out his practice for obtaining an estimate of out-of-pocket costs and asserted that this was acceptable and common practice. It is not for this Panel to determine the nature of the Registrant's practice and whether it is acceptable; for the purposes of this hearing, the Panel finds this allegation is not manifestly unfounded.

66. The Panel also finds the various allegations that the Registrant was practicing during his suspension are not manifestly unfounded. In response, the Registrant denied treating these patients and referred to patient charts that do not refer to him as the treating dentist. However, this evidence does not render these allegations manifestly unfounded and the specific details provided in the complaint along with the common pattern of conduct alleged makes these allegations credible.

67. The Panel acknowledges that the Registrant referred to evidence that undermined the credibility of the allegations relating to [redacted] (billing after deceased) and [redacted] (billing without providing treatment). However, the Panel is not to make any findings regarding whether the substantive allegations are well-founded or not and as set out above, the Panel's assessment of whether there is a *prima facie* case supporting the Complaints is not a min-trial of the various allegations. In any event, the Panel also does not find that these examples undermine the credibility of the other allegations in the [redacted] Complaint.

68. Finally, the Panel does not agree with the Registrant's suggestion that [redacted] is a manifestly unreliable witness. Although her employment with Lifetime Dental was terminated, the Panel does not find that [redacted] was motivated to harm the Registrant or to fabricate or exaggerate the allegations in her complaint.

The [redacted] Complaint

69. The Panel also finds that the [redacted] Complaint contains credible allegations of misconduct that are not manifestly unfounded.

70. For example, [redacted] allegation that the Registrant interfered with her treatment of patients on August 25, 2024, (meaning that he was practicing while suspended) contained specific examples of the treatment she alleges the Registrant provided to her patients: performing pulpectomies, making a "very large, aggressive incision" and performing the entire comprehensive exam including making a diagnosis and treatment plan.

71. In his affidavit the Registrant confirmed that he was in the office on August 25, 2024, and that he communicated with [redacted] regarding these patients, but he asserted that "any communication" was intended to support administrative activities or orient her to office protocols, not to direct or interfere with her clinical care. It is not for the Panel to make findings regarding the nature of the interactions the Registrant had with [redacted] and her patients that day; for the purposes of this hearing, the Panel finds these allegations are credible.

72. The Panel also finds that [redacted] allegation that the Registrant was not transparent regarding his suspension is credible. In the email the Registrant referred to to undermine this allegation, he wrote: "[a]s you may know, I have been not working for almost a year…" This statement supports rather than undermines the allegation that the Registrant had not explicitly or directly advised [redacted] that he was suspended.

73. With respect to [redacted] allegation that some of the patient records she received after leaving Lifetime Dental appear to have been altered, she had a specific recollection of her treatment of these patients (as set out in paragraph 70 above) and her allegation that her treatment notes were missing from the records she received is credible.

74. The allegation that the Registrant has been using uncertified dental assistants for tasks requiring certification is also credible. The Registrant's argument that under the College's Guide to CDA Services, the "long term or foreign-trained and experienced dental assistants" he employs at Lifetime Dental are permitted to carry out the scope of work identified in the [redacted] Complaint goes to the substance of the allegation and is

not for the Panel to determine at this hearing. The Panel finds that this allegation is not manifestly unfounded.

75. Finally, although [redacted] left Lifetime Dental because the Registrant had not paid her and posted a poor review of the clinic, the Panel does not find that this makes her an unreliable witness or undermines the credibility of the other allegations in her complaint.

Protection of the Public

76. Having found that there is a *prima facie* case supporting the Complaints, the Panel must consider whether an interim order is required to protect patients, colleagues or the public from harm pending a resolution of the Complaints.

77. The Panel must consider whether the Complaints give rise to a real or imminent risk of harm, and consider the seriousness of the allegations, the seriousness of the risk to the public and the likelihood of the alleged misconduct being repeated if an interim order is not imposed.

78. The Complaints include allegations that the Registrant practiced while suspended, used uncertified dental assistants for tasks requiring certification, altered patient records, billed insurers directly instead of seeking pre-determinations and billed for treatments that were not performed. While these allegations are serious and concerning, with the one exception set out below, the Panel does not find that they pose a real risk of imminent harm that requires an interim order.

79. The Panel is mindful that s. 35 of the *HPA* provides an extraordinary remedy that should be used sparingly. While the Complaints contain serious allegations, they are not of the same serious, urgent nature as allegations of incompetence, sexual abuse, substance use and mental health issues, that often precipitate a s. 35 application. For example, in the cases the Panel was referred to where orders under s. 35 were made, the allegations of misconduct included allegations of sexual misconduct (*Scott*), manufacturing and selling fecal microbial transplant material for use in treating children with autism (*Klop*) and providing vaccine exemptions to high risk immuno-compromised patients (*Dr. Luchkiw v. College of Physicians and Surgeons of Ontario*, 2022 ONSC 5738 (***Luchkiw***)).

80. The allegations in the Complaints are serious and ought to be determined through the College's discipline process, but they do not rise to a level that requires the interim suspension sought by the College pending resolution of the Complaints.

81. However, the Panel does find that there is a real risk of harm to patients arising from the allegation that the Registrant has been using uncertified dental assistants for tasks that require certification. Although the Registrant argued there is no such risk of harm because no allegations of sub-standard care or clinical error have been made as a result, this misses the point. Certification requirements are put in place to ensure patient safety and cannot be disregarded.

82. [redacted] also alleged that she had not been advised that some of the dental assistants were not certified and that she had practiced under the assumption that they were all CDAs. The Registrant's failure to communicate the certification of each dental assistant also presents a risk to the other dentists at Lifetime Dental who could have been unknowingly using uncertified dental assistants for tasks requiring certification.

83. The College submitted that the need for public protection does not arise just from the Complaints, but also from the Registrant's extensive discipline history, which indicates a likelihood of repeated conduct. The College also submitted that a suspension was necessary to protect the public because the Registrant has shown himself to be unwilling to meet his professional obligations, and unwilling to respect the regulatory authority of the College – essentially that he appears to be ungovernable.

84. The College relied on *Nova Scotia Barristers' Society v. Wood*, 2009 NSBS 1 (***Wood***) and *Luchkiw* as precedent for professional regulatory bodies imposing interim suspensions on the basis of ungovernability or a failure to cooperate.

85. In *Wood*, there were complaints against the respondent for failing to honestly advise clients, failing to provide competent service, and failing to respond to communications from the Barrister's Society. A year after the first complaints were received the Society found that an interim suspension was necessary because the evidence disclosed serious concerns with Wood's competence to practice, and that he was ungovernable. Wood later agreed to a disbarment.

86. In *Luchkiw*, the underlying complaints included providing vaccination exemptions to immuno-compromised patients, failing to follow COVID protocols when seeing patients and failing to cooperate with the College's investigation. The inquiry committee determined that a interim suspension was warranted because Dr. Luchkiw's conduct exposed patients to a real risk of harm, which was *exacerbated* by her failure to cooperate with the College.

87. In *Wood* and *Luchkiw*, the interim suspensions were based on very serious allegations of misconduct and incompetency that created a real risk of harm to the public and the failure to cooperate was relevant, but as a secondary or aggravating factor supporting the need for an interim suspension.

88. Here, the allegations in the Complaints are not of the same serious nature as those in *Wood* and *Luchkiw* and do not on their own create a real risk of harm requiring an interim suspension. The Registrant's failure to cooperate and the indicia of ungovernability referred to by the College are very serious, but they cannot be the predominant factors supporting a suspension as a result of the Complaints.

89. The Panel also notes that while in *Wood*, the Barrister's Society made a finding of ungovernability to support the interim suspension, it is clear that the Panel cannot and should not be making any determinations on whether the Registrant is ungovernable at this hearing.

90. The Panel is entitled to consider and has considered the Registrant's discipline history and it does not appear that the previous sanctions against the Registrant have created lasting changes in his practice and there is a real likelihood that the misconduct will be repeated. However, the Panel must still be satisfied that there is a real risk to the public that requires the extraordinary remedy of an interim suspension.

91. The issue of ungovernability raised by the College is a very serious issue, but it must be addressed and determined at a discipline hearing.

Interim Measures

92. Under s. 35 of the *HPA*, the Panel may order limits or conditions on the Registrant's practice or a suspension of his registration. The Panel should not automatically impose a suspension and must first consider whether there are conditions that would be sufficient and proportionate in terms of the seriousness of the allegations and the potential harm.

93. As set out above, the Panel finds the there is a real risk of harm associated with the allegation that the Registrant has been using uncertified dental assistants for tasks requiring certification. The Panel is satisfied that this risk can be managed through the imposition of conditions on the Registrant's practice.

94. The Panel find that the following conditions are sufficient to address the risk of harm arising from this allegation:

(a) Within seven days of the date of this decision, the Registrant must provide the College with a list of the current dental assistants at Lifetime Dental and their specific certification with the College (the **List**). The Registrant must also indicate in the List which dental assistants have completed the Dental Radiography Module and append confirmation of their completion of the module.

(b) Within seven days of the date of this decision, the Registrant must provide the List to all dentists and staff at Lifetime Dental. The Registrant must also provide any updates to the List to all dentists and staff at the clinic.

(c) Within seven days of the date of this decision, the College will provide the Registrant with the relevant standards and scope of practice pertaining to CDAs and uncertified dental assistants. Within one day of receiving this material from the College, the Registrant must review it and circulate it to all dentists and staff at Lifetime Dental.

(d) The College may conduct random audits at Lifetime Dental to ensure the Registrant's compliance with these conditions.

95. These conditions are mandatory for the Registrant's continued practice pending the resolution of the Complaints and shall remain in place until the Complaints are resolved. If the Registrant fails to comply with these conditions prior to the resolution of the Complaints, the matter may be brought back before the Panel.

96. The Panel has already addressed the College's submissions on a suspension being the appropriate remedy and will not address this further here except to say that a suspension

would be disproportionate to the nature and seriousness of the risk to the public as a result of the Registrant's use of uncertified dental assistants.

97. As a final note, the Panel wishes to emphasize the seriousness of the Complaints, including the allegation that the Registrant practiced while he was suspended and his failure to cooperate with the College. While a suspension may well be desirable in the circumstances, that is not sufficient to meet the second part of the *Scott* test and the Panel did not find a real risk of harm sufficient for the extraordinary remedy of an interim suspension under s. 35 of the *HPA*.

E. PUBLIC NOTIFICATION

98. The Panel reminds the BCCOHP of its obligations under s. 39.3 of the *HPA*.

F. NOTICE OF RIGHT TO APPEAL

99. The Registrant is advised that under s. 35(5) of the *HPA*, a registrant against whom action has been taken under subsection (1) may appeal the decision to the Supreme Court of British Columbia, and for the purposes of the appeal, the provisions of s. 40 of the *HPA* apply to an appeal under s. 35(5).

100. Section 40(2) of the *HPA* provides that an appeal must be commenced within 30 days after the date on which these Reasons are delivered to the Registrant.

Dated: June 25, 2025

[redacted]

Dr. Jonathan Adams, chair

[redacted]

Thelma O'Grady

[redacted]

Charanpreet Dhami