BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In the Matter of: Daniel Wayne Driskill, D.D.S. (License No. 9447; Permit No. 1124)	)	**CONSENT ORDER OF SURRENDER**

THIS MATTER is before the North Carolina State Board of Dental Examiners ["Board"] as authorized by N.C. Gen. Stat. 90-41.1(b) for consideration of a Consent Order of Surrender concerning Daniel Wayne Driskill, D.D.S. ["Dr. Driskill" or "Respondent"] in lieu of a formal administrative contested case hearing. Carrie E. Meigs and Ginger B. Hunsucker represented Respondent. Douglas J. Brocker and Whitney S. Waldenberg represented the Board's Investigative Panel. Based upon the consent of the parties hereto, the Board enters the following:

FINDINGS OF FACT

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding pursuant to the authority granted to it in Chapter 90 of the North Carolina General Statutes, including the Dental Practice Act and the Rules and Regulations of the Board.

2. Respondent was licensed to practice dentistry in North Carolina on January 18, 2013 and has held license number 9447 since then. Respondent has also held moderate conscious sedation permit number 1124.

3. Respondent is subject to the Dental Practice Act and the Board's Rules and Regulations.

4. On December 29, 2023, Respondent submitted an Adverse Occurrence Report related to the sedation treatment of his patient, Dana S., on November 29, 2023,

her medical emergency, subsequent hospitalization, and ultimate death on December 4, 2023.

5. On January 4, 2024, Respondent and the Board entered into a Consent Order Summarily Restricting Moderate Sedation Permit.

6. On January 23, 2024, Respondent and the Board entered into an Amended Consent Order Summarily Suspending Moderate Sedation Permit.

7. On June 26, 2024, the Investigative Panel issued a Notice of Hearing to Respondent, which is attached to this Consent Order ("Notice of Hearing").

8. The hearing of this matter was originally scheduled for September 12, 2024. On July 15, 2024, Respondent submitted a Motion to Continue the hearing to a later date. On August 16, 2024, the Hearing Panel granted the Motion and set the hearing for January 9, 2025.

9. The parties engaged in discovery. Following discovery, the Investigative Panel elected not to pursue allegations 28, 29, 30, 35, and 36 of the Notice of Hearing. The remaining allegations in the attached Notice of Hearing are incorporated by reference ("Remaining Allegations").

10. Respondent has agreed not to contest the Remaining Allegations for purposes of this proceeding and any future proceeding before or in which the Board is a party, including any potential license reinstatement proceedings. Even though Respondent has elected not to contest the Remaining Allegations in this and any future proceedings involving the Board, he does not admit any of the allegations in the Notice of Hearing and reserves the right to contest all allegations in any other proceedings not involving the Board.

11. Respondent has been fully cooperative, candid, and truthful with the Board at each stage of the proceeding.

12. Respondent sought professional treatment for his mental health crisis following the events described in the Notice of Hearing, including upon learning of the death of Patient Dana S.

13. In lieu of proceeding with a contested case evidentiary hearing concerning the allegations in the Notice of Hearing, Respondent has agreed to permanently surrender his moderate conscious sedation permit and to surrender his North Carolina dental license.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter of this proceeding.

2. Respondent was properly notified of this matter and has agreed to the entry of this Consent Order.

3. Except for Paragraphs 28, 29, 30, 35, and 36 of the Notice of Hearing which the Investigative Panel has elected not to pursue, Respondent has agreed not to contest the alleged violations in the Notice of Hearing for purposes of this proceeding or any future proceeding involving the Board, including any potential proceeding regarding reinstatement of his dental license. Even though Respondent has elected not to contest them in this and any future proceedings involving the Board, he does not admit any of the alleged violations in the Notice of Hearing and reserves the right to contest all alleged violations in any other proceedings not involving the Board.

4. No provision of this Consent Order or any other pleadings or orders entered

in this matter shall constitute an admission for any purpose.

5. This consent to permanent surrender of Respondent's moderate conscious sedation permit shall have the same effect as a permanent revocation of such permit, and the consent to surrender Respondent's dental license shall have the same effect as license revocation, pursuant to N.C. Gen. Stat. 90-41.

Based upon the foregoing Findings of Fact and Conclusions of Law and with the consent of the parties hereto, it is ORDERED as follows:

ORDER OF DISCIPLINE

Respondent Daniel Wayne Driskill, D.D.S., permanently surrenders his moderate conscious sedation permit No. 1124 effective upon entry of this Consent Order.

Respondent Daniel Wayne Driskill, D.D.S., also surrenders his dental license No. 9447.

The revocation of Respondent's license to practice dentistry shall be effective on February 1, 2025 ("Effective Date"). The purpose of the delayed Effective Date is to allow Respondent time to notify current patients and provide a wind-down period to complete patients in mid-treatment and, if necessary, refer existing patients to another provider to ensure continuity of dental care. Respondent shall not accept any new patients or begin new treatment on existing patients that would require him to provide treatment after Effective Date. Prior to the Effective Date and to ensure continuity of dental care, Respondent shall notify all patients with pending or unfinished treatment plans that he will not be able to provide care as of Effective Date and, if necessary, either refer existing patients to another provider or explain how the patient or a subsequent provider may obtain the patient's record from his office. By the Effective Date, Respondent shall submit to the Board his original license, 2024 license renewal, and his moderate conscious sedation

permit. Proof of compliance with these wind-down provisions shall be a prerequisite for any potential license reinstatement.

This the 9th day of December 2024.

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

Casie S. Goode
Director of Investigations

STATEMENT OF CONSENT

I, Daniel Wayne Driskill, D.D.S., have read the foregoing Consent Order in its entirety. I assent to its terms and conditions set out herein. I voluntarily and knowingly acknowledge and agree to the following:

- I elect to permanently surrender my moderate conscious sedation permit;
- I cannot reapply for nor regain a sedation permit in North Carolina at any time in the future, and the Board will not consider nor hold any hearing on any possible future attempt to reapply, reinstate, or regain a sedation permit;
- I elect to surrender my North Carolina dental license;
- I would have the burden to demonstrate that I have satisfied all applicable requirements for reinstatement, including proper reformation under N.C. Gen. Stat. 90-42 for restoration of a revoked license, to potentially reinstate my dental license in the future;
- The Board has sufficient evidence to support the findings of fact, conclusions of law, and order of discipline, but without admitting these matters for other proceedings not involving the Board;
- I will not contest the findings of fact, the conclusions of law, or the order of discipline in any potential future proceedings before, by, against, or involving the Board, including in any potential future license reinstatement proceedings;
- I voluntarily waive any right to seek judicial review, appeal, or otherwise later challenge this Consent Order once entered;
- I understand that the Board will report the contents of this Consent Order to the National Practitioner Data Bank and that this Consent Order will become part of the Board's permanent public record;

- I also understand that the reporting of this Consent Order may have adverse consequences to me in other contexts and that such other consequences will not be a basis to reconsider or modify this Consent Order or to reapply for or regain my moderate conscious sedation permit in North Carolina; and
- I consulted with my counsel before signing this Consent Order.

This the 5th day of Dec, 2024.

Daniel Wayne Driskill, D.D.S.

Waiver of Limited Ex Parte Communication

I understand that the proposed Consent Order that I have signed is subject to review and approval and is not effective until approved by the Hearing Panel. **I agree and consent that the Hearing Panel members may be provided the proposed Consent Order for review and consideration.**

I further agree and consent that the Board staff, the Investigative Panel (IP), and its counsel may discuss the proposed Consent Order and related information and documentation with Hearing Panel members for the purpose of advocating approval of the proposed Consent Order without me or my counsel being present.

If the proposed Consent Order is not approved, I agree and consent that neither I nor anyone on my behalf will assert that these limited ex parte communications, including review of the documents, will disqualify any Hearing Panel members from considering and deciding this matter after a contested case hearing. I also understand that rejection of the proposed Consent Order will not be a basis for a further continuance of the scheduled hearing dates.

I also agree that I am not entitled to obtain or discover the above-referenced limited communications or the substance of these communications between the Hearing Panel members and the Board staff, the IP, and its counsel, regardless of whether the proposed Consent Order is approved.

I have consulted with my counsel before signing and agreeing to this waiver of limited ex parte communication.

Respondent — 12/5/2024 Date

Counsel for Respondent — 12/6/24 Date

BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In the Matter of: Daniel Wayne Driskill, D.D.S. (License No. 9447; Permit No. 1124)	)	**NOTICE OF HEARING**

TAKE NOTICE that on September 12, 2024, at 6:30 p.m., or as soon thereafter as it can be heard, the North Carolina State Board of Dental Examiners ["the Board"], pursuant to N.C. Gen. Stat. §§ 90-41.1 and 150B-38, and the Board's rules and regulations, 21 N.C.A.C. 16N .0504, will conduct a hearing at the offices of the North Carolina State Board of Dental Examiners located at 2000 Perimeter Park Drive, #160, Morrisville, North Carolina. The hearing will continue from day to day until completed. The hearing is to determine whether Daniel Wayne Driskill, D.D.S. ["Respondent"] violated the Dental Practice Act including N.C. Gen. Stat. § 90-41(a)(6), (12), (19), and (26); and the Board's rules and regulations, including 21 N.C.A.C. 16Q .0101, .0301, and 0302 and 16T .0101 and .0103.

Pursuant to N.C. Gen. Stat. § 91-41, the Board may revoke or suspend a license to practice dentistry or sedation permit and invoke such other disciplinary measures, censure, or probative terms against a licensee as it deems fit and proper if such licensee has violated any provision of the Dental Practice Act including:

> (6) Has engaged in any act or practice violative of any of the provisions of this Article or violative of any of the rules and regulations promulgated and adopted by the Board, or has aided, abetted or assisted any other person or entity in the violation of the same;
>
> (12) Has been negligent in the practice of dentistry;

(19) Has, in the practice of dentistry, committed an act or acts constituting malpractice; and

(26) Has engaged in any unprofessional conduct as the same may be, from time to time, defined by the rules and regulations of the Board.

At the times relevant to the allegations in this Notice, the Board's rules and regulations set out in 21 N.C.A.C. Chapter 16 provided, in pertinent part:

"Moderate conscious sedation" is characterized by a drug induced depression of consciousness, during which patients respond to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients 13 years of age or older, by oral, nasal, rectal, or parenteral routes of administration of single or multiple pharmacological agents, in single or multiple doses, within a 24 hour period, including the time of treatment, possibly in combination with nitrous oxide. Moderate conscious sedation may be provided for behavior control by licensed dentists who comply with the terms of Rule .0301 of this Subchapter.

A moderate conscious sedation provider shall not use the following:

(a) drugs designed by the manufacturer for use in administering general anesthesia or deep sedation; or

(b) drugs contraindicated for use in moderate conscious sedation.

See 16Q. 0101.

A dentist who holds a moderate conscious sedation permit shall not intentionally administer deep sedation. See 16Q .0301.

The [moderate conscious sedation] permit shall be renewed annually and shall be displayed with the current renewal at all times in the facility of the permit holder where it is visible to patients receiving treatment. See 16Q .0301.

A dentist permitted to administer moderate conscious sedation must hold an unexpired ACLS certification. See 16Q .0301.

The permit holder shall also provide training to familiarize auxiliaries in the treatment of clinical emergencies. See 16Q .0302.

The dentist shall maintain the following records for at least 10 years: (A) patient's current written medical history and pre-operative assessment; (B) drugs administered during the procedure, including route of administration, dosage, strength, time, and sequence of administration; and (C) a sedation record. See 16Q .0302.

The sedation record shall include: (A) base line vital signs, blood pressure (unless patient behavior prevents recording), oxygen saturation, ET CO2 if capnography is utilized, pulse and respiration rates of the patient recorded in real time at 15 minute intervals; (B) procedure start and end times; (C) gauge of needle and location of IV on the patient, if used; (D) status of patient upon discharge; (E) documentation of complications or morbidity; and (F) consent form, signed by the patient or guardian, identifying the procedure, risks and benefits, level of sedation, and date signed. See 16Q .0302.

The facility shall be staffed with at least two BLS certified auxiliaries, one of whom shall be dedicated to patient monitoring and recording sedation data throughout the sedation procedure. See 16Q .0302.

A moderate conscious sedation permit holder shall evaluate a patient for health risks before starting any sedation procedure ... See 16Q .0302.

A dentist must obtain informed consent from the patient or other authorized person for the procedures to be performed, including the level of sedation administered. See 16T .0101 and .0103.

Unprofessional conduct by a dentist as set out in G.S. 90-41(a)(26) shall include ...presenting false or misleading testimony, statements, omissions, or records in any communication to the Board or the Board's investigators, employees, or agents regarding any matter subject to the provisions of the Dental Practice Act or Dental Hygiene Act. See 16V. 0101(2).

NOTICE OF FACTUAL ALLEGATIONS

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding pursuant to the authority granted to it in Chapter 90 of the North Carolina General Statutes, including the Dental Practice Act in Article 2, and the rules and regulations of the Board set forth in 21 North Carolina Administrative Code Chapter 16.

2. Respondent was licensed to practice dentistry by credentials in North Carolina on January 18, 2013 and has held license number 9447 and moderate conscious sedation permit number 1124 at all times relevant to the allegations in this Notice.

3. Respondent has not been trained to sedate patients to the level of general anesthesia or deep sedation.

4. Respondent is subject to the Dental Practice Act and the rules promulgated thereunder.

5. At all times relevant to the allegations in this Notice, Respondent practiced as a general dentist in North Carolina, including performing dental surgery and administering sedation medications.

Respondent's Treatment of Patient Dana S.

6. Patient Dana S. presented to Respondent's office on November 9, 2023 for a consultation regarding her remaining teeth. Respondent developed a treatment plan for extraction of several of Patient Dana S.'s teeth, implant placement, and delivery of prostheses.

Failure to Assess Patient Dana S. Properly

7. During the November 9, 2023 visit to Respondent's office, Patient Dana S. disclosed that she suffered from Type 2 diabetes, sleep apnea, asthma, and bipolar disorder. She also disclosed that she was taking the following medications: Effexor, Buspirone, Vraylar, Lyrica, Trazadone, Montelukast, Trulicity, Metformin, and Albuterol. Her reported height and weight also disclosed that she was clinically obese.

8. On November 20, 2023, Patient Dana S. returned to Respondent's office for him to take impressions of her mouth. During this visit, Patient Dana S. again

disclosed that she was diabetic, a smoker, and suffered from asthma. She also confirmed that she was taking the same medications disclosed during her November 9, 2023 visit.

9. During the November 20, 2023 visit, Patient Dana S. signed a consent for moderate conscious sedation. Patient Dana S. did not consent to being placed in deep sedation or under general anesthesia.

10. On November 29, 2023, Patient Dana S. presented to Respondent's office for the planned surgery including extractions, alveoplasty, bone grafting, and implant placement.

11. Despite Patient Dana S.'s reported diabetes, bipolar disorder, sleep apnea, asthma, and obesity, Respondent did not investigate the severity of Patient Dana S.'s health conditions or consult with Patient Dana S.'s physician(s) regarding her disclosed conditions, nor do Respondent's records indicate that he evaluated Patient Dana S. for an ASA classification or that Respondent documented his evaluation of her airway or other baseline vital statistics, including her glucose levels, prior to sedation. Respondent's records are devoid of any meaningful assessment of any of Patient Dana S.'s health conditions or evaluation of her risks of sedation for the planned procedure.

Respondent Over Sedated Patient Dana S. by Excessive Administration of Fentanyl and Midazolam, as well as Unlawful Administration of Propofol

12. According to Respondent's report to the Board, Patient Dana S.'s IV was placed around 12:00 pm on November 29, 2023. According to his report, Respondent proceeded to administer initial doses of diphenhydramine, 100 mcg of fentanyl, and 2.5 mg of midazolam, along with local anesthetic. Respondent proceeded to extract seven teeth and perform the alveoplasty along the full arch.

13. According to Respondent's report, at this point in the procedure, at least thirty minutes after the initial doses of sedatives were administered, Patient Dana S. expressed that she was "not asleep," and Respondent administered an additional 100 mcg dose of fentanyl and 2.5 mg of midazolam.

14. Respondent reported to the Board that Patient Dana S. continued to state that she was "not asleep" following the second doses of sedatives, and so Respondent then administered to Patient Dana S. a third dose of 100 mcg of fentanyl and 2.5 mg of midazolam, thirty minutes after the second doses.

15. After already administering 300 mcg of fentanyl and 7.5 mg of midazolam to Patient Dana S., Respondent administered propofol to Patient Dana S. by placing 50 mL of propofol into a pump, set to infuse the medication at a rate of 80 mcg/kilogram with saline.

16. As Respondent was nearing completion of the procedure, he administered to Patient Dana S. a fourth dose of 100 mcg of fentanyl and 2.5 mg of midazolam, followed by a fifth additional 2.5 dose of midazolam, according to Respondent's December 29, 2023 Adverse Occurrence Report to the Board.

17. During the November 29, 2023 procedure, Respondent administered to Patient Dana S. a total of 400 mcg of fentanyl and 12.5 mg of midazolam, in addition to 750 mg of propofol administered via pump, according to his Adverse Occurrence Report.

18. Respondent's Controlled Substance Inventory Records from 2023 ("DEA log") were inconsistent with the Adverse Occurrence Report to the Board and indicate that he administered a total of 15 mg of midazolam and 300 mcg of fentanyl, and further indicated that he administered 750 mg of propofol to Patient Dana S.

19. When the Investigative Panel requested a sworn statement from Respondent regarding the amount of medications administered to Patient Dana S., Respondent conformed his answer to the amounts appearing in the DEA log. In a May 31, 2024 verified statement provided to the Investigative Panel, Respondent indicated he administered 300 mcg of fentanyl, 15 mg of midazolam, and 750 mg of propofol to Patient Dana S.

Respondent Failed to Recognize and Respond Adequately to the Medical Emergency

20. Following the administration of these drugs, Patient Dana S.'s oxygen saturation decreased and her heart rate steadily declined until it stopped, consistent with a patient experiencing respiratory depression and arrest as well as bradycardia and eventually cardiac arrest.

21. Respondent reported that he stopped the propofol pump at that point and administered flumazenil to Patient Dana S. to reverse the effects of the midazolam. Respondent further reported that he performed a vasovagal maneuver, but the patient's heart rate did not recover.

22. Respondent did not administer a reversal agent for the effect of the fentanyl administered to Patient Dana S.

23. Propofol has no reversal agent and is contraindicated for use and should not be administered by someone trained only to the level of moderate conscious sedation.

24. Propofol should be administered only by someone trained in administering general anesthesia or deep sedation and not involved in the underlying procedure, according to its manufacturer's label approved by the United States Food and Drug Administration ("USFDA").

25. Respondent was unable to recover Patient Dana S.'s heart rate and initiated emergency protocol and contacted EMS at 2:46 pm.

26. Respondent's office administered chest compressions and, at the direction of the 911 operator, attempted to place an AED on Patient Dana S. while EMS was in route. Respondent, however, neither placed an advanced airway device, which he is required to maintain, nor attempted to intubate Patient Dana S.

27. First responders arrived within minutes and took over CPR upon arrival. EMS placed an advanced airway and then recovered Patient Dana S.'s pulse, but noted that her pupils were dilated, fixed, and nonreactive.

28. EMS asked Respondent and Respondent's staff for the records showing what medications and dosages had been administered to Patient Dana S. Respondent and staff were unable to provide any record of the medications administered.

29. Respondent verbally told one of the EMS workers that he administered 50 mg of Benadryl, 200 mcg of fentanyl, and 6 mg of versed to Patient Dana S., but he was unable to tell her how much propofol had been administered to Patient Dana S. The EMS worker made notes of Respondent's statements about the medications administered, which were later provided to the hospital staff.

30. Respondent did not provide a sedation record for Patient Dana S. to anyone who was responding to the emergency, nor did Respondent provide any vital strips from a monitor to anyone responding to the emergency.

31. After recovering Patient Dana S.'s pulse, EMS transported her to UNC Hospital, where she was diagnosed with post-cardiac arrest cerebral anoxia, consistent with prolonged oxygen deprivation and with EMS' observations of her condition upon

arrival at Respondent's office. Testing later confirmed that Patient Dana S. was brain dead.

32. Patient Dana S. died a few days later on December 4, 2023, as a result of these catastrophic cerebral injuries.

33. Respondent reported the incident involving Patient Dana S. by submission of an Adverse Occurrence Report on December 29, 2023. In his Adverse Occurrence Report, Respondent stated that he provided the sole copy of the sedation record for Patient Dana S.'s procedure to the emergency responders on November 29, 2023.

34. Respondent also submitted a verified statement to the Investigative Panel on May 31, 2024, in which he stated that the timing and dosages of medications were recorded by handwritten record, simultaneously with Patient Dana S.'s procedure. He also stated that the vital statistics monitor printed vital strips for Patient Dana S.'s procedure. He repeated that he provided the emergency responders the sole copy of the sedation record and also stated that he provided the emergency responders the sole copy of the vital strips for Patient Dana S.'s procedure.

35. Upon information and belief, emergency responders did not receive Patient Dana S.'s sedation record from Respondent on November 29, 2023.

36. Respondent made false statements to the Board regarding Patient Dana S.'s sedation record, in violation of Board rule 16V.0101(2) and N.C. Gen. Stat.§ 90-41(a)(26).

Inspection of Respondent's Office Revealed Inadequate Training and Safeguards at the Time of Patient Dana S.'s Procedure

37. Respondent agreed to a summary restriction of his sedation permit through a Consent Order entered on January 4, 2024, shortly after the Board received his Adverse Occurrence Report.

38. Following entry of the Consent Order, a Board investigator conducted an inspection of Respondent's office on January 17, 2024. During the inspection, the Board investigator discovered that:

(i) Respondent did not have a sedation permit for the office location where he performed Patient Dana S.'s sedation procedure;

(ii) Respondent's ACLS certification expired on June 29, 2023, and Respondent had been performing sedation procedures for almost five months without a current ACLS certification or BLS certification, including the procedure involving Patient Dana S.;

(iii) neither of Respondent's assistants had completed the requisite sedation emergency response training; and

(iv) at least one of Respondent's two assistants was not BLS certified during the time he was administering sedation to patients, including at the time Respondent sedated Patient Dana S.

Violations of the Standard of Care and the Board's Rules for Patient Dana S.

39. Respondent violated Board regulations 21 NCAC 16Q .0101, .0301, and .0302, 16T .0101 and .0103 respectively and the standard of care for dentists licensed to practice dentistry in North Carolina and permitted to administer moderate conscious sedation at the time Respondent treated Patient Dana S. by:

a. Failing to properly evaluate and assess Patient Dana S. as a patient with multiple health conditions, including failing to consult with her treating physician(s) about the risks of administering sedation to Patient Dana S. before starting the November 29, 2023 procedure;

b. Sedating Patient Dana S. to a level of deep sedation or general anesthesia resulting in a cascading series of medical emergencies during the November 29, 2023 procedure that he did not properly address;

c. Administering propofol to Patient Dana S. during the November 29, 2023 procedure;

d. Failing to obtain Patient Dana S.'s informed consent to deep sedation or general anesthesia and exceeding the level of sedation to which Patient Dana S. consented;

e. Failing to stop the November 29, 2023 procedure and administer adequate medications to reverse the effects of sedation when Patient Dana S. exhibited low SpO2 levels and suppressed breathing;

f. Failing to place an advanced airway and intubate Patient Dana S. when Respondent lost her airway and she was unable to breathe on her own;

g. Failing to have a sedation permit for the facility where he administered sedation;

h. Failing to hold an unexpired ACLS certification at the time he administered sedation to Patient Dana S.;

i. Failing to ensure that the staff assisting in Patient Dana S.'s sedation procedure were trained on how to respond to an emergency;

j. Failing to ensure that two assistants involved in Patient Dana S.'s sedation held unexpired BLS certifications; and

k. Failing to create and maintain a written record of the medications and dosages administered to Patient Dana S. and Patient Dana's S.'s vital statistics during the November 29, 2023 procedure, recorded in real time.

40. Respondent violated the standard of care and the Board's rules, was negligent, and committed malpractice in his treatment and care of Patient Dana S., in violation of N.C. Gen. Stat. § 90-41(a)(6), (12), and (19).

41. Respondent's violations of the standard of care, the Dental Practice Act, and the Board's rules harmed Patient Dana S. including causing or contributing to her respiratory and cardiac depression and arrest, anoxic brain injury, and ultimately her death.

Additional Patient Records:

Pattern of Standard of Care and Board Rules Violations

42. As part of the investigation into Respondent's treatment of Patient Dana S. and her resulting severe medical emergency and subsequent death, the Board's Investigative Panel obtained from Respondent additional patient treatment records for

patients undergoing surgical procedure(s) with the administration of sedation prior to his treatment of Patient Dana S.

43. The additional patient records reviewed demonstrate violations of the standard of care and the Board's rules that occurred prior to and were similar to the violations set out above with respect to Respondent's treatment and care of Patient Dana S.

44. The additional patient records also indicate that the violations with respect to Respondent's treatment and care of Patient Dana S. were part of a pattern of violations that preceded Patient Dana S.'s severe medical emergency and death.

45. Respondent repeatedly:

a. administered ketamine and propofol to patients, without having the required training or permit to administer such drugs;

b. administered excessive doses of sedative medications intended or likely to induce patients to a level of deep sedation or general anesthesia, despite Respondent only holding a moderate conscious sedation permit;

c. sedated patients to a point where the patients' SpO2 levels were dangerously low and did not act promptly to reverse the drop in SpO2 levels;

d. failed to conduct a proper pre-operative assessment of his patients' health conditions prior to administering sedation;

e. failed to maintain adequate sedation records;

f. failed to obtain informed consent from his patients, including as to the level of sedation to be administered;

g. failed to hold a sedation permit for the facility where he administered sedation;

h. failed to hold an unexpired ACLS certification at the time he administered sedation to his patients;

i. failed to ensure that the staff assisting in sedation procedures were trained on how to respond to an emergency; and

j. failed to ensure that two assistants involved in sedation procedures held unexpired BLS certifications.

46. As with Patient Dana S., Respondent violated the standard of care and the Board's rules and was negligent in his treatment and care of patients, including the example patients listed in Paragraphs 47-63 below, in violation of N.C. Gen. Stat. § 90-41(a)(6) and (12).

Respondent's Pattern of Unlawfully Administering Propofol and Ketamine to Patients

47. Respondent, who was not trained in the administration of general anesthesia and did not hold a general anesthesia permit, violated the standard of care and the Board's rules in his treatment of Patient Dana S. by administering propofol to her during her sedation procedure on November 29, 2023.

48. Respondent's treatment records reveal a pattern—prior to the November 2023 procedure on Patient Dana S.—in which Respondent similarly administered to patients drugs not designed to be given by moderate conscious sedation permit holders, in violation of the applicable standard of care and the Board's rules.

49. Specifically, according to his sedation records and drug logs, Respondent administered propofol to these example patients in the documented amounts on the following dates:

a. Patient Richard B. 2500 mg on May 31, 2022;

b. Patient Angela B. 810 mg on March 9, 2023;

c. Patient John C. 500 mg on May 10, 2022;

d. Patient Andrew D. 1410 mg on May 16, 2023 (5/17 per log)

e. Patient Katherine G. 1000 mg on June 28, 2022 (6/27 per log);

f. Patient Carol G. 680 mg on February 7, 2023 and 540 mg on November 10, 2023;

g. Patient Monica G. 1780 mg on March 17, 2022;

h. Patient Wanda H. 1500 mg on April 20, 2022;

i. Patient Darryl H. 680 mg on July 26, 2023;

j. Patient Jinqiang L. 1000 mg on June 2, 2022;

k. Patient Sharon M. unknown amount on October 18, 2021 and 820 mg on May 12, 2022;

l. Patient Elizabeth M. 850 mg on January 26, 2022;

m. Patient Clara N. 770 mg on July 7, 2022;

n. Patient Waymond P. 830 mg on May 11, 2023; and

o. Patient David. S. 1000 mg on January 27, 2022.

50. Respondent also administered the following amounts of ketamine to patients: Wanda H. 75 mg on April 20, 2022, Phyllis L. 150 mg on January 10, 2023, and Shane W. 50 mg also on January 10, 2023.

51. Ketamine is a drug designed by the manufacturer and approved for use by the USFDA in administering general anesthesia or deep sedation. It is contraindicated for use in any amount by a provider trained only to the level of moderate conscious sedation.

52. Respondent's 2022 through 2023 DEA logs further demonstrate that, prior to Patient Dana S.'s death, Respondent regularly administered propofol, and on multiple occasions ketamine, to his patients.

Respondent's Pattern of Administering Excessive Amounts of Sedatives

53. Respondent, who held a moderate conscious sedation permit, violated the standard of care and the Board's rules in his treatment of Patient Dana S. by administering excessive amounts of sedatives during the procedure, inducing deep sedation or general anesthesia, and causing significant respiratory depression, hypoxia, and resulting cardiac arrest and anoxic brain injury.

54. Respondent's treatment records and sedation drug logs reveal a pattern—prior to the November 2023 procedure on Patient Dana S.—in which Respondent similarly administered excessive amounts of sedatives to his patients that were designed or likely to induce deep sedation or general anesthesia in violation of the applicable standard of care and the Board's rules, including for the following example patients and procedure dates:

a. **Patient Richard B.:** During the course of a procedure on May 31, 2022, and in addition to administering 2500 mg of propofol, Respondent administered a total of 1100 mcg of fentanyl to Patient Richard B., with several doses being 125 mcg. Respondent also

administered 37.5 mg of midazolam during the same procedure. Respondent placed an advanced airway for Patient Richard B. during the procedure. Respondent also administered flumazenil at 5:33 pm, one minute following the last 125 mcg dose of fentanyl. Respondent's records do not reflect Patient Richard B.'s vital statistics at the time of the last dose of fentanyl and subsequent dose of flumazenil. Flumazenil is a reversal agent for midazolam but not fentanyl.

b. **Patient Angela B.:** During a March 9, 2023 sedation procedure, Respondent administered to Patient Angela B., who was over 60 years old, 810 mg of propofol and 15 mg of midazolam. The first 2.5 mg dose of midazolam was administered at 9:50 am, followed by a second 2.5 mg dose at 10:07 am, followed by a 2.5 mg third dose just 4 minutes later at 10:11 am. Similarly, Respondent administered a fourth dose at 10:53 am, followed by a fifth dose just 8 minutes later, at 11:01 am. Respondent administered a sixth dose of midazolam at 1:13 pm. Respondent then placed an advanced airway for Patient Angela B. at 1:16 pm, three minutes following the last dose of midazolam, which was not removed until 3:04 pm, almost two hours later. Respondent never activated any emergency response after inserting an advanced airway, which demonstrates that the patient could not maintain her airway and was in deep sedation or general anesthesia.

c. **Patient John C.**: On June 30, 2022, Respondent administered a total of 1500 mg of propofol, 450 mcg of fentanyl, and 40 mg of midazolam to Patient John C. The records indicate that Patient John C. was intubated during the procedure, possibly with an advanced airway, which demonstrates that the patient could not maintain his airway and was in deep sedation or general anesthesia.

d. **Patient Barry C.**: On August 28, 2023, Respondent administered to Patient Barry C., who was over 60 years old, 200 mcg of fentanyl in two 100 mcg doses and 10 mg of midazolam. Similarly, on December 4, 2023, Respondent administered 200 mcg of fentanyl in two 100 mcg doses and 10 mg of midazolam to Patient Barry C.

e. **Patient Andrew D.:** On May 16, 2023, Respondent administered to Patient Andrew D. a total of 1410 mg of propofol, 12.5 mg of midazolam, and 600 mcg of fentanyl. Respondent administered the fentanyl in six 100 mcg doses.

f. **Patient Katherine G.:** On June 28, 2022, Respondent administered 1000 mg of propofol, 225 mcg of fentanyl, and 15 mg of midazolam to Patient Katherine G.

g. **Patient Carol G.:** On February 7, 2023, Respondent administered to Patient Carol G. 680 mg of propofol, 42.5 mg of midazolam, and 100 mcg of fentanyl. During a November 10, 2023 procedure, Respondent administered to Patient Carol G., who only weighed 100

pounds at the time, 540 mg of propofol, 400 mcg of fentanyl, and 17.5 mg of midazolam.

h. **Patient Monica G.**: On March 17, 2022, Respondent administered to Patient Monica G. 1780 mg of propofol and 12.5 mg of midazolam.

i. **Patient Wanda H.:** On April 20, 2022, in addition to the ketamine, Respondent administered to Patient Wanda H. 1500 mg of propofol, 525 mcg of fentanyl, and 15 mg of midazolam. Three of the fentanyl doses were 125 mcg each.

j. Patient **Darryl H.**: During a November 2, 2022 sedation procedure, Respondent administered 77.5 mg of midazolam and 550 mcg of fentanyl to Patient Darryl H., who was over 60 years old. Subsequently, on July 26, 2023, Respondent administered to Patient Darryl H. 680 mg of propofol, 100 mcg of fentanyl, and 2.5 mg of midazolam.

k. **Patient Jinqiang L.**: During a June 2, 2022 sedation procedure, Respondent administered to Patient Jinqiang L, who was over 60 years old, 150 mcg of fentanyl, 7.5 mg of midazolam, and 1000 mg of propofol.

l. **Patient Sharon M.**: During an October 18, 2021 sedation procedure, Respondent administered to Patient Sharon M., who was over 60 years old, 550 mcg of fentanyl and 10 mg of midazolam, in addition to an unknown amount of propofol. Then during a May 12, 2022

sedation procedure, Respondent administered to Patient Sharon M. 820 mg of propofol, 225 mcg of fentanyl, and 10 mg of midazolam.

m. **Patient Elizabeth M.**: During a January 26, 2022 sedation procedure, Respondent administered to Patient Elizabeth M, who was over 60 years old, 850 mg of propofol, 450 mcg of fentanyl, and 21 mg of midazolam.

n. **Patient Clara N.**: During a July 7, 2022 sedation procedure, Respondent administered 770 mg of propofol, 150 mcg of fentanyl, and 7.5 mg of midazolam to Patient Clara N. Respondent administered flumazenil to Patient Clara N. at the end of the sedation procedure.

o. **Patient Waymond P.**: During a May 11, 2023 sedation procedure, Respondent administered 830 mg of propofol, 200 mcg of fentanyl, and 12.5 mg of midazolam to Patient Waymond P.

p. **Patient David S.**: During a January 27, 2022 sedation procedure, Respondent administered 1000 mg of propofol and 12.5 mg of midazolam to Patient David S. Respondent eventually administered flumazenil to Patient David S. toward the end of the procedure.

55. Respondent's DEA logs from 2022 through 2023 further demonstrate that, prior to Patient Dana S.'s death, Respondent regularly and consistently administered excessive doses of anesthetic and sedative agents to his patients.

Respondent's Pattern of Failing to Respond to Low SpO2 Levels During Sedation

56. Respondent violated the standard of care by failing to timely intervene or undertake corrective action to ensure Patient Dana S. was able to breathe on her own.

57. Respondent's treatment records reveal a pattern—prior to the November 2023 procedure on Patient Dana S.—in which Respondent similarly failed to act to reverse sedation when his patient's oxygen saturation dropped below clinically safe levels during the sedation procedures in violation of the applicable standard of care for several of the following example patients:

a. **Patient Richard B.**: During the May 31, 2022 sedation procedure, Patient Richard B.'s oxygen saturation rate dropped into the 60 percents several times and lingered for extended periods of time in the 70 and 80 percents. Respondent continued administering additional sedatives to Patient Richard B. despite low oxygen saturation for long periods of time. Respondent had to place an advanced airway for Patient Richard B. because the patient could not maintain his airway and was in deep sedation or general anesthesia.

b. **Patient John C.**: During the June 30, 2022 sedation procedure, Patient John C.'s oxygen saturation levels dropped several times into the 70 and 80 percents. Respondent continued administering additional sedatives to Patient John C. despite low oxygen saturation. Respondent had to place an advanced airway for Patient John C. because the patient could not maintain his airway and was in deep sedation or general anesthesia.

c. **Patient Barry C.**: During the December 4, 2023 sedation procedure, Patient Barry C.'s oxygen saturation level dropped to 75 percent, and Respondent continued with the sedation procedure without any intervention to support Patient Barry C.'s oxygen saturation.

d. **Patient Wanda H.**: During the April 20, 2022 sedation procedure, Patient Wanda H.'s oxygen saturation level dropped into the 80 percents several times, and Respondent continued with the sedation procedure despite the poor oxygen saturation.

e. **Patient Darryl H.**: During the November 2, 2022 sedation procedure, Patient Darryl H.'s oxygen saturation level dropped into the 70 and 80 percents, and Respondent continued with the sedation procedure despite the poor oxygen saturation.

f. **Patient Jinqiang L.**: During the June 2, 2022 sedation procedure, Patient Jinqiang L.'s oxygen saturation level dropped to 71 percent and 77 percent. Respondent did not attempt to reverse sedation despite the low level of oxygen saturation and instead continued with the sedation procedure.

g. **Patient Sharon M.**: During the May 12, 2022 sedation procedure, Patient Sharon M.'s oxygen saturation level plummeted to the 60s at least twice. Respondent elected to continue with the sedation procedure.

h. **Patient Elizabeth M.**: During the January 26, 2022 sedation procedure, Patient Elizabeth M.'s oxygen saturation level dropped to

40 percent, then again to the 60, 70, and 80 percents. Respondent elected to proceed with the sedation procedure despite the low oxygen saturation levels.

i. **Patient Clara N.**: During the July 7, 2022 sedation procedure, Patient Clara N.'s oxygen saturation levels lingered in the 80 percents for approximately one hour. Respondent elected to continue and finish the surgery, after which he administered flumazenil to Patient Clara N.

j. **Patient David S.**: During the January 27, 2022 sedation procedure, Patient David S.'s oxygen saturation hovered in the 80 percents to low 90 percents for approximately one hour and then dropped to 75 percent. Respondent continued with the procedure despite these vitals but eventually administered flumazenil after an extended period of low oxygen saturation.

Respondent's Pattern of Failing to Properly Assess Patients Prior to Sedation Procedures

58. Respondent violated 16Q .0302 and the standard of care by failing to properly evaluate and assess Patient Dana S.'s health conditions and by failing to consult with her medical doctors about the risks of administering sedation to Patient Dana S. before starting the November 2023 procedure.

59. Respondent's treatment records of example patients demonstrate he also violated 16Q .0302 and the standard of care by failing to adequately or properly assess other patients prior to sedation procedures. Respondent's example records are devoid of any meaningful assessment of his patients' health conditions, including their basic vital

statistics or their unique risks presented for sedation procedures. The failure to fully assess a patient's condition was particularly critical when they reported pre-existing conditions. For example:

a. **Patient Richard B.**: On March 23, 2022, months prior to his May 31, 2022 sedation procedure, Patient Richard B. filled out a form at Respondent's office disclosing that he had high blood pressure, snored, suffered from narcolepsy, and was taking several medications, including lisinopril, tramadol, and methocarbamol. A pre-sedation form filled out on May 13, 2022 noted the same conditions and medications. Nothing in the treatment notes indicates that Respondent investigated whether Patient Richard B.'s health conditions were under control or what impact his medications would have on the sedation procedure.

b. **Patient Angela B.**: Before her March 9, 2023 sedation procedure, Patient Angela B. disclosed to Respondent that she suffered from asthma and anxiety and was taking albuterol as needed, tramadol three times a day, and lorazepam as needed. Nothing in the record produced by Respondent indicates that he investigated whether Patient Angela B.'s health conditions were under control or what impact her medications would have on the sedation procedure. Respondent assigned Patient Angela B. an ASA classification II, without conducting this inquiry, and a Malampati score of III on the day of the sedation procedure.

c. **Patient John C.:** On May 27, 2022, Patient John C. disclosed to Respondent that he had the following health conditions: high blood pressure, shortness of breath, asthma, and diabetes. The clinical notes for May 27, 2022 indicate that the severity of these conditions is unknown and there is nothing else in the treatment notes to indicate that Respondent investigated the severity of Patient John C.'s conditions or whether they were controlled prior to classifying Patient John C. as an ASA II and administering sedation on June 30, 2022. Additionally, Respondent did not record any sort of glucose test or obtain a recent A1C score prior to administering sedation.

d. **Patient Barry C.:** On August 4, 2023, Patient Barry C. disclosed to Respondent that he was hypertensive and obese. He also disclosed that he was taking several medications including a beta blocker and atorvastatin. Nothing in the records indicate that Respondent adequately investigated whether Patient Barry C.'s blood pressure was under control prior to assigning Patient Barry C. an ASA II classification and performing the sedation procedures later that month and in December 2023.

e. **Patient Carol G.:** Prior to the sedation procedures in 2023, Patient Carol G. disclosed that she was taking klonopin and other medication for epilepsy and that she was a smoker. Respondent's October 26, 2022 clinical note indicates that the severity of Patient Carol G.'s epilepsy was unknown and nothing else in the records indicate that

Respondent investigated the severity of her disease or consulted a physician regarding the risks of performing a sedation procedure prior to sedating Patient Carol G. on two occasions.

f. **Patient Wanda H.**: Prior to the April 20, 2022 sedation procedure, Patient Wanda H. disclosed that she had high blood pressure, and Respondent's clinical notes indicate that the severity of the condition was "unknown." There is nothing in the record to indicate that Respondent adequately investigated whether Patient Wanda H.'s blood pressure was under control prior to the administration of sedation. Patient Wanda H. also disclosed that she suffered from severe anxiety and had prior complications with anesthesia, which Respondent did not further investigate or document.

g. **Patient Phyllis L.**: Prior to her January 10, 2023 sedation procedure in which Respondent administered ketamine to her, Patient Phyllis L. reported to Respondent that she had several conditions, including a heart murmur, high blood pressure, anemia, and type 2 diabetes. She also disclosed several medications. Despite reporting all of these conditions, Respondent failed to adequately investigate whether these conditions were under control before he administered ketamine to Patient Phyllis L. on January 10, 2023. Respondent's record is devoid of adequate pre-sedation assessment and vital information, such as Patient Phyllis L.'s A1C or blood glucose level.

h. **Patient Sharon M.**: Prior to the October 18, 2021 and May 12, 2022 sedation procedures, Patient Sharon M. disclosed to Respondent that she had high blood pressure. The records do not contain any indication that Respondent investigated whether Patient Sharon M.'s blood pressure was well controlled and whether there were correlating risks for the sedation procedures.

i. **Patient Elizabeth M.**: Prior to the January 26, 2022 sedation procedure, Patient Elizabeth M. disclosed that she had a thyroid condition and that she had previously had difficulty with anesthesia. She also disclosed she was taking gabapentin, among other medications. Nothing in Respondent's records reflect any investigation into whether these conditions were well controlled or the potential effect of the medications she was taking.

j. **Patient David S.**: Prior to his January 27, 2022 sedation procedure, Patient David S. disclosed to Respondent that he had asthma. Respondent assigned Patient David S. an ASA I classification despite his disclosed asthma and did not investigate whether the asthma was well controlled before administering sedation.

Failure to Maintain Adequate Sedation Records

60. When Respondent submitted his Adverse Occurrence Report to the Board, Respondent provided his treatment record for Patient Dana S., but failed to provide a sedation record or vital strips for the November 29, 2023 procedure.

61. Respondent represented to the Board in his Adverse Occurrence Report that EMS took the original anesthesia record with them following the emergency response on November 29, 2023, and that he had been unable to retrieve it.

62. A review of the sedation records for Respondent's other patients listed above, as well as Patient Kimberly E., reveals that the records lack the necessary information to comply with the requirements of the Board's rules and applicable standard of care in North Carolina for the level of sedation achieved by Respondent's administration of sedatives.

Respondent Failed to Obtain Informed Consent in Each Case Reviewed

63. Respondent violated the standard of care and the Board's regulations, 16T .0101 and .0103, by failing to obtain informed consent from Patient Dana S. and other example patients because his consent form for each patient listed above only included up through a moderate level of sedation and the associated risks, but he induced Patient Dana S. and other example patients to a level of deep sedation or general anesthesia, as set forth in Paragraphs 12-19 and 53-55.

NOTICE OF PROCEDURAL MATTERS

At the formal hearing of this case, you will be given an opportunity to defend against these allegations. This opportunity will include to appear and be heard in person and by counsel, to confront and cross-examine the witnesses appearing for the Board, and to offer witnesses or other evidence in support of your position on issues of fact, and to present arguments on issues or law or policy, pursuant to N.C. Gen. Stat. §§ 90-41.1, 150B-40, 150B-41, and 150B-42.

You are entitled to be represented by counsel at the Hearing or you may appear on your own behalf without counsel. Continuances will be granted only for good cause. Failure to retain counsel will not be considered as a basis to grant a continuance unless a motion or request seeking one is filed with the Board more than 30 days prior to the scheduled hearing date. If you fail to appear in a contested case after receiving proper notice, the Board may proceed with the hearing and make its decision in your absence.

You may contact Betty A. Sines, Assistant Director of Investigations and Administration, at the Board office located at 2000 Perimeter Park Drive, Suite 160, Morrisville, North Carolina, 27560; telephone number (919) 678-8223; for further information.

This the 26th day of June 2024.

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

BY: Betty Ann Sines

Betty A. Sines
Assistant Director of Investigations
On behalf of and at the direction of the
Investigative Panel