DISCIPLINE COMMITTEE OF THE
ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Ms. Judy Welikovitch, Chair	)	
Dr. Peter Delean	)	WEDNESDAY, THE 26TH
Dr. Rajiv Butany	)	DAY OF APRIL, 2023
	)	

B E T W E E N:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

- and -

DR. ADAM CHAPNICK

ORDER FOR PUBLICATION BAN AND BROADCASTING BAN

THIS MOTION, brought by the Royal College of Dental Surgeons of Ontario, for an order that no person shall publish, broadcast, or otherwise disclose the name of any patient referred to during the hearing or in documents filed at the hearing that commenced on April 26, 2023, or any information that would disclose the identity of any patient, was heard this day by a panel of the Discipline Committee.

UPON THE CONSENT OF THE PARTIES, and on hearing the submissions of counsel for the parties,

1. **THE DISCIPLINE COMMITTEE ORDERS** that no person shall publish, broadcast, or otherwise disclose the name of any of the patients referred to during the hearing or in documents filed at the hearing that commenced on April 26, 2023, or any information that would disclose the identity of the patient.

Date: ___April 26,2023_____

Ms. Judy Welikovitch, Chair

21-1118
21-1119

THE DISCIPLINE COMMITTEE OF THE
ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one **DR. ADAM CHAPNICK,** of the City of Toronto, in the Province of Ontario;

AND IN THE MATTER OF the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation).

AND IN THE MATTER of the *Statutory Powers Procedure Act,* R.S.O. 1990, c. S.22, as amended ("*Statutory Powers Procedure Act*")

Members in Attendance: Ms. Judy Welikovitch
Dr. Rajiv Butany
Dr. Peter Delean

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Andrea Gonsalves
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -		
	)	Bernard LeBlanc
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. ADAM CHAPNICK	)	Alan Gold
	)	For Dr. Adam Chapnick

Hearing held by way of videoconference.

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on April 26, 2023. This matter was heard electronically.

At the outset of the hearing, the College sought an order that no person shall publish, broadcast, or otherwise disclose the name of any patient referred to during the hearing or in documents filed at the hearing that commenced on April 26, 2023, or any information that would disclose the identity of any patient. The Member consented to the request. The Panel granted the order.

THE ALLEGATIONS

The allegations against Dr. Chapnick (the "Member" or the "Registrant") are set out in two notices of hearing. The parties requested, and the Panel granted, an order pursuant to s. 9.1(1) of the *Statutory Powers Procedure Act*, RSO 1990, c S.22 combining the two proceedings in a single hearing. Considering the related questions of fact and law arising in the two proceedings, the parties' consent and that the parties have entered into a combined resolution of both matters, the Panel was satisfied that the order was appropriate and would promote efficiency in the discipline process.

The first Notice of Hearing, 21-1118, dated January 12, 2022, sets out the following allegations:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18, in that in or around the years 2015, 2016, 2017 and/or 2018, you sexually abused a patient, Patient A.

   Particulars:

   - In or around the years 2015, 2016, 2017 and/or 2018, you engaged in sexual intercourse and/or other forms of sexual relations with Patient A.

   - Patient A was your patient from on or about April 29, 2015 until on or

about July 2018.

- During this time, you also engaged in touching of a sexual nature and/or behaviour or remarks of a sexual nature towards Patient A.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016 and/or 2017, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to Patient A, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2015, 2016 and/or 2017, you prescribed an excessive number of opioids and/or failed to limit the number of tablets dispensed for opioid prescriptions to Patient A. You gave no rationale for exceeding the recommended maximum dosage and no indication of a stepwise approach to the prescription of opioids for Patient A.

   - On or about June 13, 2017 and/or June 21, 2017, you prescribed an excessive number and dose of benzodiazepines for Patient A.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you contravened the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation to Patient A, and to yourself, contrary to paragraph 11 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2015, you administered nitrous oxide sedation to Patient A, for a non-dental purpose.

- In or about 2015, 2016, 2017 and/or 2018, you self-administered nitrous oxide sedation for a non-dental purpose.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you recommended and/or provided an unnecessary dental service to Patient A and to yourself contrary to paragraph 6 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2015, you unnecessarily administered nitrous oxide and oxygen sedation to Patient A and self-administered nitrous oxide and oxygen sedation for a non-dental purpose.

   - In or about 2015, 2016, 2017 and/or 2018, you unnecessarily self-administered nitrous oxide sedation for a non-dental purpose.

   - On or about June 13, 2017 and/or June 21, 2017, you unnecessarily prescribed benzodiazepines for Patient A.

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015 and/or 2017, you prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs to Patient A contrary to paragraph 10 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On or about November 9, 2015, you prescribed amoxicillin trihydrate for Patient A, for a non-dental purpose.

   - On or about June 13, 2017 and/or June 21, 2017, you prescribed benzodiazepines for an improper purpose for Patient A.

- On or about July 11, 2017, you prescribed levofloxacin for Patient A, for a non-dental purpose.

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016 and/or 2017, you failed to keep records as required by the Regulations for Patient A, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended, and contrary to s.38(b) and/or s.38(c) of Regulation 547, Revised Regulations of Ontario, 1990, as amended, under the *Drug and Pharmacies Regulation Act*, [R.S.O.] 1990, c. H.4.

   Particulars:

   - In or about 2015, 2016 and/or 2017, you failed to keep records of your prescriptions as required for Patient A.

   - In or about 2015, 2016 and/or 2017, you failed to document patient pain, the rationale for selecting a narcotic and the possible contraindications or indications for the use of a narcotic for Patient A.

7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to Patient A and relative to yourself, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2015, 2016, 2017 and/or 2018, you:

     - administered nitrous oxide sedation to Patient A and self-administered nitrous oxide sedation, for a non-dental purpose;

- misused Adderall medication prescribed for Patient A;
- prescribed medication for Patient A, that was returned to you for self-use;
- misused cocaine.

The second Notice of Hearing, 21-1119, is also dated January 12, 2022. The College sought leave to withdraw certain factual particulars in that Notice of Hearing but proceeded on all the allegations of professional misconduct. The Panel granted the withdrawals. The allegations of professional misconduct in the second Notice of Hearing, 21-1119, with the withdrawn admissions removed, are as follows:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the Regulated Health Professions Act, 1991, Statutes of Ontario, 1991, Chapter 18, in that in or around the years 2015, 2016, 2017 and/or 2018, you sexually abused a patient, Patient A.

   Particulars:

   - In or around the years 2015, 2016, 2017 and/or 2018, you engaged in sexual intercourse and/or other forms of sexual relations with Patient A.
   - Patient A was your patient from on or about April 29, 2015 until on or about July 2018.
   - During this time, you also engaged in touching of a sexual nature and/or behaviour or remarks of a sexual nature towards Patient A.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to the patients noted below, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- For the patients listed below:

    - You prescribed an excessive number of opioids and/or failed to limit the number of tablets dispensed for opioid prescriptions.

    - There was no rationale for exceeding the recommended maximum dosage and no indication of a stepwise approach to the prescription of opioids.

Patients	**Dates**
Patient A	January 21, 2015, July 3, 2015, June 2, 2016, June 13, 2017, October 27, 2017
Patient B	April 23, 2015, September 10, 2015, August 15, 2016, November 26, 2016, December 22, 2016, March 14, 2017, August 25, 2017, February 7, 2018, June 5, 2018, July 30, 2018, October 10, 2018, February 23, 2019
Patient C	July 5, 2016

- You prescribed an excessive number and dose of benzodiazepines for the following patients:

Patients	**Dates**
Patient D	April 27, 2016
Withdrawn	
Withdrawn	
Patient A	June 13, 2017, June 21, 2017
Patient G	July 3, 2017
Withdrawn	
Withdrawn	

- On or about July 14, 2015, September 27, 2015, November 20, 2015, December 11, 2015, June 14, 2016, August 23, 2017, February 8, 2018, October 2, 2018 and/or October 11, 2018, you self-prescribed and/or prescribed for office use an excessive number and dose of

benzodiazepines.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you contravened the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation to Patient A and to yourself, contrary to paragraph 11 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2015, you administered nitrous oxide sedation to Patient A, for a non-dental purpose.

   - In or about 2015, 2016, 2017 and/or 2018, you self-administered nitrous oxide sedation for a non-dental purpose.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you recommended and/or provided an unnecessary dental service relative to the patients noted below, contrary to paragraph 6 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2015, you unnecessarily administered nitrous oxide and oxygen sedation to Patient A and self-administered nitrous oxide and oxygen sedation for a non-dental purpose.

   - In or about 2015, 2016, 2017 and/or 2018, you unnecessarily self-administered nitrous oxide sedation for a non-dental purpose.

   - On or about July 14, 2015, September 27, 2015, November 20, 2015, December 11, 2015, June 14, 2016, August 23, 2017, February 8, 2018, October 2, 2018 and/or October 11, 2018, benzodiazepines were

unnecessarily self-prescribed and/or prescribed for office use.

- You unnecessarily prescribed benzodiazepines for the following patients:

Patients	**Dates**
Patient D	April 27, 2016
Withdrawn	
Withdrawn	
Patient A	June 13, 2017, June 21, 2017
Patient G	July 3, 2017
Withdrawn	
Withdrawn	

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs relative to the patients noted below, contrary to paragraph 10 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On or about July 14, 2015, September 27, 2015, November 20, 2015, December 11, 2015, June 14, 2016, August 23, 2017, February 8, 2018, October 2, 2018 and/or October 11, 2018, benzodiazepines were self-prescribed and/or prescribed for office use for an improper purpose.

   - You prescribed benzodiazepines for the following patients for an improper purpose:

Patients	**Dates**
Patient D	April 27, 2016
Withdrawn	
Withdrawn	

Patient A	June 13, 2017, June 21, 2017
Patient G	July 3, 2017
Withdrawn	
Withdrawn	

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017, 2018 and/or 2019, you failed to keep records as required by the Regulations relative to the patients noted below, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended and s.38(b) and/or s.38(c) of Regulation 547, Revised Regulations of Ontario, 1990, as amended, under the *Drug and Pharmacies Regulation Act*, [R.S.O.] 1990, c. H.4.

   Particulars:

   - For the following patients, you failed to keep records of your prescriptions as required:

Patient	**Dates**
Patient A	January 21, 2015, July 3, 2015, June 2, 2016, June 13, 2017, October 27, 2017
Patient B	April 23, 2015, September 10, 2015, August 15, 2016, November 7, 2016, November 26, 2016, December 22, 2016, March 14, 2017, August 25, 2017, February 7, 2018, June 5, 2018, July 30, 2018, October 10, 2018, February 23, 2019

   - For the following patients, in the years 2015, 2016, 2017, 2018 and/or 2019, you failed to document patient pain, the rationale for selecting a narcotic and the possible contraindications or indications for the use of a narcotic:
     - Patient A
     - Patient J
     - Patient B
     - Patient K
     - Patient C

7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, 2017 and/or 2018, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to Patient A and relative to yourself, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2015, 2016, 2017 and/or 2018, you:
     - administered nitrous oxide sedation to Patient A and self-administered nitrous oxide sedation for a non-dental purpose
     - misused Adderall medication prescribed for Patient A
     - prescribed medication for Patient A, that was returned to you for self-use
     - self-prescribed benzodiazepines for an improper purpose and/or that were in excess of any dose permitted for oral minimal sedation as per the College's standard of practice, Use of Sedation and General Anaesthesia in Dental Practice
     - misused cocaine.

THE MEMBER'S PLEA

The Registrant admitted the allegations of professional misconduct contained in both Notices of Hearing (except those allegations that were withdrawn). The Registrant signed a written plea inquiry, which was entered into evidence at the hearing as Exhibit 3. The Panel also conducted an oral plea inquiry at the hearing and was satisfied that the Registrant's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, the College introduced into evidence an Agreed Statement of Facts (Exhibit 4). The Agreed Statement of Facts provides as follows:

The Registrant

1. Dr. Adam Chapnick ("Dr. Chapnick") was at all material times a dentist registered to practise dentistry in the Province of Ontario.

2. He was the practice owner of and is currently the associate at Molson Park Dental Office in Barrie, ON.

Background

3. On or about October 23, 2014, Dr. Chapnick first communicated with a patient ("**Patient A**") on an internet dating website. They subsequently connected directly on December 27, 2014.

4. In or about February 2015, Dr. Chapnick and Patient A went on their first date at a restaurant in Barrie, Ontario.

5. In or about March 2015, Dr. Chapnick and Patient A entered into a sexual relationship when they had sexual intercourse for the first time.

6. Dr. Chapnick and Patient A engaged in sexual intercourse as well as other forms of sexual relations from in or about March 2015 until approximately July 2018, after a trip to Las Vegas when they engaged in (among other things) sexual intercourse. According to Patient A, the relationship was always "off and on"; they would "break up for three days and get back together and break up again." According to Dr. Chapnick, there were breaks in their relationship but it remained exclusive and committed. He had given her a promissory necklace (an infinity necklace) to demonstrate their long-term commitment.

7. Dr. Chapnick rented a house for himself and Patient A to live together as a family with their children. They were there together during the week. On weekends, Patient A would mostly stay with Dr. Chapnick in Toronto. This went on for approximately eight months in 2017, during which time

they engaged in sexual activity as described above. Dr. Chapnick also purchased a car for Patient A. During their relationship, they also engaged in (among other things) sexual intercourse at Dr. Chapnick's home, in Las Vegas (on at least two trips), in Jamaica (during three trips), in New York, in hotels in Barrie, and in Patient A's house.

8. As described below, during their sexual relationship, Patient A was Dr. Chapnick's dental patient and he improperly administered nitrous oxide and oxygen sedation to her and self-administered nitrous oxide and oxygen sedation, misused drugs, as well as improperly and unnecessarily prescribing opioids, benzodiazepines and other medications to her and other patients, many of which were then returned to him for self-use. This conduct breached several different regulatory provisions and accordingly the paragraphs below allege multiple violations based upon the same conduct.

Sexual Abuse of a Patient

9. Patient A was Dr. Chapnick's patient from on or about April 29, 2015 until on or about July 2018. As noted previously, during this time Dr. Chapnick engaged in sexual intercourse, touching of a sexual nature and/or behaviour or remarks of a sexual nature towards Patient A.

10. Patient A's dental chart from Dr. Chapnick's office is attached at **Tab "A"** [omitted from these Reasons for Decision]. As demonstrated by the chart, Patient A received dental care from Dr. Chapnick on or about April 29, 2015, August 6, 2015, October 9, 2015, November 9 and 16, 2015, March 10 and 30, 2016, July 7, 2016, August 12, 2016, March 15, 2017, June 8 and June 13, 2017.

11. While Patient A was Dr. Chapnick's patient, she received regular dental cleanings, exams, and x-rays. Among other things, Dr. Chapnick made an orthotic (night guard) for her and performed gum surgery as well as performed dental examinations. However, Dr. Chapnick did not bill her for any of the treatment he provided.

12. Dr. Chapnick also wrote the following prescriptions for Patient A:

Date	Medication	Dentist	Purpose / Chart Entry
Jan 21/15	Endocet (30 tabs, 5/325 mg)	Chapnick	No chart entry provided/found regarding the prescription.
Jul 3/15	Endocet (30 tabs, 5/325 mg)	Chapnick	Filled by her and given to Dr. Chapnick at his request for his personal use. No chart entry provided/found regarding the prescription.
Nov 9 /15	Amoxicillin Trihydrate (22 tabs, 520 mg)	Chapnick	Medication prescribed for her by Dr. Chapnick to treat a non-dental illness. No chart entry provided/found regarding the prescription.
Nov 10/15	Oxycodone (30 tabs, 5/325 mg)	Chapnick	Prescription written by Dr. Chapnick. Filled by her and given to Dr. Chapnick at his request for his personal use. No chart entry provided/found regarding the prescription.
Nov 10/15	Triamcinolone Acetonide (15 tabs)	Chapnick	Prescription written by Dr. Chapnick. No chart entry provided/found regarding the prescription.
Jun 2/16	Ratio-Oxycocet (30 tabs, 5/325 mg)	Chapnick	Filled by her and given to Dr. Chapnick at his request for his personal use. No chart entry provided/found

Date	Medication	Dentist	Purpose / Chart Entry
			regarding the prescription.
Jun 13/17	Apo-Lorazepam sublingual (20 tabs, 1 mg/SL)	Chapnick	No chart entry provided/found regarding the prescription.
Jun 13/17	Ratio-Oxycocet (30 tabs, 5/325 mg)	Chapnick	No chart entry provided/found regarding the prescription.
Jun 21/17	Apo-Lorazepam (10 tabs, 1 mg)	Chapnick	Prescribed by Dr. Chapnick for a non-dental purpose. No chart entry provided/found regarding the prescription.
Jul 11 /17	Levofloxacin (10 tabs, 500 mg)	Chapnick	Filled by her and prescribed to treat a non-dental illness. No chart entry provided/found regarding the prescription.
Oct 27 17	Ratio-Oxycocet (40 tabs, 5/325mg)	Chapnick	Filled by her and given to Dr. Chapnick at his request for his personal use. No chart entry provided/found regarding the prescription.

13. It is admitted that the above conduct constitutes professional misconduct under section 51(1)(b.1) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (sexual abuse of a patient, more specifically sexual intercourse and/or other forms of sexual relations with a patient and touching of a sexual nature and/or behaviour or remarks of a sexual nature towards a patient).

Over-Prescribing

14. With respect to the following patients, Dr. Chapnick prescribed an excessive number of opioids. These amounts exceeded the recommended maximum dosage and/or failed to limit the number of tablets dispensed for opioid prescriptions. There was no rationale for exceeding the recommended maximum dosage and no indication of a stepwise approach to the prescription of opioids. The patients included:

    a) Patient A: January 21, 2015, July 3, 2015, June 2, 2016, June 13, 2017, October 27, 2017

    b) Patient B: April 23, 2015, September 10, 2015, August 15, 2016, November 26, 2016, December 22, 2016, March 14, 2017, August 25, 2017, February 7, 2018, June 5, 2018, July 30, 2018, October 10, 2018, February 23, 2019

    c) Patient C: July 5, 2016

15. Attached at **Tab "B"** [omitted from these Reasons for Decision] is an analysis performed by the College of these prescriptions, the substance with which Dr. Chapnick agrees.

16. Dr. Chapnick prescribed an excessive number and dose of benzodiazepines for the following patients:

    a) Patient D: April 27, 2016

    b) Patient A: June 13, 2017, June 21, 2017

    c) Patient G: July 3, 2017

17. On or about July 14, 2015, September 27, 2015, November 20, 2015, December 11, 2015, June 14, 2016, August 23, 2017, February 8, 2018, October 2, 2018, and/or October 11, 2018, Dr. Chapnick self-prescribed and/or prescribed for office use an excessive number and dose of benzodiazepines. Again, Dr. Chapnick agrees with the substance of the analysis contained in Tab "C".

18. Attached at **Tab "C"** [omitted from these Reasons for Decision] is a copy

of the College's analysis of this issue, the substance with which Dr. Chapnick agrees, along with an excerpt from the Ontario Public Drug Programs Narcotic and Controlled Drug Claims on the Narcotics Monitoring System.

19. It is admitted that the above conduct constitutes professional misconduct under section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 and as defined in paragraph 1 (contravening a standard of practice or failing to maintain the standards of practice of the profession) of section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Failing to Maintain the Standards of the Profession When Administering Nitrous Oxide and Oxygen Sedation

20. On one occasion, in or about 2015, Dr. Chapnick administered nitrous oxide and oxygen sedation to Patient A and self-administered nitrous oxide and oxygen sedation while in the dental office during their second date for a non-dental, recreational purpose.

21. In or about 2015, 2016, 2017, and/or 2018, Dr. Chapnick self-administered nitrous oxide and oxygen sedation after work hours, both in the office and outside the office, on three or four occasions for non-dental, recreational purposes.

22. It is admitted that the above conduct constitutes professional misconduct under section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 and as defined in paragraph 11 (contravening the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation) of section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Unnecessary Dental Services

23. On one occasion, in or about 2015, Dr. Chapnick unnecessarily administered nitrous oxide and oxygen sedation to Patient A and

unnecessarily self-administered nitrous oxide and oxygen sedation for a non-dental purpose.

24. In or about 2015, 2016, 2017 and/or 2018, Dr. Chapnick unnecessarily self-administered nitrous oxide and oxygen sedation, on three or four occasions, for a non-dental purpose.

25. On or about July 14, 2015, September 27, 2015, November 20, 2015, December 11, 2015, June 14, 2016, August 23, 2017, February 8, 2018, October 2, 2018, and/or October 11, 2018, Dr. Chapnick unnecessarily self-prescribed and/or prescribed for office use benzodiazepines: see Tab "C". Dr. Chapnick unnecessarily prescribed benzodiazepines for the following patients (see Tab "C"):

    a) Patient D: April 27, 2016

    b) Patient A: June 13, 2017, June 21, 2017

    c) Patient G: July 3,2017

26. It is admitted that the above conduct constitutes professional misconduct under section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 and as defined in paragraph 6 (recommending or providing an unnecessary dental service) of section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Improper Exercise of Authority to Prescribe, Dispense or Sell Drugs

27. On or about July 14, 2015, September 27, 2015, November 20, 2015, December 11, 2015, June 14, 2016, August 23, 2017, February 8, 2018, October 2, 2018 and/or October 11, 2018, Dr. Chapnick self-prescribed benzodiazepines and/or prescribed benzodiazepines for office use for an improper purpose (see Tab "C").

28. Dr. Chapnick prescribed benzodiazepines for the following patients for an improper purpose (see Tab "C"):

    a) Patient D: April 27, 2016

b) Patient A: June 13, 2017, June 21, 2017

c) Patient G: July 3, 2017

29. On or about November 9, 2015, Dr. Chapnick prescribed amoxicillin trihydrate for Patient A, for a non-dental purpose.

30. On or about July 11, 2017, Dr. Chapnick prescribed levofloxacin for Patient A, for a non-dental purpose.

31. It is admitted that the above conduct constitutes professional misconduct under section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 and as defined in paragraph 10 (prescribing, dispensing or selling a drug for an improper purpose, or otherwise using improperly the authority to prescribe, dispense or sell drugs) of section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Failed to Keep Records

32. In respect of the following patients, Dr. Chapnick failed to keep records of prescriptions as required:

a) Patient A: January 21, 2015, July 3, 2015, June 2, 2016, June 13, 2017 and October 27, 2017

b) Patient B: April 23, 2015, September 10, 2015, August 15, 2016, November 7, 2016, November 26, 2016, December 22, 2016, March 14, 2017, August 25, 2017, February 7, 2018, June 5, 2018, July 30, 2018, October 10, 2018, February 23, 2019

33. For the following patients, in the years 2015, 2016, 2017, 2018 and/or 2019, Dr. Chapnick failed to document patient pain, the rationale for selecting a narcotic and the possible contraindications or indications for the use of a narcotic (see Tab “B”):

a) Patient A

b) Patient J

c) Patient B

d) Patient K

e) Patient C

34. It is admitted that the above conduct constitutes professional misconduct under the following grounds of misconduct:

a) Section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 and as defined in paragraph 25 (failing to keep records as required by the regulations) of section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended; and

b) Section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 and as defined in the following paragraphs of sections 38 of Regulation 547, Revised Regulations of Ontario, 1990, as amended, under the *Drug and Pharmacies Regulation Act*[, R.S.O.] 1990, c H.4:

i. paragraph b – make and keep clinical and financial records respecting his or her patients and the record for each patient shall contain not less than,

(i) the patient's history

(ii) the examination procedures used

(iii) the clinical findings obtained

(iv) the treatment prescribed and provided, and

(v) the member's fees and charges

ii. paragraph c – keep the records required under clause (b) in a systematic manner and such records shall be retained for a period of at least ten years after the date of the last entry in the record or until two years following the death of the member, whichever first occurs.

Disgraceful, Dishonourable, Unprofessional and Unethical Conduct

35. In or about 2015, 2016, 2017 and/or 2018, Dr. Chapnick:

    a) administered nitrous oxide and oxygen sedation to Patient A and self-administered nitrous oxide and oxygen sedation for a non-dental purpose

    b) on one occasion in Las Vegas, Dr. Chapnick ingested one tablet of Adderall medication prescribed for Patient A

    c) prescribed medication for Patient A, that was returned to him (Dr. Chapnick) for self-use

    d) self-prescribed benzodiazepines for an improper purpose and/or that were in excess of any dose permitted for oral minimal sedation as per the College's standard of practice, *Use of Sedation and General Anesthesia in Dental Practice*, and

    e) used cocaine on approximately three occasions.

36. It is admitted by Dr. Chapnick that the above conduct constitutes professional misconduct under Section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 and as defined in paragraph 59 (engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical) of section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Additional Factors

37. It is Dr. Chapnick’s position that the following constitute mitigating factors:

    a) Dr. Chapnick has taken responsibility and is not contesting the facts

    b) Dr. Chapnick has been cooperative throughout the College process, and

c) Dr. Chapnick has no previous discipline history.

DECISION

Having considered the evidence and submissions of the parties, the Panel found that the Registrant committed professional misconduct as set out in the allegations in both Notices of Hearing, except in respect of those particulars that were withdrawn.

REASONS FOR DECISION

For the reasons set out below, the Panel finds that the Registrant engaged in professional misconduct as alleged in that:

(a) he engaged in sexual relations with a patient (Patient A), who was not his spouse;
(b) he thereby sexually abused a patient, namely Patient A;
(c) he prescribed an excessive number of opioids for Patient A;
(d) he unnecessarily prescribed an excessive number and dose of benzodiazepines for Patient A and other patients;
(e) he unnecessarily self-prescribed or prescribed for office use benzodiazepines, contrary to the *Health Professions Procedural Code;*
(f) in 2015, he administered nitrous oxide sedation to Patient A for a non-dental purpose;
(g) in 2015, 2016, 2017 and/or 2018, he administered nitrous oxide sedation to himself for a non-dental purpose;
(h) in 2015, he prescribed amoxicillin trihydrate to Patient A for a non-dental purpose;
(i) in July 2017, he prescribed levofloxacin for Patient A for a non-dental purpose;
(j) he failed to keep proper records of the prescriptions he wrote, as required;
(k) he failed to document patient pain, the rationale for selecting a narcotic, and possible contraindications for the use of a narcotic, as required;
(l) he misused Adderall medication that was prescribed for Patient A;
(m) he prescribed medication to Patient A that was returned to him for self-use;
(n) he misused cocaine,

In reaching these findings, the Panel relied upon the admissions by Dr. Chapnick contained in the Agreed Statement of Facts. More particularly, the Panel found as follows.

Sexual Abuse of a Patient:

(a) Dr. Chapnick commenced dating Patient A in or about October, 2014;
(b) Dr. Chapnick and Patient A were engaged in a relationship from October, 2014 until July 2018;
(c) Dr. Chapnick and Patient A commenced a sexual relationship in or about March 2015;
(d) At no time was Patient A Dr. Chapnick's spouse;
(e) Dr. Chapnick began providing dental services to Patient A in or about April, 2015 and continued to do so until July 2018. During that time, he provided regular dental cleanings and examinations, took x-rays, performed gum surgery and made her a dental night guard;
(f) Dr. Chapnick did not charge Patient A for any of the work/treatment that he provided;
(g) In 2017, Dr. Chapnick purchased a car for Patient A;
(h) During the period of their relationship, Patient A went with Dr. Chapnick for holidays to Las Vegas (at least two trips), Jamaica (three trips), and New York. Dr. Chapnick admits that he and Patient A had sexual intercourse during these trips, and at hotels in Barrie, Ontario, and at Patient A's house.

The conduct engaged in by Dr. Chapnick with Patient A falls squarely within the meaning of "sexual abuse" of a patient, as that term is defined in s. 1(3), (4) and (5) of the *Health Professions Procedural Code*, namely:

(a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
(b) touching, of a sexual nature, of the patient by the member, or
(c) behaviour or remarks of a sexual nature by the member towards the patient.

The Panel thus found that by his conduct, Dr. Chapnick committed acts of professional misconduct, contrary to sections 51(1)(b.1) and 51(1)(c) of the *Code*.

In this regard, the Panel was persuaded by the admissions made by Dr. Chapnick at Paragraph 13 of the Agreed Statement of Facts, which states:

> "13. It is admitted that the above conduct constitutes professional misconduct under section 51(1)(b.1) of the *Health Professions Procedural Code*…(being) sexual abuse of a patient, more specifically, sexual intercourse and /or other forms of sexual relations

with a patient and touching of a sexual nature and/or behaviour or remarks of a sexual nature towards a patient."

Having found that Dr. Chapnick is guilty of sexual abuse of a patient who was not his spouse, the Panel thus found that Dr. Chapnick is guilty of professional misconduct.

Prescription/Over-prescription of medications for Patient A, himself and others:

(a) With respect to Patient A, during the period January 2015 to October 2017, Dr. Chapnick wrote eleven (11) prescriptions for drugs including Endocet, Oxycodone, Ratio-Oxycocet, Lorazepam, Amoxicillin, LevoFloxacin, and Triamcinolone, for which no chart entries were found;

(b) Further with respect to Patient A, Dr. Chapnick admitted that he prescribed excessive amounts of opioids – amounts which exceeded the recommended dosage – when no rationale for the prescription was documented, nor was there an indication of a documented, step-wise approach to the prescription of the narcotic;

(c) Dr. Chapnick further admitted that he engaged in the same conduct with respect to two other patients;

(d) Further with respect to Patient A, Dr. Chapnick admitted that on one occasion in 2015, he administered nitrous oxide and oxygen sedation to her for a non-dental recreational purpose. He admitted that this took place in his dental office during their second date;

(e) Dr. Chapnick admitted that in July, September, November and December 2015, and in June 2016, August 2017 and twice in October 2018, he self-prescribed and/or prescribed for office use an excessive number and dose of benzodiazepines;

(f) Dr. Chapnick admitted that he unnecessarily prescribed benzodiazepines for three other persons, including Patient A;

(g) In or about 2015, 2016, 2017 and/or 2018, Dr. Chapnick admitted that he unnecessarily self-administered nitrous oxide and oxygen sedation, on three or four occasions and for a non-dental purpose.

The conduct in which Dr. Chapnick admitted that he engaged with respect to Patient A constitutes professional misconduct. More specifically, the Panel found that Dr. Chapnick's conduct was unprofessional and that he failed to maintain the standards of practice of the profession and that he thereby contravened Section 51(1)(c) of the *Health Professions Procedural Code* (the "*Code*") and as defined in s. 2(1) of *Ontario Regulation 853.*

More particularly, the Panel found that Dr. Chapnick prescribed amoxicillin and levofloxacin for Patient A for a non-dental purpose and that he prescribed benzodiazepines for Patient A for an improper purpose and that he thus contravened the *Code* and the *Regulation*.

Dr. Chapnick's conduct in self-prescribing medication and unnecessarily self-administering nitrous oxide and oxygen sedation further contravened the standards of practice of the profession and thereby constituted misconduct.

The Panel further found that Dr. Chapnick's conduct in unnecessarily prescribing benzodiazepines for three patients, including Patient A, contravened the standards of practice of the profession and thereby constituted misconduct.

Lastly, the Panel found that Dr. Chapnick's conduct in administering nitrous oxide and oxygen sedation to both himself and Patient A constituted professional misconduct, contrary to section 51(1)(c) of the *Code* and section 2(11) of *Ontario Regulation 853*.

Improper Exercise of Authority to Prescribe, Dispense or Sell Drugs:

(a) On an admitted ten occasions over the period July 2015 to October 2018, Dr. Chapnick prescribed benzodiazepines either for himself or for office use and for an improper purpose;
(b) Dr. Chapnick further admitted that he prescribed benzodiazepines for three patients, including Patient A, for an improper purpose;
(c) Dr. Chapnick prescribed amoxicillin for Patient A on one occasion, for a non-dental purpose, and levofloxacin for Patient A on one occasion for a non-dental purpose, as described above (**Prescription/ Overprescription**, subpara. a).

The College did not allege, nor did Dr. Chapnick admit, that he sold drugs. The Panel thus finds that while Dr. Chapnick did admittedly prescribe medication for improper purposes, or for non-dental purposes, and that he thereby abused his authority to prescribe or dispense drugs, there is no factual basis upon which to find that he sold drugs. The Panel therefore finds that Dr. Chapnick's conduct constituted professional misconduct within the meaning of section 51(1)(c) of the *Code* and section 2(10) of *Ontario Regulation 853.*

Disgraceful, Dishonourable, Unprofessional or Unethical Conduct:

(a) Dr. Chapnick administered nitrous oxide and oxygen sedation to Patient A and to himself for a non-dental purpose;
(b) Dr. Chapnick misused Adderall medication that had been prescribed for Patient A;

(c) Dr. Chapnick prescribed medication for Patient A that was ultimately returned to him by Patient A for his own self-use;
(d) Dr. Chapnick used cocaine on approximately three occasions.

The Panel found that the conduct in which Dr. Chapnick admittedly engaged falls within the meaning of “disgraceful, dishonourable, unprofessional or unethical conduct” as set forth in *Ontario Regulation 853* and that it constitutes professional misconduct pursuant to Section 51(1)(c) of the *Code.*

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission with respect to Penalty and Costs (Exhibit 5), which reads as follows:

1. The Royal College of Dental Surgeons of Ontario ("College") and Dr. Adam Chapnick ("the Member") jointly submit that this panel of the Discipline Committee, impose the following penalty on the Member as a result of the panel's finding that the Member is guilty of professional misconduct, namely, that it make an order:

    a) requiring the Member to appear before the panel of the Discipline Committee, virtually or in person as directed, to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

    b) directing the Registrar to revoke the Member’s certificate of registration immediately upon this Order becoming final; and,

    c) that the Member pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing within six (6) months of this Order becoming final.

2. The College and the Member acknowledge that pursuant to the Code, as amended, the results of these proceedings must be recorded on the Register of the College and any publication of the Decision of the panel would therefore occur with the name and practice address of the Member included.

PENALTY DECISION

The Panel accepted the Joint Submission on Penalty and made the following order (the "Order"):

1. The Registrant shall appear before the panel of the Discipline Committee, virtually or in person as directed, to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

2. The Registrar shall revoke the Registrant's certificate of registration immediately upon this Order becoming final; and,

3. The Registrant shall pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing within six (6) months of this Order becoming final.

REASONS FOR PENALTY DECISION

It is settled law that a decision-maker should not lightly depart from an agreement with respect to penalty that has been reached by the parties upon the Registrant agreeing to enter a plea of guilty to the allegations against him. The test is not one of "fitness of sentence" but rather, the more stringent test as to "whether the proposed sentence would bring the administration of justice into disrepute or would otherwise be contrary to the public interest".[1]

The Panel accepted the Joint Submission on Penalty and Costs. The goal of a penalty is to protect the public from dentists who have engaged in misconduct and to maintain public confidence in the profession and its ability to self-regulate. A penalty must serve as a measure of both general deterrence – in that it sends a message to the College membership that this type of conduct will not and cannot be tolerated – and specific deterrence with respect to the dentist concerned, in this case, Dr. Chapnick. An appropriate penalty should also provide for remediation or rehabilitation of the dentist, where possible.

Counsel for both parties argued that the Panel should accept the Joint Submission. The parties submitted that the joint proposal meets the goals of public protection, specific and general deterrence, and remediation. They argued that the proposed penalty reflects the seriousness of the misconduct and that it is appropriate having regard to the aggravating and

[1] *R v Anthony Cook* 2016 SCC 43 per Moldaver J.

mitigating factors, to prior decisions of the Discipline Committee in similar cases, and to the interests of the public, the profession, and the Registrant himself.

The actions on which the Panel's misconduct findings are based, as admitted by the Registrant, took place over a period of approximately four (4) years. The misconduct as admitted by Dr. Chapnick, is serious: it includes sexual abuse of a patient. The investigation that led to this admission and finding was extensive and comprehensive.

Members of Ontario's regulated health professions are deemed guilty of professional misconduct under s. 51(1) of the *Health Professions Procedural Code* (the "***Code***"), being Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, if they commit "sexual abuse" against a patient. Sexual abuse is defined broadly under s. 1(3) of the *Code* as including sexual intercourse or other forms of physical sexual relations between the member and the patient, as well as touching of a sexual nature, or even behaviour or remarks of a sexual nature. Notably, sexual abuse, as defined in s. 1(3) of the *Code* includes those sexual acts between a patient and a regulated health professional, even if they are consensual.

In reaching its decision to accept the parties' Joint Submission and revoke Dr. Chapnick's professional license, the Panel considered the recent case of *Tanase v. College of Dental Hygienists of Ontario*.[2] In *Tanase,* the Ontario Court of Appeal held that while revocation is an extremely serious penalty, the Ontario Legislature decided "that sexual abuse in the regulated health professions is better prevented by establishing a bright-line rule prohibiting sexual relationships – an approach that provides clear guidance to those governed by the rule".[3]

In all the circumstances of this case – including the admission by Dr. Chapnick of the facts underlying the Panel's finding that Dr. Chapnick sexually abused a patient – revocation of Dr. Chapnick's certificate of registration is mandatory pursuant to s. 51(5) of the *Code*.

The Panel finds that the Joint Proposal meets the goals of protection of the public interest, and specific and general deterrence.

---

[2] *Tanase v College of Dental Hygienists of Ontario*, 2021 ONCA 482 (released July 5, 2021)
[3] *Ibid*, para 7

THE REPRIMAND

At the conclusion of the discipline hearing, the panel delivered the reprimand to the Member. A copy of the reprimand is attached as Appendix “A” to these Reasons.

I, Judy Welikovitch, sign these Reasons for Decision as Chairperson of this Discipline Panel.

August 16, 2023

Judy Welikovitch — Date

Dr. Rajiv Butany

Dr. Peter Delean

APPENDIX “A”

Dr. Adam Chapnick, as you know, the Discipline panel has ordered you be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you that seriousness of your misconduct.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

You will be given an opportunity to make a statement at the end of the reprimand, if you so wish.

The Panel has found that you have engaged in multiple acts of professional misconduct. The misconduct related to multiple aspects of your practice, including:

(a) Sexual abuse of a patient
(b) Prescribing an excessive amount of opioids and benzodiazepines
(c) Failing to maintain the standard of professionalism of the profession when administering nitrous oxide and oxygen sedation
(d) Improperly exercising your authority to prescribe or dispense drugs
(e) Failing to keep patient records of prescriptions, of patient pain, and the rationale for the use of narcotics.

Your professional conduct is completely unacceptable to the public and to the profession. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged has involved:

(a) Sexual abuse of a patient. This is of particular concern because the dentist/patient relationship is one that includes an inherent imbalance of power.
(b) Self-administration of nitrous oxide and oxygen sedation for non-dental purposes
(c) Self-prescription of benzodiazepines. These latter two actions are of particular concern to us because they involve abuse of the privilege of prescribing, thereby contravening the College “standard” and putting the public at risk

In these circumstances, it is requested by the parties, and the Panel agrees, that it is entirely appropriate that we revoke your license to practice dentistry.

That being said, the Panel is pleased that Dr. Chapnick is taking SCERP courses to manage his issues with drugs and is doing what he needs to do to protect the public.

The Panel acknowledges Mr. Gold's comments on behalf of Dr. Chapnick reminding the panel of Dr. Chapnick's conduct in voluntarily taking the SCERP courses, is staying away from drugs, and conducting himself in a manner that complies with the requirements of the profession.

As I advised you earlier, you will now be given an opportunity to make a comment if you wish to do so. This is not an opportunity for you to debate the merits or correctness of the decision(s) we have made.

Do you have any questions or do you wish to make any comments?

Thank you for attending today. We are adjourned