

BEFORE THE WEST VIRGINIA BOARD OF VETERINARY MEDICINE

**WEST VIRGINIA BOARD OF
VETERINARY MEDICINE,**

Complainant,

v.

Case No. 0517A

**KEVIN J. ROWLES, DVM,
Veterinarian License No. 2002-22,**

Respondent.

FINAL ORDER

Pursuant to W. Va. Code § 30-10-20, the West Virginia Board of Veterinary Medicine ("Board") hereby ADOPTS and incorporates by reference, in its entirety, the *Recommended Decision* issued by Hearing Examiner Jeffrey G. Blaydes on November 26, 2019, as the Board's Findings of Fact and Conclusions of Law in this matter. A copy of the *Recommended Decision* is attached to this Final Order.

This matter proceeded to hearing on September 6, 2018 and March 20, 2019, at the Board's office in Cross Lanes, West Virginia, before Hearing Examiner Jeffrey G. Blaydes. The Board appeared by Assistant Attorney General, Keith D. Fisher, and presented testimony and other evidence. Kevin J. Rowles, DVM ("Dr. Rowles") appeared in person and with his counsel, Herbert L. Hively, II, but he did not present any testimony or evidence of his own. The Board submitted its proposed findings of fact and conclusions of law to the Hearing Examiner on May 1, 2019. Dr. Rowles submitted his proposed findings of fact and conclusions of law on May 16, 2019.

Based on the evidence of record, the Board has shown by a preponderance of the evidence that Dr. Rowles violated the Board's governing statutes and rules by engaging in unprofessional

and unlawful conduct in the course of his work as a licensed veterinarian, all as more fully described in the attached *Recommended Decision*.

NOW, THEREFORE, in consideration of the foregoing, the Board does hereby ORDER and DECREE as follows:

1. Dr. Rowles' license, License No. 2002-22, is hereby REVOKED indefinitely for a period of no less than three (3) years from the date of entry of this Order.

2. Dr. Rowles may not apply for any type of license or registration with the Board until the expiration of this three-year period, and prior to any such application, he must have completed the following:

a. Dr. Rowles shall reimburse the Board the reasonable and necessary expenses incurred in its investigation and disposition of this matter, which expenses total Twenty Four Thousand Nine Hundred Nineteen Dollars and Thirty Nine Cents (\$24,919.39).

b. Within five (5) days of making such application, Dr. Rowles shall submit to a hair follicle drug test, at his own expense, and shall have the results thereof transmitted directly to the Board. The results of the test must be negative for any non-prescribed drugs.

c. Dr. Rowles shall request and submit to the Board the results of a state and national criminal history record check completed pursuant to the Board's then-existing statutes and regulations.

3. Dr. Rowles is hereby on notice that any failure to comply with the conditions set forth in Paragraph 2 will result in the denial of any subsequent application made to the Board.

4. Should Dr. Rowles comply with the conditions set forth in Paragraph 2 and make successful application to the Board for licensure, he shall be placed on probation for a period of two (2) years effective upon the date of licensure. During this two-year probationary period, Dr. Rowles shall adhere to the following terms:

- a. Dr. Rowles shall work under the direction of a Board-approved Supervisory Veterinarian.
- b. The supervisor shall be identified by mutual agreement between the Board and Dr. Rowles through the execution of a Supervisory Agreement. The supervisor shall be required to enter into such Supervisory Agreement as well as the parties to this Order.
- c. Dr. Rowles shall be responsible for making his first contact with the supervisor no later than fifteen (15) days from the date of signing the Supervisory Agreement.
- d. Specific reporting requirements shall be outlined in the Supervisory Agreement.
- e. Dr. Rowles shall be responsible for any costs associated with the supervision.
- f. The supervisor shall submit a letter of completion to the Board at the conclusion of the two-year supervisory period unless the supervisor determines that one or more issues have not been addressed by Dr. Rowles or that Dr. Rowles has otherwise failed to practice in conformity with the statutes and rules of the Board. If the supervisor makes such determination, the supervisory period will be extended until the supervisor submits a letter of completion.

5. During the entirety of the probationary period, Dr. Rowles shall be subject to urinalysis drug tests at random times selected by the Board, not to exceed three such tests within a twelve-month period. These random drug tests shall be at Dr. Rowles' expense. Dr. Rowles shall complete the necessary documents for the Board to obtain copies of the drug test results. Any results that are not satisfactory to the Board shall be cause for further disciplinary proceedings.

6. Dr. Rowles is hereby on notice that any failure to practice in conformity with the statutes and rules of the Board during the probationary period shall be cause for the immediate suspension of his license pending a final disciplinary hearing.

7. This document is a public record as defined in W. Va. Code § 29B-1-2.

ENTERED this, the 11 day of December, 2019.

WEST VIRGINIA BOARD OF
VETERINARY MEDICINE

BY: John R. Wilson
Dr./John R. Wilson, Board Chairman

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Veterinarian License No. 2002-22,**

Respondent.

RECOMMENDED DECISION

This matter was heard on September 6, 2018, and continued on March 20, 2019, in Cross Lanes, West Virginia, by the West Virginia Board of Veterinary Medicine ("Board"), by its designated Hearing Examiner, Jeffrey G. Blaydes, Esquire. The Board was represented by Keith D. Fisher, Assistant Attorney General, and the Respondent Kevin J. Rowles, DVM ("Respondent"), was represented by Herbert L. Hively, II, Esquire.

Based upon the testimony and the record in this case, the undersigned makes the following Findings of Fact, Analysis and Conclusions of Law.

FINDINGS OF FACT

1. Respondent is a licensee of the Board, having been issued License No. 2002-22, and at the time of the events in question, held an active license issued by the Board.
2. At all times relevant, Respondent practiced veterinary medicine at the Humane Society of Parkersburg's Spot Clinic ("Spot Clinic"), located in Parkersburg, West Virginia, and at Animal Veterinary Emergency Treatment ("AVET"), also located in Parkersburg.
3. At its meeting on May 23, 2017, the Board initiated disciplinary proceedings against

Respondent, based on information that he had surrendered his Drug Enforcement Administration (“DEA”) license due to failure to comply with federal regulations pertaining to controlled substances, and informed him of the same via correspondence dated May 25, 2017.

4. Respondent timely responded to this correspondence, and further transmitted an updated response to the Board on October 4, 2017.

5. The Board hired an investigator, Michael L. Kidd (“Mr. Kidd”), to investigate this matter. After interviewing multiple witnesses, Mr. Kidd submitted several written reports and gave a verbal report to the Board at its meeting on October 6, 2017.

6. The Board’s Complaint Committee reviewed the complaint letter, Respondent’s responses thereto, Mr. Kidd’s investigation reports, and accompanying documents. It found probable cause to believe that: (1) Respondent failed to maintain complete and accurate logbooks for controlled substances, with noted chronic shortages, over a two-year period of time; (2) Respondent failed to secure and store controlled substances in compliance with federal regulations; and (3) Respondent consumed a controlled substance while on duty and thereafter practiced veterinary medicine while under the influence of the same.

7. At its meeting on October 6, 2017, a majority of the Board, upon recommendation of the Complaint Committee, determined that there was sufficient evidence to warrant further proceedings and that further action should be taken against Respondent.

8. On December 13, 2017, the Board issued a formal *Complaint*, including a statement of charges, informing Respondent that it had found the existence of probable cause at its October 6, 2017, board meeting, and that a hearing would be scheduled in this matter.

9. On June 1, 2018, the Board issued a *Notice of Hearing* setting this matter for hearing

on September 6, 2018.

10. This matter proceeded to hearing before the undersigned Hearing Examiner.

11. The Board presented the testimony of Robert A. Otero ("Mr. Otero"), a diversion investigator with the United States Department of Justice, Drug Enforcement Administration ("DEA"). Mr. Otero has worked with DEA since June 1989. (TI 14-15)¹

12. Mr. Otero, on behalf of the DEA, commenced an investigation of Respondent on September 14, 2015, following a call from Respondent's employer, the Spot Clinic. An employee of the Spot Clinic had reported that Respondent abruptly quit his employment on September 11, 2015, and in doing so, removed controlled substances and drug logbooks from the premises. Respondent also left behind a partially-filled bottle of Telazol, four empty bottles of Zetamine, and an empty bottle of Morphine Sulfate in his desk.² (TI 15-17, 128)

13. At the time, Respondent held a DEA license, which authorized him to purchase and store controlled substances; he was registered to store controlled substances only at the Spot Clinic. (TI 17-19) Respondent was thus prohibited from removing controlled substances from the Spot Clinic at the time of his departure; instead, he should have locked them in the clinic's safe, arranged for their transfer to another registered location, or sent them to a reverse distributor to be destroyed. (TI 139-140)

¹The transcript for the hearing held September 6, 2018, is designated herein as "TI" while the transcript for the hearing held March 20, 2019, is designated as "TII."

²Telazol is a nonnarcotic, nonbarbiturate, injectable anesthetic agent for dogs and cats. Zetamine, also known as "Ketamine hydrochloride," is a rapid-acting, nonnarcotic, nonbarbiturate agent for anesthetic use in cats and for restraint in subhuman primates. Morphine Sulfate is used in veterinary medicine to alleviate moderate to severe pain, but in some cases, it is used to help diminish coughing and decrease diarrhea in dogs.

14. On September 25, 2015, Mr. Otero traveled to the Spot Clinic and spoke with employees Michelle Earl and Sonny Dills. In addition to inventorying the aforementioned drug bottles, Mr. Otero obtained partial logbooks for the drugs Ketamine, Morphine Sulfate, and Telazol. A preliminary review of the Ketamine logbooks revealed that a relatively large amount of the drug appeared to be missing. (TI 23-28)

15. On March 31, 2016, following further investigation, Mr. Otero and other law enforcement personnel executed a search warrant at AVET in Parkersburg, West Virginia, where Respondent was then employed. (TI 35-36)

16. During execution of the search warrant, the following items were located in an athletic bag belonging to Respondent: two bottles of Diazepam that were nearly empty; one empty bottle of Metoclopramide; one empty bottle of Phenobarbital; a loaded firearm; and a two-inch copper pipe believed to have been used to snort drugs.³ (TI 36-41)

17. When asked about these drug bottles, Respondent stated that they were in his bag because he was checking the lot numbers; however, Respondent could not explain for what purpose he was checking lot numbers. (*Id.* at 36-37) Further investigation revealed that these bottles were registered not to Respondent, but to another veterinarian at AVET, Dr. Joseph Conlin. (TI 45)

18. Respondent was also questioned about his handling of controlled substances, at which time he admitted that he had never performed an initial inventory or biannual inventory of the

³Diazepam is a sedative with anti-anxiety, muscle relaxing, and hypnotic properties. It can be used to treat seizures, appetite loss in cats, anxiety, and other disorders. It may also be used to sedate a pet before surgery or other procedures. Metoclopramide is often used as an anti-vomiting drug and helps reduce the delay by speeding up the passage of food in animals. Phenobarbital is used to control epilepsy in animals. It may be used alone or in conjunction with other drugs to reduce the number and severity of seizures.

controlled substances he ordered and was responsible for. (TI 38-39)

19. During the search of AVET, Respondent indicated that pertinent records and approximately six vials of Morphine Sulfate could be found at his residence. Therefore, with Respondent's consent, Mr. Otero and other law enforcement personnel traveled to Respondent's personal residence and searched the premises. (TI 42-44) Drug logbooks were found in a Tidy Cat container in Respondent's barn. Despite an exhaustive search of the barn and house, law enforcement was unable to locate the Morphine Sulfate. (TI 43-44)

20. It is undisputed that Respondent's personal residence was not a registered location where controlled substances could be lawfully stored. (TI 45)

21. On April 5, 2016, Respondent contacted Mr. Otero to report that his girlfriend had located the missing Morphine Sulfate in his barn. On April 14, 2016, Mr. Otero met Respondent at AVET, at which time Respondent turned over nine full vials and one partial vial of Morphine Sulfate. (TI 47-48)

22. The drug logbooks seized from the Spot Clinic and Respondent's residence contain an accounting of the usage of three controlled substances Ketamine, Morphine Sulfate, and Telazol during Respondent's employment at the Spot Clinic. (TI 49-54; Exs. 2(a)-2(c)) Each logbook consists of an "Unopened Container Log," which records the number of full bottles Respondent had purchased and received, followed by an "Opened Container Log," which contains an entry for each separate usage of a particular bottle (expressed in milliliters). (TI 65-66) Although other employees can, and did, make entries in the logbooks, it is, according to Mr. Otero, Respondent who is ultimately responsible for their accuracy and for "account[ing] for everything that he's purchased and used." (TI 66, 86)

23. Mr. Otero conducted a thorough review and analysis of the logbooks and recorded his findings both in notes appended to the logbooks and in an official DEA report that he prepared on September 27, 2016. (TI 51-55; Exs. 2(a)-2(c)) In short, based on the logbooks alone, Mr. Otero found that Respondent could not account for:

- a. 594.70 mL (or approx. 54 full vials) of Ketamine between the dates December 19, 2013, and September 11, 2015, an average of 2.219 mL shortage per vial of Ketamine used.
- b. 60.6 mL (or approx. 3 full vials) of Morphine Sulfate between the dates December 23, 2013, and September 11, 2015, an average of 0.527 mL shortage per vial of Morphine Sulfate used.
- c. 141.37 mL (or approx. 28 full vials) of Telazol between the dates December 22, 2013, and September 11, 2015, an average of 0.604 mL shortage per vial of Telazol used.

(TI 85-86; Exs. 2(a)-2(c))

24. Mr. Otero explained that, according to the logbooks, each bottle still contained a certain amount of controlled substance at the time the bottle ceased being used. (TI 68-71) This remaining amount could not be accounted for anywhere within Respondent's records and, therefore, was termed a "discrepancy." (TI 55-57).

25. During the DEA investigation, and upon inquiry as to such discrepancies, Respondent claimed that, once a bottle gets down to 2 or 3 milliliters, he is unable to extract any more liquid. As a result, he discards the bottle and starts a new one. (TI 68)

26. However, according to Respondent's logbooks, when the bottles of Ketamine were discarded, they routinely had a significant quantity remaining in the bottles. In contrast, the bottles of Morphine Sulfate and Telazol were able to be extracted down so that the quantities remaining were far less. (TI 70-78; Exs. 2(a)-(c)) In fact, one bottle of Morphine Sulfate was able to be

completely emptied down to zero milliliters remaining. (TI 76)

27. Having conferred with other veterinarians, and based on his extensive experience, Mr. Otero found that Respondent's explanation "doesn't make any sense" and that Respondent's methods of accounting for controlled substances are "highly unusual." (TI 69-73, 77)

28. Mr. Otero explained that Ketamine is a Schedule III controlled substance, primarily used for anesthesia, and is "known nationwide as a party drug" and is heavily abused. (TI 78-79) The DEA has investigated doctors and veterinarians nationwide for abusing Ketamine. (TI 79) During the DEA investigation, several employees of the Spot Clinic expressed concerns to Mr. Otero about Respondent's handling of Ketamine and other controlled substances, including that too much was allegedly being left in discarded bottles. (TI 112, 132)

29. In addition to reviewing the aforementioned logbooks, Mr. Otero obtained a purchasing profile from Respondent's supplier, MWI Veterinary Supply, and reviewed purchasing and shipping records for drugs purchased by Respondent. (TI 56-69) Mr. Otero found that additional full vials of Ketamine, Morphine Sulfate, and Telazol were missing. As a result of his interview and analysis, Mr. Otero concluded that Respondent could not account for a total of 61 vials of Ketamine, 13.2 vials of Morphine Sulfate, and 33.27 vials of Telazol. (TI 84-86; Ex. 2)

30. From the purchasing profile, Mr. Otero also discovered that Respondent had purchased Euthanasia, Diazepam, and Buprenorphine. However, Respondent "had almost no records whatsoever for the euthanasia" and "could not account for a single one" of the 90 injectables of Diazepam or 475 ampules of Buprenorphine he had purchased. According to Mr. Otero, for these drugs, Respondent had "no records of their usage, no records of their distribution, no records of their destruction, [and] no records whatsoever of their receipts[.]" (TI at 59-60, 84-86; Ex. 2)

31. As a DEA licensee, Respondent was required to keep records of the receipt and distribution of these drugs for a minimum of two years. (TI 60) These drugs were Respondent's property and he was ultimately responsible for their safekeeping and accurate distribution and recording. (TI 86)

32. The DEA ultimately determined that Respondent committed the following violations of federal regulations:

- a. Failure to maintain complete and accurate records of receipt and distribution of controlled substances for the missing vials and ampules, and shortages for the Buprenorphine, Diazepam, Euthanasia, Ketamine, Morphine Sulfate, and Telazol.
- b. Failure to maintain controlled substances records for a minimum of 2 years, for the incomplete records of receipt for the Buprenorphine, Diazepam, Euthanasia, Ketamine, Morphine Sulfate, and Telazol.
- c. Failure to take and maintain a Biennial Inventory.
- d. Failure to record on DEA-222 order forms for Morphine Sulfate the date and quantity received.
- e. Storage of controlled substances at an unregistered location, namely the bar/garage at his personal residence.
- f. Failure to provide adequate security for all controlled substances.

(TI 86-88; Ex. 2)⁴ In fact, Mr. Otero remarked that Respondent's record keeping was "probably one of the worst I've ever seen from a vet standpoint" in his thirty years of experience. (TI 136-137)

33. As a result of the DEA investigation, and based upon his failure to comply with federal regulations, Respondent voluntarily surrendered his DEA license and all attendant controlled substance privileges on October 31, 2016. (TI at 88-91; Ex. 3) At present, Respondent cannot

⁴The pertinent regulations can be found in Parts 1301, 1304, and 1305 of Title 21, Chapter II, of the Code of Federal Regulations.

purchase, handle, distribute, or administer any controlled substances. (TI 90-91)

34. The Board also presented the testimony of Jessica Barnes ("Ms. Barnes"). Ms. Barnes was the hospital manager at AVET from 2010 to 2017, and now resides in St. Augustine, Florida. Ms. Barnes was at AVET for the entirety of Respondent's employment there. (TI 144-145)

35. As hospital manager for AVET, Ms. Barnes was responsible for ordering supplies, double-checking the inventory of controlled drugs, and also performed some veterinary technician services. (TI 145-146)

36. Ms. Barnes was present when Mr. Otero and others executed a search warrant at AVET on March 31, 2016. She is aware that several vials of controlled substances were discovered in Respondent's athletic bag in the back bedroom of the AVET facility. (TI 155-157) Such vials should have been disposed of in a "sharps container"⁵ and it was a violation of AVET policy for Respondent to have had them among his personal belongings in the back bedroom. (TI 183-184)

37. Ms. Barnes handled complaints at AVET and received complaints about Respondent from several veterinary technicians, including Jeremy Martin, Jennifer Carabine, and Ian Joseph. (TI 147-148) The chief complaint from these persons was that Respondent "was abusing controlled substances while he was on duty at the clinic." (TI 152)

38. More particularly, Ms. Barnes testified that Respondent "was drawing up more medication than what was needed to administer to the patient, squeezing the excess medication into the hub of the cap of the needle and then putting that in his mouth." (TI 152) The aforesaid technicians personally observed this several times. (TI 152)

⁵A container that is used to hold used medical needles and other sharp medical instruments.

39. Ms. Barnes further testified that, around the time she received the aforementioned complaints, she personally observed Respondent's behavior change; to wit, Respondent "would complain that he was having trouble focusing with his vision and that he couldn't see" and, as a result, she or another attending technician would have to take over the patient's care. (TI 161-164) In fact, Ms. Barnes heard Respondent state more than one, "I can't see. You're going to have to give the injection." or "You're going to have to draw the blood." (TI 164) According to Ms. Barnes, "the main times we noticed this weird behavior would be right after he had one of the injection caps in his mouth" (TI 161)

40. Based on her personal observations and the complaints of others, Ms. Barnes believed that Respondent would, on occasion, draw up a dosage of Ketamine, squirt some of into the cap of the needle before giving the injection, and then put the cap in his mouth to consume the Ketamine. (TI 162) Ms. Barnes added that Respondent "was constantly chewing on needle caps," and that this was not typical behavior in the veterinary setting. (TI 162-163)

41. Ms. Barnes investigated the aforementioned complaints and did not find significant discrepancies in the drug logbooks suggesting that they were doctored. Rather, based upon her investigation of the complaints, Ms. Barnes believed that Respondent "was actually taking some of the medication that he was drawing up and giving the patient less than what he was saying it was supposed to get." (TI 153-154, 181-182) Although a technician may draw up medicine, it is always the veterinarian who determines the dosage. (TI 175)

42. Ms. Barnes did not address her concerns, or the complaints she received, with Respondent because she was not his boss; instead, she left it to the AVET board of directors to handle. Ms. Barnes understands that Respondent was terminated from employment with AVET

shortly after the DEA executed its search warrant on March 31, 2016, because the board of directors found him to have misrepresented himself. (TI 154-155, 157-158) Ms. Barnes explained that AVET was hesitant to hire Respondent in the first place based on reports from employees of the Spot Clinic that Respondent had possibly abused controlled substances while working there. (TI 159-160)

43. Finally, the Board presented Ian Joseph ("Mr. Joseph"). Mr. Joseph is a veterinary technician at AVET and has held that position since September 2015. (TII 6-7)

44. In that role, Mr. Joseph worked alongside Respondent to treat patients at AVET. This work included the administration of medicines to patients by syringe. (TII 7-9)

45. It was Respondent's responsibility, as the doctor, to determine the dosage of any controlled substance administered and, typically, a doctor would be the one to administer a controlled substance to a patient. (TII 9-10)

46. Mr. Joseph could specifically recall Respondent determining dosages of Ketamine, drawing up Ketamine into a syringe, and administering Ketamine to animals during their work together. (TII 12)

47. Mr. Joseph often saw Respondent chewing on needle caps during work at AVET. (TII 5-16)

48. On one occasion, in preparing for surgery on a female cat, Mr. Joseph personally observed Respondent squirt Ketamine into the cap of a needle and then immediately put the cap into his mouth and chew on it. (TII 13-16, 26) Mr. Joseph elaborated during his testimony that

we had the suspicion that this was going on for a while, but, of course, me and him were working together by ourselves and we were doing a save-the-kitty spay. I was in the x-ray, where we have our large run, and I came around the corner, he had drawn up the ketamine, and we gave ketamine and acepromazine to sedate them. We don't have it predrawn up or premixed. We draw the ketamine and then the

acepromazine.

He drew up the ketamine, you know, looked to make sure there's no air in it, and he used it in the same motion, you draw up the ketamine, you draw up the acepromazine and it mixes. He drew up the ketamine, put the cap back on, looked at it, got the air out, then put the cap in his mouth and then put it into the acepromazine and injected the cat and continued to chew on the cap. You know, it was odd, the process that that happened.

(TII 14-15)

49. Mr. Joseph further clarified that the cap was fully in Respondent's mouth and, based on what he saw, believed the cap contained Ketamine. (TII 15) Mr. Joseph has never witnessed another veterinarian chew on a needle cap in that manner and, based on his experience, found it to be unusual. (TII 15-16) He also believed it unusual that Respondent put the cap back on the needle after drawing up Ketamine because he still had to draw up Acepromazine into the same syringe; to wit, "the flow wasn't normal to what we usually do." (TII 46-48)

50. Upon realizing Mr. Joseph had witnessed him consume Ketamine on the job, Respondent gave him an "oh, crap" look, to wit, "we made eye contact and [Respondent] gave me that look like, oh, no, you caught me." (TII 6, 28)

51. Mr. Joseph did not discuss the incident with Respondent, but instead immediately reported it to Ms. Barnes via text message. (TII 17, 29) For Mr. Joseph, the incident confirmed suspicions that he and others, including Ms. Barnes and Jeremy Martin, already had that Respondent was using drugs on the job. (TII 18-19, 21)

52. Mr. Joseph personally observed Respondent have problems with his vision and his hands such that it required a technician to give an injection or draw blood. (TII 18, 21-22, 34-35) Mr. Joseph believes that consuming Ketamine could have impaired Respondent. (TII 48)

53. In addition to reporting the above-described incident, Mr. Joseph also reported to Ms. Barnes general complaints about Respondent such that Mr. Joseph would not trust his own pet to the care of Respondent. (TII 27-18)

54. The Board rested its case following Mr. Joseph's testimony. (TII 64) Respondent did not offer any witnesses, testimony, or other evidence at the hearing. (TII 65)

ANALYSIS

The case presented by the Board is uncontested other than through cross-examination of the Board's witnesses. Respondent elected not to testify and called no witnesses support of his case.

It is undisputed that Respondent improperly: (1) removed controlled substances from the Spot Clinic when he left employment there; and (2) stored controlled substances at his home, which was not a registered location for the same. Moreover, there is no dispute that Respondent could not account for approximately 61 full vials of Ketamine; approximately 13.2 vials of Morphine Sulphate; and approximately 33.27 vials of Telazol. Ketamine is a Schedule III controlled substance that is "known nationwide as a party drug." (TI 78-79)

The record also establishes that Respondent purchased Euthanasia, Diazepam, and Buprenorphine. According the Mr. Otero, Respondent maintained virtually no records related to the Euthanasia and could not account for a single injectable of the 90 Diazepam injectables he purchased. Nor could Respondent account for any of the Buprenorphine that he purchased. Indeed, Respondent had no record of usage, distribution, receipts, or destruction relating to these drugs.

As a DEA license holder, Respondent was required to keep records of the receipt and distribution of these drugs for a minimum of two years. Respondent was responsible for the safekeeping and accurate distribution and recording of the same. He utterly failed in this regard.

Ultimately, the DEA found that Respondent had violated federal regulations as follows:

- a. Failure to maintain complete and accurate records of receipt and distribution of controlled substances for the missing vials and ampules, and shortages for the Buprenorphine, Diazepam, Euthanasia, Ketamine, Morphine Sulfate, and Telazol.
- b. Failure to maintain controlled substances records for minimum 2 years, for the incomplete records of receipt for the Buprenorphine, Diazepam, Euthanasia, Ketamine, Morphine Sulfate, and Telazol.
- c. Failure to take and maintain a Biennial Inventory.
- d. Failure to record on DEA-222 order forms for Morphine Sulfate the date and quantity received.
- e. Storage of controlled substances at an unregistered location, namely the bar/garage at his personal residence.
- f. Failure to provide adequate security for all controlled substances.

Based upon the DEA investigation and its findings, Respondent surrendered his DEA license and his controlled substance privileges on October 31, 2016. Currently, Respondent cannot purchase, handle, distribute or administer controlled substances.

The uncontraverted record establishes, by a preponderance of the evidence, that Respondent's record keeping fell well below a standard of professionalism for a veterinarian. According to Mr. Otero – an employee of the DEA for three decades – Respondent's record keeping relating to drugs was “very bad” and “probably one of the worst I’ve ever seen from a vet standpoint.” (TI 137) Based upon Respondent's unlawful handling of controlled substances the record in this case requires that Respondent's license be revoked.

Among other practice standards, a “veterinarian shall maintain all drugs and biological agents in compliance with state and federal law,” and a “veterinarian that has a Federal Drug Enforcement

Administration (DEA) number and uses, dispenses, administers or prescribes controlled substances shall comply with the federal and state laws pertaining to the dispensing, prescribing, storage and usage of controlled substances. “ 26 C.S.R. § 4-4.4(C)(G) (2011).

Also, the Board has proved, by a preponderance of the evidence, that Respondent failed to conduct the required inventories of the controlled substances he purchased, failed to maintain complete and accurate records of the receipt and distribution of those controlled substances, failed to properly account for large quantities of those controlled substances, improperly removed controlled substances from a registered location, and stored controlled substances at an unregistered location, all in violation of DEA regulations. *See* 21 C.F.R. §§ 1301.12, 1301.71, 1301.75, 1304.04, 1304.11, 1304.21, and 1305.03.

The Board’s *Rules of Professional Conduct* require that a licensee protect the health safety and welfare of the public. W. Va. Code § 30-10-19(g)(6). Respondent has failed in this regard.

Moreover, the Board has proved, by a preponderance of the evidence, that Respondent consumed Ketamine on at least one occasion while on duty and in the course of treating patients, in violation of law, *see* W. Va. Code §§ 60A-1-101 *et seq.*, and that such consumption appeared to affect his sight and dexterity. Ketamine is a schedule III controlled substance, used for sedation, and is “known nationwide as a party drug.” (TI 79) Respondent placed the health, safety, and welfare of his patients (and perhaps others) at risk by consuming Ketamine on the job. He has failed to offer a valid excuse for such blatant disregard of patient safety.

Based upon the foregoing, the undersigned recommends that Respondent’s license be revoked and that he be assessed the reasonable costs of this proceeding consistent with 26 C.S.R. § 1-8.4.

CONCLUSIONS OF LAW

1. Respondent is a licensee of the Board, holding License No. 2002-22, and is, therefore, subject to the licensing requirements and disciplinary rules of the Board. See W. Va. Code §§ 30-10-1, *et seq.*, 26 C.S.R. § 26-1-1, *et seq.*

2. The Board is a regulatory board created and governed by W. Va. Code §§ 30-10-1 *et seq.*, 26 C.S.R. § 1-1, *et seq.* and is empowered to regulate the practice of veterinary medicine in the State of West Virginia.

3. The West Virginia Legislature has declared that “[t]he fundamental purpose of licensure and registration is to protect the public, and any license, registration, certificate or other authorization to practice issued pursuant to this chapter is a revocable privilege.” W. Va. Code § 30-1-1a.

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

5. More particularly, the Board is authorized to impose one or more of the following disciplinary measures in any given case;

- (1) Reprimand;
- (2) Probation;
- (3) Suspension;
- (4) Revocation;
- (5) Administrative fine, not to exceed \$1,000 per day per violation;
- (6) Mandatory attendance at continuing education seminars or other training;

- (7) Practicing under supervision or other restriction;
- (8) Requiring the licensee, registrant or permittee to report to the board for periodic interview for a specified period of time; or
- (9) Other corrective action considered by the board to be necessary to protect the public, including advising other parties whose legitimate interests may be at risk. W. Va. Code § 30-10-19(g); *see also* 26 C.S.R. § 2.4.

6. In addition to any other sanction imposed, the Board “may assess the costs of the investigation, hearing, hearing examiner, legal fees and all other reasonable and necessary costs incurred by or on behalf of the Board to the veterinarian who was the subject of the disciplinary action.” 26 C.S.R. § 1-8.4

7. By *Complaint* issued December 13, 2017, Respondent was notified of the allegations against him pursuant to the rules of the Board and the laws of this State.

8. The Board issued a timely *Notice of Hearing* in this matter on June 1, 2018. *See* W. Va. Code § 30-1-8(f).

9. As the charging party, the Board bears the burden of proving any and all violations by a preponderance of the evidence. *See* W. Va. Code § 30-1-8(f); 26 C.S.R. § 2A-1, *et seq.*; *Lester v. Flanagan*, 113 S.E.2d 87, 89 (W. Va. 1960); *McClure v. McClure*, 403 S.E.2d, 197, 201 (W. Va. 1991); *cf. Carte v. Cline*, 488 S.E.2d 437, 442 (W. Va. 1997). A “preponderance of the evidence” means the greater weight of the evidence, “even in the slightest degree.” *McCullough v. Clark*, 106 S.E. 61, 70 (W. Va. 1921)

10. In an administrative proceeding, credibility determinations by the trier of fact are “binding unless patently without basis in the record.” *Martin v. Randolph Cty Bd. of Educ.*, 465

S.E.2d 399, 406 (W. Va. 1995). The trier of fact is uniquely situated to make such determinations. *Webb v. W. Va. Bd. of Med.*, 569 S.E.2d 225,232 (W. Va. 2002); *In re Queen*, 473 S.E.2d 483, 490 n.6 (W. Va. 1996). The undersigned Hearing Examiner determines credibility based upon a thorough evaluation of witness testimony. Credibility determinations may be based upon many factors, including the following: the general demeanor and comportment of the witness at the hearing; the bias interest of the witness; the consistency or inconsistency of the statements of the witness; the witness's ability and acuteness to observe; the memory of the witness; the reputation for honesty of the witness; and other factors which tend to cause the trier of fact to believe or disbelieve the testimony of the witness. See Franklin D. Cleckley, *Handbook on Evidence for West Virginia Lawyers*, § 607.02(1)(b) (5th Ed. 2012).

11. The Hearing Examiner finds the testimony of the Board's witnesses to be credible and reliable.

12. The Hearing Examiner further finds that the Board has established, by a preponderance of the evidence, that Respondent's unprofessional conduct described herein violates the statutes and rules of the Board, as more specifically set forth below, which renders Respondent subject to discipline by the Board.

13. Under its governing statutes, the Board may "refuse to renew, suspend or revoke the license, permit, registration or certificate of, impose probationary conditions upon or take disciplinary action against, any licensee, permittee, registrant or certificate holder for . . . [b]eing guilty of unprofessional conduct; . . . or [e]ngaging in any act which has endangered or is likely to endanger the health, welfare or safety of the public." W. Va. Code § 30-10-19(g)(3), (6).

14. Additionally, the rules of the Board provide that it may "revoke or suspend a license,

impose a civil penalty, place a person's license on probation, [or] reprimand a licensee," if it finds the licensee "has engaged in dishonest unethical or illegal practices in or connected with the practice of veterinary medicine" and/or "has engaged in practices or conduct in connection with the practice of veterinary medicine which violate the standards of professional conduct as duly established by the Board[.] 26 C.S.R. § 1-9(c),(e) (2013).

15. The Board has promulgated Rules of Professional Conduct and Minimum Standards of Practice, the violation of which is cause for disciplinary action. *See* W. Va. Code §§ 30-10-6-19; 26 C.S.R. §§ 1-9, 4-4.

16. Among other practice standards, a "veterinarian shall maintain all drugs and biological agents in compliance with state and federal law," and a "veterinarian that has a Federal Drug Enforcement Administration (DEA) number and uses, dispenses, administers or prescribes controlled substances shall comply with the federal and state laws pertaining to the dispensing, prescribing, storage and usage of controlled substances." 26 C.S.R. §4-4.4 (C) and (G) (2011).

17. The evidence presented in this matter, particularly the testimony of Mr. Otero and the exhibits admitted therewith, establishes that Respondent failed to comply with federal regulations pertaining to the purchasing, storage, accounting, and usage of controlled substances while employed at the Spot Clinic and AVET, which unprofessional and illegal conduct, in turn, is a violation of W. Va. Code § 30-10-19(g)(3), (6), 26 C.S.R. §1-9.1(c)and (e) (2013), and 26 C.S.R. § 4-4.4(C) and (G) (2011).

18. The record amply supports the findings of the DEA, as reported in the September 27, 2016, report of Mr. Otero. Respondent has presented no evidence to refute or otherwise question those findings.

19. As more fully described in the above Findings of Fact, the Board has proved, by a preponderance of the evidence, that Respondent failed to conduct the required inventories of the controlled substances he purchased, failed to maintain complete and accurate records of the receipt and distribution of those controlled substances, failed to properly account for large quantities of those controlled substances, improperly removed controlled substances from a registered location, and stored controlled substances at an unregistered location, all in violation of DEA regulations. *See* 21 C.F.R. §§ 1301.12, 1301.71, 1301.75, 1304.04, 1304.11, 1304.21, and 1305.03.

20. Such conduct violated the Board's *Rules of Professional Conduct and Minimum Standards of Practice*, set forth above, and was "a threat to the public health and welfare" in violation of W. Va. Code § 30-10-19(g)(6). (TI 87, 88) Respondent is subject to discipline for such unsafe conduct.

21. Furthermore, the evidence presented in this matter, particularly the testimony of Ms. Barnes and Mr. Joseph, establishes, by a preponderance of the evidence, that Respondent consumed Ketamine while on duty as a veterinarian and in the course of treating patients, which unprofessional and illegal conduct, in turn, is a violation of W. Va. Code § 30-10-19(g)(3), (6) and 26 C.S.R. § 1-9.1(c) and (e) (2013).

22. Ms. Barnes reliably testified that she received multiple complaints about Respondent consuming controlled substances on the job, both before and during his employment at AVET, and that she personally observed Respondent's behavior change around the time of those complaints and after seeing him with a needle cap in his mouth. Based on her investigation, Ms. Barnes was able to conclude that Respondent would, on occasion, draw up a dosage of Ketamine, squirt some of it into the cap of the needle before giving the injection, and then put the cap in his mouth to consume the

Ketamine. Ms. Barnes is a credible witness with no animus toward Respondent and her testimony is corroborated by that of Mr. Joseph and Mr. Otero and by the logbooks demonstrating large quantities of missing Ketamine.

23. Mr. Joseph reliably testified that he personally observed Respondent place a cap onto a needle unnecessarily, squirt Ketamine into the needle cap under the guise that he was eliminating air, and then immediately place that cap into his mouth to chew on it. Respondent visually acknowledged he had been caught, and Mr. Joseph immediately reported the suspicious conduct to his supervisor. Like Ms. Barnes, Mr. Joseph observed Respondent frequently chew on needle caps and exhibit diminished sight and dexterity when doing so. Mr. Joseph is a credible witness with no animus toward Respondent and his testimony is corroborated by that of Ms. Barnes and Mr. Otero and by the logbooks demonstrating large quantities of missing Ketamine.

24. Respondent presented no witnesses or evidence of his own to refute the testimony of the Board's witnesses or to otherwise defend against the Board's charges.

25. As more fully described in the above Findings of Fact, the Board has proved, by a preponderance of the evidence, that Respondent consumed Ketamine on at least one occasion while on duty and in the course of treating patients, in violation of law, *see* W. Va. Code §§ 60A-1-101, *et seq.*, and that such consumption appeared to affect his sight and dexterity. Ketamine is a schedule III controlled substance, used for sedation, and is "known nationwide as a party drug." (TI at 79) Respondent placed the health, safety, and welfare of his patients (and perhaps others) at risk by consuming Ketamine on the job. Respondent has no valid excuse for such blatant disregard of patient safety.


26. Respondent's illegal conduct violates the Board's *Rules of Professional Conduct*, set forth above, and endangered the health, safety, and welfare of the public, in violation of W. Va. Code

§ 30-10-19(g)(6). Respondent is subject to discipline for his unlawful conduct.

RECOMMENDED DECISION

Based upon the foregoing, the undersigned substantiates the incidents of Respondent's unprofessional conduct; find such incidents of unprofessional conduct to have been proven by a preponderance of the evidence; concludes that such unprofessional conduct violates the Board's statutes and legislative rules as noted herein; and recommends that the Board revoke the license of Respondent in accordance with the provisions of West Virginia Code § 30-10-1 *et seq.* and 26 C.S.R. § 1-1, *et seq.* Moreover, the undersigned recommends that the costs of these proceedings be assessed to Respondent.

Entered this 26th day of November, 2019.



JEFFREY G. BLAYDES
HEARING EXAMINER