BEFORE THE ARIZONA STATE BOARD OF DENTAL EXAMINERS

In the Matter of: Aaron LeGrand Roberts, D.M.D. Holder of License No. D9441 For the Practice of Dentistry In the State of Arizona.	Case Nos. 201700266-AO; 201800046; 201800047 **CONSENT AGREEMENT AND ORDER**

CONSENT AGREEMENT

In order to resolve these cases quickly and judiciously, the Arizona State Board of Dental Examiners ("Board") and Aaron LeGrand Roberts, D.M.D. ("Respondent") enter into this Consent Agreement and Order ("Consent Agreement") as a final disposition of these matters and in lieu of further administrative and judicial proceedings. It is consistent with the public interest and the requirements and statutory authority of the Board, specifically, A.R.S. §§ 32-1263.01, -1263.02, and 41-1092.07(F)(5). This Consent Agreement shall resolve all issues the Board has reviewed and investigated regarding the allegations in these matters.

Therefore, in lieu of further proceedings, Respondent admits and understands that:

1. Any record prepared in this matter, all investigative materials prepared and received by the Board concerning the allegations, and all related materials and exhibits may be retained in the Board's file pertaining to these matters.

2. Respondent waives any right to a hearing or re-hearing of these matters and any right to judicial review of the attached Findings of Fact, Conclusions of Law, and Order.

3. Respondent has had the right to consult with an attorney prior to entering into this Consent Agreement or has waived the opportunity to do so.

4. The findings contained in the Findings of Fact portion of the Consent Agreement are conclusive evidence of the stated facts. The Board may consider this Consent Agreement when and if future disciplinary proceedings arise.

5. This Consent Agreement is subject to the Board's approval and will be effective only when the Board accepts it and it is signed on behalf of the Board. In the event that the Board, in its discretion, does not approve this Consent Agreement, it will be deemed withdrawn, will be of no evidentiary value and shall not be relied upon or introduced in any disciplinary proceeding by any party. Respondent agrees that should the Board reject this Consent Agreement and these cases continue through the administrative process and/or judicial process, he shall assert no claim that the Board was prejudiced by its review and discussion of this document or any related records.

6. Respondent acknowledges and agrees that upon signing this Consent Agreement and returning it to the Board's Interim Executive Director, Respondent may not revoke his acceptance of this Consent Agreement or make any modifications to it. Any modification of this original document is ineffective and void unless mutually approved by the parties in writing.

7. Respondent further understands that this Consent Agreement, if approved and signed by the Board, constitutes a public document that may be disseminated as a formal action by the Board, including reporting it to the National Practitioner Data Bank.

8. Respondent agrees to the Board approving the following Findings of Fact, Conclusions of Law and Order.

DATED this 30th day of August, 2018.

Aaron LeGrand Roberts, D.M.D.

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FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of dentistry in the State of Arizona.

2. Respondent is the holder of License No. D9441 for the practice of dentistry in the State of Arizona. Respondent also holds a Dental Anesthesia 1301 permit ("1301 permit") which authorizes him to administer general anesthesia. Respondent is a board-certified anesthesiologist.

Case No. 201700266-AO

3. The Board initiated case number 201700266-AO after receiving an adverse occurrence report from Respondent in which he reported that patient ZG, a 2 year-old male, experienced complications from general anesthesia after dental treatment.

4. Respondent administered general anesthesia to ZG on December 16, 2017 as an adjunct to dental treatment by a pediatric dentist performed on ZG.

5. While in recovery, ZG became unresponsive, was transported by emergency services to a hospital, and subsequently passed away.

6. An Outside Dental Consultant ("ODC") reviewed Respondent's care of ZG and found the following deviations from the standard of care:

- The standard of care requires a dental anesthesiologist, prior to the start of anesthesia, to ensure the immediate availability of an adequate oxygen supply and a positive pressure oxygen delivery system. Respondent deviated from the standard of care because the oxygen tank connected to the valve mask was empty or not working properly and could not be used to resuscitate ZG;
- The standard of care requires a dentist anesthesiologist to ensure the patient has recovered sufficiently from the effect of

anesthetic medications prior to being placed in recovery. Respondent deviated from the standard of care by failing to ensure that ZG was sufficiently recovered from the effects of anesthetic medications prior to being placed in recovery;

- The standard of care requires a dental anesthesiologist to record in the anesthesia record vital signs in recovery, including pulse oximeter and blood pressure readings. Respondent recorded pulse oximeter readings for ZG but failed to record blood pressure readings;
- The standard of care requires a dental anesthesiologist to ensure the adequacy of support staff who will be monitoring a patient during recovery. Respondent deviated from the standard of care by relying on the representations of the dental practice at which he administered anesthesia that the support staff monitoring ZG was adequately trained. The dental assistant monitoring AG in recovery twice misidentified a monitor alarm as a false alarm and failed to recognize signs of respiratory distress in ZG until he stopped breathing;
- The standard of care requires a dental anesthesiologist to ensure the patient in recovery has progressed sufficiently to a point where direct intervention would no longer be necessary prior to redirecting attention to the next scheduled patient. Respondent deviated from the standard of care by failing to ensure that ZG was sufficiently recovered prior to initiating general anesthesia on his next patient. This resulted in

Respondent having to terminate the anesthesia administration on the subsequent patient in order to use the equipment and monitors in the operatory on ZG.

Case No. 201800046

7. The Board initiated case no. 201800046 after receiving a complaint regarding Respondent's administration of general anesthesia to patient OG, a 2 year old male.

8. Respondent administered general anesthesia to OG on December 16, 2017 as an adjunct to dental treatment by a pediatric dentist performed on OG.

9. An Outside Dental Consultant reviewed Respondent's care of OG and found the following deviations from the standard of care:

- The standard of care requires a dental anesthesiologist to record in the anesthesia record vital signs in recovery, including pulse oximeter and blood pressure readings. Respondent failed to record pulse oximeter and blood pressure readings for OG's recovery;
- The standard of care requires a dentist anesthesiologist to ensure the patient has recovered sufficiently from the effect of anesthetic medications prior to being placed in recovery. Respondent deviated from the standard of care by failing to ensure that OG was sufficiently recovered from the effects of anesthetic medications prior to being placed in recovery..

1 **Case No. 201800047**

2 10. The Board initiated case no. 201800047 after receiving a complaint
3 regarding Respondent's administration of general anesthesia to patient AL, a 5 year old
4 male.

5 11. Respondent administered general anesthesia to AL on December 16, 2017
6 as an adjunct to dental treatment by a pediatric dentist performed on AL.

7 12. The anesthesia care administered by Respondent to AL was interrupted by
8 the anesthetic emergency with patient ZG. Respondent abruptly terminated AL's
9 anesthesia and placed AL in recovery in order to prioritize ZG's emergency.

10 13. An Outside Dental Consultant reviewed Respondent's care of AL and
11 found the following deviations from the standard of care:

12 - The standard of care requires a dentist anesthesiologist to
13 ensure the patient has recovered sufficiently from the effect of
14 anesthetic medications prior to being placed in recovery and
15 to ensure the patient is safe for discharge. As a result of the
16 emergency with ZG, Respondent compromised the anesthesia
17 care of AL by terminating AL's anesthesia abruptly and
18 placing AL in recovery and discharging AL without
19 providing AL sufficient time to recover from a deep state of
20 anesthesia;

21 - The standard of care requires a dental anesthesiologist to
22 record in the patient's anesthesia record information that
23 accurately reflects the course of the anesthesia. Respondent's
24 anesthesia record for AL fails to adequately chart the course
25 of the anesthesia. The recorded times for the dental surgery
26 start and end do not fit the anesthesia start and end times and

the vital signs recorded in the anesthesia record extend beyond the time of AL's discharge.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct as defined in A.R.S. §32-1201.01(14) and are grounds for disciplinary action pursuant to A.R.S. § 32-1263(A).

3. The conduct and circumstances described in the above Findings of Fact constitute a violation of A.A.C. R4-11-1301(E) and are grounds for disciplinary action pursuant to A.R.S. § 32-1263(A).

ORDER

IT IS HEREBY ORDERED THAT:

1. Within 30 days of the effective date of this Consent Agreement, Respondent shall enroll in a Continuing Education Remediation Program in Dental Anesthesiology ("the Program") to consist of instruction from a CODA-approved institution and clinical supervision in a JCAHO accredited surgery center or hospital for a total of four weeks with the objective of providing Respondent with the basis for a safe and reasonable practice of office-based or hospital-based dental anesthesiology after completion of the Program including a training focus on the following: 1) pharmacology of sedative drugs; 2) management of medical emergencies: 3) opioid and non-opioid analgesics; 4) local anesthesia pharmacology; 5) pediatric medicine.

Upon completion of the Program, Respondent shall ensure that the director or supervisor of the Program issues a competency assessment report to the Board regarding Respondent's ability to safely practice dental anesthesiology.

In the event the Board is satisfied that Respondent is able to safely and competently practice dental anesthesiology, the Board shall lift the restriction on Respondent's 1301 permit, which was restricted on June 7, 2018 pursuant to an Interim Consent Agreement. Respondent's 1301 permit shall then be placed on probation for a three-year period subject to the terms stated below.

2. Within thirty days of the effective date of this Consent Agreement, Respondent shall submit the name of a practice monitor who is a dental anesthesiologist licensed and in good-standing with the Board and who holds a 1301 permit. The practice monitor shall be responsible for ensuring that Respondent's anesthesia care of patients is in accordance with current guidelines and that Respondent is demonstrating appropriate anesthesia administration skills, including observing appropriate recovery and discharge guidelines, and that Respondent is ensuring that the facilities in which Respondent provides anesthesia care have personnel who are qualified to monitor patients in recovery and appropriate equipment to handle medical emergencies. Respondent shall agree during the first twelve months of the probationary period to allow the monitor to directly view and supervise his interactions with a minimum of three patients per month. In addition, during the first twelve months of the probationary period, Respondent shall agree to submit to three random chart audits per month by the monitor. During the second and third years of the probationary period, Respondent shall agree to allow a random audit by the monitor of a minimum of six patient charts per month. The monitor shall provide written reports to the Board of all activity on a monthly basis or at any time the monitor has concerns regarding Respondent's safety to practice. Respondent shall be responsible for all expenses relating to the practice monitor and preparation of the monthly reports. After 24 consecutive favorable reports from the monitor, Respondent may petition the Board in writing for termination of this requirement. Respondent's request for termination must be accompanied by a report from the practice monitor that

1 Respondent's fund of knowledge regarding current treatment guidelines for the anesthesia
2 care is adequate and meet the standard of care.
3 3. Any violation of this Consent Agreement constitutes unprofessional
4 conduct under A.R.S. § 32-1201.01(22) for failing to comply with a Board order and
5 grounds for further disciplinary action, including summary suspension and revocation of
6 Respondent's dental license and 1301 permit.
7
8 DATED this 4th day of September, 2018.

ARIZONA BOARD DENTAL EXAMINERS

9
10 By Nancy Chambers
Nancy Chambers
11 Interim Executive Director

12
EXECUTED COPY of the foregoing e-mailed this 4th day of September, 2018 to:
13
Frederick M. Cummings
14 1850 N. Central Avenue
Suite 1400
15 Phoenix AZ 85004

16 Aaron LeGrand Roberts, DMD
P.O. Box 11765
17 Glendale, AZ 85318

18 ORIGINAL of the foregoing filed this 4th day of September, 2018 with:

19 Arizona State Board of Dental Examiners
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