DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Danielak, 2026 ONRCDSO 12

Date: 2026-08-24

File No.: 25-0770

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

- and -

Dr. Michael Danielak
Registration No: 100957

FINDING AND PENALTY REASONS

PANEL MEMBERS:
Judy Welikovitch, Public Member (Chair)
Neil Gajjar, Professional Member
Luisa Ritacca, Subject Matter Expert

APPEARANCES:
Alexandra Matushenko, for the College
Matthew Wilton, for Dr. Michael Danielak

Heard: July 20, 2026, by videoconference
Decision Date: July 20, 2026

REASONS FOR DECISION

[1] This matter came on for a hearing before a panel of the Discipline Committee (the "**Panel**") of the Royal College of Dental Surgeons of Ontario (the "**College**") on July 20, 2026, by videoconference. Dr. Michael Danielak (the "**Registrant**") admitted to the acts of professional misconduct alleged by the College. The hearing proceeded by way of an Agreed Statement of Facts (the "**ASF**"). The Panel made findings of professional misconduct and imposed a penalty in accordance with the parties' Joint Submission on Order (the "**JSO**").

[2] These are the Panel's Decision and Reasons for Decision.

THE ALLEGATIONS

[3] The allegations of professional misconduct against Dr. Danielak are set out in Notice of Hearing 25-0770 dated September 17, 2025 (Exhibit 1).

[4] In the Notice of Hearing, the College made two allegations 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* (the "**Code"**) against Dr. Danielak, as follows:

> 1. That he contravened the standards of practice of the profession in relation to inducing general anaesthesia or conscious sedation relative to eight (8) patients, contrary to paragraph 11 of section 2 of Ontario Regulation 853/93, as amended, made under the *Dentistry Act, 1991* (the "**Professional Misconduct Regulation**"); and
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> 2. That he committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Code in that he engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by registrants of the profession as disgraceful, dishonourable, unprofessional or unethical, contrary to paragraph 59 of section 2 of the Professional Misconduct Regulation.

[5] With respect to both allegations 1 and 2, the College alleged the following particulars:

a. That in or about 2022, 2023 and/or 2024, Dr. Danielak provided doses of an oral sedative (Triazolam) to eight (8) patients that exceeded his minimal sedation authorization;
b. That Dr. Danielak did not have the required Facility Permit to administer doses of Triazolam that exceeded his minimal sedation authorization;
c. That in or about 2022 and/or 2023, Dr. Danielak used incremental dosing for five (5) of those eight (8) patients, which is strongly discouraged and, if used, must be carried out with great caution in accordance with the College's Standard of Practice, *Use of Sedation and General Anesthesia in Dental Practice*;
d. That Dr. Danielak used incremental dosing with respect to five (5) of those eight (8) patients that exceeded the dosage levels permitted by his authorization for minimal sedation, and in one instance, he exceeded oral *moderate* sedation dosing levels, which he did not have authorization to administer; and
e. That in or about 2022, 2023 and/or 2024, Dr. Danielak did not exercise great caution and administered incremental dosing to five (5) of those (8) patients who had complex histories and whom he should have anticipated may have required sedation doses above his minimal sedation authorization, such as patients who used cannabis or narcotic medication.

THE REGISTRANT'S PLEA

[6] Dr. Danielak admitted to each of the allegations contained in the Notice of Hearing. The Chair conducted an oral plea inquiry to confirm that the Registrant's admissions of professional misconduct were voluntary, informed and unequivocal. In addition, a Plea Inquiry, signed by the parties, was entered into evidence as Exhibit 2.

[7] The Agreed Statement of Facts entered into evidence (Exhibit 3) and signed by the parties also confirmed Dr. Danielak's understanding of the nature of the allegations against him and the consequences of admitting to the alleged acts of professional misconduct.

[8] The Panel was satisfied that Dr. Danielak's plea was voluntary, informed and unequivocal.

THE EVIDENCE

[9] As noted, the parties provided the Panel with an ASF (Exhibit 3). The relevant facts set out in the ASF are as follows (any Tabs referred to in the ASF have not been included):

Background

1. At the material times, Dr. Michael Danielak (the "Registrant") was a duly registered member of the Royal College of Dental Surgeons of Ontario (the "College"), practising at Northern Horizon Dental Centres in Barrie, Ontario and Dr. Dove Dental in Barrie, Ontario (cumulatively, the "Facilities"). A copy of the Registrant's profile from the Dentist Register is attached as **Tab A**.

Facilities Inspection Program Inspection and Concerns

2. On or about December 8, 2021, the Registrant applied for and received authorization from the College's Facilities Inspection Program ("FIP") to administer minimal sedation to patients. The Registrant has renewed his sedation authorization annually since 2021. During all material times, he was authorized to administer minimal sedation to patients. A copy of the Registrant's minimal sedation authorization from the relevant time is attached as **Tab B**.

3. On or about July 31, 2024, the Registrant submitted an application to increase his sedation authorization to visiting parenteral conscious (1-drug) sedation authorization.

4. In response to the Registrant's application, on September 11, 2024, a FIP inspector conducted an initial inspection of the Registrant's visiting sedation kit for parenteral conscious (1-drug) sedation. The inspector requested a sample drug log, and the Registrant provided a drug log that he used at Northern Horizon Dental Centres. The drug log showed that the Registrant administered doses of oral sedation to eight patients that exceeded the maximum dosages permitted by the Registrant's minimal sedation authorization.

5. On or about September 23, 2024, FIP staff informed the Registrant that he had administered sedation in doses that exceeded his current authorization for minimal sedation, in breach of the Standard of Practice for *Use of Sedation and General Anesthesia in Dental Practice* ("Sedation Standard"). FIP staff directed the Registrant to cease administering all levels of sedation as a result. FIP staff also requested additional information, including specified drug logs from all facilities at which the Registrant administered oral sedation.

6. On or about October 1, 2024, the Registrant responded to FIP staff's request and provided, among other things, drug logs that he used at both Facilities. These drug logs showed that, on multiple occasions and at both Facilities, the Registrant administered sedation in doses higher than permitted by his minimal sedation authorization.

7. On or about October 3, 2024, FIP staff advised the Registrant that due to concerns about the Registrant's breaches of the Sedation Standard, his application for visiting parenteral conscious (1-drug) sedation authorization was denied. FIP staff also advised the Registrant that the matter would be referred to the Registrar for review.

Appointment of Investigators and Interim Order

8. On January 13, 2025, investigators were appointed pursuant to subsection 75(1)(a) of the *Health Professions Procedural Code* (the "Code"), being Schedule 2 of the *Regulated Health Professions Act, 1991*, SO 1991, c 18, to investigate whether the Registrant had engaged in professional misconduct, including whether he failed to comply with the College's Sedation Standard. A copy of the Appointment of Investigators is attached as **Tab C**.

9. On February 25, 2025, a panel of the College's Inquiries, Complaints and Reports Committee ("ICRC") issued an Interim Order, placing terms, conditions and limitations ("TCLs") on the Registrant's certificate of registration. The Interim Order required the Registrant to do the following:

a. save and except for the provision of minimal sedation through the administration of nitrous oxide and oxygen sedation:

i. not to administer any form of sedation,

ii. not to be responsible for monitoring a patient under any form of sedation, and

iii. to refer all patients who required any form of sedation to another dentist or medical doctor who was authorized to provide sedation services and worked at a facility with the required permit.

10. The Registrant was also required to maintain a log of all patients and practitioners referenced in paragraphs 9(a)(i)-(iii) above, to comply with unannounced monitoring visits by the College, and to post a notice at all locations where he practised dentistry advising patients of the restrictions on his certificate of registration. A copy of the Interim Order and Reasons for Decision dated February 25, 2025 are attached as **Tab D**.

11. On May 15, 2025, a panel of the ICRC issued a Supplementary Interim Order, which replaced the Interim Order. The Supplementary Interim Order varied the Interim Order to permit the Registrant to administer and monitor patients that received all forms of minimal sedation. The other terms of the Interim Order, as reflected above, including the restrictions on administering or monitoring any patients that received any form of moderate sedation, deep sedation, or general anesthesia, remained in place. A copy of the Supplementary Interim Order and Reasons for Decision dated May 15, 2025 are attached as **Tab E**.

12. The Supplementary Interim Order remains in effect.

Administration of Sedation in Breach of Standard of Practice

13. A copy of the College's Sedation Standard is attached as **Tab F**. The Sedation Standard states that adult dose ranges for oral sedatives for minimal sedation are as follows:

Appointment 2 hours or less

- triazolam 0.125 to 0.25 mg

Appointment longer than 2 hours

- triazolam 0.25 mg OR
- diazepam 10 to 15 mg OR
- temazepam 15 mg OR
- oxazepam 10 to 15 mg

Appointment longer than 3 hours

- lorazepam 0.50 to 1.0 mg OR
- alprazolam 0.25 mg

14. The Sedation Standard also states that the maximum dose of an oral sedative for minimal sedation must not be exceeded, unless the dentist provides care that meets all requirements for oral moderate sedation, including the professional responsibility of obtaining authorization and a facility permit from the College to administer higher doses of sedation, regardless of whether the minimal or moderate sedation is intended or achieved.

15. During the years 2022, 2023, and 2024, the Registrant administered doses of an oral sedative (Triazolam) to eight patients that exceeded his minimal sedation authorization, in breach of the Sedation Standard, as follows:

	Date of Sedative Appointment(s)	**Total Triazolam Dosage Amount**
Patient 1	August 15, 2023	0.375 mg
Patient 2	September 20, 2023	0.5 mg
	December 6, 2023	0.5 mg
Patient 3	January 22, 2024	0.375 mg
Patient 4	October 26, 2023	0.5 mg
Patient 5	November 27, 2023	0.875 mg

	Date of Sedative Appointment(s)	Total Triazolam Dosage Amount
Patient 6	March 20, 2023	0.375 mg
	September 7, 2023	0.375 mg
Patient 7	September 23, 2022	0.625 mg
	April 10, 2023	0.375 mg
Patient 8	September 25, 2023	0.5 mg

16. These dosage amounts were at levels consistent with moderate sedation and, in the case of Patient 5, deep sedation levels.[1] At no time did the Registrant have authorization to administer doses of moderate sedation or deep sedation to patients.

17. The Sedation Standard also states that the administration of multiple doses of an oral sedative until a desired effect is reached, known as "incremental dosing", is strongly discouraged and, if used, must be carried out with great caution. Before an additional dose of an oral sedative is administered, the Sedation Standard requires the dentist to ensure that the previous dose has taken full effect, and states that the maximum dose of an oral sedative must not be exceeded at any one appointment.

18. In 2022 and 2023, the Registrant used "incremental dosing" for five patients, in breach of the Sedation Standard, as follows:

	Date of Sedative Appointment(s)	Triazolam Dosage Administered / Time Administered
Patient 2	September 20, 2023	0.25 mg / 12:30
		0.125 mg / 1:30
		0.125 mg / 2:30
	December 6, 2023	0.25 mg / 2:00
		0.25 mg / 3:00
Patient 4	October 26, 2023	0.25 mg / 12:50
		0.25 mg / 1:45

[1] The adult dose ranges of oral sedatives for moderate sedation are stipulated at Table 2, p. 16 of the Sedation Standard.

	Date of Sedative Appointment(s)	Triazolam Dosage Administered / Time Administered
Patient 5	November 27, 2023	0.25 mg / 11:55
		0.375 mg / 12:50
		0.25 mg / 1:55
Patient 6	March 20, 2023	0.25 mg / 9:15
		0.125 mg / 10:10
Patient 7	September 23, 2022	0.375 mg / 8:39
		0.25 mg / 9:38
	April 10, 2023	0.25 mg / 9:15
		0.125 mg / 10:10

19. “Incremental dosing” increases the risk of oversedation. The Registrant’s use of “incremental dosing” was particularly concerning because it resulted in the administration of total dosages that were consistent with oral moderate and deep sedation levels, and which exceeded his minimal sedation authorization. This made the risk of oversedation even more acute.

20. In addition, the Registrant administered “incremental dosing” in circumstances where the Registrant should have anticipated that patients may require higher doses of sedation than permitted by his minimal sedation authorization. This included patients who were known to the Registrant to use cannabis or narcotic or benzodiazepine medication, namely, Patients 2, 4, 5, 6, and 7.

Registrant’s Completion of Additional Training

21. On April 4, 2025, the Registrant voluntarily completed a Continuing Dental Education course at the University of Toronto, Faculty of Dentistry, titled “Medical Emergencies in the Dental Office”. A copy of the Registrant’s Certificate of Attendance is attached at **Tab G**.

22. On April 5 and 6, 2025, the Registrant voluntarily completed a Continuing Dental Education course at the University of Toronto, Faculty of Dentistry, titled “Oral Sedation & Nitrous Oxide Sedation”. A copy of the Registrant’s Certificate of Attendance is attached at **Tab H**.

Professional Misconduct Admitted

23. By this document, the Registrant admits to the truth of the facts referred to in paragraphs 1-22, above (the "Agreed Facts"). The Registrant agrees that Tabs A to H form part of the Agreed Facts.

24. The Registrant admits that during the years 2022, 2023 and 2024, he contravened the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation relative to multiple patients, as outlined in paragraphs 2-7 and 13-20, above.

25. The Registrant admits that he 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, as outlined in paragraphs 2-7 and 13-20, above.

26. The Registrant admits and acknowledges that the Agreed Facts as described above constitute professional misconduct pursuant to section 51(1)(c) of the Code, and as defined in the following paragraphs of section 2 of Ontario Regulation 853/93 made under the *Dentistry Act, 1991*:

a. Paragraph 11: contravening the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation; and

b. 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.

DECISION

[10] The Panel found that Dr. Danielak engaged in professional misconduct as alleged by the College and as set out in the Notice of Hearing. The College discharged its burden of proving the allegations on a balance of probabilities.

REASONS FOR DECISION

[11] The College bears the onus of proving the allegations against the Registrant on a balance of probabilities through clear, cogent and convincing evidence. The Registrant's admissions of professional misconduct are material but must be supported by evidence. The evidence in the ASF supports the Registrant's admissions and satisfies the College's burden of proof.

Allegation 1: Contravention of the Sedation Standard of Practice

[12] The first allegation is that Dr. Danielak contravened the standards of practice of the profession, as published by the College in relation to inducing general anesthesia or conscious sedation relative to eight (8) patients, contrary to paragraph 11 of section 2 of the Professional Misconduct Regulation.

[13] The evidence established that Dr. Danielak applied for and received authorization from the College's Facilities Inspection Program (the "**FIP**") to administer *minimal* sedation to patients

and that at all material times, his authorization was valid and in force. The Panel was satisfied on a balance of probabilities that at no time did Dr. Danielak have authorization to administer doses of *moderate* or *deep* sedation to patients.

[14] On or about July 31, 2024, Dr. Danielak submitted an application to increase his sedation authorization to a visiting parenteral conscious (1-drug) sedation authorization.

[15] During the facilities inspection that followed this application, the FIP inspector reviewed a sample of Dr. Danielak's drug log. The Panel was satisfied on a balance of probabilities that the drug log examined by the inspector showed that Dr. Danielak administered doses of oral sedation (Triazolam) to eight (8) patients in breach of the College's Sedation Standard and his minimal sedation permit.

[16] The drug logbook established that Dr. Danielak administered Triazolam to eight (8) patients in doses that significantly exceeded the amounts allowed under the Sedation Standard. In one case, with respect to Patient 5, Dr. Danielak administered sufficient Triazolam to put his patient into deep sedation. The Panel was satisfied on a balance of probabilities that the Registrant exceeded the maximum dosages of sedation permitted by his minimal sedation permit with respect to all eight (8) patients.

[17] With respect to the second particular, the Panel was satisfied on a balance of probabilities that Dr. Danielak did not have the required Facility Permit to administer doses of Triazolam that exceeded his minimal sedation permit.

[18] With respect to the third particular, the College alleged that in or about 2022 and/or 2023, Dr. Danielak used incremental dosing for five (5) patients.

[19] The evidence established that incremental dosing is strongly discouraged and if used, must be carried out with great caution. The Sedation Standard requires that before an additional dose of an oral sedative is administered, the dentist must ensure that the previous dose has taken full effect. Further, it states that the maximum dose of an oral sedative cannot be exceeded in any one appointment.

[20] The Panel was satisfied on a balance of probabilities that in 2022 and/or 2023, Dr. Danielak used incremental dosing for five (5) of the eight (8) patients whose records were examined and in breach of the Sedation Standard.

[21] Further, Dr. Danielak's use of incremental dosing was particularly concerning because it resulted in the administration of total dosages that were consistent with oral *moderate* and *deep* sedation levels which exceeded the Registrant's *minimal* sedation authorization. The Panel found, on a balance of probabilities, that Dr. Danielak thereby put his patients at risk of oversedation.

[22] With respect to the fifth particular, the College alleged that Dr. Danielak did not exercise great caution and administered incremental dosing to five (5) of those eight (8) patients, each of whom had complex histories which he should have anticipated may have required sedation doses above his minimal sedation authorization, such as patients who used cannabis or narcotic medication.

[23] The Panel was satisfied on a balance of probabilities that Dr. Danielak did not anticipate that five (5) of his patients whom he knew used cannabis or narcotic or benzodiazepine medications might have required sedation above his minimal sedation authorization.

Allegation 2: Disgraceful, Dishonourable, Unprofessional or Unethical Conduct ("DDUU")

[24] The second allegation is that Dr. Danielak engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by registrants of the profession as disgraceful, dishonourable, unprofessional or unethical, contrary to paragraph 59 of section 2 of the Professional Misconduct Regulation.

[25] The allegation is based upon the same set of facts/particulars as is Allegation 1. More specifically, it is alleged that by committing the acts described above under Allegation 1, that Dr. Danielak consequently engaged in conduct that would reasonably be regarded by registrants of the profession as DDUU.

[26] DDUU is considered a "catch-all definition" that is intended to capture any improper conduct that is not caught by the wording of any of the specific definitions of professional misconduct that are set forth in the Professional Misconduct Regulation.

[27] In his text, *Complete Guide to the Regulated Health Professions Act*[2], Richard Steinecke expands on this concept in the following way:

> The catch-all provision assumes a consensus within the profession that certain types of conduct are unacceptable for members. Members are judged according to that consensus and not on the private views of members of the Discipline Committee. The existence of this unwritten consensus prevents discipline from being arbitrary. In fact, the catch-all definition is not supposed to reflect the values of the general population, but the values of the profession itself. Members of the profession best understand the circumstances in which other members practise.[3]

[28] DDUU is intended to capture any improper misconduct that is not caught by the wording of the specific definitions of professional misconduct. Further, the misconduct need not be dishonest or immoral to be considered DDUU. A *serious or persistent disregard* for one's professional obligations is sufficient to fall within the DDUU category.[4]

[29] Registrants of the College would expect that dentists practice in a way that conforms to the standards and guidelines set by the College. The Panel found, on a balance of probabilities, that Dr. Danielak's practice with respect to eight (8) patients breached the Sedation Standards in a number of important ways as described above. He administered incremental dosing to five (5) of the eight (8) patients in breach of the Sedation Standard. He administered doses of Triazolam to these eight (8) patients in amounts that exceeded his minimal sedation authorization. Of great concern was that with respect to one (1) of these patients, Dr. Danielak administered doses of

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[2] Steinecke, Richard, *Complete Guide to the Regulated Health Professions Act* (Toronto:Thomson Reuters, 2025)
[3] Ibid, S6:332
[4] *Attallah v College of Physicians and Surgeons of Ontario*, 2021 ONSC 3722, Para. 54

Triazolam consistent with deep sedation levels. The Panel found that these practices put Dr. Danielak's patients at risk of harm.

[30] The Panel was satisfied, on a balance of probabilities, that Dr. Danielak breached the Sedation Standards of Practice and that he thereby contravened paragraph 11 of section 2 of the Professional Misconduct Regulation. On the basis of these findings of misconduct, the Panel was further satisfied, on a balance of probabilities, that Dr. Danielak also engaged in conduct that would reasonably be regarded by registrants of the profession as DDUU in that his misconduct demonstrated serious and persistent disregard for his professional obligations.

[31] Lastly, the Panel found, on a balance of probabilities, that Dr. Danielak's admissions of his own conduct as set forth in the ASF supported a finding of DDUU. The admitted facts demonstrate a serious disregard for his obligations as a registrant of the College. Further, Dr. Danielak's conduct undermines the relationship of trust that exists between dentists and their patients, the College and the public.

PENALTY SUBMISSIONS

[32] The parties presented the Panel with a JSO, asking the Panel to impose an order on the following terms:

(a) requiring the Registrant to appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of the Order becoming final or on a date fixed by the Registrar;

(b) directing the Registrar to suspend the Registrant's certificate of registration for a period of two (2) months, commencing at 12:01 am on the day after the Order. The suspension shall run without interruption;

(c) that the Registrar impose the following terms, conditions and limitations on the Registrant's certificate of registration (the "Suspension Conditions"), which Suspension Conditions shall continue until the suspension of the Registrant's certificate of registration as referred to in paragraph 1(b) above has been fully served:

(i) while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

- staff in the offices or practices in which the Registrant works, including other regulated professionals and administrative staff;
- dentists with whom the Registrant works, whether the Registrant is a principal in the practice or otherwise associated with the practice;
- dentists or other individuals who routinely refer patients to the Registrant;
- faculty members at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;
- owners of a practice or office in which the Registrant works;
- patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to

the suspension. The Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

(ii) while suspended, the Registrant must not engage in the practice of dentistry, including but not limited to:

- acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that administrative or office staff do not suggest to patients in any way that the Registrant is entitled to engage in the practice of dentistry;
- giving orders or standing orders to dental hygienists;
- supervising work performed by others;
- working in the capacity of a dental assistant or performing laboratory work;
- acting as a clinical instructor;

(iii) while suspended, the Registrant must not be present in offices or practices where the Registrant works when patients are present, except for emergencies that do not involve patients. The Registrant must immediately advise the Registrar in writing about any such emergencies;

(iv) while suspended, the Registrant must not benefit or profit, directly or indirectly from the practice of dentistry and

- the Registrant may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Registrant may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period;
- the Registrant is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension;
- the Registrant must not sign insurance claims for work that has been completed by others during the suspension period;

(v) the Registrant shall cooperate with any office monitoring which the Registrar thinks is needed to ensure that the Registrant has complied with the Suspension Conditions. The Registrant must provide the College with access to any records associated with the practice that the College may require to verify that the Registrant has not engaged in the practice of dentistry or profited during the suspension; and

(vi) the Suspension Conditions imposed by virtue of subparagraphs 1(c)(i)-(v) above shall be removed at the end of the period that the Registrant's certificate of registration is suspended.

(d) directing that the Registrar also impose the following additional terms, conditions and limitations on the Registrant's Certificate of Registration, namely:

(i) The Registrant shall be prohibited from applying for authorization to administer oral moderate or deep sedation for a period of 24 months after the Registrant's suspension concludes;

(ii) The Registrant will submit to practice monitoring for 24 months after the Registrant's suspension concludes and the Registrant returns to the practice of dentistry. The monitoring may be conducted by way of announced visits, which may be conducted virtually or in-person at the discretion of the College; and

(iii) The Registrant will pay the monitoring fee of $1,000 per visit to the College within two weeks of the invoiced date for each monitoring visit.

(e) requiring the Registrant to pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing within three (3) months of the date this Order becomes final.

[33] College counsel made submissions regarding aggravating and mitigating factors present in this case. She argued that the conduct itself was aggravating, in that the misconduct involved eight (8) patients and eleven (11) instances of misconduct. In one instance, with respect to Patient 5, Dr. Danielak administered sufficient sedation to place the patient into deep sedation and thereby put that patient at risk of harm.

[34] With respect to mitigating factors, College counsel acknowledged that Dr. Danielak admitted his misconduct and that he cooperated with the investigation; that he proactively completed remediating courses; and that he had no discipline history with the College. Dr. Danielak's counsel relied on these same factors.

PENALTY DECISION

[35] The Panel accepted the parties' JSO and made an order (the "Order) in accordance with its terms as set forth above.

REASONS FOR PENALTY DECISION

[36] Once the Discipline Committee makes findings of professional misconduct, it is incumbent upon it to impose an order that is appropriate in the circumstances. It is settled law that a decision-maker should not lightly depart from an agreement that has been reached by the parties with respect to an appropriate penalty. The test is not one of "fitness of sentence" but rather, the more stringent test of whether the jointly proposed penalty would bring the administration of justice into disrepute or would otherwise be contrary to the public interest."[5]

[37] Both counsel made submissions on the appropriateness of the penalty order being proposed. Both counsel relied on the analysis in *Ontario College of Teachers v Merolle*[6]*,* where the Court ruled that "any disciplinary body that rejects a joint submission on penalty must apply the public interest test and must show why the proposed penalty is so 'unhinged' from the circumstances of the case that it must be rejected."[7]

[38] Both counsel submitted that the penalty being proposed was aligned with the public interest and that it was not in any way unhinged from the circumstances of this case.

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[5] *R v Anthony Cook*, 2016 SCC 43, applied in the professional discipline context in *Ontario College of Teachers v Merolle,* 2023 ONSC 3453 at para 32

[6] 2023 ONSC 3453

[7] Ibid at Para. 14

[39] The Panel considered the terms of the JSO in the context of the basic principles relating to the imposition of penalties. Those principles include that: (a) the goal of a penalty is to protect the public from dentists who have committed professional misconduct and to maintain public confidence in the profession and in its ability to self-regulate; (b) a penalty must serve as a measure of general deterrence, in that it sends a message to all registrants of the dental profession that this type of conduct will not and cannot be tolerated; (c) it must also serve as a measure of specific deterrence with respect to the dentist concerned; (d) an appropriate penalty should also provide for remediation or rehabilitation of the dentist concerned, where possible and appropriate; and lastly, (e) the penalty must be proportionate to penalties ordered in similar circumstances.

[40] The panel must consider both mitigating and aggravating factors when assessing the appropriateness of the penalty in the circumstances.

[41] Overall, the Panel must be satisfied that the components of the penalty being proposed serve the objectives of penalty and ultimately, that they serve the public interest.

[42] Dr. Danielak held a *minimal* sedation permit only.

[43] One of the more significant aggravating factors in this case was that the professional misconduct took place over the course of three years. The Panel's findings of professional misconduct did not relate to a single error or lapse in judgment but impacted eight (8) patients over the course of eleven (11) instances. In one (1) instance, Dr. Danielak administered sufficient sedation that achieved deep sedation which posed potential harm to the patient.

[44] The parties jointly proposed a reprimand, a two (2)-month suspension of Dr. Danielak's certificate of registration, practice monitoring by the College for a period of twenty-four (24) months following the Registrant's return to practice from his suspension, and a prohibition period of 24 months before Dr. Danielak can apply for authorization to administer moderate or deep sedation.

[45] The Panel found that the penalty as a whole was proportionate to the severity of Dr. Danielak's misconduct and his circumstances. It reflects the relevant aggravating and mitigating factors. The most important mitigating factor is that Dr. Danielak took responsibility for his actions by admitting to the misconduct allegations and working with the College to reach an ASF and JSO. The number of patients involved and the length of time over which the misconduct occurred are relevant aggravating factors.

[46] The Panel found that a two (2)-month suspension was proportionate to the lengths of suspension ordered in other, similar cases referred to by counsel [*Royal College of Dental Surgeons v Bunt*, 2025 ONRCDSO 6; *Royal College of Dental Surgeons v Kirschner*, 2020 ONRCDSO 11; and *Attallah v College of Physicians and Surgeons of Ontario*, 2021 ONSC 3722].

[47] The suspension will achieve specific deterrence with respect to Dr. Danielak. It will also achieve general deterrence in that it will convey to other registrants that this type of misconduct cannot and will not be tolerated. The imposition of the suspension will also assure the public that the College has the ability to regulate itself and that public safety and public protection are top priorities for the College.

[48] To conclude, the Panel found the suspension and reprimand together will achieve the objectives of both specific deterrence and general deterrence. Practice monitoring will provide remediation and support. The prohibition against applying for a moderate or deep sedation permit for a period of twenty-four (24) months will achieve specific deterrence and serve to protect the public.

[49] Finally, the Panel accepted the parties' agreement on costs. An order for costs in the amount of $10,000 is proportionate with costs orders in other one-day uncontested matters that come before this Discipline Committee.

THE REPRIMAND

[50] At the conclusion of the hearing, Dr. Danielak confirmed through his counsel that he was waiving his right to appeal and wished to receive the reprimand immediately. Accordingly, the Panel delivered an oral reprimand as required by Paragraph 1(a) of the Panel's Order. A copy of the reprimand is attached as Appendix "A".

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

August 24, 2026

Judy Welikovitch
Chair, Discipline Committee Panel

Date

Appendix "A"

RCDSO v. Dr. Michael Danielak

Dr. Danielak, as you know, this Discipline panel has ordered you be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you the 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 wish.

The panel has found that you have engaged in multiple acts of professional misconduct. The misconduct related to failing to abide by the Standard of Practice for the Use of Sedation and General Anesthesia in Dental Practice. This misconduct related to 11 breaches involving 8 patients, and in one instance you exceeded oral moderate sedation levels to the point of reaching deep sedation levels. The cumulative effect of your conduct would reasonably be regarded by Registrants as disgraceful, dishonourable, unprofessional or unethical.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

As I advised 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 the correctness of the decisions we have made.

Do you wish to make any comments?

(*Hear the Registrant's comments at this point)*

Thank you for attending today. We are adjourned.