BEFORE THE WEST VIRGINIA BOARD OF VETERINARY MEDICINE

WEST VIRGINIA BOARD OF VETERINARY MEDICINE,

COMPLAINANT,

V. **CASE NO. 1223C**

LAURA SLACK, DVM,
VETERINARIAN LICENSE NO. 34-2016,

RESPONDENT.

CONSENT AGREEMENT AND ORDER

NOW COMES the West Virginia Board of Veterinary Medicine ("Board") and Laura Slack, DVM ("Respondent") for the purpose of stipulating to disciplinary action against Respondent in the above-referenced matter. As a means of compromise, the Board and Respondent hereby agree to resolve this matter by and through a voluntary agreement and consent to disciplinary action, with consideration given to appropriate safeguards for the protection of the public.

WHEREAS, Respondent acknowledges that the Board may file a formal Statement of Charges pursuant to W. Va. Code §§ 30-10-1 *et seq.* and W. Va. Code R. §§ 26-1-1 *et seq.*, and proceed to a hearing and seek disciplinary action in these matters.

WHEREAS, Respondent hereby waives the filing of a formal Statement of Charges, and the parties mutually desire to settle this matter without further prosecution and a formal hearing.

WHEREAS, Respondent and the Board agree and acknowledge that this agreement is a compromise of claims disputed by Respondent.

THEREFORE, it is hereby STIPULATED and AGREED between the undersigned parties that this matter be settled and resolved, the parties having reached an understanding concerning the proper disposition of the matter in controversy, and the Board, approving such an agreement, does hereby FIND and ORDER as follows:

FINDINGS OF FACT

1. Respondent is a licensee of the Board, holding License No. 34-2016, and at all times relevant, practiced veterinary medicine at the Good Shepherd Veterinary Hospital ("Good Shepherd") in Charleston, West Virginia.

2. On or about December 18, 2023, the Board received a written complaint and supporting documentation from Jill and Kent Ehman ("the Ehman's") regarding the veterinary care that their dog "Piper" received from Respondent at Good Shepherd.

3. On October 19, 2023, Piper was scheduled for an ovariohysterectomy at Good Shepherd to be performed by Respondent. The Ehman's state that they declined the pre-surgical bloodwork on the advice of the front desk staff. Piper was left in the care of Good Shepherd and Respondent.

4. The Ehman's called to check on Piper mid-morning at around 10:30a.m. and were told that Piper had not gone back for surgery yet. Another call was placed at 2:00p.m. to check the status of Piper, and Piper had now successfully completed surgery. Further, the Ehman's were told that Piper was slow to wake-up. Later, the Ehman's received a telephone call from Good Shepherd informing them that Piper was still drowsy, but to come and pick her up at 5:30p.m.

5. Upon arrival, the Ehman's were informed that Narcan had been administered to Piper due to her drowsy state. They were eventually called into an exam room and left to wait for Respondent. Once Respondent arrived, the Ehman's were told that Piper had died.

6. The following day, the Ehman's retrieved Piper from Good Shepherd in order to have a necropsy performed at Ohio State University and to obtain medical records. The Ehman's had to wait for the medical records because they were not yet completed by Respondent.

7. The Board sent a copy of this complaint to Respondent dated December 18, 2023, to obtain Respondent's written answer to the complaint.

8. The Board received Respondent's timely written response on or about January 31, 2024.

9. Respondent maintains that she did not deviate from any standards of care. Respondent did review the Ohio State University's Final report on Piper and maintains she did indeed suture the uterine stump even though no sutures were found present during the necropsy.

10. Respondent does acknowledge that her staff failed to document post-surgical care on Piper from approximately 2:00p.m. to 5:00p.m., and the same does "not comport with the standard of care for medical record keeping." *See Response to Complaint by Respondent* dated January 31, 2024. Moreover, Respondent maintains that the care given to Piper after "5:30[p.m.], by both her and the staff, was appropriate given what was known at the time." *Id.*

11. The Board's Complaint Committee reviewed the Ehman's complaint, Respondent's response thereto, and the medical records submitted therewith and found probable cause to believe that Respondent failed to perform post-surgical monitoring as shown by the incomplete patient medical records, the difficulty of awaking the patient, and the resulting death of the patient in violation of W. Va. Code § 30-10-19(g)(3) and W. Va. Code R. §§ 26-1-8.1.5, and 26-4-5.8.c.

12. Upon recommendation of the Complaint Committee, and after reviewing the aforementioned complaint, response, and accompanying documents, the Board, by majority vote

at its meeting on April 24, 2024 determined there was probable cause and sufficient evidence to warrant further proceedings and that further action should be taken against Respondent.

CONCLUSIONS OF LAW

1. Respondent is a licensee of the Board, holding License No. 34-2016, and is therefore subject to the license requirements and disciplinary rules of the Board. Moreover, at all times relevant to this complaint that Respondent held an active license issued by this Board.

2. The Board is a state entity created and governed by W. Va. Code §§ 30-10-1 *et seq.*, and is empowered to regulate the practice of veterinary medicine in the State of West Virginia.

3. In order to carry out its regulatory duties, the Board may suspend, revoke, or otherwise discipline an individual's license to practice veterinary medicine because of authority granted to it by W. Va. Code §§ 30-10-5 and 30-10-19 and W. Va. Code R. §§ 26-1-8 and 26-2-1 to 26-2-6.

4. Respondent does not contest that the Board has probable cause to charge her with one or more violations of the Board's governing statutes and rules based upon its investigation and findings in this matter.

5. The conduct described in the above *Findings of Fact* would, if proven, constitute violations of W. Va. Code § 30-10-19(g)(3) and W. Va. Code R. §§ 26-1-8.1.5, and 26-4-5.8.c., and such conduct is therefore grounds for disciplinary action.

CONSENT OF LICENSEE

I, Laura Slack, by signing this Consent Agreement and Order, acknowledge the following:

1. After having had the opportunity to consult with an attorney of my choice, I sign this Consent Agreement and Order voluntarily, freely, without compulsion or duress, and understand that my signature has legal consequences.

2. No person or entity has made any promise or given any inducement whatsoever to encourage me to make this settlement other than as set forth in this document.

3. I am aware that I may pursue this matter through appropriate administrative and/or court proceedings. I am aware of my legal rights regarding this matter, but I have chosen to waive those rights intelligently, knowingly, and voluntarily.

4. I waive any defenses including, but not limited to, laches, statute of limitations, and estoppel, that I may have otherwise claimed as a condition of this agreement.

5. I acknowledge that the execution of this document constitutes disciplinary action by the Board and is therefore considered to be public information.

The Respondent, Laura Slack, by affixing her signature hereto, agrees to the following Order.

ORDER

Based on the foregoing, the Board does hereby ORDER and DECREE as follows:

1. Respondent is hereby REPRIMANDED for her actions in this matter.

2. Within three (3) months from the date of entry of this Order, Respondent shall complete three (3) hours of Board-approved continuing education on the subject of surgical anesthesia and post-surgical monitoring. These continuing education hours do not count toward the required eighteen (18) hours of continuing education.

3. Within three (3) months from the date of the entry of this Order, Respondent shall reimburse the Board the costs of this proceeding, including but not limited to, the administrative and legal expenses incurred by the Board in the investigation and disposition of this case.

4. Any failure to comply with all provisions in the Consent Agreement and Order may result in additional disciplinary action, up to and including the suspension or revocation of

Respondent's license to practice veterinary medicine in the State of West Virginia.

5. This document is a public record as defined in W. Va. Code § 29B-1-2. The Board is bound by law and by this Agreement to report the results of all disciplinary actions, including this matter, for posting in the AAVSB Veterinary Practitioners Disciplinary Database and for posting on the Board's website.

6. This Consent Agreement and Order constitutes the entire agreement between the parties.

In recognition of this Consent Agreement and Order, we hereby affix our signatures.

WEST VIRGINIA BOARD OF VETERINARY MEDICINE

By: Keith B Berkeley D.V.M
Dr. Keith Berkeley, Board Chair

Entered: 28 June 2024
Date

REVIEWED AND AGREED TO BY:

Laura D Slack, DVM
Laura Slack, DVM
Respondent

06-12-24
Date

Albert C. Dunn, Jr., Esq.
Counsel for Respondent

6/12/24
Date

This day personally appeared before me, Laura Slack, whose name is signed to the foregoing document and who is known to me, having acknowledged before me that the statements in the foregoing document are complete, true and correct, to the best of her knowledge, information, and belief, and executed the document voluntarily on the date shown above.

Given under my hand and seal on this the 12th day of June, 2024.

My Commission expires: 9-23-2025

Christina Hall

Notary Public

Official Seal
Notary Public, State of West Virginia
Christina Hall
Bailey & Wyant, PLLC
500 Virginia Street East, Suite 600
Charleston, WV 25301
My Commission Expires September 23, 2025