UNAPPROVED

BOARD OF DENTISTRY

MINUTES
SPECIAL CONFERENCE COMMITTEE "C"

TIME AND PLACE:	Special Conference Committee "C" convened on October 25, 2013, at 10:30 a.m., at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.
PRESIDING:	Myra Howard
MEMBERS PRESENT:	Evelyn M. Rolon, D.M.D. James D. Watkins, D.D.S.
STAFF PRESENT:	Kelley W. Palmatier, Deputy Executive Director Donna Lee, Discipline Case Manager Indy Toliver, Adjudication Specialist
QUORUM:	All three members of the Committee were present.
David Chapman, DDS **Case No.: 147349**	Dr. Chapman appeared with counsel, Kenneth Hirtz, to discuss the allegations set forth in a Notice of the Board dated July 24, 2013. The Committee received statements from Dr. Chapman and Mr. Hirtz and discussed the allegations with them.
Closed Meeting:	Dr. Watkins moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of David Chapman. Additionally, Dr. Watkins moved that Ms. Palmatier, Ms. Lee, and Ms. Toliver attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.
Reconvene:	Dr. Watkins moved that the Committee certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.
DECISION: **Case No.: 147349**	Ms. Toliver reported that the Committee found that during an unannounced inspection of Dr. Chapman's dental practice, the Department of Health Professions' investigator observed that Dr.

Chapman's nitrous oxide machine had a loud hissing sound when in operation; that his practice last received a nitrous tank on November 13, 2006 and an oxygen tank on November 20, 2012; and that he continued to use this faulty equipment on his patients.

The Committee also found that Dr. Chapman failed to obtain an American Society of Anesthesiologists (ASA) Risk Category prior to administering anesthesia to Patients A, F,G, H, J and K; thereby failing to determine the appropriateness of general anesthesia or sedation and its safety to patients.

The Committee further found that Dr. Chapman failed to diagnose decay on Patient B's tooth #4, as evidenced by radiographs taken at his practice on March 28, 2011; and that he failed to diagnose decay on Patient I's tooth L, as evidence by radiographs taken at his practice in 2009, 2010, 2011 and 2012.

Dr. Chapman billed Patient C's insurer on October 8, 2012 for a one surface restoration that was placed on Patient C's teeth M and R, despite the fact that treatment records do not indicate that a restoration was placed on teeth M and R. While providing treatment to Patient C, Dr. Chapman failed to include a diagnosis in the treatment record to justify treatment that was proposed on October 8, 2012, which included a stainless steel crown on tooth T, the extraction of tooth M, if present, and sealants. Dr. Chapman also failed to include a diagnosis in Patient C's treatment record to justify the treatment provided on October 8, 2012 that included sealants placed on teeth #14 and 19, the pulpotomy performed on Tooth T, and the stainless steel crown placed on tooth T.

Dr. Chapman administered 8 mg of Versed to Patient F on January 27, 2010 at 8:12 a.m., despite the fact that he noted on Patient F's Sedation and Anxiety Control Record that the patient had previously consumed cereal at 7:20 a.m.

While providing treatment to Patient G, Dr. Chapman failed to diagnose decay on tooth #2, until the patient presented at his practice on April 11, 2011 complaining of pain and discomfort, although radiographs taken on October 5, 2010 and February 18, 2011 showed decay; he cut into the distal side of tooth #14 when he prepared tooth #15 for a stainless steel crown, as evidenced by radiographs taken on November 22, 2011; and prior to administering Versed on February 18, 2011, he failed to record in his Sedation and Anxiety Control Record the last time the patient had eaten.

While providing treatment to Patient L, Dr. Chapman failed to diagnose decay on tooth #13, as evidenced by radiographs taken at his practice on August 11, 2007. Between August 24, 2011 and March 12, 2012, Dr. Chapman performed multiple dental procedures on tooth #13, despite the fact that tooth #13 had a hopeless prognosis because of undiagnosed decay and abscess. The remainder of Patient L's tooth #13 was below the level of the bone after Dr. Chapman's multiple dental procedures and, as a result, tooth #13 was extracted by an oral surgeon on September 6, 2012.

An unannounced inspection of Dr. Chapman's dental practice revealed that his practice did not have a clean appearance; the nitrous and tubing mask for the nitrous oxide machine was unclean and had a tear in the seal; bur blocks and operative trays that were rusty and in poor condition were utilized until November 2012; he failed to post his dental license in plain view of his patients; and he failed to post radiation certificates of those individuals in his office qualified to expose dental x-ray film in plain view of patients.

The inspection of the dental practice further showed that Dr. Chapman failed to include his name as the treating dentist in his patient records; failed to keep controlled substances maintained in his office stored in a securely locked, substantially constructed cabinet; failed to take an inventory of controlled substances in his practice that documented the dates the drugs were purchased, administered, dispensed or disposed of, including the date of the transaction, the name of the patient, the drug name and the quantity of medication administered or dispensed; and failed to take a biennial inventory of his stock of controlled substances and maintain records of receipt and distribution of such drugs. Dr. Chapman also maintained expired medications within the working stock of his drugs.

Dr. Chapman practiced under the name of D. Courtney Chapman rather than David C. Chapman, the name under which he is licensed by the Board.

The sanctions reported by Ms. Toliver were that Dr. Chapman shall pay a $8,000.00 monetary penalty, and that his license shall be placed on probation subject to the terms and conditions that within 6 months from the date of entry of the Order he shall successfully complete 3 hours of continuing education in recordkeeping and 8 hours of continuing education in pediatric sedation. Dr. Chapman's practice shall be the subject of an

unannounced inspection of a random sample of 10 complete patient records for review by the Board. Dr. Chapman shall also provide evidence that he has taken and passed the Board's Dental Law Examination.

Dr. Watkins moved to adopt the decision of the Committee. The motion was seconded and passed.

Approval of Minutes: Upon a motion by Dr. Watkins, the minutes from the Informal Conference conducted on September 20, 2013 were approved.

ADJOURNMENT: With all business concluded, the Committee adjourned at 5:30 p.m.

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Myra Howard, Chair

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Sandra K. Reen, Executive Director

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Date

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Date