IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA, *ex rel.*, THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
vs.	)	**Case No. 23-02-6201**
DANIEL RIVERA, M.D., LICENSE NO. MD 39937,	)	
Defendant.	)	

VERIFIED COMPLAINT

The State of Oklahoma, *ex rel.*, the Oklahoma State Board of Medical Licensure and Supervision ("Board"), alleges and states as follows for its Complaint against DANIEL RIVERA, M.D. ("Defendant"):

I. JURISDICTION

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. § 480 *et seq.*

2. Defendant holds Oklahoma medical license number 39937. The acts and omissions complained of herein were made while Defendant was acting as a physician pursuant to the medical license conferred upon him by the State of Oklahoma, and such acts and omissions occurred within the physical territory of the State of Oklahoma.

II. ALLEGATIONS OF UNPROFESSIONAL CONDUCT

3. This case was initiated by multiple complaints alleging Defendant admitted to an addiction relapse, admitted he would fail a urine drug screen and admitted to getting fentanyl from his cases at work.

4. Defendant worked for a medical contracting company in which physicians such as Defendant would work as contract physicians for a period of time. During the relevant time periods Defendant worked at Mercy in Ada, Oklahoma and at Ascension St. John in Tulsa, Oklahoma.

5. While working at Mercy, several incidents caused concern from employees working with Defendant. These employees observed certain behaviors which were "red flags" for diversion of CDS.

- Defendant relieved a CRNA for a break and left a used syringe labeled fentanyl for the CRNA when they returned. That CRNA was relieved by a second CRNA. The turnover instructions were that the syringe was left by Defendant and apparently contained fentanyl. The second CRNA, after contacting Spencer Phillips, Manager of Surgical Services, took the syringe to the pharmacy and watched the pharmacist place the syringe in a tamper proof bag.

- On or about February 7 Defendant relieved a CRNA to give them a short break. When Defendant left the room, the CRNA called Spencer Phillips, Manager of Surgical Services, over and stated that this is the syringe that Dr. Rivera left me. The CRNA administered 50mcg of the "fentanyl" that Defendant left. The patient had no response to the medication. The CRNA then used a new syringe and pulled another vial of fentanyl and gave another 50mcg. The patient immediately had a response to the fentanyl given. The Circulator called for relief and took the syringe left by Defendant to Mr. Mike O'Grady, Director of Pharmacy, who placed it in a tamper proof bag.

- Defendant got a patient ready and gave medications to the CRNA on the case. The CRNA called Spencer Phillips, Manager of Surgical Services, over and showed him a full syringe labeled fentanyl. The CRNA and Spencer Phillips took the syringe to Mr. Mike O'Grady, Director of Pharmacy, who placed the syringe in a pamper proof bag.

6. The syringes were sent to DynaLabs for testing. The results of that investigation were:

DynaLabs Certificates of Analysis: Three syringes

Test date: 02/10/2023: Syringe(s) 1x1 ml: Fentanyl: Test Result: 0.0000% Date Compounded: 2/6/2023

Test date: 02/10/2023: Syringe(s) 1x4 ml: Fentanyl: Test Result: 0.0000% Date Compounded: 2/6/2023

Test date: 02/20/23: Syringe(s) 1x5 ml: Fentanyl: Test Result: 0.0000% Date Compounded: 2/9/2023

7. Further "red flags" noted were that large amounts of pentanyl was used in a short amount of time, the patients were waking up and their responses were not matching up to the drug allegedly given. Examples noted were:

- Patient A- Total fentanyl used: 2,350mcg. The concern is that the patient started out on a Levophed drip but was able to be removed from it during the procedure and in report ICU "patient's blood pressure had been good, titrate as needed."

- Patient B- Total fentanyl used: 1000mcg. The patient is a paraplegic, severe injury below the waist, patient didn't need pain meds in preop or PACU because he can feel no pain.

- Patient C- Total fentanyl used: 1000mcg. Patient woke up in PACU with severe pain, 10/10 and had to be given additional pain medication to control pain.

- Patient D- Total fentanyl used: 400mcg. Patient woke up in PACU, given additional 100mcg of fentanyl and patient's blood pressure dropped like she hasn't received any pain medication.

8. Based on the foregoing, a Drug Diversion Response Team Investigation was initiated. The investigation determined the following:

   -"Previous history with substance abuse. Completed the impaired provider program in 2008".

   -"Peer reported concerns of patients waking up immediately following a case and always wanting to start the case and pull meds, but wants the CRNA to finish the case by handing off syringes of medication. Also, reports by peers of doses given and vitals are not dipping/responding appropriately".

   -"High doses of Fentanyl being used".

   -"High dose for case severity".

   -"Wasting full vials of Fentanyl"

   -..."The audit has 1050mcg of Fentanyl unaccounted for and 5 full vials of Fentanyl wasted by Dr. Rivera."

9. A member of the Ascension Medical Staff in Tulsa reported that "On March 27th, my office was informed that an anesthesiologist was working under the influence of drugs, additionally a rapid Inventory of his narcotic administration per case was very high and inappropriate. The physician was confronted and very quickly admitted he was diverting Fentanyl for his use. His behavior was consistent with narcotic usage and a drug screen was obtained. He was searched by our security and no drugs were noted on him or in his locker. As per our policy, a ride was obtained to return him to his residence. He was summarily removed from our medical staff."

10. Captain Thomas West, Campus Police Ascension St. John, also investigated Defendant based on complaints made by colleagues at St. John. On Mach 28, 2023, Captain West was notified by Dr. John Forest of an anesthesiologist, Defendant, that may be under the influence of narcotics and has taken them from cases he has worked. Captain West questioned Defendant. Defendant told Captain West that he had relapsed and he was

using again, he also stated that he needed help. The ensuing investigation found significant evidence of diversion. The investigative report states that Defendant admitted stealing fentanyl from surgery.

11. On numerous occasions Defendant stated he was going to get a nail or hair follicle drug test. Board staff has never received a result from any such test. Further, Defendant spent from April through October repeatedly stating he was going to attend in patient treatment, yet to date he has not done so. Defendant signed an agreement not to practice on April 26, 2023 and has relinquished his DEA certificate. Emails from Defendant to Board Investigator Melissa Davis stated:

-April 25, 2023 - "Due to family/financial reasons, I will start my treatment at Florida Recovery Center on Monday 5/15 at the earliest and 5/30 at the very latest."

-May 23, 2023 - "With the cost told to me by the treatment center, I will enter treatment as soon as our loan is approved."

-July 28, 2023 - "My wife is still working and extended her contract through November. I plan on entering treatment Monday 10/16 at the absolute latest."

-September 20, 2023 - "May need another month or so."

-October 24, 2023 – "Unfortunately my situation hasn't changed but is slightly getting better financially. At this rate I will enter treatment in Florida in February/March at the latest."

III. VIOLATIONS

12. Based on the foregoing, the Defendant is guilty of unprofessional conduct as follows:

a. Habitual intemperance or the habitual use of habit-forming drugs in violation of Title 59 § 509(4):

b. Dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public in violation of Title 59 § 509(8) and OAC 435:10-7-4(11):

c. The inability to practice medicine with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition in violation of Title 59 § 509(15) and OAC 435:10-7-4(40):

d. The habitual or excessive use of any drug which impairs the ability to practice medicine with reasonable skill and safety to the patient in violation of OAC 435:10-7-4(3):

e. Gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15):

f. Being physically or mentally unable to practice medicine and surgery with reasonable skill and safety in violation of OAC 435:10-7-4(17):

g. Practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery in violation of OAC 435:10-7-4(18):

h. Violating any state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27):

CONCLUSION

Given the foregoing, the undersigned requests the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to the Defendant's professional license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

Joseph L. Ashbaker, OBA No. 19395
Assistant Attorney General
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
313 NE 21ST Street
Oklahoma City, Oklahoma 73105
405/522.2974
405/522.4536 – Facsimile

VERIFICATION

I, Melissa Davis, under penalty of perjury, under the laws of the State of Oklahoma, state as follows:

1. I have read the above Complaint regarding the Defendant, DANIEL RIVERA, M.D.; and

2. The factual statements contained therein are true and correct to the best of my knowledge and belief.

M Davis, RN

Melisa Davis, Investigator
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

Date: 11-22-2023