FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION TO THE DIRECTOR

Now comes the Illinois Board of Dentistry of the Division of Professional Regulation of the Department of Financial and Professional Regulation of the State of Illinois and, after reviewing the record in this matter, a majority of its members hereby makes the following Findings of Fact, Conclusions of Law and Recommendation to the Director:

FINDINGS OF FACT:

The Board adopts the Findings of Fact contained in the Report and Recommendation of Administrative Law Judge Michael J. Lyons and incorporates them herein.

CONCLUSIONS OF LAW:

The Board adopts the Conclusions of Law contained in the Report and Recommendation of Administrative Law Judge Michael J. Lyons and incorporates them herein.

RECOMMENDATION:

The Board adopts in part and rejects in part the recommendations contained in the Report and Recommendation of Administrative Law Judge Michael J. Lyons.
SPECIALTY LICENSE:

Based upon the above Findings of Fact and Conclusions of Law the Illinois Board of Dentistry of the Division of Professional Regulation of the Department of Financial and Professional Regulation of the State of Illinois accepts the recommendation of Administrative Law Judge Michael J. Lyons with respect to Respondent's specialty license in pedodontics and therefore recommends that the Certificate of Registration, Specialty License in Pedodontics No. 021-00184 of Hicham K. Riba be Indefinitely Suspended for a minimum of 3 years from the date of the Director's Order.

GENERAL DENTISTRY LICENSE:

The Board rejects the recommendation of Administrative Law Judge Michael J. Lyons in regard to his recommendation of an 18 month indefinite suspension of Respondent's license to practice general dentistry, and instead recommends that Respondent's Certificate of Registration, General Dentistry License No. 019-024373 of Hicham K. Riba be Suspended for 6 months from the date of the Director's Order followed by an Indefinite Probation of 4 Years with the following conditions:

1. Respondent shall submit quarterly statements setting forth the details of his practice during the preceding quarter to the Probation Unit of the Division of Professional Regulation, 100 W. Randolph St., Suite 9-300, Chicago, IL 60601.
2. Respondent shall complete 100 hours of in-person continuing education, pre-approved by the Dental Coordinator, in addition to those hours of continuing education required to renew his license in the following areas:
   a. at least 40 hours in behavioral management of pediatric patients;
   b. at least 20 hours in pharmacology;
   c. at least 20 hours in medical emergencies in the dental office;
   d. at least 14 hours in record keeping and office management; and
   e. at least 6 hours in the Illinois Dental Practice Act.
3. Respondent shall maintain current certification in basic life support.
4. Respondent shall successfully complete a course in advanced life support and a course in pediatric advanced life support.

The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is too severe given that the actual general dental procedures performed on the patient were not the proximate cause of the patient's death. The Board finds that 6 months is a sufficient length of time to keep Respondent from practicing his profession, and 4 years of probation will give the Respondent an opportunity to rehabilitate himself.

CONSCIOUS SEDATION PERMIT:

The Board rejects the recommendation of Administrative Law Judge Michael J. Lyons in regard to his recommendation of an indefinite suspension for a minimum of 3 years of Respondent's conscious sedation permit and instead recommends that the conscious sedation Permit A, No. 137-000432 of Hicham K. Riba be Revoked.

The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent demonstrated a complete lack of understanding of
conscious sedation after 9 years of practice in the area of conscious sedation, and after performing some 32,000 procedures involving conscious sedation. The Board finds that given this lack of understanding at this point in his career Respondent unfit to administer conscious sedation.

CONTROLLED SUBSTANCE LICENSE:

The Board rejects the recommendation of Administrative Law Judge Michael J. Lyons in regard to his recommendation of an indefinite suspension for a minimum of 3 years of Respondent's controlled substance license and instead recommends that the controlled substance license, No. 319-013001, of Hicham K. Riba be Indefinitely Suspended for a minimum of 5 years.

The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

DATED THIS 7th DAY OF February, 20...[redacted]

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Dr. Thomas Fonner, D.M.D.

MEMBER, Ms. Debra Grant, R.D.H.

MEMBER, Dr. Charles Johnson, D.D.S.

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MEMBER, Ms. Carlene Snell, R.D.H.

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DATED THIS 7th DAY OF February, 2007.

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

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The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.


CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Dr. Thomas Fonner, D.M.D.

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The Board rejects the recommendation of Administrative Law Judge Michael J. Lyons in regard to his recommendation of an indefinite suspension for a minimum of 3 years of Respondent's controlled substance license and instead recommends that the controlled substance license, No. 319-013001, of Hicham K. Riba be Indefinitely Suspended for a minimum of 5 years.

The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

DATED THIS 1st DAY OF February, 2007

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Thomas Foner, D.M.D.

MEMBER, Dr. Charles Johnson, D.D.S.

MEMBER, Dr. Alan Shapiro, D.D.S.

MEMBER, Anthony Spina, D.D.S., M.D.

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Ms. Debra Grant, R.D.H.

MEMBER, Dr. J. Michael Krisko, D.D.S.

MEMBER, Ms. Carlene Snell, R.D.H.

MEMBER, Dr. Melanie Watson-Montgomery, D.D.S.
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The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

DATED THIS 29 DAY OF JANUARY 2007

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Dr. Thomas Fonner, D.M.D.

MEMBER, Ms. Debra Grant, R.D.H.

MEMBER, Dr. Charles Johnson, D.D.S.

MEMBER, Dr. J. Michael Krisko, D.D.S.

MEMBER, Dr. Alan Shapiro, D.D.S.

MEMBER, Ms. Carlene Snell, R.D.H.

MEMBER, Anthony Spina, D.D.S., M.D.

MEMBER, Dr. Melanie Watson-Montgomery, D.D.S.
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CONTROLLED SUBSTANCE LICENSE:

The Board rejects the recommendation of Administrative Law Judge Michael J. Lyons in regard to his recommendation of an indefinite suspension for a minimum of 5 years of Respondent's controlled substance license and instead recommends that the controlled substance license, No. 319-013001, of Hicham K. Riba be Indefinitely Suspended for a minimum of 5 years.

The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

DATED THIS 7th DAY OF FEBRUARY, 2007

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Dr. Thomas Fonner, D.M.D.

MEMBER, Ms. Debra Grant, R.D.H.

MEMBER, Dr. Charles Johnson, D.D.S.

MEMBER, Dr. J. Michael Krisko, D.D.S.

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The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

DATED THIS 6 DAY OF JUN, 2007

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Thomas Fonner, D.M.D.

MEMBER, Dr. Charles Johnson, D.D.S.

MEMBER, Dr. Alan Shapiro, D.D.S.

MEMBER, Anthony Spina, D.D.S., M.D.

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Ms. Debra Grant, R.D.H.

MEMBER, Ms. Carlene Snell, R.D.H.

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The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

**DATED THIS** 7th **DAY OF** February, 2007.

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Thomas Fonner, D.M.D.

MEMBER, Dr. Charles Johnson, D.D.S.

MEMBER, Dr. Alan Shapiro, D.D.S.

MEMBER, Anthony Spina, D.D.S., M.D.

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The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

DATED THIS 7th DAY OF February, 20__

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Dr. Thomas Fonner, D.M.D.

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The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

DATED THIS 30 DAY OF January, 2007

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas
MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Dr. Thomas Fonner, D.M.D.
MEMBER, Ms. Debra Grant, R.D.H.

MEMBER, Dr. Charles Johnson, D.D.S.
MEMBER, Dr. J. Michael Krisko, D.D.S.

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The Board finds that the discipline recommended by Administrative Law Judge Michael J. Lyons is not sufficient to protect the public. Respondent's actions demonstrated a complete lack of understanding of the proper use of controlled substances in conscious sedation; however, Respondent may be able to demonstrate appropriate use of controlled substances in other areas involved in the practice of dentistry after adequate rehabilitation. The Board finds that a 3 year suspension is insufficient to accomplish this purpose.

**DATED THIS 13TH DAY OF February, 2007**

CHAIRMAN, Dr. Barbara Mousel, D.D.S.

MEMBER, Mr. Bob Bastas

MEMBER, Dr. Geri Ann DiFranco, D.D.S.

MEMBER, Dr. Thomas Fonner, D.M.D.

MEMBER, Ms. Debra Grant, R.D.H.

MEMBER, Dr. Charles Johnson, D.D.S.

MEMBER, Dr. J. Michael Krisko, D.D.S.

MEMBER, Dr. Alan Shapiro, D.D.S.

MEMBER, Ms. Carlene Snell, R.D.H.

MEMBER, Anthony Spinna, D.D.S., M.D.

MEMBER, Dr. Melanie Watson-Montgomery, D.D.S.
STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION
of the State of Illinois.

Complainant, No. 200612566

HICHAM K. RIBA
License No. 19024373
License No. 137000432
License No. 21001848
License No. 319013001

Respondent.

REPORT OF THE ADMINISTRATIVE LAW JUDGE
TO THE BOARD OF DENTISTRY

BACKGROUND

On September 29, 2006, the Department of Financial and Professional Regulation (hereinafter the Department) petitioned Daniel E. Bluthardt, Director of the Department’s Division of Professional Regulation, pursuant to Section 26(b) of the Illinois Dental Practice Act (225 ILCS 25/1, et seq.), to issue an order temporarily suspending the licenses as a dentist, pediatric dental specialist, controlled substance prescriber/dispenser and conscious sedation provider of respondent Hicham K. Riba. The Department’s petition alleged that on September 23, 2006, the respondent provided dental treatment to a five year old female patient, Diamond Brownridge, who weighed 35 pounds at the time. Various drugs were administered to the patient
for anesthetic purposes, which the petition states placed her in a state of deep sedation from
which she fell into an irreversible coma, and she remained in that coma until her death on
September 27, 2006. The Department alleged that the respondent did not properly monitor the
patient’s vital statistics, and that the public interest required that respondent’s licenses be
temporarily suspended because his conduct demonstrated a likelihood that he would engage in
similar conduct in the future, posing an immediate danger to the public. After hearing evidence
presented by the Department, Director Bluthardt signed an order on September 29 temporarily
suspending Dr. Riba’s licenses. Along with its petition the Department filed a seven count
complaint against the respondent, which alleged various violations of the Dental Practice Act. A
notice of summary suspension was personally delivered that same day to the respondent’s
attorney, Glen Crick. The notice set a hearing on the charges contained in the complaint for
October 13 at 10:00 a.m.

On October 10 the Department filed an amended complaint of four counts. Count 1 alleges
that the respondent violated Section 23(20) of the Dental Practice Act by committing gross
malpractice which resulted in the death of a patient by administering excessive doses of
medication and failing to properly monitor the patient. Count 2 alleges that the respondent acted
contrary to Section 23(15) of the Act and Section 1220.520(a-f) of the Rules for the
Administration of the Dental Practice Act because he placed his patient in deep sedation and he
did not hold a deep sedation permit. Count 3 alleges that the respondent’s acts and omissions
constituted dishonorable, unethical or unprofessional conduct of a character likely to deceive,
defraud or harm the public, in violation of Section 23(11) of the Act. Count 4 alleges that
Section 23(23) was violated because respondent’s conduct amounted to professional
incompetence as manifested by poor standards of care. Through his attorney, Dr. Riba on October 11 filed an answer to the amended complaint denying the legal conclusions drawn by the Department.

The exchange of discovery between the parties prior to the formal hearing proceeded smoothly. A pre-hearing was held on October 12, during which the administrative law judge ruled on five motions made by the respondent. The motion to dismiss the first amended complaint was denied; the motion in limine to prohibit the broadcast or recording of the hearing was granted; the motion to quash and prevent use of records improperly obtained was denied; the motion to exclude witnesses was granted; and the motion to recuse Director Bluthardt from this matter was referred to the Director for decision. The formal hearing commenced on October 13, with additional proceedings occurring on October 16, 18 and 19. Representing the respondent at trial were attorneys Glen Crick, Lillian Walanka and Alan Rhine. The Department was represented by John Lagattuta, Sadzi Oliva and Eileen Lewalski. Illinois Board of Dentistry member Dr. Gerri DiFranco attended the first 3 days of the hearing, while Dr. Alan Shapiro was present on the final day.

EXHIBITS

The following exhibits were submitted by the Department and admitted into evidence:

Group Exhibit A - records of Diamond Brownridge's dental treatment at Dr. Riba's clinic

Exhibit C - adverse occurrence report sent by Dr. Riba to Department Dental Coordinator Mary Ranieli, dated September 26, 2006

Group Exhibit D - Chicago Fire Department records of paramedic response to Dr. Riba's clinic and treatment of Diamond Brownridge on September 23, 2006

Exhibit S - certified Department licensure file for Dr. Hicham Riba
Exhibit U - transcript of temporary suspension hearing before Director Bluthardt on 9/29/06

Exhibit V - curriculum vitae of Department expert witness William G. Flick

Exhibit W - Rules for the Administration of the Illinois Dental Practice Act, Section 1220, Appendix D, chart of characteristics of levels of anesthesia (definitions and requirements of the Rules placed in chart form)

Exhibit Z - amended adverse occurrence report sent by Dr. Riba to Department Dental Coordinator Mary Ranieli, dated October 6, 2006

Group Exhibit AA - copies of Department licenses issued to Dr. Riba

Exhibit BB - yellow “post-it” note from Dr. Riba’s clinic regarding pre-med pill dosage based on weight of patient

Exhibit CC - certified copy of letter from the Cook County Medical Examiner stating the cause of death of Diamond Brownridge

The following exhibits were submitted by the respondent and admitted into evidence:

Exhibit B - log of activity at dental clinic on September 23, 2006, as shown by security camera 3; prepared by private detective Michael Fullman

Exhibit C - affidavit of Michael Fullman regarding 10 minute discrepancy between time stamped on security video and real time; events on video (and log) occurred 10 minutes earlier than time stamped.

Exhibit D - affidavit of security technician regarding retrieval of data from security hard drive

Exhibit F - card showing completion by Maribel Robles of Heart Association BLS course

Exhibit G - certificate of completion by Maribel Robles of nurse assistant program

Exhibit H - copy of state ID card of Carmen Martinez and certificate of her completion of Red Cross CPR course

Exhibit I - copy of Illinois drivers license of Zoila Ocampo and certificate of her completion of Red Cross CPR course

Exhibit J - certificate of completion by Zukaey Allababidi of Red Cross CPR course

Exhibit Q - curriculum vitae of respondent’s expert witness S. Dale Hibbert
FINDINGS OF FACT

Dr. Riba, the respondent, was called by the Department to testify on adverse examination. He stated that prior to the temporary suspension of his licenses he held 4 types of licensure with the Department. These were for general dentistry, pediatric dentistry, controlled substance dispensing, and conscious sedation. The last license is also referred to as a Permit A. In order to qualify to obtain a Permit A and perform conscious sedation, the respondent took an anesthesia rotation during his postgraduate training at New York University. He testified that during the rotation he learned that medication dosages may be different for adults and children, and also may differ between patients due to weight.

The respondent was asked to define conscious sedation. He stated that “a general definition of conscious sedation is applying medication to the patient ... with the patient maintaining his or her good airway, and having a response to verbal communication and/or physical stimulation...” (transcript, p. 21). There is a definition of conscious sedation contained in the Rules for the Administration of the Dental Practice Act, Section 1220, Appendix D (chart of characteristics of levels of anesthesia), which was admitted into evidence as Department exhibit W. The term is defined in the chart as a “pharmacologically induced state of depressed consciousness (altered consciousness, signs of sleep) under which an individual retains the ability to independently and continuously maintain an airway and respond to physical stimulation and verbal commands.” There is an important difference between respondent’s definition and that contained in the Rules in that the latter requires the patient to respond to both physical stimulation and verbal commands, while the respondent’s is satisfied by one or the other.
The Department contends that the inability of Diamond Brownridge to respond to verbal commands while being treated, among other things, means that she was in a state of deep sedation. Since Dr. Riba did not possess the appropriate license to place patients in deep sedation (Permit B), the Department maintains that he was in violation of the Dental Practice Act and Rules, as alleged in Count 2 of the amended complaint. The chart in the Rules (exhibit W) defines deep sedation as a "pharmacologically induced controlled state of depressed consciousness, accompanied by partial loss of protective reflexes, including inability to respond purposefully to verbal command." The issue of whether Diamond Brownridge was in a state of deep, as opposed to conscious, sedation will be decided at a later point in this opinion. However, it should be noted that for the purposes of this opinion the definitions which will govern are those stated in the Rules for the Administration of the Dental Practice Act.

Dr. Riba acknowledged that in order to work on a sedated patient there must be 2 trained people to assist the dentist during the procedure, and with the preoperative, intra-operative, and pre-discharge monitoring required by the Rules. He testified that his assistants are trained in CPR, in monitoring patient breathing and the pulse oximeter device, and in handling the "premed" process (the first part of the visit when the patient is weighed and given the initial dosage of medication). His assistants are not taught how to record patient vital signs or how to take blood pressure readings as the respondent takes responsibility for those tasks. Also, they are not trained in the use of a stethoscope to monitor the lungs (transcript, p. 25). On September 23, 2006, Maribel Robles and Zoila Ocampo were the assistants helping Dr. Riba during the treatment of Diamond Brownridge.
On that day Diamond and her mother arrived at the dental office, known as Little Angel Dental Clinic, between 8:30 and 9:00 a.m. According to Dr. Riba, the dental work he planned to perform included 5 fillings, 2 pulpotomies and 2 crowns. The first step in the treatment process was when mother and child went to the lab sterilization area, where an assistant (in this case Zoila Ocampo), weighed the child on a scale and gave her oral pre-medication. In the area where this took place was a yellow “post-it” note to guide the assistant regarding the proper dosage to be given to the patient. This note has been admitted into evidence as Department exhibit BB. The note says that if the patient weighs less than 35 pounds he or she is given one pill; those between 35 and 46 pounds are given one and a half pills; and those weighing more than 46 pounds receive two pills. Each pill contains 5 milligrams of Diazepam. Diamond was weighed at 35 pounds and was given one and a half pills, or 7.5 milligrams of Diazepam.

At a quarter to ten that morning, Dr. Riba observed Diamond sitting in a dental chair in examining room number four. She had a mask on her face and was receiving a mixture of oxygen and nitrous oxide, the latter being at a level of less than 50% of the mix. The respondent increased this level to 50%, and then proceeded to talk to the mother, who was still in the room at this point. He asked if the child had anything to eat or drink and if she had any medical problems or conditions. He also gave the mother a consent form and a set of post-operative instructions; signed copies of both forms may be found in the dental records contained in Department group exhibit A. The child was attached by finger to the pulse oximeter device, which was later removed for a time during IV insertion. At ten o’clock the respondent testified that he was monitoring his patient’s respiration, pulse and oxygen saturation level, but only recorded the last statistic in the dental records (transcript, p. 39). Prior to the insertion of the IV
the mother was asked to leave the room, leaving the patient with Dr. Riba and his assistants Maribel Robles and Zoila Ocampo. A third assistant (presumably Zukaey Allababidi, although the testimony doesn't refer to him by name) was in the room fixing the squeaky hinges on a door, but he was called upon to help stabilize the child for the IV insertion because “she was moving very violently” (transcript, p. 41). After the successful insertion of the IV the respondent made his initial injection of anesthetic medications.

According to his testimony, the respondent at 10:00 a.m. intravenously administered 1.3 milliliters, or 1.3 milligrams, of Midazolam, which is similar to Valium but shorter-acting. Also administered was .25 milliliters, or .1 milligrams, of Atropine to reduce saliva secretion; and .25 milliliters, or 7.5 milligrams, of Talwin for pain management. He also gave his patient 1.3 milliliters, or 6.5 milligrams, of Diazepam. Lidocaine and epinephrine complete the list of administered medications. After five minutes the patient started to settle down, so the respondent started working on her teeth. However, there was a sudden movement so he administered another dosage of Diazepam at 10:05 a.m., according to the anesthesia record prepared by the respondent and contained in Department group exhibit A. The record indicates this second dose was 1.2 milliliters, or 6 milligrams, although the respondent on the stand denied giving his patient the full amount because she was starting to calm down during the injection, stating that he only administered .8 milliliters, or 4 milligrams (transcript, p. 44). There is a similar discrepancy between the first adverse occurrence report (Department exhibit C) sent by the respondent to the Department's Dental Coordinator on September 26, 2006; and the amended report (Department exhibit Z) dated October 6, 2006. The first report lists the second Diazepam IV dose at 1.2 milliliters, while the amended report says .8 milliliters.
After all the medications were delivered the patient settled down. In fact, according to Dr. Riba's testimony, the patient “was not awake” (transcript, p. 47). The respondent testified that while he performed the dental work, he checked respiration, pulse and blood oxygen saturation level. Of these three stats only the last is charted in the anesthesia record. He did not take a blood pressure reading, so that is not in the record. The oxygen saturation level is noted at five minute intervals in the record from 10:00 to 10:30 a.m. and is generally 99%, except for the 97% recorded at 10:20 and the 98% at 10:25. The dental work was complete at 10:30, at which time the respondent pinched the patient’s trapezius muscle and elicited a “very significant response” (transcript, p. 56) in terms of arm movement and facial expression. He did not attempt to elicit a verbal response, leaving that for when the mother returned to the room. He turned the child on her side for airway maintenance, removed the pulse oximeter and left the room after instructing his assistant Zoila Ocampo to keep pinching the trapezius muscle. Ms. Ocampo was expected to watch the patient’s breathing, but she was not checking or charting vital signs such as pulse, blood pressure or respiration counts per minute.

Ten minutes after leaving the room, the respondent returned and joined patient, mother and Ms. Ocampo. He instructed Ms. Ocampo to “Show the mom how to pinch the muscle” (transcript, p. 67). The assistant pinched the child, but she did not respond. The respondent then pinched his patient but there was still no reaction, so he replaced the pulse oximeter to get some readings of vital signs. The heart rate initially was 30 something per minute, then the respondent adjusted the device and the display read in the 60s. A normal heart rate for a child of five, according to the respondent, is about 100 plus or minus 10. Dr. Riba then asked his assistants to
call 911 and he started to perform CPR, which he continued to do for 5 or 6 minutes until the paramedics arrived and took over resuscitation efforts. The Chicago Fire Department records (Department group exhibit D) show that the paramedics arrived at the clinic at 10:58 a.m. and at the patient at 10:59 a.m., departing the scene for Mt. Sinai Hospital at 11:13 a.m. The paramedics had intubated Diamond, but Dr. Riba didn’t believe she was breathing on her own as she was taken from the clinic (transcript, p. 75). As the fire department personnel were leaving, the respondent gave them a handwritten summary of the drugs his patient had received that morning. A copy of this summary may be found in Department group exhibit A, the page being stamped with the number 31. This record shows that the patient was given 1.3 and 1.2 milliliters of Diazepam by IV, or 12.5 milligrams. Dr. Riba’s explanation as to why the amount differs from what he testified to administering (1.3 ml plus .8 ml) is that he was merely copying numbers from the incorrect anesthesia record (transcript, p. 82).

During a brief examination the respondent’s attorney questioned him regarding his background and the nature of his dental practice. Dr. Riba has been licensed as a general dentist and pediatric dentist in Illinois since 1997. Prior to his temporary suspension he was working six days a week, eight to ten hours a day. He considers his practice to be an inner city practice, and he has seen patients from many different city neighborhoods because he gets referrals from 30 dental practices. Many of these referrals are pediatric patients who are difficult to treat because of poor behavior. The respondent accepts Public Aid for payment. He estimates that during the nine years he has been a dentist in this state he has treated 32,000 patients. Most of these patients were children, and he further estimates that he has placed thousands of them under conscious sedation. (See transcript, pp.36& 37, for these estimates.) Before the incident which is the
subject matter of this opinion, there had been no complaints against him made to the Department and no malpractice cases filed against him. The respondent testified that he was “saddened” by the events which occurred in his office on September 23, 2006. During questioning his attorney suggested that his feelings of sadness or being upset may explain the discrepancy between his testimony concerning the second IV dose of Diazepam (he said he gave .8 ml.) and the amount noted in the dental records (1.2 ml.). In response to the quest on, “…Was the foremost thing on your mind to write down accurate records, or was it to take care of the patient?”; he replied, “It was the patient’s welfare was (sic) on my mind” (transcript, p. 88). This attempted explanation is not believable.

Dr. Riba was an articulate, although soft-spoken, witness. His remorse regarding the tragic death of Diamond Brownridge appeared genuine. His testimony was generally credible, with some exceptions. These exceptions include the just mentioned Diazepam dose discrepancy, as well as his attempt to redefine the concept of conscious sedation in a manner which does not correspond to the definition in the Rules of the Illinois Dental Practice Act.

The Department next called to the stand Zoila Ocampo, Dr. Riba’s dental assistant who was with Diamond at the “pre-med” portion of the visit, as well as the operative and post-operative time until the paramedics transported her to the hospital. Ms. Ocampo started working for the respondent in February, 2006; prior to that she had no dental employment experience or training. She did take a Red Cross CPR class at the office on April 7, 2006 (Her certificate of completion is copied in respondent exhibit I.) She also received some on the job training from Dr. Riba such as how to read the pulse oximeter, but she was not taught how to take blood
pressure. Ms. Ocampo was also trained at the office to take x-rays and how to do some coronal polishing, and how to hold a patient’s head to facilitate breathing.

On September 23, 2006, Ms Ocampo started work at 8:00 a.m., and she stated that Diamond and her mother arrived 10 or 15 minutes later. Ms. Ocampo conducted the “pre-med” in the lab, where she weighed the child, who received one and a half pills of oral Diazepam (7.5 milligrams) per the yellow “post-it” dosage chart (Department Exhibit BB). The pills were crushed into lemonade and given to the mother to give to the child. Ms. Ocampo left mother and daughter together for a period of time of one half hour to 45 minutes to allow the pills to take effect, then she led the pair to exam room four. She directed the young patient to the dental chair and placed a mask on her which began delivering nitrous oxide. Ms. Ocampo connected the pulse oximeter so it could provide its readings, but she was not monitoring patient signs such as pulse, blood oxygen saturation level, respiration or blood pressure (transcript, pp. 103 & 104).

Shortly after the patient was seated and started on nitrous oxide (3 to 5 minutes per transcript, p.104), Dr. Riba entered the room. According to Ms. Ocampo, Diamond was awake, talkative and moving around at this time. The respondent discussed the consent form and care instructions with the mother, who then left the room. Ms. Ocampo, Maribel Robles and “Zac” (Mr. Allababidi, who had been working on the door) assisted during the IV insertion. The respondent started to deliver drugs through the IV, but Diamond was still moving and crying. “Then he numbed her...It took like a couple of minutes for her to go to sleep,” stated Ms. Ocampo (transcript, p. 108). Ms. Ocampo testified that Diamond was asleep the whole time the respondent was performing the dental work (transcript, p. 110). Assistant Maribel Robles’ main
duty during the procedure was to watch the heart rate and blood oxygen saturation readings on the pulse oximeter, while Ms. Ocampo was assisting Dr. Riba as he performed the dental work.

After the work was complete, Diamond was “waking up” (transcript, p. 110), moving around, but there was no verbal communication. The patient was placed on her side to facilitate breathing, and Ms. Ocampo was pinching her muscle to continue the waking up process. Dr. Riba left the room after disconnecting the pulse oximeter, leaving Ms. Ocampo alone with the patient for approximately ten minutes. After some more moving around Diamond went back to sleep (transcript, p. 114). Then the mother returned to the exam room, followed shortly thereafter by the respondent. He pinched his patient but she didn’t move. Ocampo and Riba noticed Diamond wasn’t breathing (transcript, pp. 118, 119 & 120), so he started CPR and the paramedics were called. At some point during these resuscitation efforts, the mother left the room because she was upset and Ms. Ocampo reconnected the pulse oximeter.

Zoila Ocampo was a truthful witness, but she was not very articulate when expressing herself on the stand, possibly because of nervousness. She is a young and inexperienced dental assistant who was not very well trained for her job. Dental board member Dr. DiFranco elicited from the witness the information that she had not taken a course in the administration and monitoring of nitrous oxide (transcript, p. 129).

The Department also called as a witness dental assistant Maribel Robles, who had just started her job at Dr. Riba’s clinic on September 20, 2006, or three days before the incident at issue. Her previous dental experience was nine months of employment at Studio Dental, where
she was an assistant but was not involved in IV sedation as they did not perform it there. She took an American Heart Association CPR course in 2005 (respondent exhibit F), and completed a basic nurse assistant training program at the Samland Institute from September 13 to October 15, 2005 (respondent exhibit G). She did not receive training from Dr. Riba, but she did observe some patients being treated while IV sedation was occurring.

Ms. Robles testified that she observed Diamond running in the dental clinic prior to her treatment on September 23. The next time she saw the child was in the dental chair in the exam room, and Dr. Riba and Zoila Ocampo were already in the room. Her primary duties in the room were to “hold Diamond” and monitor the pulse oximeter (transcript, p. 354). While she was in the exam room she did not check the patient’s blood pressure nor did she monitor respiration by counting, but she did check to see if the patient was breathing. Ms Robles escorted the mother from the room and the IV sedation began. After the initial IV dose she stated that Diamond was “still moving around, kicking and crying”, so Dr. Riba said he was going to apply more medicine (transcript, p. 358). Ms. Robles does not remember Dr. Riba checking the patient’s blood pressure or respiration. In response to a question of whether Diamond was awake during the procedure, the witness stated, “She had her eyes closed” (transcript, p. 361). After the procedure was over she applied pressure to Diamond’s arm and put a band-aid where the IV had been removed. Ms. Robles then left the room with a tray of instruments and proceeded to contact the patient’s mother, leaving the child with Zoila Ocampo. This was the fourth or fifth time Ms. Robles had assisted in an IV sedation procedure (transcript, p. 362). On cross-examination the respondent’s attorney elicited from the witness that to the best of her knowledge Diamond was never left unattended.
Maribel Robles was a believable witness. As a dental assistant she is inexperienced, having worked as one for only nine months prior to starting at the respondent's office. As noted above, she had little experience assisting during IV sedations and received no formal training from Dr. Riba, although the nurse assistant program she took in 2005 gave her some exposure to medical concepts and procedures.

The Department also called as a witness the investigator assigned to this case, Pete Vasiliades. He has been employed as an investigator by the Department for 21 years, has investigated over 1000 dental cases during his career and has been assigned to investigate the case against the respondent. As a part of his work on this case he obtained records which have been admitted into evidence such as the patient dental records (Department group exhibit A) and the paramedic records from the Chicago Fire Department (Department group exhibit D). The paramedic records of the September 23 call to the respondent's clinic note the case type as "person unconscious not breathing"; an arrival time of 10:58 a.m.; that the patient was found in cardiac arrest and was successfully intubated; and a departure time of 11:13 a.m. Mr. Vasiliades also was responsible for obtaining from the medical examiner's office Department exhibit CC, which is a certified letter signed by Chief Medical Examiner Edmund Donoghue confirming that Diamond Brownridge died in Cook County on September 27, 2006. The letter also states that the body was examined and the cause of death was found to be anoxic encephalopathy due to anesthesia during dental procedure. Investigator Vasiliades testified that the autopsy report was not yet completed.
Mr. Vasiliades also conducted interviews of witnesses, including Zoila Ocampo. He testified that she told him that shortly after the completion of the dental procedure and the removal of the IV, "the girl was breathing heavily and gasping for air" and then was rolled on her side (transcript, p. 380). On cross-examination the witness acknowledged that the word gasping was his term and not Ms. Ocampo's, as she had demonstrated by acting how the child was breathing. He characterized her re-enactment as "gasping for air", to which she responded "Yeah" (transcript, p. 419). Also on cross-examination Mr. Vasiliades, in response to questioning by the respondent's attorney, stated that his investigation was not completed at the time of the temporary suspension on September 29, 2006, and was still continuing on the day he testified as to certain aspects of the case. To summarize regarding this witness, this administrative law judge finds that Mr. Vasiliades is a competent and experienced investigator whose testimony regarding his knowledge of this case is credible.

The Department's expert witness was William Flick, who has had an Illinois dental license since 1974, the year he graduated from the University of Illinois College of Dentistry. Dr. Flick is also an oral surgeon, having completed in 1977 his residency in oral and maxillofacial surgery at Cook County Hospital. During this residency he received training in sedation and anesthesia, and he holds a Permit B from the Department, which allows him to work on patients using deep sedation and general anesthesia. His other current Illinois licenses include a specialty license in oral surgery and a controlled substance license. Dr. Flick has been board certified in oral and maxillofacial surgery since 1979. Past career highlights include two years as a surgeon for the United States Air Force, nine years as a clinical professor at the Loyola University School of Dentistry, and providing input to the Board of Dentistry regarding the drafting of the rules.
governing dental anesthesia permits in 1995, 1996 and 2003. He has been in private practice treating patients of all ages since 1979 and has been a clinical professor at the University of Illinois College of Dentistry since 1993. For a complete recitation of Dr. Flick’s many accomplishments refer to Department Exhibit V, his resume.

Dr. Flick testified for the Department at the temporary suspension hearing before Director Bluthardt on September 29, 2006. With regard to the dosages of the medications which were given to Diamond Brownridge on September 23, Dr. Flick stated, “These dosages are all high dosages for a patient of this size and height, and the dosages probably would have placed the patient in a deep plaintive (sic, should probably read, state of) sedation” (transcript of Sept. 29 temporary suspension hearing, pp. 8&9, Department exhibit U). The doctor agreed with the Department’s question that the continued practice of the respondent constituted an imminent danger to the people of Illinois (Department exhibit U, pp. 10 & 11).

Dr. Flick testified at the formal hearing on October 13 & 16, 2006, and expressed a number of opinions about the case based on his review of documents provided him by the Department. He especially relied on the anesthesia record in the dental records (Department group exhibit A) and the statement of adverse occurrence written by the respondent (Department exhibit C) as sources of information. When asked his opinion regarding the appropriateness of giving the patient by IV two doses of diazepam, amounting to 2.5 milligrams, in a period of five minutes, he said, “...perhaps 5 milligrams would be the dose that we would possibly want to try and remain at” (transcript, p. 161). The witness stated a number of times during his testimony that the effect of all the drugs given to the patient was additive, increasing the sedative effect.
Another opinion expressed by the witness was that all the drugs administered to the patient that morning produced a deep level of sedation (transcript, p. 168).

Dr. Flick also concluded that in his opinion there was inadequate intra-operative monitoring of vital signs by the respondent, as well as inadequate pre-discharge monitoring (transcript, p. 182). The witness noted that in the anesthesia record prepared by the respondent, the only patient vital sign recorded was the blood oxygen saturation level. There was no record of blood pressure, pulse, respiration or electrocardiogram monitoring. The first three are required by the Dental Practice Act Rules (see Department exhibit W) to be monitored during conscious sedation; all four are required to be monitored during deep sedation. In Dr. Flick's opinion, failure to record patient signs which are required to be monitored is a deviation from the standard of care (transcript, p.175). Dr. Flick also opined that to a reasonable degree of medical and dental certainty the lack of monitoring by the respondent in this case “would be a very probable cause” of the patient’s death (transcript, p. 189).

The witness also formulated the following opinions to a reasonable degree of medical and dental certainty: that the respondent's actions constituted gross improper or negligent treatment; that he did not have the permit required by the Act and Rules for the type of sedation he administered to the patient; that the respondent engaged in unprofessional conduct resulting in harm; and that he engaged in professional incompetence as manifested by poor standards of care (transcript, pp. 190 & 191). A lengthy and spirited cross-examination failed to dislodge Dr. Flick from his conclusions. On re-direct examination the witness had the opportunity to elaborate on some aspects of his opinion making process which were called into question during the cross.
For example, he acknowledged that he had not seen the letter from the medical examiner’s office stating that the cause of Diamond’s death was anoxic encephalopathy due to anesthesia during dental procedure (Department exhibit CC) prior to formulating his opinions. However, he testified that the letter “...certainly reinforces the notion that the practice or procedure as performed here was probably the proximate cause of death” (transcript, p. 323). Dr. Flick also said that a final autopsy report (not completed at the time of the hearing) would not alter his opinion “…because the dental record showed so many deviations from what we would anticipate the normal practice of care, and those basically were the high dosages used for the size of the patient and lack of accurate monitoring, that even if the death was not the proximate cause (sic), certainly there were enough deviations to question this dental practice” (transcript, pp. 322 & 323). Finally, after having been shown the respondent’s amended incident report (Department exhibit Z) which lists the IV Diazepam dose as lower than in the original incident report (Department exhibit C), the witness stated that the change in amount would not change his opinion since, “We’re still in a high-dose range” (transcript, p. 327).

This administrative law judge finds that Dr. Flick is an exceptionally well-qualified expert witness. His testimony was informed, thoughtful and credible.

The respondent’s attorneys called Carmen Martinez, the office manager at Little Angel Dental Clinic, as their first witness. She has known Dr. Riba for two years, having met him when they were both working at another dental office. Ms. Martinez started her employment for the respondent as a receptionist before moving to her current role; she has not worked as a dental assistant. On September 23, 2006, she checked in Diamond and her mother when they arrived at
the clinic. Ms. Martinez was the person who called 911 that day, after she did that she said she had a conversation with the mother, who was understandably upset at the time. According to the witness, the mother said to her that she “...just went through this last week with her brother” (transcript, p. 447).

The next witness called by the respondent was Dr. Deanna Groen, a dentist who while working in the respondent’s clinic on September 21, 2006, conducted an exam on Diamond’s brother. Prior to that date she had worked at another office and had frequently referred difficult pediatric cases to Dr. Riba because she thought he handled these cases well, and she didn’t do sedation work. September 21 was the first and only day that Dr. Groen worked in the respondent’s office. In the course of performing the exam on Diamond’s brother, Dr. Groen had a conversation with the mother, who told the doctor that “...the young boy had a difficult time with general anesthesia...and during the course of a test, I believe it was an MRI, he barely made it out of general anesthesia” (transcript, p. 467). The mother provided her with a medical document which she copied and placed in the boy’s file. Dr. Groen wrote on the boy’s chart in large block letters the words “medical alert, no IV sedation” (transcript, p. 467). The witness did not discuss this issue with the respondent, and there is nothing in the record which indicates that he knew about it prior to treating Diamond on September 23. Dr. Groen severed her ties with the respondent on the Monday following the incident of the 23rd on the advice of her malpractice insurance carrier.

What should be made of this information regarding Diamond’s brother? There is no reason to question the truthfulness of Carmen Martinez and Dr. Groen on this point. However, as to
whether Diamond had a pre-existing "difficulty with general anesthesia" based on the experience of her brother is, absent any medical documentation, highly speculative and thus not helpful to the decision in this case. Also, it must be noted that Diamond was in the respondent's clinic for procedures to be done with conscious sedation, not general anesthesia. However, the question arises, if this information about the brother was deemed to be of importance in the treatment of his sister as the respondent seems to suggest, why was it not disseminated to a dentist treating the sister? Two conclusions can be drawn. Either the reaction of the patient's sibling is irrelevant (again, respondent presented no definitive medical evidence on this issue); or there were no procedures in this dental office to ensure that dissemination would occur. It would seem that such a procedure should be in place in a pediatric dental practice where the treatment of siblings must be commonplace.

The respondent called as his expert witness S. Dale Hibbert, who practices pediatric dentistry in Utah and is licensed in that state and in Idaho. In both states he holds a dental license, a DEA license and a permit which allows him to perform conscious sedation. These states apparently do not issue specialty licenses for pediatric dentistry. Dr. Hibbert has been a dentist since 1991 and has concentrated in the pediatric area since 1992. After receiving his dental degree from Creighton University in 1990, he attended a two year postgraduate pediatric program at the University of Michigan. In 2000 he was board certified by the American Academy of Pediatric Dentistry. He is on staff at two hospitals in Utah. For all of his background, please refer to his curriculum vitae, which was admitted into evidence as respondent's exhibit Q.
Prior to his testimony Dr. Hibbert reviewed the dental records of Diamond Brownridge, which were admitted into evidence as Department exhibit A. He was asked the following question by the respondent’s attorney: “Given your review of the records for Diamond Brownridge, were the drugs and dosages administered to Diamond Brownridge within the ranges that would be used by a reasonable pediatric dentist who does office sedation in his practice or her practice considering the patient’s age, weight and type of procedure?” His answer was “Yes.” He was also asked, “Considering your review of the records, would the drugs and dosages administered to Diamond Brownridge put her into a deep sedation?” His response was, “Generally not” (transcript, p. 512). Dr. Hibbert answered “no” to questions if Dr. Riba’s treatment was dishonorable, unethical or unprofessional; if the treatment was incompetent; and if the treatment was grossly negligent or gross malpractice. The reason for his negative response to these questions was, “The drugs were appropriate sedative agents, the sedation was indicated based upon the age and the number of restorations that needed to be completed, and the proper consent forms were signed” (transcript, p.515 & 516).

The cross-examination brought out that Dr. Hibbert had no knowledge of the Illinois Dental Practice Act and Rules, and was at times unsure about the Utah Rules concerning conscious sedation. Dr Hibbert does not have a permit in Utah to perform deep sedation or general anesthesia. Because of all this, his expertise in the area of sedation and anesthesia in general, and specifically as it is practiced in Illinois, is much less than that of Dr. Flick. Therefore, his opinions regarding the appropriateness of the amount of sedative drugs given to Diamond, and whether these drugs put her in a state of deep sedation, are less persuasive than those of Dr. Flick. Also, while Dr. Hibbert is certainly an experienced pediatric dentist, Dr. Flick has a depth
and range of clinical experience which, when combined with his academic and professional accomplishments and his superior anesthesia expertise; makes him the better witness. This administrative law judge therefore adopts Dr. Flick’s opinions that the respondent’s treatment was grossly negligent, incompetent and unprofessional.

The final witness called by the respondent was Michael Fullman, a former Illinois State police officer and Department enforcement manager, who has been a licensed private detective in this state for thirteen years. At the request of the respondent’s attorneys, Mr. Fullman retrieved the video from the security cameras at the Little Angel Dental Clinic for September 23 and prepared a log of the events which were observed that day. The log was admitted into evidence as respondent exhibit B. Mr. Fullman also played portions of the video during the formal hearing at the direction of attorneys representing both parties. The main point which the respondent’s attorneys wished to make with this witness and his evidence is that Diamond was not left alone or unattended during her treatment that day, contrary to some media reports. This point was also made during earlier testimony by Dr. Riba and his employees.

The following conclusions are drawn from the facts:

- Diamond was not left alone or unattended at the clinic during her treatment.
- The cause of death was anoxic encephalopathy due to anesthesia during the dental procedure (Department exhibit CC).
- Dr. Riba placed his patient in a state of deep sedation, not conscious sedation.
- Dr. Riba did not possess the required permit to put patients in deep sedation.
- Monitoring of the patient’s signs was not adequate for deep or conscious sedation.
- The drugs given to Diamond were excessive for her age and weight.
Dr. Flick's opinions that the treatment was grossly negligent, incompetent and unprofessional were persuasive.

DISCUSSION

The attorneys for both parties, as well as the respondent, have expressed their sorrow regarding the tragic death of Diamond Brownridge. This administrative law judge would also like to express his sympathy to the family, knowing full well that mere words offer little solace in the face of the loss of a young child. All this hearing process can do is determine whether the respondent violated the Dental Practice Act and Rules, and if so, fashion a discipline that will help prevent such a tragedy from occurring in the future.

Count 1 of the Department’s amended complaint alleges that the respondent violated Section 23(20) of the Dental Practice Act because he committed gross malpractice which resulted in the death of a patient. The two major deviations from proper care alleged are that the respondent gave his young patient excessive dosages of drugs in light of her age and weight, causing her to fall into a state of deep sedation and an irreversible coma; and he and his assistants failed to properly monitor patient signs during the dental treatment. Reviewing the record as a whole, it seems clear that the drugs given to Diamond placed her in a state of deep, not conscious sedation, and she subsequently experienced breathing and cardiac disruption, coma and death. Dr. Riba admitted that Diamond was asleep during the dental work. The respondent’s assistant Zoila Ocampo testified that the patient was asleep during the procedure and that she started to wake up afterward, but without any verbal communication. (Note that the inability to respond purposefully to verbal commands is a mark of deep sedation, as defined by the Dental Practice Act Rules, Department exhibit W.) Assistant Maribel Robles did not directly respond to a question concerning whether the patient was awake during the dental work, but she said that she
had her eyes closed. When the eyewitness testimony is combined with the opinion of Dr. Flick on this issue, the conclusion is inescapable: the patient was in a state of deep sedation. Even Dr. Riba’s less than convincing attempts to redefine conscious sedation, as well as his amended incident report which reduces the amount of the second dose of IV Diazepam, only serve to highlight an awareness on his part that he may well have crossed a line. Dr. Flick was of the opinion that even if one accepts the respondent’s amended report regarding the IV Diazepam, the patient was still in a high dose range. Considering the additive effect of all the drugs given in a short period of time to a 5 year old patient who weighs 35 pounds, the only reasonable conclusion a trier of fact can draw is that the amount given was excessive for a child of that age and weight, especially in light of the tragic end result.

With regard to the issue of proper patient monitoring, it is clear from the record that there was no EKG monitoring before, during or after the procedure, which is required by the Dental Practice Act Rules (Department exhibit W) in cases of deep sedation. Since the patient was in a state of deep sedation, the respondent was in violation of the Rules. In cases of both conscious and deep sedation, the Rules require blood pressure monitoring. Again, the record shows definitively that this was not done. So, even if one adopts the respondent’s position that his patient was in a state of conscious sedation, he was still in violation of the Rules. Although it can be said that pulse and blood oxygen saturation level were monitored during the procedure by means of the oximeter, the quick removal of the device after the dental work was done was in contravention of the pre-discharge monitoring of these signs which is required in both conscious and deep sedation situations. Finally, the last patient sign required to be tracked during both forms of sedation is respiration. Although there was some testimony that the patient’s breathing
was being watched, there is nothing in the testimony or dental records indicting that respiration was being scientifically monitored or charted (by tracking respirations per minute, for example).

Diamond’s death was caused by anoxic encephalopathy due to anesthesia during the dental procedure, as stated in the letter from the medical examiner’s office (Department exhibit CC). Even if the final autopsy report were to provide additional information, Dr. Flick’s opinion would remain that the respondent’s actions constituted deviations from acceptable dental practice. The deviations were “… the high dosages used for the size of the patient and lack of adequate monitoring…” (transcript, pp. 322 & 323). This constitutes gross malpractice, and it resulted in the injury or death of a patient. The Department has proven Count 1 of its amended complaint by clear and convincing evidence.

Count 2, which alleges the practice of deep sedation without the requisite permit, does not need much discussion. The respondent administered drugs to his patient which placed her in a state of deep sedation, and he did not possess Permit B. Count 2 is proven. Count 3 alleges that the respondent’s acts and/or omissions amounted to dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public. Count 4 alleges that the respondent’s acts and/or omissions constituted professional incompetence as manifested by poor standards of care. When one considers the findings of fact section of this report, especially Dr. Flick’s opinions on these issues, as well as the discussion of some of these facts in this section, it is fair to conclude that Counts 3 & 4 have also been proven. The respondent’s practice with regard to the patient on the day of the incident was unprofessional and it harmed her. Also, his treatment of the patient that day was incompetent and deviated from the standard of care.
In fairness to Dr. Riba it should noted again at this point that prior to the events of September 23, 2006, no complaints had been made to the Department about his dental care and no malpractice claims had been filed against him. Although these facts do not minimize the seriousness of what happened, they should be taken into consideration in arriving at the recommendation. Also, as it appears to be a matter of emphasis in the respondent’s case, it should be stated again that Diamond was not left unattended at any time that morning.

Respondent’s attorney argued during his final statement that there should be a distinction made between the dental and pediatric specialty licenses on one hand, and the sedation and controlled substance licenses on the other, in the application of any discipline. His argument is that the respondent’s basic dental skills did not cause the problems in this case, and the Department can adequately protect the public from improper sedation by suspending only the sedation permit and the controlled substance license. However, the respondent’s conduct in exceeding the scope of his sedation permit, as well as his dental treatment which has been labeled negligent, incompetent and unprofessional; reflect poorly upon his ability to practice any kind of dentistry and his dental license should be suspended. This administrative law judge accepts the idea that the sedation permit and controlled substance license should be disciplined more severely, but would also include the pediatric specialist license in this grouping. A good period of time should pass before the respondent is able to hold himself out to the public as an expert in the dental treatment of children.
CONCLUSIONS OF LAW

The Illinois Board of Dentistry has jurisdiction over the subject matter and parties in the case.

The Department has proven Counts 1, 2, 3 & 4 of its amended complaint by clear and convincing evidence.

RECOMMENDATION

The administrative law judge recommends to the Illinois Board of Dentistry that the dental license of the respondent, number 19024373, be indefinitely suspended for a minimum period of one year and six months from the date of the Director’s final order in this case. The other licenses (pedodontics specialist - no. 21001848, conscious sedation permit - no. 137000432 and controlled substance – no. 319013001) should be indefinitely suspended for a minimum period of three years from the date of the Director’s final order in this case. The Board may wish to suggest specific areas of study that it believes the respondent should pursue, which the Board believes will assist a future Board in deciding any petition for restoration filed after the applicable minimum period of suspension.

Dated: December 27, 2006

Michael J. Lyons, Administrative Law Judge