June 16th, 2021

File Number: 19-HPP-0008

Health Professions Appeals and Review Board

IN THE MATTER OF:

RITA KILISLIAN and KAWARTHA ENDODONTICS v.
DR. ROSANA SALVATERRA,
MEDICAL OFFICER FOR THE
PETERBOROUGH PUBLIC HEALTH UNIT

Attendance

Ms. Beth Downing
Lawyer - Presiding Member

Mr. Michael Bossin
Public Member

Ms. Michel Schofield
Public Member

Mr. Jennifer Sarjeant
Guest Observer

Ms. Natalie Moskowitz
Case Officer

Ms. Suzanne Hunt
Counsel for Dr. Salvaterra

Mr. Andy Curnew
agent for the Appellant

Mr. N. Garry Zagerman
Court Reporter

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1 **E X H I B I T S**

2

3 (No Exhibits Entered)

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5

1 MR. CURNEW: Sorry, Madam Chair, if we
2 can't see the witness, how are we conducting this?
3 DR. MAZURAT: Yes, I'm trying. You know
4 what, I'm going to turn it off. I'm going to try to come
5 back on again because it seems to make this program, does
6 this, that if you don't get it right away then you miss it.
7 So, I'm going to leave for a moment, and I'll come back--
8 MS. DOWNING: Okay.
9 MS. MOSKOWITZ: --and see if I can get
10 that right.
11 MS. DOWNING: Okay.
12 MR. CURNEW: And while Dr. Mazurat is
13 away, I have indicating yesterday that I would be challenging
14 whether or not she is an expert for the purposes of
15 determining reasonable and probable grounds. She'll be....
16 MS DOWNING: Sorry, you cut out a bit.
17 I missed the beginning of that sentence.
18 MR. CURNEW: Yesterday – sorry, Madam
19 Chair. Yesterday before we left off, I indicated that I was
20 challenging whether or not the Expert Report tendered by Dr.
21 Mazurat is, in fact, qualified – or qualifies, sorry, as an
22 expert for giving any evidence with respect to the matters
23 here before the Board. If the....
24 MS. DOWNING: Okay, so you'll have an
25 opportunity to ask questions. We'll go through the formal
26 qualification process, okay?
27 MR. CURNEW: Thank you, and....
28 MS. DOWNING: Here we go.

1 MR. CURNEW: Thank you.
2 MS. DOWNING: Okay. Okay, hello, Dr.
3 Mazurat.
4 DR. MAZURAT: Good morning.
5 MS. DOWNING: Good morning. So, I'm
6 sure Ms. Hunt has explained the process a little bit to you,
7 so I'll just turn you over to Ms. Hunt.
8 MS. HUNT: Thank you.
9 MS. DOWNING: Actually, maybe I'll
10 affirm your testimony first. So, could you state and spell
11 your name for the record?
12 DR. MAZURAT: It's Dr. Nita Mazurat.
13 The last name is spelled M as in mother, A-Z-U-R-A-T. Dr.
14 Nita, N-I-T-A.
15 MS. DOWNING: Thank you. Do you
16 solemnly affirm the information you are about to give this
17 Tribunal to be the truth and nothing but the truth?
18 DR. MAZURAT: Yes.
19 MS. DOWNING: Thank you.
20 DR. MAZURAT: I do.
21 MS. DOWNING: Okay, go ahead, Ms. Hunt.
22 MS. HUNT: Thank you, Chair Downing.
23 I'm going to be referring today to two documents, Exhibit 8
24 that we identified yesterday which is the Respondent's Expert
25 Report, and Exhibit 4 which are the Respondent's Amended
26 Grounds.
27 MS. DOWNING: Okay.
28

EXAMINATION IN-CHIEF BY MS. HUNT:

DR. NITA MAZURAT, WITNESS:

MS. HUNT: Q. Dr. Mazurat, you can hear me, okay?

A. I can, actually.

Q. Have you been retained to reach an expert opinion in this case?

A. I have.

Q. Turning to Page 2 of your report, now I'm going to share your screen here. I had - let's see here. No, I'm going to two. I believe that you reviewed some documents in the preparation of your report. Can you please advise the panel which documents you reviewed in preparing for today?

A. I reviewed the Appellant's Grounds for the hearing, the Respondent's Grounds of Response Amended, Witness Statement from Mr. Sammon, Dr. Hardie's Expert Report, Dr. Hardie's Addendum Expert Report, the Closure Order for Kawartha Endodontics from Mr. Brian Sammon, the signed Rescind Order from Mr. Sammon and Dr. Salvaterra's Order for Patient Notification.

MS. HUNT: And for the panel's reference, that is on Page 2 of Exhibit 8, if you want to refer to it at a later date.

Q. Dr. Mazurat, did you reach an opinion based upon a review of the evidence provided to you?

A. Yes, I did.

1 Q. We're going to deal with your opinion in
2 detail in a few minutes, but first let me turn to your
3 qualifications to testify as an expert in this case. I'd
4 like to take you to Page 31 of the report that you provided.
5 I believe this is the second page of the resume that you
6 provided at the end of your report, correct?
7 A. Correct.
8 Q. I see at the top, Dr. Mazurat, can you please
9 tell us about your post-secondary education?
10 A. I received my Doctor of Dental Surgery in
11 1976, and my Masters of Science from the University of
12 Manitoba 2006.
13 Q. I see you've done some work with the
14 University of Manitoba further down, also on Page 31. Can
15 you please tell us about any appointments you have relating
16 to Infection Prevention and Control?
17 A. Yes. The reason that I was appointed, had a
18 full-time position, was because I was appointed as Director
19 of Infection Prevention and Control with the - what was
20 called then the Faculty of Dentistry, is now the College of
21 Dentistry, University of Manitoba.
22 Q. Now, I understand that you're currently
23 retired. You've retired since this resume?
24 A. Correct. I sent an addendum correction to
25 that and Dr. Hardie, I noticed, picked that up and that's
26 when I noticed it. I retired in 2019. My apologies for that
27 error.

1 Q. So, to be clear then, the Director of
2 Infection Prevention and Control, did that end in 2019?
3 A. It did, when I retired.
4 Q. I see under Professional Experience, were you
5 a Practicing Dentist?
6 A. I certainly was.
7 MS. MAZURAT: Did I miss something?
8 MR. CURNEW: I'm frozen as well. I
9 don't hear anything.
10 MS. MAZURAT: Yes.
11 MR. CURNEW: I believe it's Ms. Hunt
12 has frozen.
13 MS. DOWNING: There she is.
14 MS. HUNT: Can you hear me now?
15 MS. MAZURAT: Yes, thank you.
16 MS. DOWNING: Yes.
17 MS. MAZURAT: I thought I was supposed
18 to be speaking. We've lost you again, perhaps?
19 MS. DOWNING: Yes. We've lost you, Ms.
20 Hunt.
21 MS. HUNT: Just, Madam Chair, I just
22 want to let you know, I've sent IT staff to see if we can
23 rectify the problem.
24 MS. DOWNING: Okay, thank you.
25 MS. HUNT: Okay, I understand IT is
26 onsite, they're with her now so hopefully they can find a way
27 to bring her back.
28 MS. DOWNING: Okay, thank you very much.

1 MR. CURNEW: Madam Chair, may I mute
2 my microphone and turn my camera off until they come back?
3 MS. HUNT: I'm here, can you hear me
4 now?
5 MS. DOWNING: Oh, there she is.
6 MS. HUNT: Sorry about that.
7 Thankfully, we have an IT professional onsite here who is
8 tried to get reloaded, so hopefully this will all work now.
9 MS. DOWNING: Okay.
10 MS. HUNT: The fun of electronic
11 hearings.
12 MS. DOWNING: Yes. Okay, please
13 continue.
14 MS. HUNT: Yes, I'm going to. I'm
15 just getting my ducks back in order. I lost a doc. Okay.
16 MS. HUNT: Q. Dr. Mazurat, we were - I
17 had asked you the question about whether or not you had ever
18 been a practicing Dentist?
19 A. Yes.
20 Q. And in that role, did you have experience
21 implementing Infection Prevention and Control Practices?
22 A. Yes, actually. I practiced a very long time
23 ago and so Infection Control was in its infancy, so I've
24 watched it develop, but of course, I was probably one of the
25 first ones to wear gloves all the time.
26 Q. I'm taking you to Page 34 of your CV under
27 Interests and Expertise. I see a section regarding the
28 Manitoba Dental Association Infection Control Resource

1 Manual. Can you please tell us about your involvement in
2 that project?
3 A. In the 2006 Development, I was the principal
4 author of the IPAC Guidelines and the new ones that are being
5 revised at this moment, I am part of the committee that is
6 developing that.
7 Q. We're going to go to Page 43 now. I see you
8 have a number of publications here that you have been
9 involved or written or authored. I'm not going to take you
10 through all of those. Section - Page 43 at the top, Advisory
11 Activities, can you please tell us about the professional
12 services you offer to the Canadian Armed Forces Dental Units
13 regarding IPAC and reprocessing?
14 A. We have completed the Reprocessing Module, so
15 I've been with the Canadian Armed Forces since 2018, I
16 believe, doing that, and we are just starting to do the IPAC
17 Module and we're utilizing the KIMATUM, Canadian
18 Accreditation format, for that, the template for that.
19 Q. So, I've....
20 A. I'm involved with that as a Consultant.
21 Q. Further down, can you please tell us about
22 your appointment to the Standards Council of Canada and, in
23 particular, your work as a member of the CSA Technical
24 Committee on sterilization?
25 A. Yes, I was the first Canadian - the first
26 Dentist to join the Technical Committee. We're the committee
27 that develops the standards for Medical Device Reprocessing
28 in all healthcare settings in Canada. That includes

1 Dentistry, Footcare, Private Doctor’s Offices as well, so
2 all Hospital and Non-Hospital Medical Device Reprocessing.
3 Q. I see you are also a member of Community
4 Association of Medical Device Reprocessing Education
5 Committee. Can you please tell us about the work of that
6 committee?
7 A. It is responsible for Continuing Education for
8 Canadian - for Reprocessing in Canada.
9 Q. Did you bring the skill and experience that is
10 reflected on this Curriculum Vitae to this project and, in
11 particular, the drafting of your Expert Report?
12 A. I feel that I did.
13 Q. Are Ontario standards the same as Manitoba
14 standards?
15 A. They are very similar. There is only a
16 certain amount of resources that are available. They are
17 Canadian resources. I notice that RCDSO used mostly Ontario
18 resources. Ontario, in turn, looks to PHAC, Public Health
19 Agency of Canada, largely, and I understand that because in
20 Manitoba we were utilizing CDC and Ontario and our Board has
21 asked us to strictly look at Manitoba, which is very
22 difficult. Very difficult to do that, so the - your question
23 was again?
24 Q. Are Ontario standards the same as Manitoba
25 standards?
26 A. Very similar because the - we get our
27 motherload of information from the same place largely.

1 Q. Sorry. Would you consider yourself then to
2 be very familiar with the Ontario standards?
3 A. I am familiar and also, they are very
4 available to me. They are on my computer at my demand.
5 Q. In particular, are you also familiar with a
6 checklist that we'll be referring to called Reprocessing in
7 Dental Practice Settings? That was produced by Public Health
8 Ontario and that was in use in July of 2019?
9 A. Yes, because we're going to be doing – we have
10 been doing inspections, we'll continue to do inspections and
11 we're looking at various checklists to be able to utilize for
12 our new ones, our new guidelines, and so yes, I am familiar
13 with those and also with the newer ones. This – we utilized
14 the older one here.
15 MR. CURNEW: Madam Chair, I have an
16 objection that I'd like to put onto the record.
17 MS. HUNT: Can I complete my
18 qualifying of the witness?
19 MR. CURNEW: I object to any line of
20 questioning that is going to lead this witness to produce
21 evidence before the Board that deals with an IPAC lapse.
22 What we're dealing with here today, or are supposed to be
23 dealing with, is a response to Dr. Hardie's Report to be able
24 to establish whether reasonable and probable grounds exist
25 two years later to test patients where a thousand patients
26 have already been tested, than there's been an immediate
27 campaign amplified and Dr. Kilislian contests that these –
28 that there was never an IPAC lapse that existed.

1 In those circumstances, I vehemently object to
2 any sort of questioning along these lines. The purpose of
3 the Expert Report was to rebutt Dr. Hardie's Expert Opinion
4 and we've yet to hear two years later why we are here today
5 with respect to what are the reasonable and probable grounds
6 that testing these patients will reduce a health hazard that
7 exists within the City of Peterborough for patients that
8 expand all the way to Peel Region.
9 MS. DOWNING: Okay, so I think you're
10 getting ahead of us. We're just qualifying the witness.
11 We're not getting into the issues just yet, and once we
12 finish hearing from Ms. Hunt, I'll give you an opportunity to
13 ask any questions about Dr. Mazurat's qualifications.
14 MR. CURNEW: Thank you, Madam Chair,
15 thank you.
16 MS. DOWNING: Okay, so please continue,
17 Ms. Hunt.
18 MS. HUNT: That was actually my last
19 question. I was going to say at this point that we tender
20 Dr. Nita Mazurat as an Expert Witness in the Field of
21 Infection Prevention and Control in Dental Settings.
22 MS. DOWNING: Sorry, in the field of?
23 MS. HUNT: Infection Prevention and
24 Control in Dental Settings.
25 MS. DOWNING: Thank you. So, Mr.
26 Curnew, do you object to the qualification of Dr. Mazurat as
27 Ms. Hunt just described?

1 MR. CURNEW: I object to – I'm sure
2 that Dr. Nazaret or Mazuret is an expert in Infection
3 Prevention and Control, and I think that all Dentists are
4 held to the same standards regardless of whatever courses she
5 has taken that surpass that of her colleagues.
6 Notwithstanding her expertise or the use of her
7 evidence today, is to be able to refute Dr. Hardie's Expert
8 Opinion that a health hazard does not exist, one, two, and
9 there's no reasonable and probable grounds for this Board to
10 make an order, especially in the circumstances where a
11 thousand patients have been tested so far and there's no
12 genetic link to the practice of Kawartha Endodontics, that
13 the order has been expanded upon by the amplified media
14 release and Dr. Nazaret hasn't even – or Mazurat, hasn't even
15 read Dr. Kilislian's Affidavit and the evidence that
16 accompanies that.
17 MS. DOWNING: Okay.
18 MR. CURNEW: So....
19 MS. DOWNING: So, I'm going to stop you
20 there because I just asked you whether you objected to the
21 qualification of Dr. Mazurat as an Expert in the Field of
22 Infection Prevention and Control in Dental Settings, and I
23 believe you consented that she is so qualified. Is that
24 correct?
25 MR. CURNEW: With one caveat, Madam
26 Chair. The caveat is that the issue here is Infection
27 Disease Transfer.

1 MS. DOWNING: Okay, we're not talking
2 about the issue yet, okay, so....
3 MR. CURNEW: But if she's not – sorry,
4 Madam Chair. If she's not qualified to give evidence about
5 Infectious Disease Transmission, then I think that her
6 evidence should be excluded.
7 MS. DOWNING: Okay, but you just told me
8 that you agree that she is qualified. That's all--
9 MR. CURNEW: No.
10 MS. DOWNING: --I want to know.
11 MR. CURNEW: We're playing cute, Madam
12 Chair, or Ms. Hunt is playing cute. The issue is not IPAC.
13 The issue is Infectious Disease Transmission and if you talk
14 to....
15 MS. DOWNING: Okay, I'm going to ask you
16 one more time, one more time. I believe I heard you say you
17 agree that Dr. Mazurat is qualified as an Expert, yes or not?
18 MR. CURNEW: Not in Infectious
19 Diseases.
20 MS. DOWNING: It is – okay, so you don't
21 accept that she is – so we didn't qualify her as an Expert in
22 Infectious Diseases. She is being--
23 MR. CURNEW: No.
24 MS. DOWNING: --qualified as an Expert
25 in Infection and Prevention Control in Dental Settings.
26 That's all I'm asking, and you agree to that, correct?
27 MR. CURNEW: Yes, I agree to that.

1 MS. DOWNING: Okay, thank you. All
2 right. So, I'll just check in with my colleagues on the
3 panel. I don't have a – I accept the witness as an Expert as
4 described. Does anyone have any concerns?
5 MR. BOSSIN: None.
6 MS. SCHOFIELD: I do not.
7 MS. DOWNING: Okay, thank you. So go
8 ahead then, Ms. Hunt, with your questions.
9 MS. HUNT: Thank you. Maybe I'll
10 preempt this by saying that, you know, we're here today to
11 discuss whether or not Dr. Salvaterra had reasonable and
12 probable grounds to issue her Order. The, you know, the fact
13 that Mr. Sammon identified significant IPAC lapses in
14 Kawartha Endodontics is key to why Dr. Salvaterra had RPG to
15 issue the Order, and I am going to be taking Dr. Mazurat to
16 the checklist to review why they were serious enough that it
17 went to Dr. Salvaterra's RPG. It sounds like Mr. Curnew
18 intends to fight that from the get-go. Do we need to have a
19 discussion about that now if he's going to object, or can I
20 continue?
21 MR. CURNEW: I'm going to object
22 because you led evidence yesterday that suggested that we're
23 not going to discuss whether an IPAC lapse had happened or
24 not. The issue was moot before the Board. So, you can't....
25 MS. HUNT: That is where it's....
26 MR. CURNEW: You can't lead it today in
27 evidence. That's my submission.

1 MS. HUNT: Well, that is what I
2 submitted yesterday, but you were very clear yesterday, Mr.
3 Curnew, that you intended - and through the Chair, I
4 apologize - that you intended to go right back to the Closure
5 Order and the circumstances that gave rise, and you
6 questioned my witnesses on both of those things.
7 MR. CURNEW: I don't have a reverse
8 onus. There is no onus for us to prove that you had
9 reasonable and probable grounds. The reasonable and probable
10 grounds should be demonstrated by you and we're talking about
11 two years later. I'm not talking about whether she had
12 grounds to give the order then. We're talking about whether
13 or not she has grounds to get the Board to enforce her order
14 today, today, not two years--
15 MS. HUNT: Okay.
16 MR. CURNEW: --ago, today.
17 MS. DOWNING: So, I think it's entirely
18 appropriate to hear Dr. Mazurat's comments on the checklist
19 and that's what she talked about in her Witness Report. So
20 please go ahead with your questions, Ms. Hunt.
21 MS. HUNT: Thank you, Chair Downing.
22 Q. Dr. Mazurat, you can hear me?
23 A. I can.
24 Q. From your point of view...?
25 A. I apologize for the noise in the background.
26 This is my home and its noisy.
27 Q. I actually can't hear it.
28 MR. CURNEW: Neither can I, I'm fine.

1 MS. HUNT: Q. Dr. Mazurat, from your
2 review of the evidence, do you have an opinion as to whether
3 there were visible Infection Prevention and Control Lapses at
4 Kawartha Endodontics in July 2019?
5 A. Yes.
6 MR. CURNEW: I object. There is no
7 evidence before the Board that suggests that those pictures
8 were even taken at Kawartha Endodontics, no witness led
9 evidence that those pictures were taken at Kawartha
10 Endodontics, and there's no evidence before the Board to
11 suggest that those pictures were given context or are in
12 evidence as having been taken by Brian Sammon at there. The
13 only person that led evidence was Dr. Salvaterra and I
14 objected to that.
15 MS. DOWNING: Ms. Hunt, do you have
16 any...?
17 MS. HUNT: I'm going to be taking Dr.
18 Mazurat to the checklists. Mr. Sammon's from yesterday.
19 MS. DOWNING: So, Dr. Mazurat isn't a
20 fact witness. She's been given the documents to review and
21 then give us her opinion on them, so any dispute about facts
22 is not - we're not asking her to resolve disputes about the
23 evidence. We're asking her to apply on the evidence she has
24 been provided. So go ahead, please, Ms. Hunt.
25 MS. HUNT: Thank you.
26 Q. Dr. Mazurat, did you prepare a Written Report
27 for Peterborough Public Health?
28 A. I did.

1 Q. And panel, this is the report that we have
2 already categorized as Exhibit 8 and the one that is on the
3 screen in front of you now. Dr. Mazurat, do all IPAC...?
4 MS. DOWNING: Ah, sorry, I don't have
5 any – you said it's on the screen?
6 MS. HUNT: It's the one I – let me
7 see if I can, maybe I stopped sharing it. Here, I can do
8 that again. Apologies. It's this one that I refer to. It's
9 a 49-Page Document from – it's the – so the beginning of this
10 is the – starting from Page 1 is the Expert Report, and we've
11 had categorized it as Exhibit 8 yesterday morning. Can I
12 continue?
13 MS. DOWNING: Yes, please.
14 MS. HUNT: Q. Dr. Mazurat, do all IPAC
15 lapses pose a serious threat to Public Health?
16 A. Yes, but some are more serious than others.
17 Q. I see that you reviewed the Respondent's
18 documents which included a checklist, dated July 15, 2019,
19 which depicted lapses that were considered to pose a serious
20 threat to Public Health. Do you agree with the
21 categorization of the lapses that were categorized as non-
22 compliant high-risk?
23 A. Yes.
24 Q. I'd like to take you to that first checklist.
25 We're going now to the Respondent's Grounds of Response and
26 I'm going to ask you please to go to Page 95, which is the
27 beginning of the two – or July 15 document. Can you see that
28 on your screen, Dr. Mazurat?

1 A. I can.

2 Q. There's a – and again, you said you're
3 familiar with this checklist. There's a category here signed
4 by Public Health Ontario. I'm referring to 2.1.

5 A. Yes.

6 Q. And it states that staff assigned to reprocess
7 instruments have completed Formal Education and Training.
8 Mr. Sammon found that staff stated that they completed Formal
9 Training but could not provide evidence at the time of
10 inspection. Why is that a high-risk lapse, in your opinion?

11 A. Staff who are performing reprocessing need to
12 understand the nuances. They needed to understand that MIFUs
13 need to be followed and that the parameters for sterilization
14 must be followed, that all the steps – there are up to 13
15 steps for reprocessing, and all of those steps have to be
16 appropriately and correctly done, and if - without formal
17 training, then I don't know how we expect people to be able
18 to do that. So yes, not only are they – do they need to be
19 trained but they need to be competent and need to have annual
20 reviews done--

21 Q. Where...?

22 A. --to keep them current.

23 Q. You referred to a term called MIFU. What is
24 that?

25 A. Manufacturer's Instructions for Use which is a
26 – which are instructions from the manufacturer telling us how
27 to clean and the parameters for reprocessing and its more
28 than that.

1 Q. I'd like to take you now to Section 4.2 of
2 the checklist. Can you see it before you?
3 A. I can.
4 Q. Items packaged according to the manufacturer
5 recommendations for both the packaging and the instruments.
6 Mr. Sammon found that again that term MIFUs were not known or
7 available for review. In your opinion, why is that a high-
8 risk item?
9 A. Instruments are – or devices are packaged so
10 that they stay sterile to the time of use for the patient,
11 and how we package is important because if we don't package
12 properly, just like everything else, then the sterility is
13 compromised.
14 Q. In the next Section 7.3, the standard is that
15 each package is labelled with date processed, sterilizer
16 used, cycle or load number and the healthcare provider's
17 initials in a manner that does not puncture or dampen the
18 package. If instruments are not visible, package contents
19 should be labelled. Mr. Sammon found that labelling was not
20 complete. It should have included the processing date, the
21 sterilizer used, cycle number and staff initials. A Sharpie
22 pen was used on the paper side. This was resulting in the
23 ink running. The packages were also being released and
24 cleared for use when visibly very wet and with ink stains
25 evident, an autoclave pen should be used to prevent this. In
26 your opinion, why is that a high-risk lapse?
27 A. The high-risk lapse, there are a couple of
28 reasons. Number one, you need to label properly so that you

1 can trace the package should there be a recall of patients,
2 a relook at patients. The correct type of labelling needs to
3 be – because Sharpie that is appropriate needs to be used so
4 that it is non-toxic. In this case, the Sharpies were used,
5 or whatever it was that was being used, was being used on the
6 paper side, not on the plastic side. If you place it on the
7 paper side, it prevents steam from entering in that area
8 where the lettering has been placed. Mostly, it's because
9 you need proper labelling so that you can recall those
10 instruments should that be required.
11 Q. Why is the issue of packages being released
12 when visibly very wet a significant lapse?
13 A. It demonstrates that there – that
14 sterilization probably did not occur in those packages. When
15 you've got excess moisture, then biofilm will form on the
16 devices, especially if it is left, and they are not
17 reprocessed. They need to be reprocessed. They cannot
18 simply be dried on the countertop. The wicking occurs,
19 bacteria – sorry, microorganisms return or go – can
20 recontaminate the instruments and then if you leave it in
21 storage like that, you're using contaminated instruments.
22 Q. Thank you. I'd like to take you now to 7.6 on
23 Page 104, the standard of sterilizer mechanical display
24 printout or USB is checked, verified and signed for each
25 cycle by the person sterilizing the instruments. Mr. Sammon
26 found that this was not taking place and that was according
27 to the staff. Why is that a high-risk item?

1 A. Now, one of the, or the standard for release
2 says that you have to check the physical parameters to make
3 sure that they were reached and that you actually sign for it
4 on a load log. I did not see evidence of the load log.
5 Again, so number one, we don't know that instruments were,
6 devices were actually sterile because the parameters were not
7 checked and the loads were released without doing that, and
8 again if you need to check, if you need to recall those
9 instruments – actually that has nothing to do with this one.
10 This one has to do with release.
11 Q. Do you have anything further to add on this
12 one, then?
13 A. Ask again?
14 Q. The Sterilizer Mechanical Display Printout or
15 USB is checked, verified and signed for each cycle by the
16 person sterilizing--
17 A. Yes.
18 Q. --the instrument. So, this wasn't.
19 A. Yes, no, it has to do with release. You can't
20 release without checking that. If you're not going to
21 quarantine until your BI is – the results are known. But
22 even then, each load, each individual load, has to be signed
23 for and from what I saw, the printout – there was no
24 printout, but a USB was not checked, so I'm not convinced
25 that sterilization occurred in each cycle, each load.
26 Q. Thank you. 7.10 now, please. That's on
27 Page 105. Records are kept to document that all
28 sterilization parameters have been met, and this included I

1 think you were referring before to BI's, CI's, time,
2 temperature, pressure readings. Mr. Sammon found that the
3 records were unavailable, and that staff had indicated they
4 did not regularly check the parameter logs. Why is that a
5 high-risk lapse in your opinion?
6 A. That's exactly what I was talking about. You
7 have to check the parameters and then you need to verify with
8 your signature to state that that had actually occurred, and
9 the records are always kept so that we can go back if there –
10 in the case if there's a recall.
11 Q. So, when you talk about...?
12 A. It's one of the first things you do is check
13 that, sorry.
14 Q. Sorry. When you talk about parameters, so
15 something has to be operated within the parameters, what are
16 the parameters in this case?
17 A. Time, Temperature and Pressure from – in the –
18 of the Sterilizer Load.
19 Q. And what happens if the Time is incorrect, or
20 the Temperature is incorrect or the Pressure is incorrect?
21 A. Then the load is not sterile.
22 Q. Thank you. 7.12, instrument packs are allowed
23 to dry inside the Sterilizer Chamber before removing and
24 handling. Mr. Sammon found that instrument packages are
25 being placed in storage containing drawers after being
26 removed from autoclave soaked with moisture condensation. I
27 believe you touched on this earlier, but do you have anything

1 further to add in terms of your opinion regarding why this
2 would be a high-risk IPAC lapse?
3 A. These packages, the devices that inside those
4 packages, are not sterile. They – and they cannot just
5 simply be repackaged. They need to be reprocessed right to
6 the beginning from cleaning. You need to determine what the
7 problem is. You can’t have this happening over and over
8 again without determining the problem, and if you leave those
9 instrument packs, then as I said biofilm forms on – biofilm,
10 a thin layer of microorganisms which can be – can penetrate
11 the package and recontaminate the package, the instruments
12 that are in those packages and so you’ve got unsterile -
13 you’re working with unsterile instruments.
14 Q. Section 7.14, sterile packages are inspected
15 for integrity, contents of compromised packages cannot be
16 used until the items have been reprocessed again, and I’m
17 referring to the bottom of Page 105 there and the top of Page
18 106. Mr. Sammon found that wet packages had compromised
19 integrity as a result of excessive moisture. And again, this
20 – you’ve touched on this already. Do you have anything
21 further to add in terms of your opinion regarding why this
22 would be a high-risk lapse?
23 A. Yes. Also, if they’re wet, then there’s
24 higher potential for the packages being compromised by
25 opening, seals breaking or the paper part of a peel pouch or
26 of a wrapped instrument or a wrapped package could – if
27 they’re open because they’ve been compromised that way, then
28 the contents are not sterile.

1 Q. Next page now, Page 107, I'm taking you to
2 10.1. A written log of test results is maintained. Mr.
3 Sammon found that logs of only biological tests were found at
4 the time of inspection. Staff were unaware of Physical
5 Parameter Test results of Autoclave Unit. Test results need
6 to be interpreted, checked on a continual basis. In your
7 opinion, why are Mr. Sammon's findings, why is that
8 considered to be a high-risk lapse.
9 A. It's part of the documentation. If you don't
10 have documentation, you can't do – you can't look back to see
11 if there is a trend anywhere, if there's a – no, like you
12 need to be documented so that you can recall, if you need to
13 recall. All – there were no load logs, so nothing, no
14 parameters were being maintained. There wasn't any policy, I
15 didn't see any policy as to what to do if a BI failed or if
16 any of the chemical indicators, the internal or external
17 chemical indicators and those would be on the load logs. So
18 why is it important? Because if we have to recall those
19 packages, then we need to also look to see what was happening
20 from that load.
21 Q. Dr. Mazurat, when you say you didn't see a
22 policy, is that because Mr. Sammon didn't find those
23 policies?
24 A. There were - there were three pages of policy
25 of standard operating procedures that I saw at the time of
26 inspection, and I didn't see anything about a load log.
27 MR. CURNEW: I'm sorry, I object to
28 that question. She can't testify to what Brian Sammon found

1 or not. The question was, if I'm correct, that are you
2 saying that you didn't see this document because Brian Sammon
3 hadn't found one. That's not a proper question to ask this
4 expert.
5 MS. HUNT: I'm simply trying to
6 clarify whether the policy – the witness believes the policy
7 exists and she didn't see it, or whether it was her
8 understanding that it didn't exist.
9 MR. CURNEW: She can't testify to that.
10 She's an expert for the purposes....
11 MS. HUNT: As per her understanding.
12 MR. CURNEW: She can't speculate
13 whether the Policy and Procedures Manual existed or not when
14 we already have evidence in the record that it did exist and
15 was passed in the other locations contemporaneous to the
16 event. So, your attempt to lead--
17 MS. DOWNING: Well, she's just....
18 MR. CURNEW: --this evidence is
19 improper.
20 MS. DOWNING: She's just testifying as
21 to her understanding. Okay, go ahead, please.
22 MS. HUNT: Thank you, Chair Downing.
23 MS. HUNT: Q. Dr. Mazurat, I believe
24 that you also reviewed a checklist, dated July 18, 2019, is
25 that correct?
26 A. Yes.
27 Q. That has been referred to as the Reinspection
28 Checklist. Is it your opinion that evidence that was

1 provided to you in that checklist depicted lapses that are
2 also considered to pose a serious threat to public health?
3 A. I think that there are. I'm concerned about
4 points that weren't on the checklist that I can see having
5 happened. I personally would not have reinstated based on
6 what I was seeing, just from - I thought it was very kind in
7 reinstating.
8 Q. So, based upon the evidence that you reviewed,
9 is it your opinion that Dr. Salvaterra had reasonable and
10 probable grounds to issue her Order for Kawartha Endodontics
11 to produce patient names, looking back for a two-year period?
12 A. Yes.
13 Q. Is it your opinion, based upon the evidence
14 that you reviewed, that these patients should be tested in
15 the initial two-year timeframe recommended and determined by
16 Public Health Ontario to ensure that no transmission of
17 blood-borne pathogens had occurred?
18 A. Yes.
19 MS. HUNT: Thank you, Dr. Mazurat,
20 those are my questions.
21 DR. MAZURAT: Thank you.
22 MS. DOWNING: Thank you very much.
23 Quickly, so over to you, Mr. Curnew. Do you have questions
24 for Dr. Mazurat?
25
26 **CROSS-EXAMINATION BY MR. CURNEW:**
27 **DR. NITA MAZURAT, WITNESS:**
28 MR. CURNEW: I do.

1 MR. CURNEW: Q. Dr. Mazurat, do you
2 understand that the Order is to recommend the patients see
3 their Healthcare Provider to determine whether or not testing
4 is to be done and not to skip that step. Do you understand
5 that?
6 A. Say it again.
7 Q. That the Order that - would you agree then
8 that getting tested is a prescription to, or sorry a
9 diagnosis, a diagnostic tool and in order to prescribe that,
10 a person should see their Healthcare Provider. Would you
11 agree with that?
12 A. Yes.
13 Q. Okay, but what your evidence was as an Expert,
14 was that basically they should skip that step and just go
15 right to testing because of the Brian Sammon evidence that
16 led to Dr. Salvaterra, is that correct?
17 A. I'm not sure of the process, to be honest with
18 you. I think that there are grounds here where I'm concerned
19 and that patients should be tested.
20 Q. Which would...?
21 A. How it goes about doing, I'm not aware of that
22 process.
23 Q. Well, this is your evidence before this Board.
24 Do you think that it's reasonable then that patients should
25 go and see their Healthcare Provider to determine whether or
26 not testing is necessary in the circumstances?
27 A. Okay, I see what you're saying. I don't think
28 that a Physician, a Family Physician, would have any idea as

1 to what occurred and why they would – would a patient be
2 able to go to a Family Physician and say I need to be tested
3 because the – what would they say to the Family Physician?
4 Q. Well, that....
5 A. I feel that I've been told what? It depends
6 on what the patient is going to say to the Physician, isn't
7 it and some Physicians would say it sounds as if the evidence
8 is such that you won't be and others, so I'm not sure what
9 you're asking.
10 Q. What I'm asking is have you read the
11 Section 13 Order?
12 A. Originally, probably did.
13 Q. I'm going to ask that on a break you
14 refamiliarize yourself with the Section 13 Order and I'm
15 going to ask that you read the Affidavit of Dr. Rita
16 Kilislian on a break.
17 MS. HUNT: My objection. Chair
18 Downing? We did not qualify Dr. Mazurat as an Expert in the
19 process by which a patient gets tested, and the – I'm not
20 sure what the relevancy is of having her review the
21 Affidavit. She has been provided with the Appellant's
22 Grounds of Appeal; she's been provided with Dr. Hardie's
23 reports, the original and the addendum.
24 MR. CURNEW: Right, but this Appellant
25 – or sorry, this Expert, has not been afforded the
26 opportunity to read Dr. Kilislian's evidence or all the
27 evidence that would necessarily make up her expert opinion,
28 and you're giving her some information but not all the

1 information, and she needs all that information to be able
2 to make a determination.
3 MS. HUNT: I disagree.
4 MS. DOWNING: Well, I think Dr....
5 MR. CURNEW: Q. Well, let's ask the
6 experts then, their opinions.
7 A. I think you're leading me to something that
8 I'm not comfortable with. I know that there are - I feel
9 from what I saw that breaches occurred. I am extremely
10 concerned that instruments were not sterile, that we were
11 using instruments that were not sterile because they were not
12 cleaned, and I don't believe in the type of sterilization
13 process that was used. Your BI's were not challenged.
14 Mostly, your instruments were not clean to start with, so
15 that's what I saw. Beyond that, I don't feel that I have the
16 kind of expertise to comment to a patient about what they
17 would say. That would be the next process and not mine.
18 Q. No, your expert....
19 A. I think you're leading me on that way.
20 Q. I'm not leading you on in any way.
21 A. I do.
22 Q. I'm simply asking what your understanding of
23 the order is to which your expert opinion is supposed to
24 solidify?
25 MS. DOWNING: I think you need to make
26 your question more specific.
27 MR. CURNEW: Okay.

1 Q. What qualifies you, Dr. Mazurat, to
2 determine whether patients should be tested for infectious
3 diseases in these circumstances?
4 A. And that brings you to what you had objected
5 to in the first place, which is that I'm not an infectious
6 disease person and it's true. I'm not an infectious disease
7 person. There were lapses here. There were lapses and
8 that's what I'm reporting on.
9 Q. Okay.
10 A. There are serious lapses.
11 Q. Would - did you witness any lapses at Kawartha
12 Endodontics?
13 A. I saw a report and I'm concerned about what I
14 saw in that report.
15 Q. Are you...?
16 A. I saw pictures.
17 Q. Are you aware, Dr. Mazurat, that that report
18 was prepared by somebody who had never inspected an
19 Endodontic Office before?
20 A. Does that make a difference in terms of a BI
21 that is not being challenged? No.
22 Q. It....
23 A. No.
24 Q. It might make its--
25 A. No.
26 Q. --determined. How does this...?
27 A. No.

1 Q. But isn't the findings of the person – okay,
2 let me ask you this. So, when you were in a university,
3 would you have relied on the opinion of somebody – are you
4 aware that Brian Sammon drafted his checklist two or three
5 days later, and it wasn't signed or acknowledged by the
6 nurse, and it wasn't signed or acknowledged by Dr. Kilislian?
7 It's a yes or no question.
8 A. That's tricky, because I think you're trying
9 to put words in my mouth, but--
10 Q. I'm simply asking....
11 A. --it does it matter? Does it matter, is my
12 question? Are we relying on his memory? Do we know how busy
13 he was? Does he have my kind of memory and therefore if he
14 doesn't do it very quickly – I don't know that it matters,
15 and I think that's a legal sort of a question as opposed to a
16 question of an infection control person.
17 Q. Would you rely, have relied on, in your
18 professional opinion, in the same circumstances, the opinion
19 of Brian Sammon who drafted his checklist two or three days
20 later....
21 MS. HUNT: Objection, Chair Downing,
22 because the – Mr. Curnew is putting a question to the witness
23 that he actually asked Mr. Sammon yesterday and received an
24 answer to as to why the checklist came out a couple of days
25 later. The witness does not have the benefit of knowing Mr.
26 Sammon's response and therefore my view is that he is trying
27 to mislead.

1 MR. CURNEW: I'm not trying to
2 mislead anybody. I'm trying to ask a question and ensure
3 that this Board makes the right decision. Period. Full
4 stop.
5 MR. CURNEW: Q. Would you agree, Dr.
6 Mazurat, that putting a needle in a patient's arm and
7 extracting their blood is an extreme remedy?
8 MS. HUNT: I object.
9 MR. CURNEW: Okay.
10 MS. HUNT: That question is
11 irrelevant.
12 MR. CURNEW: Q. Let me ask you this, Dr.
13 Mazurat. When you were practicing in two – when was the last
14 time you practiced professionally in your own private clinic?
15 A. Oh gosh, I've been retired – probably at least
16 seven years ago.
17 Q. And seven years ago, you practiced...?
18 A. I don't know if that's even accurate, it's –
19 because I – when I practiced, it was one day a week and it's
20 been a long time since I practiced, but go ahead, ask your
21 question.
22 Q. In – did you practice when we, the public,
23 heard of HIV or Aids for the first time, like in the
24 eighties?
25 A. How old do you think I am? My goodness, HIV--
26 Q. I said...?
27 A. --was in the eighties. Please.
28 Q. Did you practice in the 1980s?

1 A. Of course.
2 Q. I wasn't trying to insult you. I was just
3 trying to make a question. And if you practiced in the
4 1980s, were the standards the same as they are today?
5 A. We've learned a lot since the 1980s. We were
6 afraid of HIV at that time. Now, we have a full
7 understanding, or an understanding. Now, we know how to
8 prevent. I could....
9 Q. So, we...?
10 A. I could say the same about COVID which we
11 learned during COVID.
12 Q. Can – I'm going to need to stop you. We're
13 talking about something different.
14 A. I know.
15 Q. With respect to the – so you're saying that
16 the practices that are employed today for the standards with
17 respect to Infection Prevention and Control in Dental
18 Settings is different from what it was in 1985, is that
19 correct?
20 A. Of course.
21 Q. Or in the eighties in general, is that--
22 A. Sure.
23 Q. --correct?
24 A. Sure, we've learned--
25 Q. Now...?
26 A. --a lot since then.
27 Q. Right, so is it safe to say that Dentists, if
28 there was a time machine and we went back to the eighties and

1 we used this checklist, were having IPAC lapses, is that
2 correct? Based on today's standards.
3 MS. HUNT: I'm sorry, I don't
4 understand that question.
5 DR. MAZURAT: I don't either. Are you –
6 like if a – I don't understand where you're going with it
7 actually? The answer is we're constantly – that's why we
8 were trying to revise our standards all the time because we
9 are learning. Now, by the same token, CDC hasn't changed
10 their standards that much since 2003 because they're saying
11 that there's no evidence to change the categories, for
12 example.
13 Q. Dentists spread HIV and Hep C in the 1980s
14 based on not following current guidelines.
15 MS. HUNT: I'm sorry, I have to
16 object. I don't understand the relevance of what Dentists
17 were doing in the 1980s to whether or not Dr. Salvaterra had
18 RPG to issue her Order.
19 MR. CURNEW: I would just like my
20 question answered.
21 MR. CURNEW: Q. At what point, did
22 Dentists start spreading HIV and Hep C, based on IPAC
23 violations?
24 MS. HUNT: What does H – I'm sorry, I
25 understand this line of questioning. I have to object. HIV
26 in the 80s, I don't understand why this is relevant.
27 MR. CURNEW: Q. At what point at any time
28 during your career were Dentists spreading HIV or accused of

1 spreading HIV or assumed to have been spreading HIV or Hep
2 C in Dental settings as a result of an IPAC violation?
3 A. I'm still not sure – there was the one – the
4 Acer case in Florida which is still, to this day, not been
5 totally determined so that was in the mid-80s. There is....
6 Q. There is with the Acer case, Dr. Mazurat, that
7 there was an allegation that the Dentist had infected the
8 patient with his own blood by intentionally using a syringe
9 to puncture.
10 MS. HUNT: Sorry, I object. I don't
11 understand what the relevance is.
12 MR. CURNEW: Q. Have you read the Acer
13 case, Dr. Mazurat?
14 A. I have. There are many, many, interpretations
15 of the Acer case.
16 Q. And is there one interpretation that it had
17 nothing to do with his Infection Control Violations?
18 A. No.
19 Q. There's not a single one?
20 A. Oh, no, no. Stop. I don't understand where
21 you're going. I think you are wasting people's time and I
22 don't understand what that has to do with this case and....
23 MR. CURNEW: I'm going to stop you for
24 a second. Madam Chair, I'm going to need you to direct the
25 witness. I am conducting a meaningful examination. It is
26 not my responsibility to tell the witness where I'm going.
27 It is the responsibility of the witness as a former
28 Healthcare Professional to give truthful evidence based on

1 the questions that I've proposed. There was no objection
2 to the question. I don't appreciate this witness objecting
3 to my questions that are--
4 MS. DOWNING: Okay.
5 MR. CURNEW: --properly before this
6 panel.
7 MS. DOWNING: Well, so I think Ms. Hunt
8 did object to your question, and it would be helpful to the
9 panel if you could rephrase or refocus your line of
10 questioning, looking at the case before us and time--
11 MR. CURNEW: How....
12 MS. DOWNING: --before us, and I think
13 you're getting at the issue of risk of HIV and Hepatitis B
14 and C Infection. Let's talk about the relevant time which is
15 August 2019 when the order was issued, if that's where you're
16 going. I'm not sure.
17 MR. CURNEW: Sure.
18 MR. CURNEW: Q. In August 2019, would wet
19 packages – or sorry, July of 2019, would wet packages have
20 caused the possible transmission of HIV or Hep C to patients?
21 A. Well, the wet packages don't. The instruments
22 came - that are inside those wet packages, if they were
23 improperly cleaned and improperly – and were not sterilized
24 properly, there is a very, very, very, very small risk, yes.
25 It's not the wet package. It's the fact that you don't have
26 sterile instruments.
27 Q. What – so when you go into a restaurant, are
28 the forks...?

1 A. Oh, dear.
2 Q. Are the forks...?
3 A. We hear this one all the time. Go ahead.
4 Q. Thank you. Are the forks, spoons or knives
5 sterilized that you put into your mouth?
6 A. They're cleaned in two sinks which is more
7 than sometimes they are in Dental Offices, and I believe they
8 need to go through a very hot process, and I don't know the
9 restaurant industry, but I do know that they do have
10 standards and sometimes their standards are higher than what
11 some Dentists thinks are their standards.
12 Q. Are you...?
13 A. The reason I groaned, and I apologize for
14 that, but we hear that comment every single conference that I
15 attend from people who are naysayers about Infection Control,
16 and its time to move on from that question.
17 Q. Is HIV or Hep C spread through cutlery in
18 restaurants?
19 MS. HUNT: Objection. The witness is
20 not qualified as an Expert in restaurant standards.
21 MS. DOWNING: I....
22 MR. CURNEW: No, we're not talking
23 about restaurant standards. We're talking about Infectious
24 Disease Transmission and the Sterilization of Instruments,
25 and she said--
26 MS. HUNT: The witness has--
27 MR. CURNEW: --without ignitions going
28 by...?

1 MS. HUNT: --an expert either.
2 MS. DOWNING: Let’s stick to questions
3 about Dental Practice.
4 MR. CURNEW: Okay.
5 MR. CURNEW: Q. So, if a dental instrument
6 is washed in the sink, does it deactivate HIV?
7 A. Depending on how it’s done, as long as it is
8 cleaned properly and there is no blood remaining.
9 Q. Right, and in those circumstances, if it was
10 then put into the sterilizer and the packages were wet, is it
11 not true that there would be no risk of HIV transmission or
12 Hep C?
13 A. There’s never a no-risk and we have to
14 remember Hep B, as well, because it’s a much higher risk than
15 Hep C or HIV. There’s never a no-risk.
16 Q. Okay, so you talked about Hep B. Is it not
17 true that a large portion of the population is immune from
18 Hep B?
19 A. Immune. Many have been immunized....
20 Q. Or that have been immunized. Sorry, that’s
21 correct.
22 A. Yes.
23 Q. Thank you.
24 A. Yes, many have bene immunized but it’s - there
25 are still populum - there’s still people who have Hep B and
26 that’s - the transmission rate for that is around 30 percent,
27 so we would certainly hope that none of our patients have
28 them, and if they do - well, our patients do have them,

1 that's not my hope. My hope is that re-processing and
2 decontamination processes are such that we decontaminate and
3 sterilize so that it is not passed on to our patients.
4 Q. Where you advised by any person connected to
5 the Respondent that Dr. Kilislian and Kawartha Endodontics
6 operate an IPAC Training Facility in the same building that
7 was inspected?
8 A. I have heard that that was true. I haven't
9 seen any standard operating procedures or any evidence of
10 that.
11 Q. Are you aware that Kawartha Endodontics was a
12 partner of Sican, Recriliam, Germaphene (ph) for the purposes
13 and the Ontario Dental Association Component Society, for the
14 purposes of providing Continuing Education. Were you aware
15 of that with respect to IPAC?
16 A. I see no evidence from what happened,
17 clinically speaking. If that's the case, then I'm concerned
18 about the standard whereby the IPAC Training was done. Very,
19 very, concerned. Number one, the Standard Operating
20 Procedures that I saw were inadequate, so if that's--
21 Q. Are you aware that?
22 A. --the kind of training that was occurring,
23 then I'm concerned about that.
24 Q. Are you aware that Dr. Kilislian's evidence is
25 that the photographs taken were taken of instruments and
26 stuff used for the purposes of IPAC Training and taken from
27 the IPAC Training Facility, which is quarantined from the
28 clinical setting.

1 A. The Standard Operating Procedures did not
2 say that any place, and I would question why you would
3 have....
4 Q. I will stop you with your question or your
5 answer because there is evidence before this Board that the
6 Standing Operating Procedures were passed....
7 MS. HUNT: She was asked, and I ask
8 that she be permitted to answer.
9 MR. CURNEW: She's going off on a
10 tangent.
11 MR. CURNEW: Q. With respect to the
12 Standard Operating Procedures, are you aware that they passed
13 in Toronto and Peel contemporaneous to this situation?
14 A. I don't understand your question.
15 Q. Are you aware that the Standard Operating
16 Procedures were held on a digital server and Brian Sammon
17 asked for paper copies and the staff did not give him paper
18 copies because they were stored digitally. Are you aware of
19 that?
20 A. I cannot answer to that because I--
21 Q. Are you aware that?
22 A. --have no way to know.
23 Q. Are you aware that the Toronto Public Health
24 who inspected the clinics of Kawartha Endodontics in Peel
25 Region and Toronto found no findings and found the manuals
26 comprehensive and thorough?
27 A. What I saw was not comprehensive nor thorough.

1 Q. What you saw, would you correct me if I'm
2 wrong, were not the digital copies, correct?
3 A. I did not see digital copies.
4 Q. That's right and--
5 A. Yes.
6 Q. --would you confirm for the record that you've
7 only seen paper copies which were incomplete?
8 A. You've got two parts to that statement. One
9 of them is that I've seen paper copies which I have, yes.
10 You're saying incomplete, I don't know. That's all I had.
11 Q. But it was your evidence that in your Expert
12 Report, that because you're forming your opinion to test
13 these patients based on the fact there was incomplete
14 Policies and Procedures Manuals, and you put special emphasis
15 on that. Is that correct?
16 A. Yes, because that's very important.
17 Q. Right. And would it change your evidence to
18 know that there was Policies and Procedures Manuals
19 Digitally?
20 MS. HUNT: Objection. The witness is
21 putting questions to Dr. Mazurat that are untrue. That's
22 evidence that he is giving now. That--
23 MR. CURNEW: I said would it change
24 your evidence?
25 MS. HUNT: --yesterday, and he
26 provided an answer that was totally different to what Mr.
27 Curnew--

1 MR. CURNEW: Would it change your
2 evidence?
3 MS. HUNT: --just now.
4 DR. MAZURAT: No, because I'm....
5 MR. CURNEW: Dr. Mazurat, listen to
6 what....
7 MS. HUNT: There were. He requested
8 all copies of policies, whether paper or electronic, and all
9 he received were the paper copies that have been provided to
10 the witness.
11 MR. CURNEW: That's not what he
12 testified. What he testified to was there was an email sent
13 and that possibly that email bounced back, and he got some of
14 the documents but not all of the documents, is what he
15 testified to.
16 MS. DOWNING: Okay, listen I'm going to
17 interrupt you because this isn't really helping us. Dr.
18 Mazurat has already told us the information she relied on to
19 form her opinion, so it's not really helpful to talk about
20 what other witnesses have said or haven't said. Do you have
21 any--
22 MR. CURNEW: I'm asking....
23 MS. DOWNING: --questions about her
24 opinion?
25 MR. CURNEW: Q. I'm asking would your
26 opinion change if you knew that another health jurisdiction
27 passed the documents. Would you still recommend that
28 patients be tested for blood-borne illnesses?

1 A. I'm very concerned about what I saw as
2 actual practice in that office, so - and also from the few
3 pages that I had, Mr. Curnew, there were - the Standard
4 Operating Procedure was there and yet I saw evidence of not
5 following the Standard Operating Procedures. So, and to
6 answer your question if there is another - if there's more
7 Standard Operating Procedures, so be it. If this was due to
8 training, I would be very - why would you train things
9 improperly? Why would you have single-use devices that
10 should have been discarded in the operatory, why would you
11 have those sitting in the same place as sterile instruments?
12 Q. There is no evidence before this panel that
13 those were sitting in the operatory. The pictures have no
14 context. Would you agree with that?
15 A. Correct. I - all I see is....
16 Q. Okay, thank you. My next follow up question
17 is given that there was no context to the pictures, is it
18 possible that those pictures were taken of Staff Training -
19 or sorry, Student Training and a position of - or sorry, a
20 policy of training staff to spot the errors was used. Is
21 that possible? Have you heard of a technique in training
22 where you spot the errors? You basically sabotage things and
23 allow the students to find what's wrong with those issues.
24 Have you heard of that?
25 A. Of course, we've heard of that, but we don't
26 do that in Infection Control because students remember - who
27 knows what people remember so to me, it would be a very poor
28 technique as an Educator. It would be a very poor technique,

1 that's number one. Number two, from everything that I
2 understood from the report, nobody commented, the Dental
3 Assistants did not comment to say we are in practice - you
4 know, we're looking at practice and there was nobody else
5 there. From what I understand of the report, it was only the
6 Dental Assistants who were assisting Dr. Kilislian at that -
7 at that time. I can't - I don't have context, you're
8 absolutely right, but it sounds to me like an excuse, not
9 evidence.
10 Q. Okay. And is it your position or opinion
11 rather that Dentists lie?
12 MS. HUNT: Objection.
13 MR. CURNEW: There's an affidavit....
14 MS. DOWNING: This is not a helpful
15 question, not a helpful question at all.
16 MR. CURNEW: Actually, it is, Madam
17 Chair.
18 MR. CURNEW: Q. So, if you read the
19 report, the report says that generally Dentists are honest
20 and care about their patients. Is that something that you
21 profess?
22 A. Yes.
23 Q. Okay. So then, why aren't you curious to know
24 what Dr. Kilislian has to say about this, and why are you
25 relying exclusively on what Brian Sammon, the person that's
26 only ever inspected one office. Why are you relying so
27 heavily on his opinion over Dr. Kilislian, a colleague's?
28 A. I don't get to....

1 MS. HUNT: Objection. Dr. Mazurat
2 has already testified.
3 MR. CURNEW: Okay.
4 MR. CURNEW: Q. Is an Endodontic Office
5 more dangerous, from an IPAC perspective, than a General
6 Dental Office?
7 A. I don't think so.
8 Q. Neither do I. And would you – are you aware
9 that Brian Sammon took the position that an Endodontic Office
10 is the most dangerous of all the Dental Offices for an IPAC
11 Prevention or an IPAC?
12 MS. HUNT: That is not what Mr.
13 Sammon said. Mr. Curnew is misleading the witness.
14 MR. CURNEW: Go ahead, Ms. Hunt, tell
15 us what he said then.
16 MS. HUNT: He did not say that. He
17 did not say--
18 MR. CURNEW: Tell us what he said.
19 MS. HUNT: --that it was most
20 dangerous.
21 MR. CURNEW: What did he say? What did
22 he say?
23 MS. HUNT: I have to go back and
24 review his transcript, but I know he never said that it was
25 the most dangerous.
26 MR. CURNEW: One of the most dangerous?
27 Did he say its more dangerous than a General Dental Office?
28 MS. HUNT: I....

1 MR. CURNEW: Q. Can we talk about an
2 Endodontic Office for a second, Dr. Mazurat? You're aware
3 that Endodontist use Rubber Dams?
4 A. Of course.
5 Q. Right. And what do those Rubber Dams do to
6 Prevent Infection Prevention and Control Issues from
7 happening?
8 A. I think it's more of a question of safety. We
9 - I think that we used the Rubber Dam to prevent files from
10 going down patient's throats, to prevent the Irrigant that's
11 being used from going down patient' throats. Like – sorry,
12 what is – what is – what's your question? Are – why are
13 Rubber Dams used?
14 Q. Sure, yes.
15 A. That they improve visibility, they prevent
16 tongues from getting cheeks, they provide an Endodontist with
17 visibility. Sorry, that's--
18 Q. Does it not...?
19 A. --an odd question. Sorry?
20 Q. You say that the question of what does a
21 Dentist do or an Endodontist do with a Rubber Dam is an odd
22 question?
23 A. In this context....
24 Q. Does it in any way...?
25 A. I'm just not sure.
26 Q. Does a Rubber Dam in any way assist with
27 Infection Prevention and Control?
28 A. Yes.

1 Q. Thank you. Does an Endodontist typically
2 use Sodium Hypochloride?
3 A. Absolutely.
4 Q. Can you tell the panel what Sodium
5 Hypochloride is?
6 A. Sodium Hypochloride is a – it's bleach, also
7 known as bleach, and it is used to disinfect the pulp and to
8 clear away debris that is in the Pulp Chamber.
9 Q. And what would bleach do to HIV or Hep C?
10 A. It would prob – because they're relatively
11 easy to kill, so yes, it would kill – sure, it would
12 inactivate.
13 Q. And you said that HIV and Hep C are relatively
14 easy to kill, is that correct?
15 A. Yes.
16 Q. Thank you. Moving back to Sodium
17 Hypochloride, when you practiced, and as you understand it
18 now in the university, is it standard practice that
19 Endodontists use Sodium Hypochloride within their practices?
20 A. Yes.
21 Q. And is it standard practice that that should
22 be at five percent Sodium Hypochloride or higher?
23 A. I find that they're diluting them.
24 Q. Diluting them from Residential Bleach or from
25 Industrial Bleach?
26 A. I think we're using most – well, when you're
27 in Healthcare, you need to be using materials that are meant
28 for Healthcare, so generally speaking it's not what we would

1 use as Residential. It's 5.25 percent and diluted. I hear
2 some people diluting it one to one, one part of....
3 Q. So, isn't it true, Dr. Mazurat, that
4 Commercial Bleach is 8.75 percent--
5 A. No.
6 Q. --or a number of eight point over--
7 A. No.
8 Q. --and Residential Bleach is 5.25?
9 A. It could be.
10 Q. And in those circumstances where the bleach is
11 diluted, would it still deactivate HIV and Hep C?
12 A. Yes. Probably.
13 Q. Do you need to take a break at all, Dr.
14 Mazurat?
15 A. No, I'm fine?
16 MR. CURNEW: Does anybody on the panel
17 need to take a break? I'd like to take a break for five
18 minutes and consider my position.
19 MS. DOWNING: Okay. I think this is as
20 good a time as any to take a break, so it's 11:10. We'll
21 come back at 11:20.
22 MR. CURNEW: Thank you.
23 MS. DOWNING: Is that okay?
24 DR. MAZURAT: Do we just leave it on?
25 MS. DOWNING: Yes, you could just mute
26 your microphone and camera if you like. Okay, we'll be back
27 in ten minutes.
28

1 **---OFF THE RECORD**
2 11:10 a.m.
3
4 **---BACK ON THE RECORD**
5 11:20 p.m.
6
7 MS. DOWNING: Hello, Mr. Zagerman, are
8 you back?
9 MR. REPORTER: Yes, I'm back and we are
10 back on the record, or I'm ready to go back on the record,
11 yes.
12 MS. DOWNING: Thank you. We're just
13 waiting for Ms. Schofield.
14 MR. REPORTER: Okay, thank you.
15 MS. DOWNING: Okay, everyone's back so
16 did you have any further questions, Mr. Curnew?
17 MR. CURNEW: Those are my questions.
18 I'd just like to thank Dr. Mazurat for her evidence today and
19 advise her that I have no animosity towards her and those are
20 my – that's my position on that. I wish her to have a great
21 rest of the day and I'd like to proceed with Dr. Hardie's
22 evidence as soon as possible.
23 MS. DOWNING: Okay. So first, I'll just
24 check if Ms. Hunt, did you have any questions in Re-Exam?
25
26 **RE-EXAMINATION BY MS. HUNT:**
27 **DR. NITA MAZURAT, WITNESS:**
28 MS. HUNT: I just have one.

1 MS. HUNT: Q. Dr. Mazurat, does the
2 fact that other Public Health Units determined that there
3 were no IPAC lapses in other clinics mean that an IPAC lapse,
4 significant IPAC lapses, did not occur in this one?
5 A. No.
6 MS. HUNT: Thank you, those are my
7 questions.
8 MS. DOWNING: Okay. And I'll check in
9 with my colleagues on the panel to see whether they have any
10 questions for you, Dr. Mazurat. Just before we let you go.
11 Ms. Schofield, did you have any questions for Dr. Mazurat?
12
13 **CROSS-EXAMINATION BY MS. SCHOFIELD:**
14 **DR. NITA MAZURAT, WITNESS:**
15 MS. SCHOFIELD: Thank you. I do have one,
16 Dr. Mazurat.
17 MS. SCHOFIELD: Q. I was looking at some of
18 the references that you had, I think that you had provided at
19 the end of your report in addition to some of the references,
20 and there was one that was discussing the issue of potential
21 for transmission of I think it was Hepatitis C in Tulsa,
22 Oklahoma, in a Dental Practice.
23 A. Oh, yes, m'hm.
24 Q. And if I remember correctly, the - it wasn't
25 the actual report, but it looked like it was a section from a
26 textbook and the text went on to say that the - there were
27 some cases in a particular dental practice and that
28 Epidemiological and Genetic Testing went on to, but then it

1 stopped. It sort of stopped mid-sentence and so I just,
2 I'm wondering if, and perhaps its – I did not have the, there
3 was some problem with transmission of all of the materials to
4 the panel. However, I guess my question is just sort of on
5 that issue, are you aware of cases that have been verified
6 where blood-borne pathogens have been spread, essentially,
7 patient-to-patient in a Dental Practice?
8 A. Yes, that was one of the most recent ones and
9 it was in an Oral Surgery Office and CDC came in to examine
10 that and found that that office was just operating absolutely
11 perfectly. They finally said that they thought that it
12 actually had occurred in a washroom setting where the patient
13 had supposedly removed her gauze pad and then touched the
14 faucets, and then the next patient touched – did the same
15 sort of thing in reverse. That was about the only way that
16 they could determine that that's how it was passed. It was a
17 very bizarre case.
18 Q. Okay.
19 A. Yes, but - and it's recent and it occurs so
20 unusually that they really scratched their heads on that one.
21 Q. Okay. And are you aware of any other cases in
22 North America where there have been instances of blood-borne
23 pathogens been passed from patient-to-patient from improperly
24 Sterilized Dental Equipment?
25 A. Not Dental, and not off the top of my head. I
26 know that there are, but I'm – not off the top of my head,
27 and I should know that at this point, but I'm retired.

1 MS. SCHOFIELD: Okay. I don't have any
2 other questions. Thank you very much.
3 DR. MAZURAT: Okay.
4 MS. HUNT: Can I ask clarification.
5 Did you say you know that there are, but you don't know the
6 names? I'm sorry, I just want to understand your answer.
7 DR. MAZURAT: I think there are. I
8 don't think there are any recent ones. There was - there are
9 recent ones coming out of an Oral Surgery Office in - oh,
10 it's American, they're all American.
11 MR. CURNEW: It's the *Oklahoma Case*
12 that you were just referring to, Dr. Mazurat. And it has....
13 DR. MAZURAT: Thank you.
14 MR. CURNEW: And it had nothing to do
15 with the dental instruments but the use of....
16 DR. MAZURAT: You had asked - you had
17 commented, by the way, about the use of Rubber Dam. My
18 concern is my....
19 MR. CURNEW: Your evidence is already -
20 your evidence is already in. Thank you, Dr. Mazurat.
21 DR. MAZURAT: Thank you.
22 MR. CURNEW: Please enjoy your
23 afternoon. Dr. Hardie will be with us is in the living room.
24 MS. DOWNING: We're not finished yet,
25 Mr. Curnew. So, Ms. Schofield, did you get your question
26 answered?

1 MS. SCHOFIELD: Yes, I think so. I
2 guess it is from Dr. Mazurat that there aren’t a lot of cases
3 that you’re aware of, is that a fair conclusion?
4 DR. MAZURAT: Not a lot, no.
5 MS. SCHOFIELD: Okay.
6 DR. MAZURAT: No.
7 MS. SCHOFIELD: All right, and none that
8 you distinctly remember off the top of your head?
9 DR. MAZURAT: None that I’ve been
10 involved with, that’s for sure.
11 MS. SCHOFIELD: Okay. Thank you. I don’t
12 have any other questions for this expert.
13 MS. DOWNING: Thank you. Mr. Bossin, do
14 you have any questions for Dr. Mazurat?
15
16 **CROSS-EXAMINATION BY MR. BOSSIN:**
17 **DR. NITA MAZURAT, WITNESS:**
18 MR. BOSSIN: I do have just a few. One
19 is very basic, and I might have just missed it.
20 MR. BOSSIN: Q. You referred several times
21 to BI. Can you just remind me what BI stands for?
22 A. It’s a Spore Test, a Biological Indicator that
23 is used to test the Sterilizer and it’s used – it’s, the term
24 I was using was challenged. We place it in a Commercial PCD
25 or Process Challenge Device or because supposedly the
26 industry is still not – they’re fighting it out. They are
27 still duking it out as to whether or not you actually can
28 have validated PCDs for Tabletop Sterilizers.

1 So, we're allowed to make Inhouse Challenge
2 Devices in which you make the challenge device - the
3 Challenge Device itself is a Cassette or whatever your
4 package is that creates the most amount of challenge to
5 steam, and you place your BI and your CI Team to that. CI,
6 Internal Chemical Indicator.
7 Q. Thank you.
8 A. It's direct evidence because its incubated,
9 the BI is then incubated and its direct evidence that the
10 Sterilizer is using properly but it has to be challenged.
11 You can't just put it into the Sterilizer and think that
12 you're doing a good job.
13 Q. The next question, I have for you are
14 admittedly pretty basic and if we could leave....
15 A. Good.
16 Q. As I understood, the greatest concern that you
17 had when you read the materials that were given to you was
18 regarding the sterilization of instruments, and my basic
19 question is why do we sterilize? Why is that so important?
20 Why is there such an emphasis on reprocessing and
21 sterilization of instruments? Maybe that--
22 A. I....
23 Q. --my question to ask but it seems to be
24 understood and it seems central to this case because, you
25 know, so my question why are we sterilizing instruments and
26 why is that so important in the context of a Dental Practice?
27 A. We are reprocessing instruments which means
28 that we go through all of the steps. Cleaning is just as

1 important as sterilization, and we do that to prevent
2 transmission of disease.
3 Q. Oh, so can I assume from that answer that if a
4 Dentist were to use an Unsterilized or Unclean Instrument
5 while treating a patient, that that might or could transmit
6 disease to the patient?
7 A. It increases the risk, yes.
8 Q. All right. I didn't really get the answer and
9 I know that Dr. Hardie talks about it, and Mr. Curnew asked
10 you a question about Rubber Dams. I think, as a patient I've
11 had that experience where some plastic device is put over my
12 mouth. My question is, where a patient is – where a Dentist
13 or Endodontist is using a Rubber Dam, does that mean that an
14 instrument is not used in the treatment of the patient's
15 teeth? I'm – my understanding of a Rubber Dam is that there
16 are still teeth that are exposed?
17 A. Yes.
18 Q. That instruments will be applied, is that
19 correct?
20 A. That's right, that's right.
21 Q. All right.
22 A. And my concern with the Rubber Dam is that if
23 you don't have a cleaned clamp, if the clamp itself is not
24 clean and if the handpiece has not been sterilized properly,
25 then there is higher risk for transmission of disease,
26 because the Handpiece is Lumen, and it can take up blood.
27 Body fluids go into the Lumen, the inside of the Rubber – of
28 the Rubber Dam, the Handpiece - in my next life, I'll be

1 articulate; not in this life – so that the Lumen of the
2 Handpiece can contain blood and if it is not properly cleaned
3 and including the lubrication. The Lubricant should be
4 removed prior to sterilization, otherwise the Lubricant goes
5 out onto the Rubber – the -- jeepers, the Handpiece and so it
6 is not sterilized properly. So, everything must be
7 absolutely squeaky clean before it is sterilized. Putting it
8 into a Sterilizer does not make it sterile. Having it clean
9 and having it sterilized makes it Sterile, and having it
10 monitored with the BI and done properly is what makes it
11 Sterile. Good question. Excellent, perfect question.
12 Q. My last question is a bit of a follow up from
13 Ms. Schofield's and she asked you about evidence or reports
14 of patient-to-patient transmission, but I think our concern
15 here is also dentist-to-patient transmission, and I don't
16 know if you're able to or you've indicated that you had read
17 Dr. Hardie's reports. As I understand, his position
18 generally, is that the dental environment really is not
19 conducive to transmission of serious – the kind of serious
20 illness that we're talking about, HIV, Hep B, Hep C, and his
21 assertion, again, as I understand it – we have not heard his
22 evidence orally – is that there is really no evidence that
23 Dentists or in the Dental Office where those diseases have
24 been transmitted from - to a patient, and my question is are
25 you able to comment on that? His thesis, if I can
26 characterize it, is that all of the checklists and standards
27 and all that stuff that you found troubling about the
28 Sterilization Practices at Kawartha Endodontics is not really

1 relevant to a dental setting. So that's generally my
2 question. Are you aware of evidence that – where there have
3 been those kinds of various illnesses transmitted in the
4 context of a Dental Clinic?
5 A. I can't give you exact – I should have, but I
6 don't. I can't give you exact evidence, the comment being
7 that if – there's always risk of transmission and if blood
8 and saliva is available because it has not been properly
9 cleaned and if instruments have not been properly sterilized,
10 the risk is always there. Remember that we don't have
11 surveillance in Dentistry like you do in Medicine. Our
12 patients would go – if they were diagnosed, the surveillance
13 would fall to the Medical people and we would certainly be
14 looked at. There's no question, but am I aware? It happens
15 as I said to Ms. Schofield. It happens. Is it common? No,
16 because we do clean our instruments, we do sterilize. We
17 sterilize and we monitor our Sterilization. It was
18 substandard in this one.
19 MR. BOSSIN: Those are my questions,
20 thank you very much.
21 DR. MAZURAT: Thank you.
22 MS. DOWNING: Thank you. I'm just
23 catching up my notes. Okay. Any more follow up questions,
24 Ms. Hunt, arising out of those questions?
25 MS. HUNT: No.
26 MS. DOWNING: Okay. All right, thank
27 you very much, Dr. Mazurat, for your testimony today.
28 DR. MAZURAT: Thank you.

1 MS. DOWNING: Okay.
2 DR. MAZURAT: Bye everyone.
3 MS. DOWNING: Good-bye, thank you. So,
4 it's 11:36 and I understand that we will be hearing from Dr.
5 Hardie next?
6 MR. CURNEW: He's in the waiting room,
7 waiting to be let in.
8 MS. DOWNING: Okay. I do want to make
9 sure we break for lunch, but it's a bit early so why don't we
10 see we could – we'll see how far we can get.
11 MS. HUNT: Chair Downing?
12 MS. DOWNING: Yes?
13 MS. HUNT: I did want to ask for
14 directions first on something that has concerned me from the
15 outset, and the direction that I'm seeking is as it applies
16 to Rule 2.3 of....
17 MR. CURNEW: Can we excuse the witness,
18 please?
19 MS. DOWNING: Okay. Mr. Hardie or Dr.
20 Hardie, are you able to mute – no, I guess that doesn't help?
21 He could still hear. Well, is this something that's going to
22 be a problem for the witness to hear, Ms. Hunt?
23 MS. HUNT: I'm asking for directions
24 on the jurisdiction of the Board to amend Governing
25 Legislation or reinterpret Governing Legislation that with
26 respect to Practices and Procedures that have been already
27 been developed and dictated by the Provincial Government and
28 the legislation in terms of what must be followed. Because I

1 can continue. I can elaborate if you like now or we can
2 excuse Dr. Hardie.
3 MR. CURNEW: What does this have to do
4 with Dr. Hardie's evidence?
5 MS. HUNT: Would it - do we want the
6 witness in the room for this?
7 MS. DOWNING: Okay.
8 MR. CURNEW: Well, I'm totally confused
9 that....
10 MS. HUNT: I'm prepared to elaborate.
11 I just want to confirm that we want the witness in the room.
12 MR. CURNEW: Well, why is Dr. Mazurat
13 still here if - I don't understand what is going on or why.
14 Right? I defer to the Board. I have no idea what just
15 happened and why?
16 MS. DOWNING: Okay, so your question, if
17 I understand it, Ms. Hunt, is can the Board change
18 Legislation.
19 MS. HUNT: Right, but....
20 MS. DOWNING: I thought that was a self-
21 evident - of course we can't.
22 MS. HUNT: So, and I guess it goes to
23 my question. My question is that we heard evidence yesterday
24 that the Complaint Protocol, the Disclosure Protocol. These
25 are all created pursuant to the regulations, and it is
26 mandatory that Health Units must comply with them. We have a
27 public - we have a checklist that is developed by Public
28 Health Ontario through the Ministry of Health that is to be

1 applied in Dental Settings by Public Health Inspectors. If
2 I'm understanding Mr. Curnew's line of questioning and Dr.
3 Hardie's Report, they intend to challenge these Mandatory
4 Practices and Procedures and Standards that have already been
5 set out by the Provincial Government and I'm not sure why
6 we're doing this. If my understanding of the Legislation is
7 correct and these things are mandatory, then I ask what the
8 direction is of the HSR to actually change any of it?
9 MR. CURNEW: Let me answer that, if you
10 don't mind--
11 MS. DOWNING: Okay.
12 MR. CURNEW: --Madam Chair. What we're
13 challenging is that the Legislation is clear and unequivocal
14 that Dr. Salvaterra had to use reasonable and probable
15 grounds and the order is issued within her discretion. Did
16 she use that discretion properly or did she have Reasonable
17 and Probable Grounds? That's it. I've said it. I think Dr.
18 Schofield knows what it is. I know Ms. Downing knows what it
19 is, and I know that Mr. Bossin is of that view, too. Like
20 it's - this isn't that difficult.
21 MS. DOWNING: Okay, so I'd like to just
22 proceed with hearing from Dr. Hardie then. I don't think I
23 need to make a ruling that we can't change Legislation. I
24 think that's understood. So welcome, Dr. Hardie. Thank you
25 for coming--
26 DR. HARDIE: No....
27
28

1 MS. DOWNING: --and so we'll go
2 through the same process, Mr. Curnew, as Ms. Hunt did with
3 Dr. Mazurat, and that is qualification of Dr. Hardie.
4 So, before we do that, I'll just ask you to affirm
5 your testimony. Dr. John Hardie, do you solemnly affirm the
6 information you are about to give this tribunal shall be the
7 truth and nothing but the truth?
8 DR. HARDIE: I do.
9 MS. DOWNING: Okay, thank you, and can
10 you please state and spell your name for the record? There's
11 quite a lag.
12 DR. HARDIE: John Hardie.
13 MS. DOWNING: Okay.
14 DR. HARDIE: There is a lag?
15 MR. BOSSIN: Yes.
16 DR. HARDIE: My name is John Hardie, J-
17 O-H-N, H-A-R-D-I-E.
18 MS. DOWNING: Thank you. So now, Mr.
19 Curnew, over to you.
20
21 **EXAMINATION IN-CHIEF BY MR. CURNEW:**
22 **DR. JOHN HARDIE, WITNESS:**
23 MR. CURNEW: Dr. Hardie, thank you for
24 attending today.
25 MR. CURNEW: Q. You are aware of the
26 reasons why we are here today?
27 A. I am.

1 Q. And I'm going to get to your expertise in a
2 second, but I want to advise you that this is a three-panel
3 Board that is going to be hearing your evidence. Only one
4 member of the Board is a Doctor. For the benefit of myself,
5 Ms. Hunt and the Non-Doctors in the room, we want – I want
6 you to spoon feed us your evidence as if I were a child, and
7 you were willing to make this as easy as possible. So, with
8 – can you tell us why you are an expert for the purposes of
9 today's hearing?
10 A. Thank you. For approximately 35 years, I have
11 been involved in the area of infection Prevention and Control
12 in the Dental Profession. During that period of time, I have
13 written a number of papers on the subject. I have had a PhD
14 thesis on the effect of HIV Aids in Dental Practice
15 published. I have had over, I think, 150 papers on that or
16 related issues published. I've given numerous lectures on
17 the topics throughout North America, Europe and the Far East,
18 and I've been, in addition, I was asked in 2000 to provide
19 for the Royal College of Dental Surgeons of Ontario an
20 Evidence-Based Report on the status of Infection Control in
21 Dentistry at that time. I had made recommendations which
22 will be evidence-based which I did for the College, as I
23 said, in the year 2000.
24 So that is a very brief summation of my area of
25 involvement in the Infection Prevention and Control as far as
26 the Dental Profession is concerned.
27 Q. Could you also tell us what degrees you
28 currently have?

1 A. I have the Bachelor of Dental Surgery from
2 the Glasgow University in Scotland. I have a Master of
3 Science in the University of Western Ontario, my PhD was
4 granted both by the Mellon University, and I have – I'm a
5 Fellow of the Royal College of Dental Surgeons of Ontario –
6 sorry, the Fellow of the Royal College of Dentists of Canada
7 and a Fellow of the International College of Dentists.
8 Q. Can you tell us about your experience with
9 Pathology, Oral Pathology?
10 A. From 1978 until 1980, Oral Pathology at the
11 University of Alberta, and from 1980 to 1990, I was appointed
12 as Head of the Department of Dentists at the Ottawa Civic
13 Hospital where I not only was practicing both Clinical and
14 Anatomical Oral Pathology, but was also setting up programs
15 to individuals that had Cancer associated with people going
16 through Heart Transplants and people receiving Stem Cell
17 Therapy. From 1990 till '94, I did the same work at the
18 Vancouver General Hospital, was affiliated with the Dental
19 School at the University of British Columbia. From 1994
20 until 2000, I was given an appointment in Saudi Arabia where
21 I set up a Major Dental Hospital Bed Program. After that,
22 for a Major Health Trust in Northern Ireland looking after
23 Community Dental Services and Affiliated Programs, and then I
24 retired from practice.
25 Q. Is it going to be your evidence today that you
26 have the requisite expertise to advise us and this panel with
27 respect to whether or not Dr. Salvaterra's Order should be

1 enforced, rescinded or substituted for information of the
2 Board?
3 A. I believe that I have information which will
4 allow the Board to give reconsideration to the idea that the
5 Section 13 Order was not justified.
6 Q. But do you have the requisite - based on all
7 of your qualifications, do you have the expertise necessary
8 to be able to comment on Dr. Mazurat's Report and the
9 information before this Board?
10 A. I believe I do.
11 MR. CURNEW: Thank you. Madam Chair,
12 does Ms. Hunt have any objection?
13 MS. DOWNING: Ms. Hunt?
14
15 **CROSS-EXAMINATION BY MS. HUNT:**
16 **DR. JOHN HARDIE, WITNESS:**
17 MS. HUNT: I have some clarification
18 questions that I would like to - some of it was cutting out
19 when Mr. Hardie was speaking, and I just want to confirm a
20 couple of things.
21 MR. HUNT: Q. Dr. Hardie, can you please
22 advise when you obtained your Bachelor of Dental Surgery?
23 A. I obtained it in 1963.
24 Q. And the - with respect to the Significant
25 Committee Appointments that you list on Page 2 of your CV,
26 have you held any Committee Appointments since 1993?
27 A. Since 1993, yes, I've held many significant
28 appointments.

1 Q. I don't see them listed on your resume. You
2 talk about Significant Committee Appointments since 1993.
3 A. I could easily list those but from 1990, 1993,
4 I was in the process of leaving the Ottawa Civic Hospital and
5 going to the Vancouver General Hospital. In 19 - sorry, I
6 did that in 1990 to 1994. Ninety-Three, I was appointed to
7 the Saudi Arabian hospitals, and I had significant
8 appointments there. I didn't list them. I usually - like, I
9 can give them to you, but I was appointed to the Chairman of
10 Infection Control Committee in Saudi Arabia. I was involved
11 with looking after medical records when I moved to the Health
12 Northern Ireland, I was very involved in the Infection
13 Control Committee Association.
14 Q. If I....
15 A. So, the fact that I didn't include these, I
16 don't know why I didn't include them, but I can certainly
17 give those to you if you so wish but it means me looking back
18 into my CV which is quite extensive.
19 Q. Okay. So, I see here when I look at your
20 resume that you were in Saudi Arabia until approximately
21 2000, is that correct?
22 A. That is correct.
23 Q. And then you were in Ireland until 2006?
24 A. Correct.
25 Q. So, you referred to those two things, your
26 work in Saudi Arabia and your work in Ireland. Anything in
27 the last 15 years relating to committee work--
28 A. Yes.

1 Q. --with IPAC?
2 A. No committee appointments but certainly lots
3 of involvement with the preparation and the publication of
4 articles on Infection Prevention and Control in Dentistry.
5 Q. So then looking at Page 3 of your resume, I do
6 see that there are a fair number of articles listed there.
7 Since 2000, I believe almost all of them appear to have been
8 written for a publication called Oral Health. Is that
9 correct?
10 A. That – that's correct.
11 Q. Is Oral Health a Peer Review Journal?
12 A. Oral Health has an Editorial Board, and the
13 publications have to be accepted by the Editorial Board of
14 Oral Health.
15 Q. Right and that's the case with many magazines
16 that there's a vetting process, but is this a Peer Review
17 Journal?
18 A. I think you would have to inquire with it. If
19 someone – if something has been looked at by my peers, which
20 the Editorial Board would be – they would be my peers, then
21 it depends on how you define a Peer Review Journal, but that
22 would be reviewed by my peers, so I would consider that to be
23 at least gone through an Editorial Review Process.
24 MS. HUNT: An Editorial Review, yes.
25 Chair, I'll tell you what my concern is. This is an
26 individual who obtained a degree in 1963, who has a – he's
27 mentioning he has a Doctorate but it's in Philosophy,

1 according to his resume. He has not been on a committee
2 since--
3 DR. HARDIE: Pardon me?
4 MS. HUNT: Q. --your Doctorate is listed
5 as being in Philosophy?
6 A. Well, it's a Doctor of Philosophy which is the
7 PhD Degree. Do you wish me to read the title of my PhD
8 Thesis?
9 Q. I see it here on your resume. I believe the
10 panel can, too. I'm simply pointing out that your PhD is in
11 Philosophy. That's what's on your resume, your CV.
12 A. It's a Doctorate of Philosophy. That's what a
13 PhD means, but you want to look at what the actual thesis,
14 the subject matter was, which was on the effect of HIV Aids
15 on the Practice of Dentistry.
16 Q. So what department was that PhD associated
17 with?
18 A. Well, I....
19 Q. It's medical, right? Is it a Medical PhD?
20 A. It was – yes. I don't understand the concept
21 of the question. I'm assuming you know what – I think it
22 would be better if I actually read the title of the thesis to
23 you.
24 Q. I can see the title here. What I'm asking is,
25 was that PhD – what's – typically, universities have
26 different schools. They'll have a School of Dentistry, a
27 School of Medicine. What school were you part of when you
28 wrote your PhD?

1 A. I - that was part of Mellon University.
2 Q. Was it a – that's what I don't understand.
3 Was it a Medical Program?
4 A. No. I wrote that thesis and I subscribed –
5 submitted it to Mellon University. It was Peer Reviewed at
6 that time, and based on that Peer Review, the degree was
7 granted.
8 MS. HUNT: Okay, thank you. So, I
9 think my concern remains. We have an individual whose
10 received a Bachelor of Dental Surgery in 1963, who has no
11 significant committee appointments that I'm aware of in
12 almost 20 years, who worked in Saudi Arabia and Ireland 15
13 years ago, and who for the last 20 years has written a number
14 of articles for a magazine. I'm not seeing how this gives
15 this witness the qualifications to testify. I grant you; I
16 agree that he probably has an opinion, but I don't see how
17 this provides him the qualifications to testify as an Expert.
18 MR. CURNEW: Madam Chair, if I may. If
19 Dr. Mazurat has the requisite skills to testify as an Expert,
20 as a General Dentist in Restorative Dentistry, certainly an
21 Oral Pathologist has the qualifications necessary to be able
22 to testify as an Expert. Moreover, yesterday it was almost
23 completed, or it was conceded, that the Expert Reports were
24 going in and the only purpose of today was to be able to
25 cross-examine, and there was no objection from Ms. Hunt
26 yesterday that Dr. Hardie was an Expert. So, you can't
27 broadside me with an argument.

1 MS. DOWNING: Okay, so I'm just going
2 to check in my panel to see whether you want to have a side
3 discussion about this or ask any questions?
4 MS. SCHOFIELD: So, I don't have any
5 questions at this point. If I have any questions for Dr.
6 Hardie, I'm happy to wait until the end of his testimony.
7 MS. DOWNING: I'm thinking that the
8 concerns you've raised, Ms. Hunt, can just go to weight. Mr.
9 Bossin?
10 MR. BOSSIN: I would like to hear Dr.
11 Hardie, and I agree with you, Chair, that the comments made
12 by Ms. Hunt, I think are appropriate to what weight we give
13 for Dr. Hardie's comments, but I would like to hear him
14 testify. And, you know, it sounds like he's an Expert and to
15 what weight we give that expertise, you know, we can decide
16 later.
17 MS. DOWNING: Okay, thank you. Okay, so
18 we'll go ahead then, Dr. Curnew – oh, I'm sorry, Mr. Curnew,
19 over to you to ask questions of Dr. Hardie.
20
21 **RE-EXAMINATION BY MR. CURNEW:**
22 **DR. JOHN HARDIE, WITNESS:**
23 MR. CURNEW: No problem. Thank you,
24 Madam Chair. So, Dr. Hardie, I'd like to remind you again
25 that it is my preference that your evidence be given to us as
26 simple as possible. Again, there is only one Doctor on the
27 Board and neither Ms. Hunt nor I are Doctors, so we want you
28 to – or I want you to spoon feed your evidence to this panel.

1 MR. CURNEW: Q. Dr. Hardie, have you
2 given any Expert Reports with respect to any other hearing
3 before HR or HPARB which any Committee Member here today has
4 worked, and I will specify that I'm referring to the *Joel*
5 *Phillip Case*, Dr. Joel Phillip?
6 A. I have not given any evidence before this
7 Board as far as Dr. Phillip is concerned, but I have given
8 Dr. Phillip some advice as to the involvement of his practice
9 as far as his Section 13 Order was concerned. So yes, I have
10 been involved peripherally with the Board through my
11 involvement, my direct involvement, with Dr. Joel Phillip,
12 but I have not been....
13 Q. Have you not...?
14 A. This is my first time ever, this particular
15 Board.
16 Q. Did you provide any letters to Dr. – or
17 opinions to Dr. Phillip to tender to the Board?
18 A. Yes, I did.
19 Q. In support of the Section 13 Order? And what
20 was the...?
21 A. With reference – I gave him information with
22 reference to the Section 13 order.
23 MS. DOWNING: I'm not sure that we
24 should be discussing another case for many reasons.
25 MR. CURNEW: If it's not....
26 MS. DOWNING: It would be and relevance.
27 MR. CURNEW: Madam Chair, if Dr. Hardie
28 has already been confirmed to be an Expert by at least one

1 member of this panel, then the weight to be given to Dr.
2 Hardie's evidence has already been determined.
3 MS. DOWNING: Okay, well....
4 MR. CURNEW: And there are similar
5 facts evident.
6 MS. DOWNING: But the Independent Case
7 and his involvement of other cases has no bearing one way or
8 another.
9 MR. CURNEW: Okay.
10 MR. CURNEW: Q. Dr. Hardie, can you tell
11 us why, slowly and succinctly, why you object to Dr.
12 Salvaterra's Order and what evidence you have reviewed to be
13 able to help you come to that determination?
14 A. I will – I'll start where it's appropriate
15 which is at the beginning, the complaint that was lodged with
16 Dr. Salvaterra's Office and it's concerning the Sterility,
17 the Questionable Sterility of Dental Drills that were lying
18 on a countertop. I believe the patient asked whether these
19 instruments were or not. The individual response to that
20 question and I believe subsequently then notified the Public
21 Health Office of her concerns regarding the Sterility of
22 Instruments and the lack of response.
23 It seems to me that that was a relatively genuine
24 question. A patient wants to know what the status of these
25 instruments. If it wasn't answered appropriately by one
26 person in the office, I don't see why it couldn't have been
27 directed to other individuals in the office or, once it was
28 received by Public Health, why they couldn't have found out

1 from the office what the status of these instruments was,
2 and it would have been important to answer that question for
3 the patient even though if today it has been answered.
4 But it seems to me that that is a genuine question
5 that required a genuine answer, and that answer could have
6 been obtained by asking suitable questions of the staff of
7 the – of the office involved. I don't think it justified the
8 further sequelae that occurred. That's my first point.
9 The second point is that the practice was audited
10 by a series of checklists. Now, those checklists, according
11 to the Ontario Ministry of Health, any item on those
12 checklists has to have been shown to have, when applied
13 clinically, resulted in a positive outcome. In other words,
14 there have to have been tests done to show that those various
15 audits, when done clinically, will definitely cause a
16 decrease in Infection Transmission in Dental Offices.
17 To the best of my knowledge, very few in any of
18 these checklist audits have been subjected to such clinical
19 studies and the opinions of individuals indicating that yes,
20 maybe these audit items will be necessary to reduce
21 infections in Dental Offices, but they have never ever been
22 tested clinically and that is mandated by the Ministry of
23 Health. Clinically, it must be shown to have positive
24 outcomes.
25 Since that hasn't been done, its my contention that
26 the checklists are valueless. They are not proving anything.
27 They are a Bureaucratic Exercise and once they're
28 accomplished, they do not indicate that the office is any

1 less prone to Infection Disease Transfer after any of these
2 procedures have been put in place, as the office was prior to
3 those audits being put in place.
4 So, for that reason, I do think that there has to
5 be a Complete Reassessment Type of Checklist Audits that are
6 done in Dental Practices and since we do not know, I will
7 challenge anyone to show me the Clinical Evidence that these
8 are valuable since that – I don't know of that. I therefore
9 say that the assessment concerning its practice were
10 validated against are indeed valueless and as such, she
11 cannot – Dr. Salvaterra cannot indicate that an Infection
12 Control Lapse has occurred.
13 So those are the two reasons why I think there are
14 justifications for giving due reconsideration to the
15 submission of the Section 13 Order.
16 Q. Let me stop you first.
17 A. Question....
18 Q. I'm going to stop you for a second, Dr.
19 Hardie.
20 A. Okay.
21 Q. What the Board wants to know, what I want to
22 know, and what Dr. Kilislian wants to know is what is the
23 likelihood that – how many instances are there of HIV or
24 Hep C spreading through Dental Practices as a result of an
25 IPAC Violation?
26 A. Well, I can give you – I cannot give you an
27 exact number of standing what that is in Dental Practice.
28 What I can do is dive right through to something that is even

1 better, and that is the study that was done on the
2 Inappropriate Disinfection and Sterilization of Endoscopic
3 Instruments.
4 Q. Okay. Can you tell us what the difference
5 between Endoscopic--
6 A. Yes.
7 Q. --sorry, Dr. Hardie, there is a Non-Doctor, or
8 sorry, three Non-Doctors on the Board.
9 A. And....
10 Q. Endoscopy sounds the same as Endodontics. I
11 do not want you to be confusing because--
12 A. No.
13 Q. --there are....
14 A. An Endoscopy Instrument would be a Flexible
15 Tube that's passed down someone's throat, someone's
16 esophagus, in an attempt to investigate the Gastrointestinal
17 System. So that's different from any Dental Instrument which
18 is just subjected to the Oral Cavity. So, this is an
19 instrument that's actually invasive. It's going into the
20 patient's body. It's a fairly complicated instrument. It's
21 difficult to sterilize. It's difficult to take apart
22 properly, and there have been instances where these
23 instruments have not been fully disinfected. So, studies
24 have been done on the effect of this and it has been shown
25 that the risk of an Endoscopy Instrument which as I said is
26 much more sophisticated than any Dental is going to
27 contaminate it more so than any Dental Instruments. The risk
28 of it inappropriately Decontaminated Endoscopic Instrument

for transmitting HIV is approximately 70 trillion for the ability for such an instrument that is being inappropriately disinfected to transmit Hepatitis B is 2.4 in one billion, and for Hepatitis C, approximately way between those. This is for a complicated medical instrument.

If we use that as a Surrogate Marker for a Dental Instrument like a Dental Handpiece, it can be shown that the chances of a Dental Handpiece transmitting such infections in just remarkably infinitesimal that it isn't even worthwhile considering.

All right. The second point that the panel might wish to rely, is that Hepatitis B, Hepatitis C and the Human Immunodeficiency Virus are what we call – excuse me, I'll just have a drink – are what are known as Lipid-Enveloped Viruses. That means that their outer surface is covered by a Lipid Membrane. That Lipid Membrane is easily destroyed by the lowest level of disinfectant, and that is even stated in the Ministry of Health Documents and indicates that Lipid Enveloped Viruses are easily destroyed by simple Household Disinfectants.

That is a fact, which means that even if the instruments were subjected to our less than Effective Sterilization Process, the very fact that they have already been cleaned, decontaminated, submerged and then subsequently wrapped in cellophane and put through a sterilizer, they are already going to be inactivated by the fact that their Lipid was destroyed by Simple Household Disinfectants that's commonly used in any Dental Practice.

1 So, I think I’ve tried to show you that through
2 using Endoscopic Instruments as Surrogate Markers for Dental
3 Handpieces in which the Sterility for those very complicated
4 instruments inappropriately decontaminated to spread disease
5 is remarkably low. That’s one factor, and the second factor
6 is that the Lipid Envelope Nature of HIV, HCV and HBV makes
7 them very easily destroyed viruses which is the reason why
8 there is an absolute posity of any constructive clinical
9 evidence of those diseases being transmitted in Dental
10 Practice. And when we combine that with the fact that in the
11 Endodontic Practice under consideration here, Endodontic
12 Treatment is done by isolating the tooth from the rest of the
13 body cavity, the rest of the oral cavity, by a material
14 called Rubber Dam, it further, further reduces any chance
15 that those viruses would have been transmitted in the
16 practice under consideration.
17 Q. Dr. Hardie, have you met with a person named
18 Sara Barradas, at any point?
19 A. I have.
20 Q. And you’re aware that she was the IPAC Lead
21 and she’s referred to in the Appellant’s Grounds of Response
22 as someone that Brian Sammon spoke to?
23 A. I have read that, yes.
24 Q. And when you spoke to Ms. Barradas, what was
25 your opinion, based on your expertise in IPAC, of Ms.
26 Barradas’ qualifications with respect to IPAC?
27 A. I had no reason not to believe that she was
28 appropriately qualified in that area.

1 Q. And you're aware that Kawartha Endodontics
2 was a training facility for IPAC?
3 A. I am indeed.
4 Q. And have you lectured at Kawartha Endodontics
5 Training Facility?
6 A. I have.
7 Q. And have you had an opportunity to look at the
8 Infection Control Practices employed by Kawartha Endodontics?
9 A. I have.
10 Q. And you've read the evidence of Dr. Kilislian?
11 A. I have.
12 Q. And you've read the evidence of Brian Sammon?
13 A. I have.
14 Q. As a Former Chief of Staff of major teaching
15 facilities and hospitals with respect to IPAC, would you have
16 relied on the information of Brian Sammon who had conducted
17 one Dental Office Inspection and Zero Endodontic Office
18 Inspections over that of a colleague?
19 A. I have never met Brian Sammon. I don't know.
20 Here are comments that he has made as part of his witness
21 statement and where his comments appear in the various
22 submissions made to the Board. What I would certainly
23 consider the qualifications of Ms. Barradas would be more
24 appropriate for if I was hiring someone in a Hospital-Based
25 Dental Program, I would certainly consider Ms. Barradas to
26 have the appropriate qualifications for such a position. I
27 would have to question Mr. Sammon. I would want to know what
28 his experience of Dental Offices was. I would want to know

1 what his experience of Endodontic Practice, want to know
2 what his experience of Prosthodontic Practice, of an
3 Orthodontic Practice, of Periodontic Practice. I would want
4 to know all of those things before I would consider him for
5 such a position. So, I hope that answers your question.
6 Q. It does. Again, what we all want to know is
7 what are the reasonable and probable grounds - do you agree
8 with Dr. Mazurat's Report that patients should be tested?
9 Have you read the report of Dr. Mazurat?
10 A. I have.
11 Q. What are the issues you see with Dr. Mazurat's
12 Report?
13 A. Well, it's an interesting report because all
14 it tends to do is to parrot many of the Checklist Audit
15 Criteria, and I don't know whether that was the mandate that
16 she was given when she was asked to provide an Expert's
17 Report. It would have seemed to me that it would have been
18 much more valuable, rather than just reiterating what the
19 Various Checklist Audits are, had she actually short point on
20 references which indicated that there was clinical evidence
21 to substantiate these audits, and she didn't. She failed to
22 do that.
23 Yes, she does identify certain references from the
24 Royal College of Dental Surgeon Materials Report on IPAC
25 procedures which I've already criticized because they again
26 do not cite Clinical Evidence. The evidence is mainly that
27 relates to groups of so-called Experts. I would like to see
28 definite evidence that if you do not have an Office Manual on

1 Infection Control, if you don’t have that, it leads to
2 horrible diseases being transmitted to your patients and I’m
3 not aware of that occurring.
4 I’m not aware of the fact that an appropriately
5 Sterilized Surgical Instrument actually causes transmission
6 of diseases and I’m going to substantiate that fact by
7 something that Ms. Hunt had alluded to. She indicated that I
8 had practiced in – sorry, I graduated in 1963. Well, most of
9 my Dental Treatment was done in the 60s and the 70s and it
10 was relatively because I had grown up in wartime Britain, so
11 I needed quite extensive Dental Treatment. That was done
12 without all of the protocols and procedures that appeared to
13 be necessary today. That was when tuberculosis was rife, it
14 was when conditions such as Syphilis were rife and seems to
15 have been forgotten that Syphilis can easily, relatively
16 easily be transmitted in the Oral Cavity, and I had no qualms
17 about undergoing that treatment in the 60s and 70s with a
18 minimal amount of Infection Control Procedures being
19 practiced, compared to what would be necessary today and I’m
20 not aware, and I can give you evidence and literature that
21 Dentists have ever died more frequently of Infectious
22 Diseases that they might have obtained from their Dental
23 Practice than of any other members of the population, and I’m
24 not aware of during the 60s and the 70s, then the 80s, there
25 being any evidence of diseases being transmitted from Dental
26 Practices and this is a very unfortunate burden that
27 Dentistry has had to bear over the last 20 years. The idea
28 that we promote Dental – that we promote what are called

1 nodes of Copomial Infections. That is infections which are
2 acquired during the course of undergoing a Program of Dental
3 Treatment. In other words, you were not – you did not have
4 that infection before you came into the practice. You get it
5 after you leave the practice.
6 I think I've just in my submissions to the Board
7 evidence that Dentistry does not warrant the attention to
8 Transmit Infectious Diseases, and I will go back to something
9 that was quoted to me in 2008, I think it was.
10 Most of you today will have heard of the Cochrane
11 Collaboration. Cochrane Collaboration has been very
12 prominent recently because of Covid, but Cochrane
13 Collaboration is based on the idea of Evidence-Based Care.
14 In fact, some of it was actually developed at McMaster
15 University in – yes, in Hamilton, Ontario. However, the
16 Cochrane Collaboration also has an Oral Health Group which
17 gathers Evidence-Based Aspects of Dentistry from around the
18 world and the Cochrane Oral of Health Group Administrator
19 said to me personally, I think it was in 2008, that the
20 amount of Infectious Diseases that is transmitted in
21 Dentistry is so low that we cannot actually produce any
22 reliable studies on it. We are chasing something that simply
23 doesn't happen.
24 So, if that was the case in 2008, it's still the
25 case today and when we put all those things together, we
26 start to appreciate what I think Mr. Sammon and the
27 Peterborough Public Health Unit failed to do, which is the
28 following. They're supposed to do a Risk Assessment. Had

1 they done a proper Risk Assessment, they would have looked
2 into the Epidemiology of Transmissible Diseases from Dr.
3 Kilislian's practice, and they would have been that there
4 were none. Then they ought to have looked at well, what does
5 it tell you about the spread of diseases in Endodontic
6 Practices. You would have found none. What is the evidence
7 of it being spread in a Dental Practice? Then they might
8 have found some evidence, and that evidence has already been
9 produced by Peterborough Public Health, and it was also given
10 to me when I was asking questions of Ontario Public Health
11 regarding Dr. Phillip's practice. And the only document that
12 the Ministry of Health can produce is one which stems from a
13 12-year investigation of Dental Clinics in America and during
14 that 12-year period, there was not a single case, not a
15 single billable case, of HIV Transmission. There were two
16 cases of Hepatitis B possibly being transmitted, both related
17 to the Oral Surgery Office and the Oral Surgeons were thought
18 to have transmitted this not through Dental Instruments but
19 through Intravenous Instruments used in putting patients to
20 sleep. Nothing to do with Dental Instruments.
21 So, in fact, the very document that Public Health
22 uses to substantiate the idea that Dentistry transmits
23 diseases is, in itself, incapable of showing a causal
24 relationship between Dental Instruments that have been
25 inappropriately sterilized or decontaminated and the presence
26 of an Infectious Disease.
27 So, it's for these reasons that I think the fact
28 that it was a question that was raised in the office, not

1 really a complaint. The question could have been addressed
2 very adequately and none of this investigation would have
3 occurred. The fact that the Checklist Audits are not
4 validated clinically, which is mandatory according to Ontario
5 Ministry of Health Guidelines. They're saying you must show
6 to us that the procedure that you're checking, it has to have
7 been shown to make a positive outcome in the transmission of
8 a disease. That's – those studies have not been done, so the
9 Checklist Audits are purely a Bureaucratic Exercise.
10 When we allied that with the fact that the viruses
11 in this diseases involve a Lipid ones which are easily
12 destroyed by Minimal Disinfection Processes, when we look at
13 the fact that there are no historical records equating the
14 practice under consideration with disease transmission, there
15 are no record indicating that Endodontic Practices in general
16 have caused this, when we look at the fact that there is an
17 absolute posity of properly controlled investigations showing
18 that Dentistry has indeed transmitted diseases, then all,
19 when I wrap all of these together, I come to the conclusion
20 that while the question regarding the appropriateness of the
21 Sterility of the Instruments on the countertop is a
22 justifiable question, I think the response to it was
23 completely over the top and unnecessary.
24 MR. CURNEW: Dr. Hardie, I'm going to
25 examine you for another five to seven minutes, and then I
26 think that the Board might want to take a break for lunch,
27 and then I'm going to turn it over to Ms. Hunt to be able to

1 cross-examine you on your evidence today. Is that okay
2 with the Board, five to ten minutes?
3 MS. DOWNING: So, you'll be finishing in
4 five to ten minutes, is what you're saying?
5 MR. CURNEW: That's correct.
6 MS. DOWNING: Okay. All right, thank
7 you.
8 MR. CURNEW: I'm okay to proceed, Madam
9 Chair?
10 MS. DOWNING: Yes, and I think we will
11 take a 30-minute lunch break at that point, and then Ms. Hunt
12 can cross-examine Dr. Hunt – or Dr. Hardie after that.
13 MR. CURNEW: No problem. Thank you,
14 Madam Chair.
15 MR. CURNEW: Q. Can you tell the Board
16 about False Positives in HIV that – that - I want you to tell
17 us about how many people live within the population that
18 already have Hep C and I'm not sure if you're aware, but
19 there have been a thousand patients that have been tested of
20 Kawartha Endodontics for Blood-Borne Illnesses, and six of
21 those patients tested have Hep C according to these reports.
22 I haven't been produced the full content, but let's take them
23 that they're true. There is six people over a ten-year span
24 that have been found to have Hep C out of a thousand
25 patients. Is that something for concern, or is that normal?
26 A. I don't know what the incidence of Hepatitis C
27 is in the area, the Peterborough Public Health Unit. I've no

1 idea what that is, so I can’t tell whether it’s, that
2 number is excessive or not excessive.
3 Q. These – not – these patients were tested
4 across...?
5 A. But what would be interesting to know....
6 Q. Sorry, Dr. Hardie, these patients were tested
7 across the Province of Ontario, from Peel Region....
8 A. Well, across the Province of Ontario?
9 Q. From Peel Region all the way to Peterborough,
10 and presumably over to Belleville, Trenton?
11 MS. HUNT: I’m sorry, I’m objecting
12 because Mr. Curnew is putting information before the witness
13 that is untrue. We don’t know where these patients were
14 tested, and we don’t know over what period of time they were
15 tested.
16 MR. CURNEW: Then perhaps--
17 MS. DOWNING: I....
18 MR. CURNEW: --a Media Campaign.
19 MR. CURNEW: Q. Can you tell us about
20 False Positives with respect to HIV and Hep C?
21 A. Well, False Positives are always a problem,
22 and one of the peculiarities of diseases when they aren’t a
23 test is that, and this is a statistical calculation, that
24 when you have a relatively low incidence of a disease and you
25 subject the population to tests for that particular disease,
26 you will tend to get a high rate of False Positives but when
27 I say we’re testing the general population. It changes
28 somewhat when you start to test individuals to may have signs

1 and symptoms of diseases or who are in the high-risk group
2 for the diseases. This means then that if you are subjecting
3 the average population of a Dental Practice, which will have
4 - the majority of individuals in their practice will be
5 healthy individuals having very few of the high-risk
6 activities that one might associate with Hepatitis B,
7 Hepatitis C. If you subject that group of patients to the
8 necessary tests for those three diseases, you will, on a
9 statistical basis, find a considerable number of False
10 Positives but I can't give you as to what that might be. It
11 will occur and that means that you are subjecting patients,
12 who are otherwise healthy, to the idea that they might get a
13 positive result that indicates they have one or other of
14 those three diseases and that both physically and emotionally
15 could be quite devastating.
16 So, I think any time that you subjecting average
17 population to the tests that are associated with these
18 diseases, you have to be very conscious of the fact that
19 False Positives can occur.
20 Mr. CURNEW: Thank you, Dr. Hardie,
21 those are my questions.
22 MS. DOWNING: Okay, thank you. So let's
23 break and come back at one o'clock and at which point, Ms.
24 Hunt will cross-examine Dr. Hardie.
25 MR. CURNEW: Thank you.
26 MS. HUNT: Thank you.
27 MR. CURNEW: Oh, just for the benefit
28 of the panel, Dr. Hardie, you are not to discuss your

1 evidence with me while you're being cross-examined. You
2 cannot contact me. We cannot have any conversation
3 whatsoever. We cannot go over your evidence that you just
4 testified. The soonest you will be able to call me is
5 sometime this evening if we conclude this today, and I
6 anticipate we will. Is that okay, Madam Chair?
7 MS. DOWNING: Yes, thank you.
8 MR. CURNEW: Thank you, bye.
9
10 **---OFF THE RECORD**
11 12:30 p.m.
12
13 **---BACK ON THE RECORD**
14 1:00 p.m.
15
16 MS. DOWNING: Okay, I think we have
17 everyone. We're just waiting for Mr. Bossin. Oh, there he
18 is. Okay. Okay, Ms. Hunt, over to you for your questions
19 for Dr. Hardie. Oh, you're on mute.
20
21 **CROSS-EXAMINATION BY MS. HUNT:**
22 **DR. JOHN HARDIE, WITNESS:**
23 MS. HUNT: Helps if I take that off.
24 Thank you, Chair Downing. I just have a couple of questions
25 that I've written here for Dr. Hardie while we were on the
26 break.
27 MS. HUNT: Q. Dr. Hardie, can you hear
28 me, okay?

1 A. Yes, I can.
2 Q. You spoke about the insufficiency of evidence
3 relating to the Transmission of HIV and Hepatitis in Dental
4 Settings. Is there a Surveillance System currently in place
5 in Ontario to identify infections occurring in Dental
6 Practices?
7 A. To the best of my knowledge, there is not.
8 Q. So, if the answer is, no, then, you'll agree
9 with me that it's hard to – you can't say there isn't any
10 evidence if no attempts have been made to collect it?
11 A. Well, what I can tell you is that in any valid
12 Infection Control Program, depends absolutely on the Presence
13 of Surveillance. Surveillance is the very heart of an
14 effective Infection Control Program. If you do not
15 understand why a disease is being transmitted, if you do not
16 understand under what conditions that is occurring, by which
17 routes, to which patients, you cannot effectively put in any
18 appropriate Infection Control Program.
19 So, the very heart, and you've raised a good point,
20 the very heart of an effective Infection Control Programs is
21 the Essence of Surveillance. And the Ontario Public Health
22 admits that and says that is the good basics. We have no
23 Surveillance in Dentistry. Therefore, it follows, we cannot
24 have Effective Infection Control.
25 Q. But Dr. Hardie, what I'm saying to you is you
26 can't say that there is no evidence of transmission when
27 there is no Surveillance System that has been collecting that
28 data, isn't that correct?

1 A. I can attest to that, yes, but using the
2 same argument.
3 Q. So...?
4 A. Sorry? Using the same argument, if you do not
5 have Surveillance in place, you cannot indicate that any
6 programs that you are insisting upon having are in effect
7 effective.
8 Q. But let me ask you another question. You said
9 that the checklists were not validated clinically and
10 therefore shouldn't be used. I wrote that down as you were
11 speaking. You'll agree with me, however, that clinical
12 evidence is just one piece of a body of evidence that can be
13 considered when making recommendations?
14 A. It is the highest-ranking evidence.
15 Q. Right, but you'll agree with me that there
16 are--
17 A. Yes, there is....
18 Q. --Non-Clinical Trials.
19 A. Yes.
20 Q. Epidemiological Assessments, Gray Literature,
21 Theoretical Science, all of these things can also be used to
22 rely on to make recommendations?
23 A. They can be, but they are at a far lower level
24 of evidence.
25 Q. Are there other...?
26 A. There is a hierarchy of evidence.
27 Q. I'm sorry, you phased out a bit there, but
28 I'll go onto my next question. Are there other viruses and

1 bacteria, besides HIV and Hepatitis, that can cause
2 infection in humans?
3 MR. CURNEW: Sorry, Ms. Hunt and sorry,
4 Madam Chair, sorry to interrupt. I didn't hear the finality
5 of Mr. Hardie's evidence on Hierarchy of Evidence or
6 Hierarchy of Infection. I heard the word "Hierarchy" and
7 didn't hear anything after that. There is a Hierarchy of
8 Investigation or Hierarchy of....
9 DR. HARDIE: I will expand upon it. I
10 will expand upon that concept. Evidence-Based Medicine and
11 Evidence-Based Dentistry depends upon a Hierarchy of Evidence
12 and the highest level of evidence is that provided by
13 endomise preferably the study and we don't have those in
14 Dentistry. Then there is a hierarchal, as Ms. Hunt
15 suggested, where you might use Cohort Studies, you might use
16 Observing Studies, you might use the Opinions of Experts, but
17 those are all of evidence, and it seems to me that if you are
18 going to be having - if you're going to be having a
19 recommendation by a body like the Royal College of Dental
20 Surgeons of Ontario, they ought to be using as high a level
21 of evidence as possible to substantiate the recommendations,
22 and my understanding of their recommendations is that there
23 are very few recommendations which are based on the highest
24 standards of evidence. Yes, as Ms. Hunt alluded to, you can
25 use the opinions of experts. Those are the very lowest level
26 of evidence, and we ought to keep that in mind. The highest
27 level of evidence is that provided through Clinical Studies,
28 and as I've indicated previously these have not been done,

1 yet they are mandated by the Ontario Ministry of Health
2 that says your checklist audits, they must be shown to have
3 resulted in Positive Clinical Outcomes and that has not been
4 done in Dentistry.
5 MS. HUNT: Q. I understand that. I was
6 merely going to your suggestion that because Clinical
7 Evidence, there was no Clinical Evidence, that was the end of
8 the story. And I think as you've confirmed that there are
9 other sources of evidence that can be relied upon to, you
10 know, to make, to – that form part of the body of evidence,
11 and so I was asking you to confirm that. My next question is
12 are there other...?
13 A. Yes, as I said, I did.
14 Q. Are there other viruses and bacteria, besides
15 HIV and Hepatitis, that can cause infection in humans?
16 A. Oh, yes.
17 Q. And is it possible for these other Pathogens
18 to be present on Unsterilized Surfaces or Instruments?
19 A. Yes.
20 Q. And so, would you agree with me that
21 Sterilization is necessary to kill these organisms?
22 A. No. Many of these organisms are destroyed by
23 disinfectants, both Low Level Disinfectants, Medium Level
24 Disinfectants and High-Level Disinfectants. They are not
25 necessarily destroyed by Sterilization. In fact, it is only
26 certain types of spores which are fungi are necessary to be
27 destroyed by Sterilization Process.

1 Q. So, it is your opinion that Sterilization is
2 only necessary in a very narrow set of circumstances?
3 A. I think it's important, Ms. Hunt, to define
4 what you mean by Sterilization. What is your define - oh, I
5 shouldn't be asking you a question. But Sterilization is
6 often banded around that, and Sterilization is a finite term.
7 It means the destruction of all forms of life. That's what
8 Sterilization means. And, in fact, all sterilizers are
9 subjected to something which is called the Assurance
10 Sterility Level. You may not have heard of that, but it
11 does, in fact, mean that no matter how effective your
12 Sterilizer is, there will always be a one in a million chance
13 that some bacteria, fungal spores, will remain alive. So
14 even the highest level of Sterilization that we're doing in
15 hospitals today, does not create the true sense of Sterile
16 which means the absence of any form Pathogenic Organisms.
17 Q. So then, let me ask you another question. Can
18 you hear me? Sorry, there's a bit of an echo there. You can
19 hear me, okay?
20 A. Yes, I can hear you.
21 Q. Okay. If you went for an Endodontic Procedure
22 and the Endodontist on that day advised you that the
23 instruments that were being used on you that day had neither
24 been Cleaned nor Sterilized, would you be comfortable
25 proceeding with the procedure?
26 A. I would not, under the terms that you have
27 indicated, I would not likely.

1 MR. CURNEW: Do not answer the
2 question, please, Dr. Hardie.
3 MS. HUNT: Excuse me.
4 MR. CURNEW: Let me put my objection on
5 the Board.
6 MS. HUNT: Mr. Curnew cannot--
7 MR. CURNEW: I'm going to put....
8 MS. HUNT: --here.
9 MR. CURNEW: I'm putting an objection
10 on the Board, Madam Chair, and the objection is because this
11 is a loaded question. An Endodontic Office uses Disposable
12 Instruments and Sterilized Instruments, and those Sterilized
13 Instruments, as Dr. Hardie knows, are often just mirrors or
14 pluggers and they're not the instruments or files that go
15 into the patient's tooth.
16 MS. HUNT: I believe Mr. Curnew is
17 feeding evidence to the witness now. That's – it's his
18 question to answer.
19 MR. CURNEW: This witness has been
20 over....
21 MS. DOWNING: I think Dr. Hardie – Dr.
22 Hardie can answer. He's been qualified as an Expert, so I'm
23 sure he can answer. Go ahead, Dr. Hardie.
24 DR. HARDIE: A. Well, it is, when you
25 think about it, Ms. Hunt, if the Endodontist or the
26 Endodontists tell me that the instruments were dirty, what is
27 any sensible person going to do under those circumstances.
28

1 MS. HUNT: Okay, thank you. Those
2 are my questions.
3 DR. HARDIE: I would say, no.
4 MS. HUNT: Thank you.
5 MS. DOWNING: Okay, thank you. Do you
6 have any question in Re-Exam, Mr. Curnew, for Dr. Hardie?
7 Oh, you're on mute.
8
9 **RE-EXAMINATION BY MR. CURNEW:**
10 **DR. JOHN HARDIE, WITNESS:**
11 MR. CURNEW: I'd like to redirect Dr.
12 Hardie.
13 MR. CURNEW: Q. With respect to an
14 Endodontic Practice, were you aware of the use of UV Lighting
15 within Dr. Kilislian's practice?
16 A. Yes, I was.
17 Q. Then, what does UV Lighting do to enhance the
18 killing of Microorganisms or things like that?
19 A. It is a mitigating factor. It will certainly
20 – it is – it is not definitive as subjecting Instruments to
21 Disinfectant and Sterilizing Techniques, but it does help
22 deactivate many Bacteria and Viruses.
23 Q. I have one other question. With respect to an
24 Endodontic Procedure, would you agree that the majority of
25 the instruments are thrown out? The files cannot be reused
26 as a matter of Safety Protocol.

1 A. It is my understanding that in Endodontic
2 Practice today, the vast majority of Instruments are Single-
3 Use Items.
4 MR. CURNEW: Thank you, Dr. Hardie. I
5 turn to the panel to ask--
6 DR. HARDIE: Thank you.
7 MR. CURNEW: --any questions they want
8 from the witness.
9 MS. DOWNING: Okay. Just catching up my
10 notes here. Okay, I'll check with the panel to see whether
11 they have any questions for you, Dr. Hardie. Mr. Bossin, do
12 you have any questions?
13
14 **CROSS-EXAMINATION BY MR. BOSSIN:**
15 **DR. JOHN HARDIE, WITNESS:**
16 MR. BOSSIN: I do have a few questions
17 if I may, and thank you very much for your testimony, Dr.
18 Hardie, and for your reports. I just wanted to follow up on
19 your Statements or Testimony – I'm having a lot of feedback,
20 is that...?
21 MS. DOWNING: Yes, there is.
22 MR. BOSSIN: Is everyone on mute except
23 me? I think that's better. Sorry, I didn't have – let's
24 start again. No, I'm still hearing it. I'll try.
25 MR. BOSSIN: Q. So, just following up on
26 your point that there is no method that would guarantee a
27 hundred percent Sterilization, and your reference in your
28 Testimony and in your Report to that Endoscopy Study done

1 where Endoscopic Instruments were used and there was no
2 evidence that that caused the kind of considerable diseases
3 that we're – that's at issue here. I guess my question then
4 is, is it your view then that Sterilization, in the context
5 of a Dental Clinic, is not necessary or is that important or
6 not needed? Did you hear that?
7 A. Thank you. Yes, I did. I did say it's a
8 good, it's an interesting question and, in fact, it alludes
9 in some ways to the comments that I was making earlier
10 regarding treatment that I received in 1960, 1970 when the
11 concept of so-called Sterilization was quite different from
12 then to what it is today and anyone with the panel might be
13 shocked with what I'm about to say. But we, the instrument
14 that we had used Surgically, particularly with the removal of
15 teeth, we subjected them to cleaning them with alcohol wipes
16 and then subjecting them to a boiling water for up to five to
17 ten minutes, which was considered then to be an effective
18 means of removing all viable organisms.
19 And that I think is the basis for the concept of
20 your question. And I do agree that it would be much better
21 if we did subject instruments to a thorough cleaning,
22 exposure to high-level disinfectants and introduce
23 Sterilization, but we ought to do this on the basis
24 identified by someone called Spalding a number of years ago,
25 and that is Spalding's classification of whether instruments
26 should be deemed Non-Critical, Semi-Critical or Critical.
27 The Non-Critical Instruments would be ones that would, as far
28 as Dentistry is concerned. Non-Critical might be ones that

1 are not exposed to the oral cavity. Semi – and these
2 instruments could be subjected just to cleaning, physically
3 cleaning the instruments.
4 Semi-Critical ones are ones which are exposed to
5 the oral cavity but do not come in contact with fluids such
6 as blood, not used in an invasive capacity and according to
7 Spalding's Classification and accepted by most people, those
8 instruments could be subjected to high-level disinfection.
9 And then we have instruments that are used on a substantial
10 basis, invasive instruments, and such are instruments which
11 are used in oral surgery and these, according to Spalding's
12 Classification, should be subjected to Sterilization Process.
13 So, to answer your question, it depends on the
14 instrument. It depends on what its purposes is. That is
15 what should dictate the level of decontamination of the
16 instrument.
17 Q. Thank you. I just have another question and
18 it's somewhat related. If I understand your testimony,
19 you're not saying that when the inspection was done at
20 Kawartha Endodontics, that the findings made were not made,
21 that the instruments found to be unclean were clean. As I
22 understand what you're saying is that the checklist of the
23 standards used are not appropriate for a dental environment.
24 In other words, you're not saying that the findings were
25 wrong, you're saying that the questions were wrong, if I can
26 put it that way.
27 A. I think you have exactly put your finger on
28 the pulse here. I can't dispute the findings. I wasn't

1 there and can't dispute them. What I can say is that as
2 I've indicated on numerous occasions, the audits are supposed
3 to be based on if they are – if the procedures are done,
4 there is a positive clinical outcome and since those – since
5 we don't know that, what I'm saying is, is that the
6 checklists are not of significant value. If they do approve
7 that – sorry, if they show that certain procedures haven't
8 been done, they don't indicate that if the procedures had
9 been done, there would have been no transmission.
10 Q. But, are you saying that--
11 A. That's the point that I'm trying to make.
12 Q. --somewhere there are Clinical Studies showing
13 a linkage between various factors and items in a Dental Study
14 that there should be no guidelines related to that usage,
15 those instruments, those procedures, that we need to get
16 those studies done first before there is a what I would call
17 a Best Practice Guide or Manual? Am I...?
18 A. Absolutely.
19 Q. Okay.
20 A. No, you're quite right. There ought to be
21 those studies. That's what the checklist should be based
22 upon is the fact that there are studies which show if you do
23 this, if you do A, you get B and those have not been done.
24 That's my point.
25 Q. My last – thank you. Thank you, and my last
26 question for you is based on – one, your Addendum in your
27 second report where you indicated that you were in discussion
28 with the College about this checklist and that got

1 interrupted by Covid, but my sense is that that's a
2 discussion, those are communications that you are engaged in
3 and also you testified that back in 2000, I think it was,
4 that you were consulted as well. But would I be wrong to say
5 that the existence of the current checklist and standards and
6 protocols are a reflection of the fact that at least at this
7 point in time, your idea of what a checklist should be and
8 what the standards should be are not those that have been
9 adopted by your College? You're trying to improve – you're
10 trying to improve a system that today--
11 A. I think that....
12 Q. --in fact, am I correct to say that we've not
13 got there yet, that the College's standards are not those
14 that you agree with?
15 A. Well, let me just revise what you indicated.
16 When I was in discussions, and I indicated it in the
17 Addendum, I wasn't in discussions with the Royal College of
18 Dental Surgeons of Ontario. I was in discussions with
19 Ministry of Health, okay, who had – I had – they had
20 requested that I send some information to them on some of the
21 articles that I had written. They had looked at those. They
22 had felt that some of the points that I was raising were
23 valid and they wanted to have further discussions on how they
24 could become more appropriate for Dental Practice. But
25 unfortunately, the Covid problem has caused that to be put at
26 the back.
27 Q. Okay.
28 A. I would like to say one other thing though--

1 Q. Sure.
2 A. --and sorry, and it is in relationship to a
3 comment that Ms. Hunt made. One of my reasons for publishing
4 recently in the Oral Health, in the past when I was actually
5 working and involved with Academia and Hospital-Based
6 Dentistry, I published in a number of Peer Review Journals,
7 but since my retirement I wanted that message – I didn't
8 require that add to my CV. I wanted to get the message on
9 Infection Control out to my colleagues, and the best way I
10 had of doing that was to publish in Oral Health, which is
11 distributed to every Dentist in Canada. I wanted them to
12 receive that message. So that's my reasons for not going
13 with the Peer Review Route.
14 MR. BOSSIN: Those are my questions.
15 Thank you very much, Dr. Hardie.
16 DR. HARDIE: Thank you.
17 MR. BOSSIN: You're on mute, yes.
18 MS. SCHOFIELD: You're on mute, Beth.
19 MS. DOWNING: Sorry, I was trying to
20 reduce the echo effect. Ms. Schofield, do you have any
21 questions for Dr. Hardie?
22 MS. SCHOFIELD: No, I don't have any
23 questions. Thank you very much.
24 MS. DOWNING: Okay, thank you. Unless
25 there is anything further, thank you very much, Dr. Hardie,
26 for your evidence.
27 MR. BOSSIN: Thank you.
28 DR. HARDIE: Thank you.

1 MR. CURNEW: Can we confirm on the
2 record, Madam Chair, that I am free to speak with my witness
3 now if I so choose, or....
4 MS. DOWNING: Yes, he's finished giving
5 his evidence, okay.
6 MR. CURNEW: Thank you. Dr. Hardie,
7 I'll call you sometime later this evening or – I'm pretty
8 eager to get home and see my daughter. Thank you, again.
9 DR. HARDIE: I would appreciate that.
10 MR. CURNEW: Thank you for your
11 evidence.
12 DR. HARDIE: Thank you.
13 MS. DOWNING: Thank you. Okay. Now, we
14 are going to Closing Submissions, I believe. Okay, so Ms.
15 Hunt, we'll hear from you. We can't hear you.
16
17 **CLOSING SUBMISSIONS BY: MS. HUNT:**
18 MS. HUNT: It's all right, I'm off
19 mute now. I'm going to be fairly brief with this and I'm
20 going to refer to the panel. I know you're all very aware of
21 this but Section 13 of the *Health Protection and Promotion*
22 *Act* says that a Medical Officer of Health can make an order
23 where she's of the opinion, on reasonable and probable
24 grounds, that a health hazard exists in the Health Unit
25 served by her, and that the requirements specified in the
26 order are necessary in to decrease the effect of or to
27 eliminate the Health Hazard, and my submission is that Dr.
28 Salvaterra has established that the Health Hazard existed and

1 that the requirements in her order to notify patients are
2 necessary in order to decrease the effect or eliminate that
3 Health Hazard.
4 With respect to the Case Law, again I'm sure you
5 all agree, I know that this panel cites the case over and
6 over again. It's the Waterloo Public - Regional Public
7 Health Unit. It's the 481, not 799 Ontario Limited, and it
8 really speaks because that's the case cited over and over
9 again by HSR and I'm only going to recite the one sentence of
10 it which basically says that reasonable and probable grounds
11 requirement create a standard of proof that is significantly
12 lower than the civil standard because the purpose of HIPA
13 helps to inform the question of what is reasonable in the
14 circumstances. The purpose of HIPA, as its name suggests, is
15 the protection of Public Health and it is sufficient if the
16 grounds are informed by scientific literature and exercised
17 fairly and suitable in the circumstances.
18 Over the last two days, we've heard very different
19 tales from two sides. My client says that they received a
20 complaint, and, pursuant to the IPAC Complaint Protocol,
21 investigated that. In doing so, they applied a checklist
22 that is prepared for Health Units by the Ministry of Health,
23 the RCDSO and Public Health Ontario. That checklist assigns
24 levels of risk to each category, and it clearly states that
25 if a lapse is associated with a high-risk item, that an
26 Immediate Health Hazard exists, and its practice must be
27 stopped. Those are the documents they relied on.

1 Then, when it came to determining next steps,
2 they didn't do it in isolation and this is an important
3 point, and they sought out the opinions of experts, Dr.
4 Michael Periga of the RCDSO, Dr. Gary Barber, Chief of
5 Infection Prevention and Control at Public Health Ontario,
6 and Dr. Barbara Yaffe, Associate Chief Medical Officer of
7 Health for Ontario. These are not lay people. They are
8 Medical Practitioners with significant experience in their
9 fields, and Peterborough Public Health, Dr. Salvaterra, Brian
10 Sammon, ask them all the same question. This is what we
11 found, what is the right thing to do now and how do we do
12 that thing the right way? And they acted according to that
13 advice.
14 The Appellant asks you to believe a different
15 version of events, and it's important to remember here that
16 we don't just have what we've heard from Mr. Curnew. Mr.
17 Curnew has repeatedly stated that you're also to rely on Dr.
18 Rita Kilislian's Affidavit.
19 Kawartha Endodontics and Dr. Rita Kilislian, on the
20 basis of an Affidavit sworn by her, ask you to believe that
21 the inspection as Dr. Salvaterra's order to produce patient
22 names arose from a malicious conspiracy involving three
23 Medical Officers of Health, employees at the HPERDHU Health
24 Unit, Mr. Sammon, three Public Health Nurses who accompanied
25 him. They ask you to believe that on the basis that Dr.
26 Noseworthy had - who was then the MOH for the Medical Officer
27 of Health for the HKPR Health Unit, it's triggered all of

1 this because she believed that she had received
2 substandard care while receiving treatment at Kawartha
3 Endodontics.
4 The Appellants ask you to believe that all of these
5 people invented a reason to inspect the practice, falsify the
6 results of the inspection, and issued orders that they knew
7 were based on lies. Importantly, very importantly, I submit,
8 they ask you to believe it on the basis of not having
9 produced a shred of documentary evidence proving these
10 allegations. Not one shred.
11 They also ask you, through their expert, to reject
12 the standards and the protocols that have been developed by
13 experts in the Province of Ontario. More importantly, their
14 expert asks you to reject the checklist that has been
15 developed by those experts. He asked the panel to substitute
16 its own standards and its own checklist or some other
17 checklist or perhaps no checklist at all, because there is no
18 clinical evidence to date that Infections and Transmissions
19 are linked to Dental Practice Settings.
20 On this evidence, which of these two tales is more
21 plausible? I submit to you that it could only be the one
22 told by Peterborough Public Health.
23 My client has another tale to tell, however. It is
24 the tale involving Harassment, Public Denigration,
25 Humiliation, and bullying by both Andrew Curnew and Rita
26 Kilislian as they perpetuated next that I have outlined just
27 moments ago.

1 You have the evidence in front of you in terms
2 of many, many, pages of Social Media Documents relating to
3 that harassment. It is a tale of Kawartha Endodontics, Rita
4 Kilislian and Andrew Curnew receiving orders that they didn't
5 like and deciding to try and destroy the reputation of the
6 individuals who issued those orders.
7 Peterborough Public Health has a responsibility to
8 carry out, which is to protect the public from Health Hazards
9 perpetuated by individuals who either, perhaps innocently,
10 don't understand the standards, or who worse have no regard
11 for those standards when set by our provincial government and
12 experts in the field of Dentistry in Ontario.
13 This is not the first time Kawartha Endodontics and
14 Andrew Curnew have employed this behaviour. I, through Ms.
15 Ms. Moskowitz's, I sent a decision that has just been
16 released a few weeks ago when a Superior Court of Justice
17 identified this exact same behaviour on the part of Andrew
18 Curnew. It's the case of *Curnew v. Lu*. I ask you to review
19 it because on almost identical facts, not the same case
20 issues but very similar behavioural facts, the court found
21 that the pleadings were vexatious and abuse of process
22 because they were brought for an improper purpose, which was
23 namely for harassing defendants.
24 I submit to the panel that the same thing occurred
25 here only worse, because here the Appellants were attacked
26 publicly through Facebook, through Instagram, through
27 Twitter, through the News Media. Dr. Kilislian perpetuated
28 this harassment because even though it came from the accounts

1 held by Andrew Curnew, she supported him. In her
2 Affidavit, she swore and she also continued to employ Mr.
3 Curnew or allow Mr. Curnew to act as the agent for Kawartha
4 Endodontics in this proceeding.
5 In that court decision, *Curnew v. Lu*, the Superior
6 Court of Justice found Mr. Curnew's similar behaviour against
7 a defendant to be vexatious and an abuse of process. As a
8 result, my client respectfully requests that this Board did
9 find - that this Board finds that Dr. Salvaterra did have
10 reasonable and probable grounds to issue her Section 13 Order
11 and that the two-year one is reasonable and so very much
12 needed given that my client has no idea how many people were
13 not reached by the Media Announcement.
14 As Mr. Curnew himself pointed out, Kawartha
15 Endodontics draws its patients from all over Ontario. It's
16 not difficult to believe therefore that someone from outside
17 this area did not see the Media Conference and has no
18 knowledge of it.
19 Finally, my client also asks that given the
20 evidence you have heard, and the documents produced by my
21 client, that this panel consider the decision recently
22 rendered by the Superior Court of Justice in *Curnew v. Lu* and
23 exercises discretion pursuant to Rule 15.8(2) of the Rules of
24 the HSR to award costs to my clients on a Substantial
25 Indemnity Basis.
26 Those are my closing submissions. Thank you very
27 much.

1 MS. DOWNING: Thank you. Mr. Curnew.
2 Oh, can't hear you.
3
4 **CLOSING SUBMISSIONS BY: MR. CURNEW:**
5 I have advised Ms. Moskowitz and I have advised Ms.
6 Hunt that if she is intending to lead evidence on this court
7 decision, that she should also lead evidence on the
8 collateral information that has already been proven and
9 established before the Royal College of Dental Surgeons.
10 So, on the Royal College of Dental Surgeons'
11 Website, a Dentist was committing gross acts of incompetence
12 with respect to Infection Prevention and Control. He was
13 injuring patients. Ms. Barradas and I were doing consulting
14 with that practice. We attempted to report it. They
15 threatened a malicious prosecution which is exactly what Dr.
16 Salvaterra did here, trying to have him arrested based on my
17 past record of offences from two decades ago which were a
18 wrongful conviction, which I submit are discrimination under
19 the *Human Rights Code*, specifically dealing with
20 discrimination based on a backless record of offences. Dr.
21 Kilislian's complaint, which has been established, is Dr.
22 Mislov Pavlick is a serial fraudster at the Royal College of
23 Dental Surgeons and that information is properly before you.
24 As well, there is a sworn transcript of Ms. Barradas where
25 she testifies that these defendants assaulted her in my home
26 in an attempt to lock me in a bedroom. As a result, the
27 allegation is that I filed a lawsuit where I used improper

1 headings in referring to the defendants, and that's on the
2 basis to which it was dismissed.
3 I'm going to my submissions now and it won't take
4 long.
5 The relief being sought here is unprecedent,
6 unprecedented, and has never before been ordered by this
7 Board or any Board in Canada in similar circumstances. What
8 a dangerous world we live in where an Endodontist is guilty
9 until proven innocent yet convicted in the media without a
10 due process. The Justice System is underpinned by the
11 presumption of innocence.
12 Dr. Kilislian and her team, her counsel and her -
13 were denied this right which is fundamental to the proper
14 Administration of Justice. Authority to enter a practice or
15 our practice was never established, and it can't be said that
16 the Inspector was fair nor was he balanced. The alleged
17 evidence was attained through what we say is an illegal
18 search and therefore in any other proceeding, including this
19 one, should have been inadmissible. Neither Dr. Salvaterra
20 nor Brian Sammon ever spoke to Dr. Kilislian about the
21 inspection, nor did they speak to the IPAC Lead, Sara
22 Barradas. Furthermore, at all material times, while Brian
23 Sammon was preparing his checklist three days later, the MHO
24 was on holidays and Mr. Sammon, who had only ever inspected
25 one other Dental Office, was otherwise unsupervised.
26 Dr. Kilislian's evidence in her Affidavit is
27 compelling. She's an Endodontist licensed to practice in the
28 Province of Ontario and is free of any Complaints, Concerns

1 or Reprimands of Professional Misconduct on the College's
2 Website or with the Registrar. The only complaints
3 registered against her are the complaints made by this
4 Medical Health Officer, for which have been resolved in Dr.
5 Kilislian's favour. Furthermore, the Inspection 75 Hearing
6 was resolved in Dr. Kilislian's favour. We've also heard
7 evidence that the other Medical Health Officers in different
8 jurisdictions also passed Dr. Kilislian's practices.
9 Our daughter was violently beaten after the Media
10 Campaign which is information before this panel and should be
11 considered. This was based on misinformation from
12 Peterborough Public Health that Dr. Kilislian had infected
13 patients or with a possible HIV or Hep B. We were given 24
14 hours' notice to hide our children or make arrangements to
15 protect our staff from possible protest or the number of
16 calls that would come into the clinic or the people that
17 would possibly attack the clinic as a result of the
18 Inflammatory Allegations made against Dr. Kilislian.
19 The motion filed by Ms. Hunt, which was dismissed
20 in our favour, was Inflammatory. It was unprofessional. It
21 bordered on Human Rights Discrimination and was, at best,
22 Frivolous and Vexatious.
23 As we stated at that time, that time should have
24 been used to conduct this hearing on its merits. I submit
25 this was in clearly by design by Ms. Hunt and her client to
26 continue the closure campaign through her Self-Serving Witch
27 Hunt employed through their amplified Media Release.

1 It is uncontested that Dr. Kilislian has
2 somewhat of a celebrity profile within the community and Dr.
3 Salvaterra's recklessness and abuse of power effectively
4 sought out to destroy Dr. Kilislian simply because Dr.
5 Kilislian disagreed with Brian Sammon, and when the media
6 wasn't enough they went to Dentists and they got those
7 patient names which, in those circumstances, which is a clear
8 and Unequivocal Breach of the Stay Order. The evidence is in
9 the Respondent's Grounds for Response that they wrote to
10 Dentists and demanded that they notify the patients and give
11 up patient names. They spoke at length of the Stay Order.
12 They have opted lawlessly, recklessly and behave like
13 Goblins.
14 Dr. Salvaterra didn't rely on an expert, she never
15 spoke to anybody at the Royal College of Dental Surgeons.
16 Rather, she relied on Brian Sammon who had inspected zero
17 Endodontic Offices, didn't know what Endodontics is, had a
18 history of sexist views against women, and that was posted in
19 Social-Media.
20 The privacy issues here. Patient's rights of
21 privacy should be given or afforded the same, if not more
22 respect than that of the complainant who is Janet Pearson
23 according to the evidence of Dr. Kilislian in her Affidavit.
24 Dr. Kilislian's Affidavit is clear and compelling. It
25 attaches multiple exhibits including the conversation between
26 Brian Sammon and Rachel Carter.
27 The Board will recall that an offer to settle was
28 made to Ms. Hunt during the Documented Case Conference which

1 is before this panel which stated, “If you can confirm
2 that Janet Pearson is not the complainant, is not, but rather
3 we will abandon this appeal.” Ms. Hunt refused. Then
4 decided to lead evidence through her witnesses that stated
5 they hadn’t even heard of Janet Pearson who works for Public
6 Health and a simple Google Search with the College of Nurses
7 will prove that she indeed works for somebody connected to
8 the *RK v. RK Decision*.
9 There is an obligation on Dr. Salvaterra’s part not
10 to seek to get a conviction but rather to conduct a proper
11 and thorough investigation which included interviewing Dr.
12 Kilislian, to be able to get her side of the story. There is
13 no explanation as to why Dr. Salvaterra chose to adopt
14 evidence of Brian Sammon, who she had only known for a few
15 months at that time and was a low-level employee within a
16 large organization. She – Dr. Salvaterra also admitted to
17 the panel that she continued to refer patients to Dr.
18 Kilislian over a 13-year period of time, and including after
19 the closure order, yet she chose the evidence of Brian Sammon
20 over Dr. Kilislian whom she trusted with her patients of the
21 Community Health Unit.
22 The approach taken by the Respondent herein has
23 been tantamount to multiple hearings. It is clearly
24 offensive to Public Policy to employ a Witch Hunt because we
25 know that public findings of guilt would have the greatest
26 impact on this professional’s reputation, which to this point
27 has remained unscathed. There have been findings in the *RK*
28 *v. RK Decision* where this panel has agreed with Dr. Kilislian

1 and was of the view that two Medical Health Officers were
2 wrong in their understanding and interpretation of IPAC and
3 causation. This is not something new, that is
4 unsubstantiated. It is clear and unequivocal that in the *RK*
5 *v. RK Decision*, both Medical Health Officers accused Dr.
6 Kilislian of causing the liver abscess and both Medical
7 Health Officers attributed it to an IPAC Violation and the
8 Medical – or sorry, the expert employed gave evidence that
9 that bacterium was pre-existing in the patient's own mouth.
10 Dr. Kilislian was subjected to Harassment and Ridicule and
11 forced to spend money to defend herself.
12 The Respondent has given evidence that her self-
13 described and Amplified Media Closure Campaign was not done
14 immediately after the inspection, or rather after she waited
15 months and after I was personally drawing attention to Public
16 Health Misconduct in my Personal Logging Practice through
17 Redemption Advocate Canada, a Non-Profit Organization housed
18 in the same building as Kawartha Endodontics or in
19 Contemplation of Litigation. The Respondent anticipates and
20 laughed as well as leaned into the camera to ensure everyone
21 was aware of her emphasis and gloating and bragging, when she
22 confirmed that she anticipates that patients would continue
23 to come forward even after the two-year mark and absent an
24 Order from the Board upholding her Order. I submit that the
25 Legislation is clear that these IPAC Lapses can only be
26 posted for two years. The way that this Media Campaign has
27 allowed it to unfold is that it will be forever available
28 through Google Searches and Media Searches and will forever

1 taint the reputation of Dr. Kilislian and hold her family
2 and her children accountable for what was caused – called to
3 be an HIV Transmission through her Practice to Patients.
4 The MHO has bragged that patients from all
5 locations, including some ones that Dr. – or sorry, that
6 Public Health in Toronto and Peel Region contemporaneously
7 passed, will continue to be tested even if this Order is
8 ruled against her. She's lawless; she's reckless as a
9 result. Her Order speaks specifically as follows, that the
10 patients were to seek out Care, Recommendation from their
11 Health Care Provider. She circumvented that. Not that
12 patients should be tested – sorry, that the patients that
13 should have been prescribed to be tested, she overstepped
14 that stay benefit of her lawyer's advice, she overstepped the
15 bounds and framework of the own – her own Legislation and
16 Order by asking all patients over a 12-year period of time to
17 be tested of any patient of Dr. Kilislian's, including those
18 Toronto Practices and the Peel Region Practices that had
19 passed with the same documents that were tendered to Brian
20 Sammon and determined were inadequate. Meanwhile, you must
21 put emphasis on the fact that Brian Sammon did not ever
22 inspect an Endodontic Practice before.
23 Lastly, she personally prepared the Blood
24 Requisition Form, she circumvented the patient's Family
25 Doctor, created a Hotline and ensured that she herself got
26 those results personally. To date, there is no Genetic Link
27 and no evidence was heard that ties the results of any
28 patient's blood-borne illnesses to the Appellant,

1 notwithstanding for two years they have been circumventing
2 this Board's stay and operating lawlessly to continue to
3 destroy the professional reputation of an untainted
4 Endodontist with 22 years professional experience, and that
5 Respondent acknowledged herself that she refers patients.
6 The Respondent also acknowledged multiple times
7 herself something free of a question that there is zero
8 Health Hazard that exists. While we're being asked to make a
9 determination on whether there is reasonable and probable
10 grounds that would serve to reduce that Health Hazard is I
11 would admit Bizarre, Frivolous and Vexatious in the
12 circumstances.
13 We can turn our minds to the jurisprudence in
14 *Fingrote v. The PCSO* or *Raininger v. The RCDSO* in 2017,
15 Ontario SC 6656. In determining the harm for the injury,
16 panels cannot rely on the expertise of the professionals
17 sitting on the panel. The same goes for Dr. Salvaterra's
18 reliance on her own opinion or the opinion of Brian Sammon
19 and completely did this devoid of any evidence of Dr.
20 Kilislian who re-emphasized she acknowledged she continues to
21 trust with her patients. The Amplified Media Campaign has
22 the effect of achieving the same results of the hearing which
23 under the law was an abuse of process with a violation of
24 this thing.
25 Moreover, the Respondent knew that the Amplified
26 Media Campaign would have accomplished much greater
27 objectives than could have ever been contemplated in her
28 Section 13 Order. These objectives were twofold: Punishing

1 Dr. Kilislian for appealing and beating Dr. Kilislian into
2 submission. The Amplified Media Campaign was self-serving,
3 was contrary to any sort of logical or lawful action ever
4 taken. These actions of the Respondent are not the actions
5 consistent with that of a Doctor, but rather they are a
6 person who wanted revenge. Dr. Salvaterra wanted to get her
7 way and doing so using her Political Office Position while
8 wearing that hat, all the while completely devoid of training
9 as a Medical Professional which is to do no harm to patient.
10 The Amplified Media Campaign completely ignores Section
11 25.tof the Health Professions Procedural Code and that
12 referenced in *Scott v. The College of Massage Therapists of*
13 *Ontario*, 2016 B.C.C.A 180, Paragraph 41 reads as follows:
14 "Issuing an Interim Order is an extraordinary measure not
15 least because it can have significant consequence on the
16 member's reputation and livelihood before there is any
17 adjudication of the professional's misconduct allegations
18 against them."
19 This was an IPAC Allegation. It was not
20 substantiated in any sort of court of law, it was not
21 substantiated by any other experts. It was substantiated
22 only by the word of Brian Sammon who is an admitted sexist.
23 Dr. Salvaterra has demonstrated that she and her lawyer will
24 do anything to protect the reputation of their staff
25 including defence of or the following: Improperly and
26 untimely preparation of the Checklist Document, including the
27 fact that it was missing both the Nurse Witness's Signature
28 and Dr. Kilislian's Signature or any other person's

1 Signature. Brian Sammon's Sexist Posts on
2 Social-Media connected to Public Health which described as
3 Sexism was only slightly inappropriate. They offered
4 explanation as to the allegation of Brian Sammon refused to
5 show his badge was evidence that's uncontested and is a legal
6 requirement that he do so. The transcript of Brian Sammon of
7 the exchange between he and Curnew unequivocally confirm that
8 this Digital Document Pre-Existed on the Server. He was
9 asked if he wanted a printed copy or if he wanted to review
10 it and he asked me to drop it off to him later. I refer the
11 panel's attention to the examination – oh, sorry, the
12 document attached to Dr. Kilislian's Affidavit marked as an
13 exhibit, the transcript of Brian Sammon and Andrew Curnew.
14 Section 25.5 of the Code indicates that the
15 Respondent breached the rules of natural justice, and Dr.
16 Kilislian asks this panel to make a finding that the
17 Respondent breached the rules of natural justice which was
18 imposed upon the Respondent by Statute and unlawfully
19 circumvented. In *ST v. AG*, 2019, CANLII H0179, that is an H-
20 Parb Decision and is readily available to this panel.
21 The question is whether this hearing was entirely
22 unwarranted. *Regular versus the Law Society of Newfoundland*,
23 *1995, 132 Newfoundland PEI*, where the referral was made
24 without reasonable justification, hiddenly unreasonable,
25 malicious or taken for bad faith or collateral purpose. I
26 think that we have established that there is considerable
27 animus that existed between the parties that pre-dated, that

1 has been proven, in *HR Decision versus RK v. RK*,
2 furthermore, in Dr. Kilislian's Affidavit.
3 With respect to the communications that Ms. Hunt
4 takes issue with and this Board has previously identified as
5 being inappropriate, with respect to this sort of
6 communication, the Board Appeal has held that the doctrine of
7 absolute privilege provides that no actions for words spoken
8 or documents used in a court of proceedings and/or for the
9 purposes of proceedings before courts or traditional
10 tribunals like this one, absolute privilege acts to bar any
11 action on such communications however it was framed and not
12 only defamation as such absolute privilege attaches to all
13 the letters or communications by the agent or lawyer for Dr.
14 Kilislian. The Court of Appeal has made clear that absolute
15 privilege extends to communications directly related to the
16 contemplated proceedings, regardless of whether those
17 communications are by counsel commencing the proceedings or
18 whoever was going to be responding.
19 Ms. Hunt has used every opportunity to remind us of
20 how experienced she is with HR, with HPAR and with tribunals
21 in general. Surely she knew that bringing a motion to
22 dismiss an appeal based on grounds protected by absolute
23 privilege is and always was an abuse of process and
24 furthermore, I submit, an abuse of power and a monumental
25 waste of resources only employed to allow her client to
26 continue to test patients without responsible nor probable
27 grounds, and further to intentionally misinform patients into
28 believing that the patient had a duty to be tested rather

1 than the patients should seek medical opinion from their
2 Health Care Provider to determine whether or not that testing
3 was appropriate. And I would say out of those thousands of
4 cases, or a thousand cases where patients were tested, they
5 weren't properly informed that they had a right to go to
6 their Health Care Provider to be able to make a determination
7 as to whether or not testing in the circumstances was
8 necessary. The pain and suffering that would have went on to
9 these patients who might have believed that they had been
10 exposed to HIV or Hep B in circumstances when there is no
11 documented cases was entirely reckless.
12 Again, I reiterate that the Brian Sammon, did not
13 sign this report contemporaneous to the situation, nor did
14 Dr. Kilislian sign it or did he even discuss it with them.
15 His evidence was that he left and Dr. Kilislian came out
16 running after him, then he came back for a minute and he
17 spoke to the IPAC Leader, only for a minute, 60 seconds. Two
18 years later, they have only spoken to Sara Barradas for one
19 minute. Two years later, they spoke to Dr. Kilislian for the
20 purpose of bringing Brian Sammon in presumably because he was
21 wrong and we wanted a chance to prove that.
22 Dr. Mazurat, I have no idea why she was brought
23 into this at such a late stage in the game. What her
24 evidence does to assist this panel in determining the
25 question whether or not, on reasonable and probable grounds,
26 adopting the language contained within Dr. Salvaterra's Order
27 will reduce a Health Hazard that she says does not exist.

1 The evidence of Dr. Hardie was compelling with
2 respect to Infectious Disease Transmission. His views about
3 the checklist related to IPAC are specifically died to the
4 issue of causation and not to be viewed in isolation. What
5 he is attempting to say or has said through his reports is
6 that we should always maintain high standards, and Dentists
7 maintain high standards. However, in the circumstances of
8 not having an Office Training Manual or not having an eyewash
9 sink or by not having some of these things that are listed on
10 the checklist, they are not going to lead to Disease
11 Transmission and certainly they would not support the relief
12 sought by this Respondent.
13 The time is now 2 p.m. Those are my submissions,
14 inclusive of this Respondent has already – or, sorry, this
15 Appellant has sent in its Cost Summary Award that it wishes
16 to receive on a Substantial Indemnity Basis, Dr. Kilislian to
17 date, has paid to Mr. Natalie off the top of my head,
18 document was signed by her. I haven't reviewed it, but I
19 believe it to be $196,000 to Mr. Natalie, Matthew Wilton,
20 another Regulated Health Care Professional Lawyer and Expert
21 who regularly appears before this Board was $23,000 plus HST.
22 The numbers are to be confirmed by Dr. Kilislian's Signed
23 Letter. There are further costs totaling up to – with Dr.
24 Hardie's appearance today and other experts, almost $400,000
25 in costs are borne.
26 The closure of Dr. Kilislian's Office for nine days
27 was extraordinary, and this panel is aware that in the case
28 of Dr. Joel Phillip, closure was two days. I would suggest

1 that evidence is before this Board that because the office
2 was closed for nine days after that existed between the
3 parties, that no objectivity could be found between this
4 practice – or sorry, between Brian Sammon's findings and this
5 practice. We are asking for a Costs Award and a finding as I
6 have outlined earlier.
7 Those are my submissions. I refer to Madam Chair
8 for next steps.
9 MS. DOWNING: Ms. Hunt, did you have
10 anything further In-Reply?
11
12 **EVIDENCE IN-REPLY BY: MS. HUNT:**
13 MS. HUNT: Very brief reply. I can
14 advise that if we are discussing legal costs, that mine to
15 date have been $94,000, and I'm not going to comment on the
16 volume of misinformation, and I would submit lies that you've
17 heard just now. I would simply ask that you review the
18 evidence and determine for yourselves, which I know you will
19 do, with respect to the decision that you make, and I would
20 finally submit that if there was any worry question as to the
21 slander after slander after slander that my clients have
22 publicly endured over the last four years, known exists, that
23 question has been answered.
24 MS. DOWNING: Thank you. Let me just
25 see if there are any final questions from Ms. Schofield?
26 MS. SCHOFIELD: No questions at this time,
27 thank you.
28 MS. DOWNING: And Mr. Bossin?

1 MR. BOSSIN: Sorry, Mr. Curnew, I
2 just wanted to get some of those sites that you referred to,
3 that you went over rather quickly. If you may, I think you
4 referred to Yaro (ph), a 2017 case. Do you have the citation
5 for that at hand?
6 MR. CURNEW: Yes. I just have to
7 reduce my screen but I'll - I'm going to be behind my word
8 document. I'm not as astute with technology. Just give me a
9 second. It is F-I-N-G-R-O-T-E, *Fingrote v. CPSO*.
10 MR. BOSSIN: Yes.
11 MR. CURNEW: And then there was
12 also....
13 MR. BOSSIN: What was the cite? The
14 other site?
15 MR. CURNEW: That's from CANLII and
16 there is also....
17 MR. BOSSIN: Yes, what's the CANLII
18 Cite?
19 MR. CURNEW: I didn't mark the
20 Citation.
21 MR. BOSSIN: Oh, that's okay.
22 MR. CURNEW: I can get the Citation.
23 MR. BOSSIN: I can look for it, no,
24 that's okay. We've got to have it on - and another case, a
25 *Newfoundland's Case* I think you referred to. Do you have the
26 cite for that? It was 132 something? I couldn't get it
27 down.

1 MR. CURNEW: Sorry, *Newfoundland* is
2 *Regular v. Society of Newfoundland*.
3 MR. BOSSIN: Yes. And that cite?
4 MR. CURNEW: So, like all regular
5 large, or not--
6 MR. BOSSIN: Okay.
7 MR. CURNEW: --regular, it's Regular v.
8 Society of Newfoundland.
9 MR. BOSSIN: Yes.
10 MR. CURNEW: So, closed brackets, 1995.
11 MR. BOSSIN: Yes.
12 MR. CURNEW: That's at 132 in
13 Newfoundland and P-E-I-R.
14 MR. BOSSIN: Yes.
15 MR. CURNEW: Newfoundland, brackets –
16 or sorry, N-F-L-D in brackets, S-C, Newfoundland Supreme
17 Court.
18 MR. BOSSIN: Okay. Thank you, that's
19 all.
20 MR. CURNEW: Thank you.
21 MS. DOWNING: Yes. Okay. Unless there
22 is anything further, I think we can bring the hearing to a
23 close. So, we will endeavor to get you a decision with
24 reasons as soon as possible and at this point, unless you
25 hear from us otherwise, we don't accept any further
26 submissions, so I would like – yes?
27 MR. CURNEW: Sorry, Madam Chair, sorry
28 to interrupt you. Can we get an Interim Order or an

1 Agreement that neither side is going to speak to the Media
2 until you've released this? We don't want any misinformation
3 going to our patients anymore. I would like you to be able
4 to make your decision before anybody goes to the Media,
5 that's all, for the benefit of the patients.
6 MS. DOWNING: I don't think I - we have
7 the authority to make that kind of Order.
8 MR. CURNEW: Well, I'm going to
9 undertake it as a matter of professionalism to my colleague
10 and I hope that Ms. Hunt would do the same. Is that
11 agreeable, Ms. Hunt?
12 MS. HUNT: I don't have any
13 instructions from my client and don't have the opportunity
14 now to obtain them.
15 MS. DOWNING: Mr. Zagerman, thank you.
16 MR. REPORTER: Ms. Downing, I just had a
17 quick question. I didn't want to interrupt during the
18 proceedings but for Dr. Gary Garber that was mentioned, I
19 believe yesterday, I have his Gary with one R and Garber, G-
20 A-R-B-O-R. I just wanted to know if I stand to be correct
21 with that spelling?
22 MR. CURNEW: Its E-R.
23 MR. REPORTER: E-R, okay and then
24 finally, there was just one more. Sara, S-A-R-A, and then
25 Barradas, B-A-R-A-T-U-S?
26 MR. CURNEW: No, I'm sorry, it's B-A-R-
27 R-A-D-A-S.

1 MR. REPORTER: And thank you so much,
2 I do appreciate that.
3 MS. DOWNING: Okay.
4 MR. REPORTER: Thank you.
5 MS. DOWNING: Okay, thank you everyone.
6 Thank you, Mr. Curnew and thank you, Ms. Hunt, for your
7 assistance.
8 MR. BOSSIN: Thank you, all.
9 MS. DOWNING: I wish you all a good
10 remainder of the day.
11 MR. BOSSIN: Ms. Downing, can we meet
12 in five minutes?
13 MS. DOWNING: Absolutely, okay.
14 MR. BOSSIN: Thanks all. Thank you
15 everyone.
16 MS. SCHOFIELD: Thank you.
17 MR. REPORTER: Take care, bye-bye.
18 MS. SCHOFIELD: Bye-bye.
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1 MR. BOSSIN: Thanks.

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This is to certify that the foregoing is a true and accurate transcription of my audio recordings made to the best of my skills and ability.

N. Garry Zagerman

N. Garry Zagerman August 27th, 2021

CERTIFIED COURT REPORTER

PROCEEDINGS CONCLUDED