DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Walia, 2026 ONRCDSO 10

Date: June 8, 2026

File No.: 25-1025

BETWEEN:

Royal College of Dental Surgeons of Ontario

-and-

Shibani Walia
Registration No: 96975

PANEL MEMBERS:
Luisa Ritacca, Subject Matter Expert (Chair)
Vivian Hu, Public Member
Peter Delean, Professional Member

APPEARANCES:
Ahmad Mozaffari and Rachel Hung, for the College
Dr. Shibani Walia, not represented

Heard: May 19, 2026, by video conference

DECISION AND REASONS

OVERVIEW

[1] This matter came on before a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario on May 19, 2026. The matter was heard by way of videoconference.

[2] At the outset of the hearing, the College advised that the parties had reached an agreement on both liability and penalty.

THE ALLEGATIONS

[3] As set out in Notice of Hearing, 25-1025, dated December 1, 2025, the College alleged that Dr. Shibani Walia (the "Registrant") committed professional misconduct as defined in subsection 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 to the Regulated Health Professions Act, 1991, S.O. 1991, c. 18 (the "Code").

[4] Specifically, the College alleged that, during the year 2025, the Registrant:

a. contravened a standard of practice or failed to maintain the standards of practice of the profession, contrary to paragraph 1 of section 2 of Ontario

Regulation 853/93 (the "Dentistry Act Regulation"), with respect to her infection prevention and control ("IPAC") practices at her dental practice located at 172 Howey Street, Red Lake, Ontario (the "Clinic"); and

b. engaged in conduct or performed acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical, contrary to paragraph 59 of section 2 of the Dentistry Act Regulation, with respect to her failure to cooperate with the College's practice monitoring and inspections by the Northwestern Health Unit ("NWHU").

THE REGISTRANT'S PLEA

[5] The Registrant admitted to the allegations of professional misconduct as set out in the Notice of Hearing (Exhibit 1) and the Agreed Statement of Facts and Admission of Professional Misconduct (the "ASF") (Exhibit 2).

[6] The Registrant acknowledged that she understood the nature of the allegations, that she was waiving her right to require the College to prove the allegations at a contested hearing, and that she voluntarily decided to admit the allegations without any pressure or inducement.

[7] The Panel was satisfied that the Registrant's admissions were voluntary, informed, and unequivocal.

THE EVIDENCE

[8] The evidence before the Panel was set out in the Agreed Statement of Facts, which is summarized below:

a. At the material times, the Registrant was a duly registered member of the College practising at Red Lake Dental Clinic in Red Lake, Ontario (the "Clinic"). She also owned the Clinic.

b. In 2023, the College received a report expressing concerns about the Registrant's IPAC practices, including that the Registrant had instructed staff to wear only one pair of gloves per patient and to reuse gloves. The matter was considered by a panel of the Inquiries, Complaints and Reports Committee ("ICRC"), which was deeply troubled by the gaps in the Registrant's knowledge and adherence to IPAC protocols.

c. On January 20, 2025, the ICRC ordered that the Registrant complete a specified continuing education or remediation program ("SCERP") in IPAC, including the College's IPAC course, as well as practice monitoring for 24 months. The Registrant was also cautioned. The Registrant completed the College's IPAC course on February 20, 2025.

d. On January 31, 2025, the College's Practice Monitor contacted the Registrant to discuss practice monitoring and advised that monitoring must take place on a working day when patients and staff were present. Despite this direction, when the Practice Monitor attended the Clinic for the first monitoring visit on February

20, 2025, no patients were booked for treatment and the Registrant's receptionist was not working. The Registrant acknowledges that she did not cooperate with the ICRC-directed practice monitoring.

e. Following the first monitoring visit, the Practice Monitor identified several significant, continuing deficiencies in the Registrant's IPAC practices, noting "general chaos" in the sterilization area. The deficiencies included:

   i. inadequate written IPAC policies and procedures and no records of staff training on IPAC;

   ii. no manufacturer instructions for use for sterilization equipment and no required emergency drugs;

   iii. inadequate personal protective equipment in each operatory and the reprocessing area, and inadequate supply of instruments and materials for instrument reprocessing;

   iv. no eyewash station;

   v. expired materials, including expired IPAC supplies;

   vi. improper storage and transportation of sharps; and

   vii. deficient reprocessing practices, including broken sterilization equipment, improperly packed and stored sterilization pouches, lack of adequate biological and chemical indicator testing, inadequate sterilization data logging, and inappropriate re-use of single use supplies and equipment.

f. The Registrant acknowledged that she failed to maintain the standards of practice of the profession in relation to her IPAC practices at the Clinic, and that she contravened the College's Standard of Practice – IPAC.

g. On April 10, 2025, the College reported the Registrant to the Northwestern Health Unit ("NWHU"). NWHU subsequently commenced an investigation and conducted a surprise inspection of the Clinic on April 14, 2025. The Registrant was uncooperative and confrontational with NWHU inspectors during the inspection.

h. On May 9, 2025, NWHU conducted another inspection. Despite advising the Registrant in advance that they wished to observe patient interactions and reprocessing steps, no patients or staff were present at the Clinic. The inspectors observed multiple gaps in the Registrant's IPAC knowledge and practices and noted that the main autoclave was not working. The Registrant was not compliant with the inspection process. The Registrant acknowledges that she did not cooperate with the NWHU inspection.

i. On May 16, 2025, NWHU issued an order under section 13 of the Health Protection and Promotion Act to cease reprocessing at the Clinic, which effectively amounted to a closure order (the "Closure Order").

j. On May 26, 2025, the Practice Monitor returned for a second visit. The Clinic's sterilization area was still not compliant with the College's IPAC standard, due to broken sterilization equipment and the Registrant retaining items she was specifically instructed to discard, such as re-usable cloth wraps, re-used air/water syringe tips, and corroded instruments.

k. On June 3, 2025, the College advised the Registrant that she was required to cease practising dentistry immediately.

l. On July 3, 2025, NWHU conducted a further on-site visit. The Registrant failed to cooperate with inspectors through the following conduct:

   i. the Registrant guided inspectors through the Clinic with the lights turned off and told them that turning on the lights was a "waste of electricity", and when inspectors stepped outside for a telephone call, she turned off all the lights again;

   ii. when inspectors saw a cassette of dental instruments with an old, stained cloth wrap in the sterile instrument cupboard, the Registrant grabbed the cassette and removed it to another area and refused to discard the cloth wrap until repeatedly asked to do so;

   iii. the Registrant recorded values in her sterilization log without clearly seeing the values on the sterilizer screen, then altered the values in front of the inspectors; and

   iv. when inspectors tried to inspect non-compliant sterilizer pouches in the reprocessed equipment storage area, the Registrant moved the pouches to another area of the Clinic.

m. The Registrant acknowledges that her behaviour towards NWHU personnel was confrontational, deceptive, and unprofessional. As a result of the Registrant's lack of professionalism, NWHU decided to pause its investigation in July 2025 until the College addressed the Registrant's underlying professionalism and conduct issues.

n. Throughout 2025, the Registrant retained items related to IPAC that she was specifically instructed to discard by either NWHU, the Practice Monitor, or both, including re-usable cloth wraps, re-used air/water syringe tips, and corroded instruments.

[9] The Registrant acknowledged the above facts and further acknowledged that the agreed facts constitute professional misconduct pursuant to section 51(1)(c) of the Code, as defined in paragraphs 1 and 59 of section 2 of Ontario Regulation 853/93.

DECISION

[10] The Panel finds that the Registrant committed professional misconduct as alleged in the Notice of Hearing.

REASONS FOR DECISION

[11] With respect to allegation #1, the agreed facts establish that the Registrant failed to maintain the standards of practice of the profession in relation to her IPAC practices. The deficiencies were extensive and well-documented by the Practice Monitor and NWHU.

[12] The Registrant did not have adequate written IPAC policies and procedures, did not maintain records of staff training, lacked manufacturer instructions for use for sterilization

equipment, did not have required emergency drugs, had inadequate personal protective equipment, lacked adequate supplies for instrument reprocessing, had no eyewash station, had expired materials, improperly stored sharps, and had deficient reprocessing practices. The Registrant's own acknowledgment that she contravened the College's Standard of Practice – IPAC confirms the finding under paragraph 1 of section 2 of the Dentistry Act Regulation.

[13] With respect to allegation #2, the agreed facts establish that the Registrant engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. The Registrant displayed a persistent lack of cooperation with the College's practice monitoring and with NWHU inspections throughout 2025. She failed to have patients or staff present during scheduled monitoring and inspection visits despite being told in advance that their presence was required. During the July 3, 2025, NWHU inspection, she engaged in actively obstructive behaviour, including turning off the lights, removing items from inspectors' view, and recording false values in her sterilization log. The Registrant herself acknowledges that her conduct was confrontational, deceptive, and unprofessional. This conduct falls squarely within paragraph 59 of section 2 of the Dentistry Act Regulation.

[14] Accordingly, based on the Registrant's admissions and the evidence before the Panel, the Panel finds that the Registrant committed professional misconduct as set out in both allegations described in the Notice of Hearing.

PENALTY SUBMISSIONS

[15] Following the Panel's finding of professional misconduct, the parties presented a Joint Submission on Order (Exhibit 3). The parties jointly submitted that the Panel impose the following order:

a. requiring the Registrant to appear before the Panel to be reprimanded;

b. directing the Registrar to suspend the Registrant's certificate of registration for a period of five (5) months;

c. directing the Registrar to impose terms, conditions, and limitations on the Registrant's certificate of registration, including suspension conditions, completion of an individualized IPAC course and the PROBE ethics and professionalism course, confirmation of substantial IPAC compliance before returning to practice, clinical supervision commencing at Level 3 (with progression through Levels 2 and 1), and 24 months of practice monitoring following clinical supervision; and

d. requiring the Registrant to pay costs to the College in the amount of $12,000, payable in 24 consecutive monthly instalments of $500 each.

[16] College counsel submitted that the joint submission appropriately addresses the sentencing principles of public protection, specific and general deterrence, and remediation.

[17] With respect to mitigating and aggravating factors to consider, counsel identified the following aggravating factors:

a. the seriousness of the misconduct relating to IPAC, which is critically important to patient safety — dental clinics need to be safe places for patients to attend;

b. the Registrant's lack of insight during this matter, including after completing the IPAC course as part of the SCERP; and

c. the Registrant's failure to cooperate with the College and NWHU inspections, which raises further concerns regarding insight.

[18] College counsel identified the following mitigating factors:

a. the Registrant has cooperated with the College in resolving this discipline matter;

b. the Registrant has already completed some coursework on her own initiative; and the Registrant has been communicative and engaged in her discipline matter and has worked with the College to move this matter forward in an expeditious manner.

[19] College counsel submitted that the reprimand addresses public protection and deterrence by allowing the Panel to express its disapproval directly to the Registrant in a public forum. The suspension serves the goals of public protection and sends a clear message to the profession and the public regarding confidence in the ability of the College to regulate dentists. Upon her return to practice, the Registrant will be working under clinical supervision, which provides further remediation and public protection.

[20] With respect to proportionality and consistency, College counsel acknowledged that there are not many IPAC-related discipline cases before this College but submitted that those that do exist provide support for the suspension proposed in this matter. In support of the position, counsel provided the Panel with cases from other Colleges with similar facts and outcomes (see *College of Nurses of Ontario v. Camp*, 2023 CanLII 69929; *College of Physicians and Surgeons of Ontario v. Ng*, 2016 ONCPSD 12).

[21] College counsel reminded the Panel that the applicable test when presented with a joint submission on penalty is that set out by the Supreme Court of Canada in *R. v. Anthony-Cook, 2016 SCC 43*, and applied in the regulatory context in *Bradley v. Ontario College of Teachers*, 2021 ONSC 2303. Under that test, a joint submission should only be departed from if the proposed penalty is so unreasonable that it would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

PENALTY DECISION

[22] The Panel accepts the joint submission on penalty and costs as set out above and orders accordingly.

REASONS FOR PENALTY DECISION

[23] In reaching its decision, the Panel was mindful of the test articulated in *R. v. Anthony-Cook* and applied in *Bradley v. Ontario College of Teachers*. A joint submission on penalty should not be rejected unless it is so unreasonable that it would bring the administration of justice into disrepute or would otherwise be contrary to the public interest. This is a high

threshold that reflects the important role that joint submissions play in the effective administration of the discipline process.

[24] The Panel considered the aggravating and mitigating factors identified by counsel. The aggravating factors are significant. IPAC is critically important to patient safety. Dental clinics must be safe places for patients to attend, and members of the public are entitled to trust that a dental practice meets the standards necessary to protect their health. The Registrant's IPAC deficiencies were extensive, varied, and persisted over time, even after the Registrant completed the College's IPAC course. This raises serious concerns about the Registrant's level of insight into the gravity of her conduct.

[25] Furthermore, the Registrant's failure to cooperate with the College's practice monitoring and NWHU inspections compounded the Panel's concerns. A registrant who obstructs regulatory oversight and engages in deceptive behaviour during inspections demonstrates a troubling disregard for the profession's self-regulatory framework and the protection of the public that it serves.

[26] The Panel also considered the mitigating factors. The Registrant has cooperated with the College in resolving this discipline matter, has completed coursework on her own initiative, and has been communicative and engaged throughout the discipline process. These factors demonstrate a degree of willingness to address the issues that led to this proceeding.

[27] The Panel is satisfied that the proposed penalty appropriately addresses the relevant sentencing principles. The reprimand allows the Panel to directly express its disapproval of the Registrant's conduct and serves the objectives of public protection and deterrence. The five-month suspension serves the goals of public protection, provides a period for the Registrant to ameliorate her practice, and sends a clear message to the profession and the public regarding the College's ability to regulate dentists. The requirement for clinical supervision upon the Registrant's return to practice provides meaningful remediation and ongoing public protection.

[28] The Panel is satisfied that the proposed penalty is proportionate to the misconduct and is not inconsistent with penalties imposed in comparable cases. The Panel is further satisfied that the costs of $12,000 are reasonable having regard to the circumstances.

[29] Having considered the joint submission in its totality, the Panel concludes that it is not so unreasonable as to bring the administration of justice into disrepute, nor is it contrary to the public interest.

THE REPRIMAND

[30] At the conclusion of the hearing, the Registrant confirmed that she was waiving her right to appeal and was prepared to receive her reprimand.

[31] The Reprimand in the form found as Appendix A of this decision was delivered to the Registrant.

I, Luisa Ritacca, sign these Reasons for Decision as Chairperson of this Discipline Panel.

June 8, 2026

Luisa Ritacca
Chair, Discipline Committee Panel

Date

Appendix A

RCDSO v. Dr. Shibani Walia

Dr. Walia, 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 your failure to maintain the standards of practice of the profession in relation to your Infection Prevention and Control Practices at your dental practice, as well as your lack of cooperation with the ICRC-directed practice monitoring and with inspections of your clinic by the Northwestern Health Unit.

The cumulative effect of your conduct would reasonably be regarded by other registrants as disgraceful, dishonourable, unprofessional or unethical.

Your professional misconduct is a matter of profound concern. 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 serious deficiencies in infection prevention and control at your clinic, including the absence of adequate written IPAC policies and procedures, the lack of records of staff training on IPAC, the absence of manufacturer's instructions for use for sterilization equipment, expired IPAC supplies, improper storage and transportation of sharps, and deficient reprocessing practices including broken sterilization equipment and inadequate biological and chemical indicator testing.

Further, you displayed a persistent lack of cooperation with the public health unit and the College – both who are tasked with ensuring patient safety, including by failing to have patients or staff present during scheduled monitoring visits and inspections, guiding inspectors through your clinic with the lights turned off, removing non-compliant items from the view of inspectors, recording values in your sterilization log without clearly seeing the values and then altering those values in front of inspectors, and retaining items in your practice that you were specifically instructed to discard. Throughout 2025, you were confrontational and unprofessional toward Northwestern Health Unit personnel.

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.