NORTH CAROLINA VETERINARY MEDICAL BOARD

November 25, 2015

Laura de Marchena Greene, DVM

Certified Mail, Return Receipt Requested

Letter of Reprimand
Board Rule 21 NCAC 66.0601(h)

Re: Complaint No. 2015008-3
Ms. Lorri Warner
Virginia Beach

Dear Dr. Greene:

I write as attorney for the N.C. Veterinary Medical Board to explain the decision of the Board, through its Committee on Investigations No. 3, on the complaint against you by Ms. Lorri Warner of Virginia Beach, Virginia.

As explained below, the decision of the Committee is to issue you a letter of reprimand pursuant to Board Rule 21 NCAC 66.0601(h).

Board Investigative Procedure

Written complaints to the Veterinary Medical Board are investigated pursuant to the Veterinary Practice Act [North Carolina General Statute § 90-179 *et seq.*] and the Board Administrative Rules [21 NCAC 66.0601 *et seq.*]. Board Rule 21 NCAC 66.0601, copy enclosed, governs the investigation.

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RALEIGH, NORTH CAROLINA 27606
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This complaint was assigned to the Board's Committee on Investigations No. 3, which reviewed the complaint, responses, replies, the medical records and other relevant materials to determine whether there is probable cause that you violated the Veterinary Practice Act and/or Board Rules on the issues presented.

Materials Reviewed

The complaint file consists of approximately 290 pages of information, including the following materials reviewed by Committee No. 3 in this investigation.

Date	Documents
3/12/15	Complaint of Lorri Warner consisting of the following:
	a. Complaint letter
	b. Letter from Lorri Warner to Dr. Steven L. Marks (11/17/14)
	c. Memo (from Pat Warner) re: Lance's sneezing/coughing condition
	d. NCSU-Veterinary Health Complex Informed Consent document (signed by Lorri Warner 10/21/14)
	e. NCSU-CVM Discharge Form/Summary for Lance
	f. Email messages, 10/15 through 10/30/14, initiated by Dr. Mark W. Honaker, DVM to NCSU-CVM veterinarians
	g. Letter from Dr. Steven L. Marks, Associate Dean/Director of Veterinary Medical Service, NCSU-CVM to the Warner family (1/22/15)
	h. NCSU-CVM Case Review Committee Report re: Lance Warner
	i. Medical records re: Lance
	j. Letter from Lorri Warner to Dr. Steven L. Marks (2/10/15)
	k. Letter from Dr. Steven L. Marks to Lorri Warner (2/16/15)
	l. Additional medical records re: Lance
4/27/15	Letter from K. Edward Greene, attorney, and response letter from Laura de Marchena Greene, DVM
5/7/15	Medical records for Lance from NCSU-CVM
5/11/15	Medical records for Lance from Mark Honaker, DVM, Virginia Beach

5/19/15	Reply from Lorri Warner to Dr. Greene's response
6/4/15	Second Response from Dr. Greene (letter of 6/4/15 from attorney K. Edward Greene)
6/16/15	Second Reply of Lorri Warner, including a recorded telephone conversation between Ms. Warner and Dr. Steven L. Marks

Summary of Complaint – Received 3/12/2015

On 10/21/14, Lorri Warner of Virginia Beach presented her family's 13 year-old Afghan Hound, Lance, to the N.C. State University College of Veterinary Medicine ("NCSU-CVM") for a consultation with you concerning the dog's nasal discharge. This consultation ultimately led to a rhinoscopy procedure as an attempt to determine the cause of the discharge and to establish a therapeutic regimen, if necessary.

A NCSU-CVM student, Nicole Gerardi, took Ms. Warner and Lance into an examination room. Ms. Warner noticed the words "Do Not Use" written in marker on the entrance and exit doors of the room. Shortly thereafter Ms. Warner brought this to your attention. Ms. Gerardi said that "the room was cleaned the night before and they could not get the writing off the glass." Ms. Warner believes that if the room had been thoroughly disinfected the warning would not have been left on the window panes. Although uncomfortable with this situation, Ms. Warner allowed you to conduct the consultation in the room.

Pat Warner, Lorri Warner's mother, participated in the consultation by telephone. She told you that Lance was in excellent health except for the nasal discharge from his left nostril, and that the Warners did not want any procedures performed on him that would harm him. You listed on the informed consent form the complications discussed to be nasal bleeding, anesthetic risk and pneumothorax. Lorri Warner alleges that you did not provide her complete and accurate information about the significant risks that were involved in order for her make a competent decision.

You were advised that Lance coughs when nervous. No medicine was administered to address this condition nor was this information given to the medical staff. You were also provided a note with additional information of concern about Lance that Pat Warner felt you should know. You glanced at the document but refused to read the information and handed the

note back to Lorri Warner, who alleges that you were negligent and careless by ignoring the information necessary to fully assess Lance's condition.

Lorri Warner asked if you were going to flush Lance's nose and you replied that you would not because it would risk aspiration. However, in her conversation with Ms. Gerardi on the evening of 10/22, she stated that you had flushed his nose. Ms. Warner did not give you permission to do this procedure.

Prior to Lance's rhinoscopy on 10/22/14, you suggested that a buccal mucosal bleeding time (BMBT) test be performed to make sure there would not be a clotting problem.

Ms. Warner asked if she would be able to see Lance following the procedure. You advised against this because you did not want to take the chance of Lance increasing his heart rate and risking more bleeding. You said that you would call her between 4:00 and 5:00 p.m. on 10/22. You did not. Ms. Warner called and asked for a status update. She spoke with Ms. Gerardi. The patient status update of 10/22 at 7:02 p.m. entered by Ms. Gerardi reads:

> Lance is doing well he is bleeding a little bit but not more than we expected and we are checking his PCV to make sure he is not losing too much blood. They asked how much blood and were very worried, told them just a few drops every few minutes. Told him he is in intermediate care and there are two technicians watching him 24/7 and he is also right next to ICU which has two doctors on 24/7. Told her I will call in the morning with an update and should have an idea of when he can go home at that time. . . They said they would have questions and I saw we could answer all of them during discharge.

This entry implies that Lance would be monitored, but the technicians "watched over him" and took no appropriate action. Ms. Warner alleges that your lack of concern and seriousness about the procedure was extremely careless and negligent.

Ms. Warner's veterinarian in Virginia Beach wrote an email to NCSU-CVM in which he advised that you told him that "Lance was transferred to ICU after he spiked a fever at midnight." However, Lance was still in the Intermediate Care Unit until approximately 5:00 a.m.

On 1/19/15, Ms. Warner spoke with Dr. Steven L. Marks, Associate Dean and Director of Veterinary Medical Services at NCSU-CVM. She requested a formal investigation into Lance's death, as well as a copy the dog's medical records.

In Ms. Warner's opinion, the medical records she received were incomplete, and the records and the NCSU-CVM Case Review Committee [which Dr. Marks established to investigate the adequacy of Lance's care] raised a number of questions, including:

- The BMBT test was to be performed.

- On 10/23 Lance was in distress at 1:30 a.m. with a temperature of 105.4°. At 3:45 a.m. it was 106.8°. The elevated temperatures were clear indications that he desperately needed medical attention.

- The 2:45 a.m. entry on the medical records indicated "paged clinician." However, the Case Review referred to this as "paged intern" on duty.

- The Case Review noted: "One of the review members (Vaden) was present near the end of the rhinoscopy. It was clear to her that this was an excessive amount of bleeding." Ms. Warner questions why you did not address this, and why did Dr. Vaden not suggest additional care.

- When Lance was transferred to ICU around 5:00 a.m., he was already dying. However, the Case Review did not reflect the medical records information about the warning signs which began at 1:30 a.m. and which showed he desperately needed care then in the ICU.

Your Response – Received 4/27/2015

You responded to Ms. Warner's complaint by letter received by the Board 4/27/15, summarized below. A letter from your attorney, K. Edward Greene, accompanied the response. He writes that you were not given an opportunity to participate in the NCSU-CVM Case Review, nor were you aware that it had taken place until after it had been completed. He adds that the Case Review findings made no recommendation of disciplinary action to be taken against you.

Your response is summarized as follows.

On 10/21/14, Lance was presented for evaluation of unilateral nasal discharge. A student brought Ms. Warner and Lance into an exam room that had been previously quarantined. You had been informed that the room has been disinfected and the "Do Not Use" sign had been removed from the door's entrance to the room. However, the sign had not been removed from the client's entrance and the student had failed to see it was still there. You do not believe this had any influence on the outcome of Lance's case.

You discussed Lance's case in person with Lorri Warner and with Pat Warner by speakerphone. You reviewed his clinical signs, physical exam findings and possible causes of the discharge. You recommended a CT scan of the skull, rhinoscopy and nasal biopsies. You discussed that for these procedures he required anesthesia. You discussed the risks of anesthesia, with particular concern for pneumothorax. You reviewed the consent form and spent time discussing the risks of nasal bleeding and anesthetic risk. You told Ms. Warner that you would not flush the nose because this would increase the risk of aspiration pneumonia.

You assured the Warners that you had performed many of these procedures and it is typically a procedure with minimal complications. You told them that you would perform a BMBT prior to obtaining nasal biopsies. You discussed that post-biopsy initial bleeding could be significant and you typically keep patients for the first night after their rhinoscopy. You said you would perform supplementary pre-anesthetic blood work to the blood work already obtained by the Warners' local veterinarian. You do not recall being handed a note by them, but you would never refuse to read any document relevant to the care of a patient provided by his owners.

Lance was admitted to the Hospital at NCSU-CVM. A chemistry panel, a repeat platelet count and a chest radiograph were performed.

Lance's CT scan revealed "minimally destructive rhinitis with nasal turbinate blunting, primarily on the left side." A technician performed a BMBT. The results were reported as normal. The BMBT test was not documented in the medical records as it should have been. However, you are confident that the BMBT was performed, and you recall that the results were normal.

Lance's throat was packed with gauze and you performed the rhinoscopy. You write:

> Having completed my examination of his nasal cavity, I performed biopsies of both the left and right nasal cavity, as per our standard

> procedure. He experienced mild-moderate hemorrhage from his left nasal cavity, and moderate to heavy hemorrhage from his right nasal cavity. Two infusions of phenyleprhine were instilled into his right nasal cavity to cause vasoconstriction and help decrease the bleeding. I believe that this may be what the student referred to as 'flushing' his nasal cavity. At no time was Lance's nasal cavity flushed with anything other than the small volume of phenylephrine instilled for purposes of hemostasis. Cold packs were also placed over Lance's nose to help induce vasoconstriction.

Bleeding from Lance's right nasal cavity was prolonged. The bleeding slowed significantly, and formed clots were observed in his nasal openings. He recovered from anesthesia under the care of an anesthesiologist. You requested a PCV to verify that he had not lost an excessive amount of blood. The results were within the normal reference range in your laboratory. A PCV was ordered to be obtained every six hours. If the PCV dropped below 30%, you were to be paged.

You elected to have Lance recover in the Intermediate Care ward (IMC), as opposed to the General Hospital ward. The IMC is staffed 24/7 by registered veterinary technicians and is used for patients requiring frequent monitoring or treatment but not requiring intensive nursing care, as provided in the intensive care unit (ICU). The IMC ward is in close proximity to the ICU and ER, ensuring that a veterinarian is available if needed for consultation about a patient in the IMC.

Technicians paged you shortly after Lance's recovery to report that he was dysphoric after anesthesia and raising and lowering his head. This activity had caused bleeding to start from his right nasal cavity. You went to the IMC ward and sat in the room with him for 20 minutes to calm him and keep him from moving his head. His nasal bleeding rapidly clotted during this time. You spoke with the Warners and told them you felt it was unwise for them to see Lance as the excitement might provoke additional bleeding. They agreed. Prior to leaving for the night, you instructed the IMC technicians to try to keep Lance as quiet as possible.

At 1:30 a.m., you were paged and informed that Lance had a temperature of 105.4°F. His respiratory rate and effort were normal. You suspected he had aspirated some blood and that his fever was secondary to aspiration pneumonia. You requested the technician to begin IV fluids and intravenous infusion of an antibiotic, ampicillin sulbactam.

At 2:45 a.m. you were paged and advised that Lance was displaying increased respiratory effort and cheek puffing. You write:

> I asked what his respiratory rate was, and was informed that it was 28 breaths per minute, which was well within the parameters I had set of 10-40 breaths per minute. I requested that she obtain a pulse oximetry measurement, which was 90%. These findings increased my suspicion that Lance did indeed have aspiration pneumonia. My assessment at this point was that Lance was displaying early signs of increased respiratory effort, but that this slow respiratory rate did not indicate distress, and that Lance's rhinoscopy and nasal bleeding both explained the cheek puffing due to congestion. Additionally, Lance's rhinoscopy and nasal bleeding precluded the placement of a nasal oxygen catheter, and it was my clinical judgment that placement of a nasal oxygen catheter would have been premature at this point. Having already initiated antibiotic therapy, I instructed the technician that I had no further changes to make to Lance's treatment, but that I would like for her to continue to closely monitor him and recheck his temperature at 4 AM, which was sooner than would have been checked per my original orders.

At 3:45 a.m., you were paged and notified that Lance's temperature was 106.8°F and that he continued to have an increased respiratory effort, but that his respiratory rate was 32 breaths per minute. You requested that one of the two overnight veterinarians present in the building evaluate Lance to determine his level of stability. At 4:00 a.m., you were informed that the overnight veterinarian felt Lance had increased respiratory effort and harsh lung sounds, but that a repeat pulse oximetry measurement was 97%. Your assessment was that while Lance was displaying signs of increased effort, his oxygenation was very good, which did not necessitate further intervention with regard to his breathing. He also had a rapid heart rate at 180 beats per minute.

You requested a blood pressure measurement and that his pulses be evaluated as evidence of adequate cardiac output. His pulses were reported to be strong and of good quality. You were informed by the technician that Lance was no longer willing to get up and had urinated and had diarrhea in his run. You had previously treated Lance's sibling, Clarke, who had been hospitalized at NCSU-CVM in 2014 for aspiration pneumonia. Clarke also was unwilling to rise

and ambulate during the most severe portion of the course of his aspiration pneumonia, and it was your assessment that Lance may have been responding similarly. You did not advise further treatments given the stability of his cardiac output, the adequacy of his oxygenation per the pulse oximetry, and the initiation of IV fluids and antibiotics for treatment of presumptive aspiration pneumonia, and further because diarrhea is a common side effect for patients recovering from anesthesia.

At 5:00 a.m. the technician monitoring Lance noted that his breathing had become irregular and he was not responsive. She determined that his pulses were poor to absent. She called a code status and immediately moved him into the ICU resuscitation area. You arrived at the Hospital 15 to 20 minutes later. You were informed that upon attachment of ECGs, Lance was found to be in ventricular fibrillation. He was shocked several times, had chest compressions performed, and received doses of epinephrine and atropine, but he did not return to normal sinus rhythm. You called the Warners and informed them of Lance's status. You shared with them your clinical judgment that you would unlikely be able to resuscitate him. They agreed to end resuscitative efforts.

You discussed with the Warners your preliminary thoughts as to what might have happened. You discussed the initial fever and that you suspected he had aspirated. You described the initiation of fluid and antibiotic therapy, and that while his respiratory effort had increased, his oxygenation had been appropriate per the pulse oximetry readings. You explained that when Lance coded and ECGs were placed, he was in an arrhythmia called ventricular fibrillation, which is less common in dogs than in humans. You then mentioned as another possibility that perhaps the degree of inflammation arising from Lance's possible aspiration event may have been profound enough to unmask or provoke an underlying cardiac condition of which you were unaware, resulting in the ventricular fibrillation. You offered a necropsy evaluation for Lance. The Warners declined the necropsy.

Reply of Lorri Warner – Received 5/19/2015

Lorri Warner replied to your response by letter received by the Board 5/19/15. She makes the following points:

- When Lance was examined, there was a "Do Not Use" sign on both the client and doctor entrance doors to the exam room.

- Even though there were no BMBT test results or notations in Lance's medical files, you expect Ms. Warner to believe that the test was performed, and that the results were properly communicated. Further, Dr. Marks on 1/19/15 confirmed that no BMBT test was performed.

- You did not read the document Pat Warner provided you at the consultation which noted medicine used to help prevent a coughing episode.

- The medical records show an entry of a page to you at 3:45 a.m., but there is no indication of instructions from you for Lance to be evaluated by an overnight veterinarian.

Your Second Response – Received 6/4/2015

After reviewing Ms. Warner's reply, you submitted a second response through your attorney, K. Edward Greene, received 6/4/15. The main points of this response are:

- The "Do Not Use" sign had not been removed from the client entrance door. However, the room had been fully disinfected. You are confident that there was no visible sign on the door through which you entered the room. The error of the signage had no impact on the care provided to Lance.

- Dr. Marks acknowledged that during his conversation with Lorri Warner he was unable to ascertain from Lance's medical records that the BMBT test was performed. However, his letter notes that after further investigation, a charge for the BMBT test was documented on the bill. Dr. Marks spoke with you and with the technician who performed the BMBT test. Both of you recall the test being done and the results being normal.

- You recall discussing the BMBT test with Ms. Warner prior to Lance's procedure. The discussion was to address her concerns about bleeding and to advise her that test would provide reassurance that Lance could clot properly after his rhinoscopy. The dangers and risks associated with excess bleeding after such a procedure were discussed during the consultation and noted on the Informed Consent form.

- You provided information about the Warners' dog, Clarke, in your response only to provide context in your decision-making and to explain your evaluation of Lance and his condition. Your knowledge about Clarke did not dictate how you cared for Lance. You evaluated Lance's case and responded accordingly in order to provide him the best care.

- Ms. Warner asserts that you did not request a veterinarian check on Lance when you were paged at 3:45 a.m. However, the medical record contains a note at 4:00 a.m. that "Intern stated lung sounds harsher." The intern had to have checked on Lance pursuant to your request in order to have known that the lung sounds were harsher.

- Dr. Paul Lunn, Dean of NCSU-CVM, responded to Ms. Warner's letter of 4/27/15 that, based upon his review of her communications, Lance's case records, the internal review, and your response to her complaint to the Board, he did not find any basis for the numerous accusations made against clinicians and staff of NCSU-CVM.

Second Reply from Lorri Warner – Received 6/17/2015

Lorri Warner submitted a second reply (received 6/17/15), the relevant parts of which include:

- During the consultation, she asked you if Lance could have a teeth cleaning and you told her "no" without explanation. Had she been aware of the excessive nasal bleeding that could occur from the procedure, she would not have made this request.

- You assert that knowledge of Clarke's case "did not dictate how you cared for Lance." Yet in your 6/27 response you write: "Clarke also was unwilling to rise and ambulate during the most severe portion of the course of his aspiration pneumonia, and it was my assessment that Lance may have been responding similarly." This is a contradiction.

- You did not have Lance's medical records from Bay Beach Veterinary Clinic. You should have had the records and fully reviewed them prior to the consultation and prior to filling out consent forms for Ms. Warner to sign.

Lorri Warner's Complaints against NCSU-CVM

1. Lorri Warner submitted with her complaint to this Board a complaint she filed against NCSU-CVM with Dr. Steven L. Marks, Associate Dean and Director of Veterinary Medical Services. Ms. Warner also submitted the findings of the Case Review Committee that Dr. Marks formed to investigate her complaint. Ms. Warner further included her letter of 2/10/15 to Dr. Marks questioning certain aspects of the medical records and the Case Review Committee's findings. Dr. Marks' subsequent response of 2/16/15 also was included. He determined that the BMBT test was performed. He discussed the findings of the Committee.

2. Ms. Warner also wrote to NCSU-CVM Dean Dr. D. Paul Lunn on 4/27/15. He responded by letter of 5/3/15, identifying the records and materials he reviewed to evaluate her criticisms of the treatment Lance received. He did not find a basis for Ms. Warner's numerous accusations against the NCSU-CVM clinicians and staff. He noted that because no post-mortem examination was permitted to determine why Lance suffered complications following his anesthetic and procedure, the cause of the dog's death remains open.

3. Committee No. 3 has determined that it is not necessary to further summarize Ms. Warner's complaints against NCSU-CVM and the related correspondence in order to identify the issues necessary to decide with respect on her complaint to the Board.

Decision of Committee on Investigations No. 3

The members of Committee on Investigations No. 3 have reviewed and discussed the materials constituting this complaint file.

First, by copy of this letter, the Committee expresses the sympathy of the Board to Lorri Warner and her family for their loss of Lance.

The Committee's findings and decision are as follows:

1. At 1:30 a.m. on 10/23/14 you were alerted at home by page from NCSU-CVM that Lance's temperature was 105.4° F. You concluded that he may have aspirated some blood and that his fever was secondary to aspiration pneumonia. While these conclusions were reasonable, they were a clear indication and warning that Lance's condition was beginning to deteriorate and that a potential critical situation was developing. Although your treatment directions were appropriate (IV fluids and intravenous infusion of ampicillin sulbactam), you erred in not consulting with the overnight veterinarians at the Hospital.

2. At 2:45 a.m. you again were paged by an IMC ward technician notifying you that Lance was displaying increased respiratory effort and cheek puffing. The dog's respiratory rate was reported to you to be 28 bpm. You requested that the technician obtain a pulse oximetry measurement. That reading was 90%. At this point you suspected that Lance had aspiration pneumonia. This information was additional evidence of Lance's continued deterioration, thus warranting your presence at the Hospital. At this point:

(a) You failed to immediately return to the Hospital to oversee and manage Lance's treatment.

(b) You failed to move Lance to the ICU for assessment and treatment. There simply were too many signs indicating his distress for you not to have immediately moved him to ICU.

(c) At a minimum you should have given directions for additional diagnostics and monitoring, including an arterial blood gas; a continuous electrocardiogram; and a chest radiograph. You failed to order those additional diagnostics.

(d) You failed to consult with an overnight veterinarian at the Hospital.

3. At 3:45 a.m. you received a third page at home. The technician notified you that Lance's temperature had risen to 106.8° F and he continued to have increased respiratory effort, although his respiratory rate was 32 bpm. You requested that one of the two overnight veterinarians present in the building evaluate Lance to determine his level of stability. However, you should have immediately returned to the Hospital.

4. You were paged again at 4:00 a.m. The technician informed you of the overnight veterinarian's findings of Lance's increased respiratory effort and harsh lung sounds, and the dog had a repeat pulse oximetry measurement of 97%. It was error for you not to have spoken to the overnight veterinarian yourself about this evaluation.

5. You did not return to the Hospital until approximately 5:20 a.m. By then Lance was dying. The Committee is not able to determine whether your personal management of the case at the Hospital from and after 2:45 a.m. would have prevented Lance's death. Nevertheless, he was your patient, and his continued deterioration required your presence. Without a necropsy the Committee lacks information that might suggest the cause of his death, although it appears aspiration pneumonia is a likely cause.

6. The foregoing findings of errors and omissions in your care and treatment of Lance constitute probable cause of violations of N.C.G.S. § 90-187.8(c)(6) as acts of incompetence in the practice of veterinary medicine, in at least the following respects:

(a) You failed to consult with an overnight veterinarian at the Hospital about Lance's condition after being paged on 10/23/15 at 1:30 a.m., at 2:45 a.m. and at 4:00 a.m.

(b) You failed to transfer Lance to the Hospital ICU after being paged at 2:45 a.m.

(c) You failed to order additional diagnostics, including an arterial blood gas; a continuous electrocardiogram; and a chest radiograph after being paged at 2:45 a.m.

(d) You failed to return to the Hospital after being paged at 2:45 a.m. and again at 3:45 a.m. to personally manage Lance's case. You had been sufficiently informed of his signs of distress. His continued deterioration required your presence and personal direction.

Letter of Reprimand

7. Based upon the foregoing findings of probable cause of your violations of N.C.G.S. §90-187.8(c)(6), and pursuant to Board Rule 21 NCAC 66.0601(h), the Committee issues you this letter of reprimand in lieu of sending the matter to a formal contested case hearing. Please review Rule 21 NCAC 66.0601(h). You may reject the reprimand and request a contested case hearing on the complaint issues. A rejection and hearing request must be in writing and be received by the Board's Executive Director within 15 days of your receiving this letter. If requested, the hearing would be conducted before a panel composed of a majority of the Board, but the members of Committee No. 3 would not serve on the panel. The panel makes its findings and decision based upon the evidence admitted. If the panel concludes that discipline is warranted, the disciplinary decision may be more severe, less severe, or similar to that set forth in this letter.

NCSU-CVM Case Review Committee Findings

Committee No. 3 notes that the following findings of the Case Review Committee established by Dr. Steven L. Marks are consistent with the findings of Committee No. 3:

> Lance Warner was a 13-year-old Afghan hound that was presented by Ms. Warner for evaluation of nasal discharge. He underwent routine evaluation for the discharge, including rhinoscopy. Unfortunately he died the night following this procedure. The exact cause of death could not be determined and a necropsy was not allowed.

* * *

The committee members, as well as the internal medicine service, were all saddened by the death of this patient. This is truly a routine procedure with a low complication rate. Although impossible to say with certainty, we believe the cause of death was aspiration, of blood or a blood clot.

One of the review members (Dr. Vaden) was present near the end of the rhinoscopy. It was clear to her that this was an excess amount of bleeding. The resident overseeing the care of Lance (Dr. Greene) instituted appropriate monitoring parameters for a dog that had excessive bleeding and placed Lance in Intermediate Care, which was appropriate for the monitoring he required. Orders were written to call Dr. Greene if Lance had excessive bleeding, if his respiratory rate was below 10/min or above 40/min or if dyspnea was observed. During the night (2:00 a.m.) his respiratory rate and temperature increased albeit below 40/min. Dr. Green was called and ordered an IV and antibiotics (Unasyn) suspecting that the rise in temperature was a fever. At 2:45 a.m., his respiratory effort increased and the intern on duty was paged. He remained hemodynamically stable. At 4:00 a.m., he had vomited a black substance and had black diarrhea (presumed to be digested blood). Lance was transferred to ICU around 5 a.m. but was already dying at that point.

The review committee believes that at 2:45 a.m., more could have been done to assess and manage the situation. Specifically, an arterial blood gas and continuous ECG were warranted, as was transfer to ICU. If moved to ICU earlier, the opportunity to place Lance on a ventilator would have been available. However, the review committee would like to emphasize that there is no way of knowing if these changes would have kept Lance from dying. It is quite possible he would have still died from what appears to be aspiration even if placed on a ventilator.

* * *

This concludes the investigation by Committee No. 3. Its findings and decisions have been reported to and accepted by the full Board.

If you have any questions about the decision or this letter, please contact Thomas M. Mickey.

Very truly yours,

George G. Hearn
Attorney for the Board

GGH/dbb
Enclosure

cc: Ms. Lorri Warner ✓
K. Edward Greene, Esq.
Board Members
Thomas M. Mickey, Executive Director

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NORTH CAROLINA ADMINISTRATIVE CODE

SECTION .0600 - ADMINISTRATIVE HEARINGS: PROCEDURES

21 NCAC 66 .0601 COMMITTEE ON INVESTIGATIONS

(a) Upon receipt of a charge alleging misconduct against a licensee or registrant of the Board, the Executive Director shall inform the accused party of the nature of the charges as filed with the Board.

(b) The accused party shall respond to the charges by filing a written answer with the Board within 20 days of the receipt of the notification of charges.

(c) The complaining party shall be provided with a copy of the accused party's answer and within 20 days from receipt there of shall file a reply to the accused party's answer.

(d) The charges as filed with the Board, the answer and reply may be referred to the Committee on Investigations (here in after referred to as "Committee"). The Committee shall consist of three members of the Board, one of whom shall serve as chairman.

(e) The Committee shall investigate the complaint referred to it by the Board and as part of the investigation may:

(1) Assign the complaint to the Board's investigator who shall submit a written report to the Committee.

(2) Invite the complaining party and the accused party before the Committee to receive their oral statements, but neither party shall be compelled to attend.

(3) Conduct any other type of investigation as is deemed appropriate by the Committee.

(f) Upon the completion of the investigation, the Committee shall determine whether or not there is probable cause to believe that the accused party has violated any standard of misconduct which would justify a disciplinary hearing based upon the grounds as specified in Article 11 of Chapter 90 of the North Carolina General Statutes or this Chapter.

(g) If probable cause is found, the Committee shall direct the legal counsel for the Board to file a Notice of Hearing.

(h) If probable cause is found, but it is determined that a disciplinary hearing is not warranted, the Committee may issue a reprimand to the accused party. A statement of such reprimand shall be mailed to the accused party. Within 15 days after receipt of the reprimand, the accused party may refuse the reprimand and request that Notice of Hearing be issued pursuant to Chapter 150B of the North Carolina General Statutes or this Chapter. Such refusal and request shall be addressed to the Committee and filed with the Executive Director for the Board. The legal counsel for the Board shall thereafter prepare and file a Notice of Hearing. If the letter of reprimand is accepted, a record of the reprimand shall be maintained in the office of the Board.

(i) If no probable cause is found, the Committee shall dismiss the charges and prepare a statement of the reasons therefore which shall be mailed to the accused party and the complaining party.

(j) If no probable cause is found, but it is determined by the Committee that the conduct of the accused party is not in accord with accepted professional practice or may be the subject of

OVER

(21 NCAC 66.0601 COMMITTEE ON INVESTIGATIONS – Continued)

* * * *

discipline if continued or repeated, the Committee may issue a letter of caution to the accused party stating that the conduct, while not the basis for a disciplinary hearing, is not professionally acceptable or may be the basis for a disciplinary hearing if repeated. A record of such letter of caution shall be maintained in the office of the Board.

(k) A Board member who has served on the Committee is deemed disqualified to act as a presiding officer or member of the Board assigned to render a decision in any administrative disciplinary proceeding brought pursuant to a Notice of Hearing for which that member has sat in an investigative capacity as a member or chairman of the Committee.

(l) The Board may assess and recover against persons holding licenses, limited licenses, temporary permits, faculty certificates, Zoo veterinary certificates or any certificates of registration issued by the Board, costs incurred by the Board for the following expenses, respectively, that have been incurred by the Board in the investigation, prosecution, hearing or other administrative action in final decisions or orders where those persons are found to have violated the Veterinary Practice Act or Administrative Rules of the Board:

(1) legal expenses, including reasonable attorney fees, incurred by the Board; and

(2) witness fees and statutorily-allowed expenses for witnesses; and

(3) direct costs of the Board in taking or obtaining of depositions of witnesses; and

(4) costs incurred by reason of administrative or staff time of employees of the Board directly attributable to the action leading to the final decision or order.

The costs assessed may be assessed pursuant to final decision or orders entered with or without the consent of the person holding the respective license, registration permit or certificate; no costs referred to in this Paragraph shall be assessed against a person holding a respective license, permit registration or certificate for an investigation or action in the nature of disciplinary action other than a final decision or order of the Board, unless and except expressly consented to by said person in a Consent Order approved by the Board.

(m) A civil monetary penalty of up to five thousand dollars ($5,000) for each violation of Article 11, G.S. 90 or Board rule may be imposed and collected from a person holding a license (the word "license" is as defined in G.S. 90-187.8(a)) upon a finding by the Board of the relevant factor or factors in G.S. 90-187.8(b)(1) through (6). With respect to this subsection, the phrase "violation of Article 11, G.S. 90 or Board rule" shall be deemed to mean Article 11, G.S. 90, the Veterinary Practice Act, or the rules of the Board, and shall include final decisions, orders, and consent orders, letters of reprimand and other permitted disciplinary actions, but it expressly excludes letters of caution issued by the Board.

History Note: Authority G.S. 90-185(3); 90-185(6);
Eff. January 1, 1987;
Amended Eff. May 1, 1996; May 1, 1989.

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