

State Office of Administrative Hearings



NOV 08 2013

Cathleen Parsley
Chief Administrative Law Judge

November 7, 2013

Nicole Oria
Executive Director
Texas State Board of Veterinary Medical Examiners
333 Guadalupe, Ste 3-810
Austin, Texas 78701-3942

VIA INTERAGENCY

RE: Docket No. 578-14-0699; Texas Board of Veterinary Medical Examiners v. Gary Brackeen, D.V.M.

Dear Ms. Oria:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

A handwritten signature in black ink, appearing to read "Hunter Burkhalter".

Hunter Burkhalter
Administrative Law Judge

HB/mle

Enclosure: (with ICD; Certified Evidentiary Record)

xc: Jonathan Crabtree, Staff Attorney, Texas State Board of Veterinary Medical Examiners, 333 Guadalupe, Ste. 3-810, Austin, TX 78701-3942 – **VIA INTERAGENCY**
Laura Moriaty, General Counsel, Texas State Board of Veterinary Medical Examiners, 333 Guadalupe, Ste. 3-810, Austin, TX 78701-3942 – **VIA INTERAGENCY**
William Pendergraft, Hayes & Pendergraft, 1704 Fifth Street, Bay City, TX 77414 – **VIA REGULAR MAIL**

DOCKET NO. 578-14-0699

**TEXAS BOARD OF VETERINARY
MEDICAL EXAMINERS,**
Petitioner

v.

GARY BRACKEEN, D.V.M.,
Respondent

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

This matter was scheduled for a hearing on November 5, 2013. Despite being sent proper notice, Gary Brackeen (Respondent) did not appear at the hearing. The relief requested by the referring agency should be granted on a default basis.

FINDINGS OF FACT

1. Notice was: (1) mailed to the Respondent's attorney, (2) at least ten days prior to the scheduled hearing, (3) published with statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short plain statement of the matters asserted, and (4) published with a statement in at least 12-point, boldface type that the factual allegations listed in the notice could be deemed admitted, and the relief sought in the notice of hearing might be granted by default against a party that failed to appear at the hearing.
2. The hearing was held as scheduled in the notice, and the record closed on November 5, 2013.
3. The Respondent did not appear at the scheduled hearing.
4. A default was granted in favor of the referring agency and against Respondent.
5. The factual allegations in the notice of hearing, which is attached hereto as Attachment A and incorporated by reference into this Finding of Fact, are deemed admitted.

CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Gov't Code ch. 2003.

2. The referring agency has jurisdiction over this matter.
3. Proper and timely notice was provided to the Respondent in accordance with Tex. Gov't Code ch. 2001 and 1 Tex. Admin. Code ch. 155.
4. The allegations in the notice of hearing were properly deemed admitted. 1 Tex. Admin. Code § 155.501.
5. The referring agency staff has established the basis for a sanction to be imposed against Respondent.
6. The referring agency is entitled to the relief requested in its notice of hearing.

SIGNED November 7, 2013.



**HUNTER BURKHALTER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS**

ATTACHMENT A



TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS

October 23, 2013

Gary Brackeen, D.V.M.
c/o William Pendergraft
Hayes & Pendergraft
1704 Fifth Street
Bay City, TX 77414

VIA FACSIMILE AT
(979) 245-1235

BY LONE STAR OVERNIGHT
Z0287330

RE: SOAH Docket No. 578-14-0699; *Texas Board of Veterinary Medical Examiners, Petitioner v. Gary Brackeen, D.V.M., Respondent*; Before the State Office of Administrative Hearings

NOTICE OF HEARING

Dear Dr. Brackeen:

The hearing in the above referenced matter is scheduled before the State Office of Administrative Hearings (SOAH) for November 5, 2013 at 9:00 AM, at 300 W. 15th St., 4th Floor, Austin, Texas 78701.

The legal authority under which the hearing will be held and to which the Court will be asked to take official notice is the following:

1 TEXAS ADMINISTRATIVE CODE (hereafter TAC), Chapter 155 (Rules of Procedure for the State Office of Administrative Hearings)

TEXAS GOVERNMENT CODE, CHAPTER 2001 (Administrative Procedures Act);

TEXAS OCCUPATIONS CODE, CHAPTER 801, the Texas Veterinary Licensing Act, including, but not limited to:

- TEXAS OCCUPATIONS CODE §801.002 (Definitions);
- TEXAS OCCUPATIONS CODE §801.151 (Board's rulemaking authority);
- TEXAS OCCUPATIONS CODE §801.159 (Board duties regarding complaints);
- TEXAS OCCUPATIONS CODE §801.201-206 (Complaint procedures);
- TEXAS OCCUPATIONS CODE §801.207 (Public Record; Exception);

TEXAS OCCUPATIONS CODE §801.351 (Existence of Veterinarian-Client-Patient Relationship);
TEXAS OCCUPATIONS CODE §801.352 (Prohibition Against Interference or Intervention);
TEXAS OCCUPATIONS CODE §801.353 (Confidentiality; Waiver);
TEXAS OCCUPATIONS CODE §801.401 (Disciplinary powers of the Board);
TEXAS OCCUPATIONS CODE §801.402 (General grounds for disciplinary action);
TEXAS OCCUPATIONS CODE §801.407 (Right to hearing; schedule of sanctions);
TEXAS OCCUPATIONS CODE §801.409 (Temporary License Suspension); and
TEXAS OCCUPATIONS CODE §801.451-452 (Administrative Penalties).

22 TAC §§571-577 (Rules Pertaining to the Practice of Veterinary Medicine ("Board Rules"), including, but not limited to:

§573.10 (Supervision of Non-Licensed Persons);
§573.11 (Responsibility for Unlicensed Employees);
§573.20 (Responsibility for Acceptance of Medical Care);
§573.21 (Direct Responsibility to Client);
§573.22 (Standard of Care);
§573.24 (Responsibility of Veterinarian to Refer a Case);
§573.25 (Issuance of Official Health Documents Through Direct Knowledge Only);
§573.27 (Honesty, Integrity, Fair Dealing);
§573.28 (Observance of Confidentiality);
§573.30 (Advertising);
§573.40 (Labeling of Medications Dispensed);
§573.41 (Use of Prescription Drugs);
§573.50 (Controlled Substances Records Keeping for Drugs on Hand);
§573.52 (Veterinary Patient Recordkeeping);
§573.54 (Patient Records Release and Charges);
§573.61 (Minimum Security for Controlled Substances);
§573.62 (Violation of Board Orders/Negotiated Settlements);
§573.75 (Duty to Cooperate with Board);
§573.80 (Definitions);
§§575.1 - 575.10 (Board procedures re: contested case hearings);
§575.25 (Recommended schedule of sanctions);
§575.27-575.28 (Complaints - receipt and investigations);
§575.29 (Informal conferences);
§575.30 (Contested case hearing at SOAH);
§575.35 (Temporary Licensed Suspension Proceedings); and
§575.36 (Rescission of Probation).

The Texas Board of Veterinary Medical Examiners ("TBVME" or the "Board") conducts investigations into allegations of violations of the Texas Veterinary Licensing Act ("the Act") and Board Rules pursuant to sections 801.201-206 of the Act. A licensee is required to comply with the provisions of the Act and Board Rules. According to §801.402 of the Act, a person is subject to disciplinary action under §801.401 if the person:

- (4) engages in dishonest or illegal practices in, or connected with, the practice of veterinary medicine;...
- (6) engages in practices or conduct that violates the board's rules of professional conduct;...
- (16) commits gross malpractice or a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine.

TBVMC asserts that Gary Brackeen, D.V.M. ("Respondent") violated the Board Rules, specifically §§ 573.10, 573.21, 573.22, 573.24, 573.25, 573.27, 573.28, 573.30, 573.40, 573.41, 573.50, 573.52, 573.54, 573.61, 573.62, 573.75 and the Act (see Act provisions cited above and below).

Rule 573.10 of the Board Rules states:

- (a) With appropriate supervision and after establishing a veterinarian-client-patient relationship, a veterinarian may delegate veterinary care and treatment duties to non-veterinarian employees...
- (b) A veterinarian shall determine when general, direct, or immediate supervision of a non-veterinarian's actions is appropriate, except where such actions of the non-veterinarian may otherwise be prohibited by law. A veterinarian shall consider both the level of training and experience of the non-veterinarian when determining the level of supervision and duties of non-veterinarians.
- (c) A veterinarian is subject to discipline if he or she improperly delegates care and/or treatment duties to a non-veterinarian, or fails to properly supervise the non-veterinarian performing delegated duties.
- (d) A non-veterinarian shall not perform the following health care services:
 - (1) surgery;
 - (2) invasive dental procedures except as allowed for licensed equine dental providers under §573.19 of this title;
 - (3) diagnosis and prognosis of animal diseases and/or conditions; or
 - (4) prescribing drugs and appliances...

Rule 573.11 of the Board Rules states:

A veterinarian shall be responsible for any acts a non-veterinarian employee commits within the scope of the employee's employment.

Rule 573.20 of the Board Rules states:

- (a) The decision to accept an animal as a patient is at the sole discretion of a veterinarian. The veterinarian is responsible for determining the diagnosis and course of treatment for an animal that has been accepted as a patient and for advising the client as to the diagnosis and treatment to be provided...

Rule 573.21 of the Board Rules states:

The professional services of a licensee shall not be controlled or exploited by any lay agency, personal or corporate, which intervenes between the client and the licensee. A

licensee shall not allow a non-licensed person or entity to interfere or intervene with the licensee's practice; nor shall the licensee submit to such interference or intervention by a non-licensed person or entity. A licensee shall avoid all relationships which could result in interference or intervention in the licensee's practice by a non-licensed person or entity. A licensee shall be responsible for his or her own actions and is directly responsible to the client and for the care and treatment of the patient.

Rule 573.22 of the Board Rules states:

Licensees shall exercise the same degree of humane care, skill, and diligence in treating patients as are ordinarily used in the same or similar circumstances by average members of the veterinary medical profession in good standing in the locality or community in which they practice, or in similar communities.

Rule 573.24 of the Board Rules states:

(a) A veterinarian shall have a duty to a client to suggest a referral to a specialist, or otherwise more-qualified veterinarian, in any case where the care and treatment of the animal is beyond the veterinarian's capabilities. A veterinarian's decision on whether to accept or continue care and treatment of an animal, which may require expertise beyond the veterinarian's capabilities, shall be based on the exercise of sound judgment within the prevailing standard of care for a veterinarian faced with the same or similar circumstances...

Rule 573.25 of the Board Rules states:

Licensed veterinarians in this state shall not issue any official health documents for an animal without first having personally examined the individual animal and know of their own knowledge, by actual inspection and appropriate tests, that said animal meets the requirements for the issuance of the official health document. A veterinarian is deemed to have issued and to have knowledge of any official health documents issued in the veterinarian's name, written by veterinarian's employee and/or maintained in veterinarian's patient or client files. A veterinarian shall be responsible for the security and proper use of all official certificates, forms, records and reports, and shall take reasonable care to prevent the misuse thereof. A veterinarian shall immediately report to the TBVMB the loss, theft or deliberate or accidental misuse of any such certificate, form, record or report.

Rule 573.27 of the Board Rules states:

Licensees shall conduct their practice with honesty, integrity, and fair dealing to clients in time and services rendered, and in the amount charged for services, facilities, appliances, and drugs.

Rule 573.28 of the Board Rules states:

(a) A veterinarian shall not violate the confidential relationship between the veterinarian and a client.

- (b) Except as provided in subsection (c) of this section, a veterinarian shall not disclose any information concerning the veterinarian's care for an animal except:
- (1) on written or oral authorization or other form of waiver executed by the client;
 - (2) on receipt by the veterinarian of an appropriate court order or subpoena; or
 - (3) as necessary to substantiate and collect on a debt incurred by a client for veterinary services.
- (c) A veterinarian may, without authorization by the client, disclose information contained in a rabies certificate to a governmental entity only for purposes related to the protection of public health and safety.

Rule 573.30 of the Board Rules states:

A licensee may not engage in advertising that is false, deceptive, or misleading. A false, deceptive, or misleading advertising statement or claim includes, without limitation:

- (2) illegal transactions;...
- (6) an expressed or implied material misrepresentation of fact.

Rule 573.40 of the Board Rules states:

A veterinarian shall affix labels to all unlabeled containers containing any medication dispensed and to all factory labeled containers that contain prescription (legend) drugs and/or controlled substances dispensed. The label must be affixed to the immediate container and include:

- (1) the veterinarian's name, address, and telephone number (including area code);
 - (2) date of delivery or dispensing;
 - (3) patient/client name (and address if drug is a controlled substance);
 - (4) species of the animal;
 - (5) name, strength, and quantity of the drug dispensed;
 - (6) directions for use; and
 - (7) cautionary statements as required by law, i.e. not for human consumption, poisonous, withdrawal periods, etc.
- (b) If the immediate container is too small to be labeled, the small container shall be enclosed within another container large enough to be labeled.

Rule 573.41 of the Board Rules states:

- (a) It is unprofessional conduct for a licensed veterinarian to prescribe, administer, dispense, deliver, or order delivered any prescription drug without first having established a veterinarian/client/patient relationship and determined that such prescription drug is therapeutically indicated for the health and/or well-being of the animal(s). Prescription drugs include all controlled substances in Schedules I - V and legend drugs which bear the federal legends, recognized as such by any law of the State of Texas or of the United States.

Rule 573.50 of the Board Rules states:

Texas veterinarians shall maintain at their place of business records of all scheduled drugs listed in the Texas Controlled Substances Act in their possession. These records

shall be maintained for a minimum of five years. The form for keeping records of those drugs shall contain the following information in addition to the name of the drug:

- (1) date of acquisition;
- (2) quantity purchased;
- (3) date administered or dispensed;
- (4) quantity administered or dispensed;
- (5) name of client and patient receiving the drug(s); and
- (6) balance on hand.

Rule 573.52 of the Board Rules states:

- (a) Individual records shall be maintained at the veterinarian's place of business, shall be complete, contemporaneous and legible and shall include, but are not limited to:
 - (10) differential diagnosis and/or treatment, if applicable;
 - (11) names, dosages, concentration, and routes of administration of each drug prescribed, administered and/or dispensed;
 - (12) other details necessary to substantiate or document the examination, diagnosis, and treatment provided, and/or surgical procedure performed;...

Rule 573.54 of the Board Rules states:

- (a) Release of records pursuant to request. Upon the request of the client or their authorized representative, the veterinarian shall furnish a copy of the patient records, including a copy of any radiographs requested, within 15 business days of the request, unless a longer period is reasonably required to duplicate the records.
- (b) Contents of records. For purposes of this section, "patient records" shall include those records as defined in §573.52 of this title (relating to Veterinarian Patient Record Keeping)...
- (d) Improper withholding for past due accounts. Patient records requested pursuant to a proper request for release may not be withheld from the client, the client's authorized agent, or the client's designated recipient for such records based on a past due account for care or treatment previously rendered to the patient.

Rule 573.61 of the Board Rules states:

Veterinarians shall adhere to the following to ensure security of controlled substances:

- (1) Establish adequate security to prevent unauthorized access to controlled substances.
- (2) Establish adequate security to prevent the diversion of controlled substances.
- (3) During the course of business activities, do not allow any individual access to controlled substances storage areas except those authorized agents required for efficient operations.
- (4) Controlled substances listed in Schedules I, II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet or security cabinet.
- (5) The term "substantially constructed cabinet" means the following:

- (A) A structure of wood or metal so constructed as to resist any entry by simple tools of attack such as screw drivers, crow bars, tire tools, pry bars, etc. Hinges should not be mounted with bolts or screws on outside of door and the locking devices should be installed internally as in a dead bolt type or the device should be of a type that has protected mounting screws or bolts to inhibit removal. The cabinet should be permanently constructed or attached to the building structure or fixtures so as to prevent the cabinet from being physically removed from the premises. If the cabinet is a metal file cabinet type, it should be permanently attached to prevent easy removal and have an external locking bar that secures the drawer or drawers.
- (B) A security cabinet or safe equivalent in construction to a Class 6 Mosler Government Sales Security Filing Cabinet or a Class 5 Mosler Government Safe.
- (C) A cabinet less substantially constructed may meet security requirements provided the cabinet is located in a room or area entrance to which has been so constructed that hinge mountings inhibit removal and a limited number of employees have keys or combinations to locking device. If combination locks are utilized, the combination can be changed upon termination of employees having knowledge of the combination. A veterinarian must maintain a written list of all persons that have access to the controlled substances storage areas, including the dates on which individuals are added or deleted from the list.

Rule 573.62 of the Board Rules states:

- (a) All persons that are subject of a Board order shall abide by the terms of the order. The Board may open a complaint against a person who violates a Board order and/or refer the person to the Attorney General for prosecution under the Veterinary Licensing Act, Texas Occupations Code, Chapter 801, and the Administrative Procedure Act, Government Code, §2001.202.

Rule 573.75 of the Board Rules states:

A licensee shall:

- (1) cooperate fully with any Board inspection or investigation; and
- (2) respond within twenty-one (21) days of receipt to requests for information regarding complaints and other requests for information from the Board, except where:
 - (A) the Board in contacting a licensee imposes a different response date; or
 - (B) the licensee is unable for good cause to meet the response date and requests a different response date.

FACTUAL BASIS

Respondent holds a license to practice veterinary medicine issued by TBVME and has held that license since July 14, 1976. As a licensed veterinarian in the State of Texas, Respondent is required to comply with the Act and the Board Rules.

From February 4, 2009, through January 21, 2011, Nettie Dunn (Mrs. Dunn) of Angleton, Texas took her Chihuahua named Jericho to Anchor Road Veterinary Clinic (Clinic) in Angleton, Texas according to the veterinary medical records that Respondent provided to the Board under subpoena. Respondent owns the Clinic, works as the only veterinarian at the Clinic, and employs all of the veterinary technicians and staff at the Clinic and has for several years.

On February 4, 2009, Respondent neutered Jericho and gave Mrs. Dunn heartworm preventative for Jericho. The patient record for Jericho from the Clinic on February 4, 2009 does not contain any examination, diagnosis, or prescription for heartworm preventative. The patient record for Jericho from the Clinic on February 4, 2009 does not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered, and details necessary to substantiate the examination, diagnosis, and treatment provided for the neuter procedure performed on Jericho on that date.

On April 28, 2009, September 16, 2009, December 7, 2009, January 19, 2010, February 19, 2010, July 19, 2010, and January 20, 2011, Respondent administered a shot of an unknown drug to Jericho according to Jericho's patient records from the Clinic. The patient record for Jericho from the Clinic on those dates do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided for the shot of an unknown drug given to Jericho on those dates.

On January 8, 2010, and January 14, 2011, Respondent administered a rabies vaccination and a DHPC vaccine to Jericho. The patient records for Jericho from the Clinic on those two dates do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided for the shots given to Jericho on those dates.

On January 21, 2011, Desiree Karr (Ms. Karr), a non-veterinarian employee of the Clinic, dispensed a bottle of prescription medicine to Mrs. Dunn for Jericho without Respondent examining Jericho, diagnosing an ailment, or prescribing any medicine for Jericho that day. Desiree Karr is not a licensed veterinarian in the State of Texas and has never been a licensed veterinarian in the State of Texas.

Jericho was seen at the Clinic on January 20, 2011, but the medical records only indicate that Jericho was given an allergy shot. Mrs. Dunn has a prescription pill bottle from the Clinic that was dispensed on January 21, 2011. The patient record for Jericho from the Clinic on that date does not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided with regards to any medicine that Respondent prescribed for Jericho on January 21, 2011.

On October 16, 2013, the Board received information from Mrs. Dunn that Respondent had released her name as a client at his clinic, her name as a complainant to the Board about Respondent's veterinary medical practice, her home address, her home phone number, and her cell phone number. Mrs. Dunn has received anonymous derogatory and vindictive notes left at her house for her complaint to the Board about Respondent. Mrs. Dunn has also received anonymous phone calls personally disparaging her character for complaining to the Board about Respondent.

On March 23, 2010, Wendy Lowe (Mrs. Lowe) of Angleton, Texas took her approximately five-month-old dog, Peaches, to the Clinic for the first time. Respondent did not perform an examination on Peaches before Ms. Karr administered a DHPC vaccine and gave Mrs. Lowe heartworm preventative. Respondent did not perform an examination of Peaches after the vaccination and prescription of heartworm preventative either.

Mrs. Lowe continued to bring Peaches back to the Clinic for three years after that time and Peaches was never examined by Respondent. Nevertheless, Ms. Karr administered a DHPC vaccine on April 12, 2010, dispensed heartworm preventative monthly from April 12, 2010 through March 25, 2011, and administered rabies vaccines to Peaches on March 25, 2011, March 28, 2012, and March 29, 2013.

The patient records for Peaches from the Clinic for those three years that Mrs. Lowe took Peaches to the Clinic for veterinary care do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided to Peaches on those dates.

On July 13, 2010, Mrs. Lowe brought her Yorkshire Terrier named Triscuit into the Clinic for the first time. Respondent likewise did not perform an examination on Triscuit before or after Ms. Karr administered a rabies vaccination. Mrs. Lowe had brought Triscuit into the Clinic for about three years after that date and Triscuit was never examined by Respondent. Nevertheless, Ms. Karr provided heartworm preventative 18 times between July 13, 2010, and April 30, 2013, administered rabies vaccinations on July 28, 2011, and August 1, 2012.

The patient records for Triscuit from the Clinic for those three years that Mrs. Lowe took Triscuit to the Clinic for veterinary care do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided to Triscuit on those dates.

Mrs. Lowe also received two bottles of prescription medication from the Clinic without the veterinarian's name, address, and telephone number (including area code), date of delivery or dispensing, patient/client name (and address if drug is a controlled substance), species of the animal, name, strength, and quantity of the drug dispensed, directions for use, and cautionary statements as required by law, i.e. not for human consumption, poisonous, withdrawal periods, etc.

On December 14, 2010, Roxanne Stibbe (Mrs. Stibbe) of Angleton, Texas brought her cat named Gabby to the Clinic for an ingrown toenail. Respondent extracted the infected and ingrown toenail from Gabby's left front paw. Mrs. Stibbe returned with Gabby on January 10, 2011, and two more pieces of infected toenail were removed from Gabby's left front paw and Respondent wrapped Gabby's left front paw with bandages.

The same paw was freshly bandaged at the Clinic on January 14, 2011, and January 17, 2011. The bandages were removed on January 22, 2011, and a notation of paw "looks great" was indicated in the patient record for Gabby from the Clinic for that date. On February 5, 2011, Mrs. Stibbe returned with Gabby to the Clinic and had Gabby's left front paw amputated after the paw had died due to a lack of blood flow to the tissue caused by inappropriately tightened bandages.

Mrs. Stibbe had been a customer of the Clinic for several years prior to the amputation of Gabby's left front paw. The first recorded time in the patient records provided to the Board by the Clinic that Gabby received veterinary care at the Clinic is April 8, 2008. The patient records for Gabby from the Clinic for the visits from April 8, 2008, through February 5, 2011, that the Board received pursuant to a subpoena do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided to Gabby on those dates.

On September 7, 2012, the Board received a complaint from Ms. Shelli Hitt of Sweeney, Texas concerning Respondent's care of her six-week old male Boxer dog named Apollo from August 24, 2012 through August 27, 2012. On August 24, 2012, Shelli Hitt of Sweeney, Texas presented her dog Apollo to the Clinic because Apollo had been vomiting, coughing, and lethargic for several days. Ms. Karr examined Apollo's ailments, administered gentamicin, dispensed ampicillian, and prescribed treatment for Apollo. Respondent did not examine Apollo.

On August 24, 2012, Ms. Karr, an unlicensed veterinary technician, examined Apollo. She noted that Apollo had an injured claw on the hind paw, and a temperature of 104.7 degrees Fahrenheit. Respondent did not examine Apollo. Ms. Karr administered gentamicin and dispensed ampicillian, and recommended soaking the injured paw in Epsom salts. Neither Respondent nor Ms. Karr provided or recorded any diagnosis for Apollo on August 24, 2012. The patient record for the treatment of Apollo on that date at the Clinic also does not contain required information including weight required for diagnosis and treatment, the concentrations of drugs administered, and details necessary to substantiate the examination, diagnosis, and treatment provided.

Overnight, Apollo's condition deteriorated as he continued to vomit repeatedly. On August 25, 2012 at 8:00 am, Ms. Hitt presented Apollo to the Clinic again. Ms. Karr examined Apollo, and found that he had a temperature of either 105.3 or 103.5 degrees Fahrenheit. Ms. Karr requested that Respondent examine Apollo, so Respondent looked at Apollo from the doorway of an adjoining room. However, Respondent did not perform an exam of Apollo. Respondent then instructed Ms. Karr to administer gentamicin and start Apollo on fluids. Ms. Karr told Ms. Hitt that she would begin running tests on Apollo to

determine what was wrong. The patient record for Apollo on August 25, 2012, does not contain any reference to any tests having been run, a differential diagnosis and/or treatment, a weight necessary for diagnosis and treatment, the concentrations of drugs administered, details necessary to substantiate examination, diagnosis and treatment, and may not contain an accurate temperature necessary for diagnosis or treatment. The patient record appears to have been written by Ms. Karr and does not contain any indication that Respondent examined Apollo at any time. Apollo was admitted into the Clinic and kept overnight.

Over the next day and a half, Ms. Hitt and members of her family called the Clinic repeatedly. At 11:30 am and 5:00 pm on August 25, 2012, Clinic staff told Ms. Hitt that Apollo was doing well, had been taken off fluid treatment, and might be released the next day. On August 26, 2012, at 8:30 am, Ms. Hitt called and was told that Apollo's condition had deteriorated overnight, and that he had been started on fluids again. At 2:30 pm and at 5:30 pm on August 26, 2012, calls to the Clinic elicited only the fact that Apollo was "resting," without any further information or diagnosis.

The patient record for Apollo on August 26, 2012, contains only observations from 9:00 am, stating that Apollo was stiff and painful, and does not contain any other entry to suggest that Apollo was observed or examined by any member of Clinic staff at any other point that day. The patient records do not contain required information including but not limited to: a differential diagnosis and/or treatment, temperature necessary for diagnosis and treatment, a weight necessary for diagnosis and treatment, the concentrations of drugs administered, details necessary to substantiate examination, diagnosis and treatment, and a temperature necessary for diagnosis or treatment. The patient record appears to have been written by Ms. Karr and does not contain any indication that Respondent examined Apollo on Sunday.

At 5:45 am on August 27, 2012, a friend of the Hitt family called the Clinic, and learned from Clinic staff that Apollo had died sometime on August 26, 2012. The patient record for Apollo on August 27, 2012, does not contain any entry before 8:00 am, suggesting that despite his critical condition, Apollo did not receive any observation, examination, or treatment from Respondent or his staff between 9:00 am on August 26, 2012, and 8:00 am on August 27, 2012, when Apollo was already dead.

Ms. Hitt requested a copy of the patient record for Apollo. Ms. Karr informed her that the patient record had been discarded already because it was policy at the Clinic to discard the patient records of all deceased patients. Ms. Karr offered to recreate the chart for Ms. Hitt. The copy of the patient record that Ms. Hitt eventually received from the Clinic does not contain any vaccination labels that typically appear in patient records for the Clinic, suggesting that it is not a contemporaneous record of Apollo's treatment at the Clinic.

On December 3, 2012, Board investigators visited the Clinic on a routine inspection. During the course of their inspection, the Board investigators witnessed Ms. Karr diagnose, prescribe, and dispense prescription drugs. Ms. Karr dispensed prescription heartworm preventative and the prescription drug Comfortis to customers when Respondent was out of the office at a doctor's appointment. Respondent had not examined these animals nor had he diagnosed, prescribed, or dispensed these medications. Ms. Karr stated after the fact that she spoke with Respondent and received authorization to administer these drugs to these

customers. However, the patient records provided to the Board by the Clinic for the two dogs that received these drugs, Charlie and Casey, confirm that Respondent did not possess sufficient knowledge of the animals to know that the drugs were therapeutically necessary for the health and well-being of the animals to be able to validly authorize Ms. Karr over the phone to provide these customers with those drugs.

During the course of their investigation, the Board's investigators discovered that the controlled substances safe was unsecured. Board investigators saw that the metallic gun safe where Respondent keeps his controlled substances was unlocked and the door was open. Board investigators also observed that a small safe was also used to store controlled substances. The safe is small enough to easily be carried out of the building by one person and is situated in a location with ready access to the outside door. Ms. Karr explained that the small unsecured safe held controlled substances that were being utilized at that time. Board investigators opened the small unsecured safe and discovered two bottles of the controlled substance Euthasol and several packets of the controlled substance Ketaset.

During the course of their investigation, Board investigators reviewed Respondent's controlled substance drug logbook and discovered that the controlled substances drug logbook did not keep balances on hand for Euthasol, Ketaset, and Dolorex. Board's investigators also looked at patient records for several animals over several years, including the dog Casey, a dog named Zoe, a dog named Mesquite, a dog named Chloe and her four puppies, a dog named Romeo, and a cat named Rusty. None of these patient records contain required information, including but not limited to: a differential diagnosis and/or treatment, temperature necessary for diagnosis and treatment, a weight necessary for diagnosis and treatment, the concentrations of drugs administered, and details necessary to substantiate examination, diagnosis, and treatment. There were no veterinary medical records for the dog Charlie that Board investigators witnessed receive Comfortis from Ms. Karr at the Clinic on December 3, 2012.

On December 16, 2012, Samantha Blanco (Mrs. Blanco) brought her dog named Koko to the Clinic because Koko had been in labor for 16 hours without delivering any puppies. Respondent proceeded to perform a caesarian on Koko and delivered one live puppy. Koko was kept at the clinic until December 22, 2012, at around 11:30 in the morning.

Mrs. Blanco called the Clinic at around 11:45 in the morning on December 22, 2012, stating that Koko's incisions had opened and her bowels were exiting her abdomen. This was roughly 15 minutes after Koko left the Clinic. Koko was returned to the Clinic at 12 noon and surgery by Respondent was attempted to repair the incision site and to place the bowels back into Koko's abdomen. Koko unfortunately died at the Clinic during that surgery.

The patient records for Koko from the Clinic for the visits from January 17, 2012, through December 22, 2012, that the Board received pursuant to a subpoena do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided to Koko on those dates.

On the morning of February 18, 2013, Cindy Bergen (Mrs. Bergen) of Angleton, Texas brought her dog named Butch to the Clinic for labored breathing. Ms. Karr and another unidentified assistant at the Clinic examined Butch. They listened to Butch's chest and determined that Butch was in congestive heart failure. Respondent did not examine Butch or listen to his chest. Mrs. Bergen was told by Ms. Karr and the other assistant that Butch had congestive heart failure and that there wasn't anything they could do for him because he was going to die of heart failure. Mrs. Bergen left with Butch at that time.

Mrs. Bergen returned with Butch around 2:15 p.m. on February 18, 2013, because the labored breathing had not improved. At that time, Respondent listened to Butch's chest and prescribed 10 milligram pills of Enalapril to be taken once a day by Butch and dispensed a quantity of 10 pills. Butch was then cleared to return home with Mrs. Bergen. As Mrs. Bergen was leaving with Butch, Ms. Karr told Mrs. Bergen that the pills would give Butch a few more months to live. Mrs. Bergen took Butch home and gave him one of the pills as per her instructions from Respondent. Butch died shortly after ingesting the pill prescribed for Butch by Respondent and dispensed to Mrs. Bergen by Respondent.

Mrs. Bergen had taken Butch to the Clinic since March 7, 2006. The patient records for Butch from the Clinic for the visits from March 7, 2006, through February 18, 2013, do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided to Butch on those dates.

Mrs. Bergen also provided the Board with photographs of a prescription pill bottle dispensed by Respondent and the Clinic on November 1, 2012, for Butch. The label on the prescription pill bottle of Tramadol does not include the quantity or strength of the Tramadol dispensed.

On April 21, 2013, Wendy Lowe (Mrs. Lowe) of Angleton, Texas took her dog named Taco to the Clinic because Taco was exhibiting heavy breathing along with coughing. Respondent listened to Mrs. Lowe recount how Taco had behaved that morning and then Respondent immediately started searching for drugs to inject Taco with. Respondent diagnosed Taco as having ingested a poisonous substance without performing an examination of Taco. Respondent injected Taco with drugs without examining Taco to diagnose what ailments Taco had or what treatment Taco needed. Respondent then sent Taco home with a prescription pill bottle and 8 pills with instructions to give Taco one pill every 12 hours. Respondent still had not examined Taco to diagnose what ailments Taco had or what treatment Taco needed.

Mrs. Lowe was charged 121 dollars by Respondent's wife, Carol Brackeen (Mrs. Brackeen), when Mrs. Lowe left with Taco. The visit was charged as an emergency visit for 100 dollars over the express command of Respondent to charge only for a regular visit. Mrs. Brackeen also charged Mrs. Lowe for the prescription pills that Respondent dispensed to her even over the express commands of Respondent not to charge Mrs. Lowe for the prescription pills.

As Mrs. Lowe was leaving she asked Mrs. Brackeen if Taco's organs would be affected if Taco had ingested a poisonous substance. Mrs. Brackeen then examined Taco's gums and determined that Taco had healthy gums, meaning that Taco had not ingested a poisonous substance, and that Taco would be fine once he ingested the medicine.

Mrs. Lowe returned to her home with Taco and proceeded to give him one of the pills that Respondent dispensed at the Clinic that day. Taco began to act differently after he ingested the pill. Taco's energy became severely diminished to the point that he fell over after evacuating his bowels. Taco also excreted bloody saliva out of his mouth and then blood running from his nose. Taco died within an hour of ingesting one of the prescription pills.

Mrs. Lowe could not determine what prescription pill was given to Taco and produced to the Board the bottle along with the remaining pills. The label on the prescription pill bottle reads Teluride as what prescription drug was dispensed and Mrs. Lowe took photographs of the 7 pills that remained after she gave Taco one. Teluride is not the name of a prescription drug. The prescription pill bottle does not list a quantity or a strength of Teluride that was dispensed by Respondent to Mrs. Lowe for Taco. Respondent later claims to have dispensed six 100 milligram tablets of Theophylline for Taco on April 21, 2013, but that is not what the label on the prescription pill bottle reads. The bottle, upon inspection by the Board, contained 7 tablets of Theophylline.

Due to this confusion, Mrs. Lowe asked her mother to return to the Clinic on April 24, 2013, and ask for the veterinary medical records for Taco from April 21, 2013. The Clinic stated at that time that there were no veterinary medical records for Taco from April 21, 2013 and did not give Mrs. Lowe's mother any records. The Clinic never gave Mrs. Lowe any veterinary medical records for Taco from April 21, 2013.

On June 13, 2013, Respondent provided the Board with veterinary medical records for Taco for April 21, 2013, pursuant to a subpoena. The patient record for Taco from the Clinic from April 21, 2013, does not contain required information including weight required for diagnosis and treatment, the concentrations of the drugs administered, and details necessary to substantiate the examination, diagnosis, and treatment provided to Taco on April 21, 2013.

Karen Nichols (Mrs. Nichols) of Danbury, Texas brought her dog to the Clinic for veterinary treatment by Respondent. Mrs. Nichols' poodle had an ear problem that she wanted Respondent to remedy. Mrs. Nichols never saw Respondent at the Clinic. Mrs. Nichols states that veterinary technicians and not Respondent diagnosed her dog as being infected with ear mites and then sedated the animal and performed a procedure to eradicate the ear mites. Mrs. Nichols also states that she returned to the Clinic on a different date and saw two veterinary technicians performing another procedure on a sedate dog when Respondent was not at the clinic.

The patient records for Mrs. Nichols' poodle that Respondent provided under subpoena do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment

provided to Mrs. Nichols' poodle who underwent a procedure to remove ear mites at the Clinic.

Carmella Tedrick (Mrs. Tedrick) of Angleton, Texas brought her dog to the Clinic for veterinary treatment by Respondent. Mrs. Tedrick's dog needed to have bladder stones removed surgically. Respondent performed the surgery at the Clinic. Mrs. Tedrick's dog was sent home from the Clinic on the same day as the bladder stone removal surgery and while still under anesthesia. The dog did not recover from anesthesia during the next day either. Mrs. Tedrick then returned her dog to the Clinic where it remained for two days on fluids to keep it hydrated. Mrs. Tedrick's dog somehow opened up the incision site from the bladder surgery while at the Clinic. Clinic staff stated that there was not anything that could be done once the incision site was opened and that the dog would simply have to heal from the inside out. Mrs. Tedrick took her dog home at that point.

The patient records for the two dogs and the cat owned by Mrs. Tedrick that Respondent provided under subpoena are devoid of any mentioning of bladder surgery. Respondent's patient records therefore do not contain required information including weight required for diagnosis and treatment, the name, dosages, concentrations, and routes of administration of the drugs administered and details necessary to substantiate the examination, diagnosis, and treatment provided to Mrs. Tedrick's dog who had bladder stone removal surgery at the Clinic.

Respondent clearly has a history of failing to properly supervise his non-veterinarian employees by allowing his non-licensed employees to examine, diagnose, and treat patients without any input from Respondent, for practicing below the standard of care, for failing to keep patient records in accordance with Board requirements, and for violating the law in connection with his practice of veterinary medicine.

Respondent has been disciplined by the Board for these actions in the past. On October 18, 2011, the Board entered Agreed Order No. 2011-74, disciplining Respondent for failing to properly supervise his non-veterinarian employees by allowing his non-licensed employees to examine, diagnose, and treat patients without any input from Respondent, for practicing below the standard of care, for failing to keep patient records in accordance with Board requirements, and for violating the law in connection with his practice of veterinary medicine. For these violations, the Board ordered that Respondent receive a formal reprimand, pay 195 dollars as reimbursement to his former client, pay an administrative penalty of 500 dollars, complete an additional 17 hours of continuing education, take and pass the jurisprudence examination, and that Respondent's license to practice veterinary medicine to be suspended for two years with all of that suspension probated once he submitted to an evaluation with the Professional Recovery Network.

On February 7, 2012, Respondent began the probation he was subject to under Agreed Order 2011-74 by submitting to an evaluation with the Professional Recovery Network. Therefore, the two year probation that Respondent agreed to in Agreed Order No. 2011-74 does not end until February 7, 2014.

Respondent violated Rule 573.10, Supervision of Non-Licensed Persons, of the Board Rules of Professional Conduct, by improperly delegating care, diagnosis, treatment,

and prescription duties to non-veterinarians, and by failing to supervise a non-veterinarian performing delegated duties.

Respondent violated Rule 573.21, Direct Responsibility to Client, of the Board Rules of Professional Conduct, by allowing at least the non-licensed Ms. Karr and the non-licensed Mrs. Brackeen to interfere or intervene in the practice veterinary medicine on several animals at the Clinic. Ms. Karr and an unidentified veterinary technician at the Clinic both practiced veterinary medicine at the clinic when they diagnosed disease, prescribed treatment, issued prognoses about the animal's conditions, administered drugs that they themselves diagnosed the need for, and charged the clients for these and other services. Mrs. Brackeen practiced veterinary medicine with regards to Mrs. Lowe's dog Taco when Mrs. Brackeen substituted the amount of money that Respondent wished to charge Mrs. Lowe for the veterinary services that Respondent provided with an amount that Mrs. Brackeen wanted to charge for her husband's veterinary services and when Mrs. Brackeen stated that Taco had not ingested a poisonous substance and would be fine. Those comments about Taco's health were a diagnosis of Taco's physical condition and a prognosis of his future well-being both of which are the practice of veterinary medicine in Section 801.002(5) of the Act. By allowing Ms. Karr, the unidentified veterinary technician, and Mrs. Brackeen to practice veterinary medicine at his Clinic, Respondent allowed non-licensed persons to interfere or intervene in his practice.

Respondent violated Rule 573.22, Professional Standard of Care, of the Board Rules of Professional Conduct, by: securing the bandages on the left front paw of Mrs. Stibbe's cat Gabby so tightly that the left front paw lost all circulation and the tissue died; failing to examine and treat Mrs. Hitt's dog Apollo before he died two days after arriving at the Clinic; improperly closing a caesarian incision site on Mrs. Blanco's Chihuahua Koko to the point that the incision opened and Koko's bowels came out of the abdomen within 15 minutes of leaving the Clinic then repaired it incorrectly and administered incorrect drugs that allowed the dog to die at the Clinic; improperly performing an intravenous injection into Mrs. Nichols' poodle that caused the poodle's back leg to shake uncontrollably and the dog's gait to become abnormal; failing to properly close the incision used after a bladder surgery that allowed Mrs. Tedrick's dog to open up its own sutures while in Respondent's care at his Clinic; as well as failing to re-suture the incision site in keeping with the standard of care as is ordinarily used by average members of the veterinary medical profession in good standing in the community in which he practices, or in similar communities. The standard of care throughout Texas is to perform an examination on a patient prior to prescribing drugs. The standard of care throughout Texas is for the veterinarian to perform an examination on the patient instead of solely relying on the examination of a patient by a veterinary technician. The standard of care throughout Texas is to secure bandages tight enough to remain in place and cover cuts and abrasions, but not so tight that the circulation is cut off to the paw and to notice that the flow of blood to the paw had ceased when repeatedly bandaging the paw, neither of which Respondent did with regards to Gabby. The standard of care throughout Texas is to close a caesarian incision so that the incision remains closed and the animals bowels do not exit the animal's abdomen after the animal leaves the veterinarian's care, which Respondent failed to do with regards to Koko. The standard of care throughout Texas is to disinfect the entire abdomen, sew up any ruptured bowels, close the abdomen, and monitor the animal's recovery none of which Respondent did or did correctly with regards to Koko. The standard of care throughout Texas is to perform an intravenous

injection into an animal's leg so that the animal is not still visibly affected by that injection months later. The standard of care throughout Texas is to close an abdominal incision and monitor the dog at the Clinic after a bladder surgery to a degree that the abdominal incision is not reopened by the dog. The standard of care throughout Texas is to repair an incision that has been reopened instead of allowing the animal to heal from the inside out.

Respondent violated Rule 573.24, Responsibility of a Veterinarian to Refer a Case, of the Board Rules of Professional Conduct, by failing to refer Apollo and Mrs. Tedrick's dog to specialists, or otherwise more qualified veterinarians, because the care and treatment of the animals were beyond the veterinarian's capabilities. Apollo was gravely ill and Respondent did not attend to his veterinary medical issues instead allowing Ms. Karr to practice veterinary medicine on Apollo. Mrs. Tedrick's dog underwent bladder stone removal surgery and when the incision reopened at the Clinic, Mrs. Tedrick was told there was nothing that could be done to repair the open incision. Respondent could have easily referred Apollo and Mrs. Tedrick's dog to one of the many veterinary clinics in the area.

Respondent violated Rule 573.25, Issuance of Official Health Documents Through Direct Knowledge Only, by issuing rabies certificates several times to Mrs. Dunn and Mrs. Lowe's animals without any direct knowledge that the animals were vaccinated against rabies since he allowed his non-licensed employees to administer the vaccine without first examining the animal. Respondent is deemed to have issued and to have knowledge of any official health documents issued in the veterinarian's name, written by veterinarian's employee and/or maintained in veterinarian's patient or client files. Respondent shall also be responsible for the security and proper use of all official certificates, forms, records and reports, and shall take reasonable care to prevent the misuse thereof.

Respondent violated Rule 573.27, Honesty, Integrity, and Fair Dealing, by allowing his non-licensed employees to practice veterinary medicine in his Clinic. The patients that were diagnosed, treated, and issued a prognosis by these non-licensed employees never received any of the veterinary care that their owners paid Respondent to perform. Respondent allowed his non-licensed employees to engage in these actions and still charged the clients for the veterinary medical work as if Respondent himself had performed the diagnosis, prognosis, and treatment of these animals.

Respondent violated Rule 573.28, Observance of Confidentiality, by releasing Mrs. Dunn's home address, telephone number, cell phone number, status as a client of the Clinic, and status as a complainant against the Clinic to Respondent's other clients. Mrs. Dunn gave Respondent this personal information entrusting that Respondent would not reveal her contact information to the public. Respondent's release of this confidential information has led to the harassment that Mrs. Dunn has received from the people whom Respondent gave this information to and is precisely the sort of harm that this rule is designed to protect against.

Respondent violated Rule 573.40, Labeling of Medications Dispensed, by failing to include the quantity or strength of the prescription drug Tramadol that was dispensed to Mrs. Bergen for her dog Butch on November 1, 2012 and for failing to include the name, strength, and quantity of a prescription drug dispensed to Mrs. Lowe for her dog Taco on April 21, 2013.

Respondent violated Rule 573.41, Use of Prescription Drugs, of the Board Rules of Professional Conduct, by prescribing the prescription drugs without first establishing a veterinarian-client-patient relationship by examining Apollo, Jericho, Peaches, Triscuit, Casey, Charlie, and Mrs. Nichol's dog. Respondent has the ability to prescribe medications and order that they be dispensed, but only after Respondent has examined the animal and determined that the medications are medically necessary for the ailment the animal has at that time. In each of these cases Ms. Karr or another non-licensed non-veterinarian employee performed the examination on the animal and then prescribed, dispensed, or administered the medication to the client.

Respondent violated Rule 573.50, Controlled Substances Recordkeeping Drugs on Hand, by failing to keep balances on hand for Rethasol, Ketaset, and Dolorex in Respondent's controlled substances logbook on December 3, 2012 when investigators for the Board inspected the Clinic. Those three drugs are all controlled substances and Respondent is required to keep an accurate and up to date record of the quantity of each controlled substance that he has at his Clinic to protect against the drugs being abused. Respondent simply had a running tally of how much drugs he used, but since Respondent did not keep a total amount of each controlled substance he had at the Clinic that he could subtract the usage from then there is no way to discern from his drug logbook whether controlled substances were being used appropriately or being abused.

Respondent violated Rule 573.52, Veterinarian Patient Record Keeping, of the Board Rules of Professional Conduct, by failing to maintain individual records at the veterinarian's place of business for a minimum of five years from the date of the last treatment by the veterinarian; by failing to note any amendment, supplementation, change or correction in a patient record not made contemporaneously with the act or observation noted by indicating the time and date of the amendment and clearly indicating that there has been an amendment, supplementation or change; and by failing to ensure that the records include required information including but not limited to: a differential diagnosis and/or treatment, temperature necessary for diagnosis and treatment, a weight necessary for diagnosis and treatment, the concentrations of drugs administered, details necessary to substantiate examination, diagnosis and treatment, and a temperature necessary for diagnosis or treatment for every animal listed above which amounts to inadequate records for 17 animals.

Respondent violated Rule 573.54, Patient Records Release and Charges, by failing to provide patient records to Mrs. Lowe for her dog Taco within 15 days after Mrs. Lowe's mother, the authorized representative of Mrs. Lowe, requested the records. Respondent never provided Mrs. Lowe with a copy of the Clinic's patient records for Taco from April 21, 2013. However, Mrs. Lowe did receive a copy of the patient records that Respondent provided the Board with under subpoena.

Respondent violated Rule 573.61, Minimum Security for Controlled Substances, by failing to secure his controlled substances. Board investigators found Respondent's controlled substances safe unlocked and the door fully open during the Board's inspection of Respondent's Clinic. Respondent was not at the Clinic at this time and because of that no one in the Clinic should have had access to the controlled substances at that time. In addition, Board investigators found a small secondary lockbox that contained several

controlled substances. This lockbox was easily removable by any person with the inclination to take it and then equally as easy to pry it open and access the controlled substances stored within.

Respondent violated Rule 573.62, Violation of Board Orders/Negotiated Settlements, of the Board Rules of Professional Conduct, by violating the Board's Rules of Professional Conduct as outlined above and below during his period of probation, which began on February 7, 2012 and ends on February 7, 2014.

Respondent violated Rule 573.75, Duty to Cooperate with the Board, by failing to provide the Board with veterinary medical records within 21 days after the Board sent several requests seeking these records. The Board then had to resort to subpoenas to obtain the veterinary medical records for Taco, Koko, Gabby, Jericho, Mrs. Tedrick's dog, and Mrs. Nichols' dog.

Respondent violated Section 801.402(4) of the Act by violating Section 801.351 of the Act because Respondent committed an illegal practice of veterinary medicine by failing to establish or maintain a veterinarian-client-patient relationship with an animal by personally examining the animal prior to practicing veterinary medicine on the animal. Respondent also violated Section 801.352 of the Act by allowing Ms. Karr, Mrs. Brackeen, and an unidentified employee of the Clinic to interfere or intervene in the veterinarian's practice of veterinary medicine. Respondent allowed his wife, Carol Brackeen, to intervene in Respondent's practice of veterinary medicine with regards to Wendy Lowe by refusing to follow Respondent's explicit orders on how much money to charge Wendy Lowe for Respondent's veterinary medicine actions on April 21, 2013. Under the Act, the receipt of compensation for the practice of veterinary medicine is also the practice of veterinary medicine. Respondent allowed Ms. Karr and the other employee to practice veterinary medicine by diagnosing ailments, prescribing drugs, and offering prognoses for the well-being of the animal in the future. That is the interference or intervention in Respondent's veterinary medical practice because it is allowing someone else to practice for him.

Respondent violated Section 801.402(6) of the Act by violating the Board's Rules as outlined above.

Respondent violated Section 801.402(7) of the Act by allowing his non-licensed non-veterinarian employees to practice veterinary medicine under his license at his Clinic. Ms. Karr, Mrs. Brackeen, and another employee routinely practiced veterinary medicine at Respondent's Clinic. They used Respondent's license because they improperly utilized drugs that Respondent was able to obtain because he holds a license to practice veterinary medicine or they used the auspices of the Clinic to practice veterinary medicine in other ways on clients that at least assumed that Respondent was involved in the practice of veterinary medicine on their animal when in fact Respondent was not involved.

Respondent violated Section 801.402(8) of the Act by issuing rabies certificates from the Clinic that indicate that the animals were properly vaccinated against, and thereby do not have, rabies. These certificates fraudulently state that these animals were protected against rabies when in fact no examination was performed by Respondent to diagnose that the

animals were not infected with rabies before the vaccination was given and if an animal that is already infected is vaccinated then the infection will not be killed by the vaccine.

Respondent violated Section 801.402(13) of the Act by ordering a prescription drug or controlled substance for the treatment of an animal that he did not have a valid veterinarian-client-patient relationship with because he had not examined the animal. Respondent has done this repeatedly throughout the years most notably in the treatment of Jericho, Peaches, Triscuit, Apollo, Casey, Charlie, Burch, and Taco outlined above.

Respondent violated Section 801.402(16) of the Act by engaging in a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine. Respondent again violated Board Rule 573.10, 573.22, and 573.52 in August 2012 not even a year removed from agreeing to punishment from the Board for violations of those Board Rules and pledging to refrain from these violations in the future. Respondent's repeated failure to supervise his non-veterinarian employees, failure to practice up to the standard of care, and failure to include required information in his veterinary medical records are a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine. By engaging in a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine, Respondent violated §801.402(16) of the Act.

Respondent's actions are a Class A violation under the Board's Recommended Schedule of Sanctions, set out in Board Rule 575.25. A Class A violation exists when the licensee presents an imminent peril to the public. The nature of Respondent's previous violations and the fact that he repeated those same violations makes him carrying a license an imminent peril to the public. Respondent routinely allows his unlicensed non-veterinarian employee Ms. Karr to practice veterinary medicine on the Clinic's patients. In doing so, Respondent's actions are potential hazards to the health, safety, or economic welfare of the public. Respondent's actions are also actual hazards to the health, safety, or economic welfare of the public because the economic property of Ms. Hitt, Mrs. Nichols, Mrs. Lowe, Mrs. Bergen, and Mrs. Blanco was harmed in that the animal died due to Respondent's actions or the animal needed further veterinary services to repair the damage Respondent's actions caused. Additionally, based on the sheer number of violations of the Board's Rules that have the same or similar factual circumstances underpinning them these actions constitute a gross malpractice of veterinary medicine based on the pattern of acts that demonstrate a consistent malpractice, negligence, or incompetence in the practice of veterinary medicine which under Board Rule 575.25 constitutes an imminent peril to the public. Respondent's issuing of rabies certifications that fraudulently allege the absence of the animal disease rabies also constitutes an imminent peril to the public under Board Rule 575.25. Therefore, Respondent's actions in this case warrant the penalties that are available to be assessed to Class A violations under Board Rule 575.25.

PENALTIES SOUGHT

According to Section 801.409 of the Act,

- (a) An executive committee of the board consisting of the president and two other board members appointed by the president may temporarily suspend the license

- of a license holder if the executive committee determines from the evidence or information presented to the committee that continued practice by the license holder constitutes a continuing or imminent threat to the public welfare. A temporary suspension may also be ordered on a majority vote of the board.
- (b) The board by rule shall adopt procedures for the temporary suspension of a license under this section.
 - (c) A license temporarily under this section may be suspended without notice or hearing if, at the time the suspension is ordered, a hearing on whether disciplinary proceedings under this chapter should be initiated against the license holder is scheduled to be held not later than the 14th day after the date of the suspension.
 - (d) A second hearing on the suspended license shall be held not later than the 60th day after the date the suspension is ordered. If the second hearing is not held in the time required by this subsection, the suspended license is automatically reinstated.

According to Section 801.401 of the Act,

- (a) If an applicant or license holder is subject to denial of a license or to disciplinary action under Section 801.402, the board may:
 - (1) refuse to examine an applicant or to issue or renew a license;
 - (2) revoke or suspend a license;
 - (3) place on probation a license holder or person whose license has been suspended;
 - (4) reprimand a license holder; or
 - (5) impose an administrative penalty...
- (d) In addition to other disciplinary actions authorized by this subchapter, the board may require a license holder who violates this chapter to participate in a continuing education program. The board shall specify the continuing education programs that the license holder may attend and the number of hours that the license holder must complete. A continuing education program specified by the board must be relevant to the violation committed by the license holder.

According to Section 801.402 of the Act,

A person is subject to denial of a license or to disciplinary action under Section 801.401 if the person...

- (4) engages in dishonest or illegal practices in, or connected with, the practice of veterinary medicine or the practice of equine dentistry;
- (6) engages in practices or conduct that violates the board's rules of professional conduct;
- (7) permits another to use the person's license to practice veterinary medicine or to practice equine dentistry in this state;
- (8) fraudulently issues a health certificate, vaccination certificate, test chart, or other form used in the practice of veterinary medicine or the practice of equine dentistry that relates to the presence or absence of animal disease;

- (13) orders a prescription drug or controlled substance for the treatment of an animal without first establishing a veterinarian-client-patient relationship; or
- (16) commits gross malpractice or a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine or the practice of equine dentistry.


TBVME asserts that Respondent has violated the Act by violating the Board Rules concerning patient record keeping, standard of veterinary care, supervision of non-veterinarian employees, non-interference with his practice by non-veterinarian employees, his duty to refer a case to another veterinarian, the issuance of official health documents, honesty/integrity/fair-dealing in his practice, confidentiality of client information, labeling of medications dispensed, the use of prescription drugs, controlled substances recordkeeping, releasing patient records, minimum security for controlled substances, violating previous Board Orders, and his duty to cooperate with the Board's investigation of complaints against him. These violations follow Respondent's prior violations of Board's Rules in Agreed Order 2011-74 for which Respondent was placed on probation for two years, formally reprimanded, ordered to pay 695 dollars, and complete an additional 17 hours of continuing education. TBVME also asserts that Respondent has violated the Act by engaging in illegal practices in or connected with the practice of veterinary medicine, permitting others to use his license to practice veterinary medicine, fraudulently issuing rabies certificates that relate to the absence of rabies, ordering a prescription drug for animals without establishing a veterinarian-client-patient relationship, engaging in a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine due to consistently violating the Board's Rules. Based on the multitude of violations that indicate that Respondent is an imminent threat to the public, TBVME is seeking to revoke Respondent's license to practice veterinary medicine.

Respondent's license was temporarily suspended under Section 801.409 of the Act and this hearing will be held within the timeline of Section 801.409(d) of the Act.

Respondent has the right to be present at the administrative hearing and to be represented by counsel. All parties may present evidence and argument to the Administrative Law Judge regarding the charges noted above and within the attachments to this notice. **RESPONDENT'S FAILURE TO APPEAR WILL NOT PREVENT THE ADMINISTRATIVE LAW JUDGE FROM PROPOSING A DECISION, OR THE TBVME BOARD FROM TAKING DISCIPLINARY ACTION AGAINST RESPONDENT IN THIS MATTER.**

PURSUANT TO I TAC, SECTION 155.501, UPON FAILURE OF A PARTY TO APPEAR AT THE HEARING, THE FACTUAL ALLEGATIONS IN THE NOTICE WILL BE DEEMED ADMITTED AS TRUE, AND THE RELIEF SOUGHT IN THE NOTICE OF HEARING MAY BE GRANTED BY DEFAULT.

Sincerely,



JONATHAN CRABTREE

Texas Board of Veterinary

Medical Examiners

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