Public

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

TYRONE WALKER, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: TYRONE WALKER, M.D.
Peninsula Hospital Center
5115 Beach Channel Dr.
Far Rockaway, NY 11691

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by TYRONE WALKER, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12), that effective immediately TYRONE WALKER, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401 . The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on March 29, 2006, at 10:00 a.m., at the offices of the New York State Health Department, 90 Church Street, 4th floor, New York, NY 10007, and at such other adjourned dates, times and places as the

committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed

or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York

March 22 ,2006

ANTONIA C. NOVELLO, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

Terrence Sheehan
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
90 Church Street, 4th Floor
New York, NY 10007

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name_____Date of Proceeding_____

Name of person to be admitted_____

Status of person to be admitted_____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

_____
Signature (of licensee or licensee's attorney)

This written notice must be sent to:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

TYRONE WALKER, M.D.

STATEMENT

OF

CHARGES

TYRONE WALKER, M.D., the Respondent, was authorized to practice medicine in New York State in 1999, by the issuance of license number 214741 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about January 29, 2005, Respondent treated Patient A (whose name together with other patient names are contained in the attached Appendix) in the emergency room at Long Island College Hospital in Brooklyn, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Patient A was a 5-week-old ex 33-week premature baby who had been discharged from the Neonatal Intensive Care Unit (NICU) seven days earlier. Patient A presented with numerous complaints suggestive of sepsis. Respondent failed to follow-up these complaints or appreciate their medical significance.

2. Patient A had had a 4 1/2 week course of treatment in the NICU for obstructive uropathy, neonatal dehydration, urinary tract infection and sepsis of the newborn. Respondent failed to

review this history or failed to appreciate its significance in his evaluation of Patient A.

3. Respondent failed to admit Patient A and to order a sepsis workup and antibiotics.

4. Respondent failed to order appropriate consultations.

5. Respondent improperly discharged Patient A with the diagnosis of "vomiting (resolved)".

6. Approximately eight hours later Patient A returned to the Emergency Room in full cardiopulmonary arrest and expired. Upon autopsy, the causes of death included enterobacteria sepsis and pyonephrosis.

7. Respondent failed to maintain a medical record for Patient A which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for discharge.

B. On or about April 18, 2005, Respondent treated Patient B in the emergency room at Long Island College Hospital in Brooklyn, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to perform and document an adequate

history and physical examination, including orthostatic vital signs and rectal examination for occult blood.

2. Respondent failed to appreciate Patient B's emergent condition and failed to appropriately follow-up on clear signs that the Patient was in a state of shock.

3. Respondent failed to make a differential diagnosis of some form of shock.

4. Respondent failed to undertake basic clinical investigation to ascertain the cause of Patient B's distress, including blood cultures, arterial blood gas, cardiac enzymes, bedside echocardiogram and spiral chest CT.

5. Respondent failed to obtain indicated consultations.

6. Respondent failed to identify and follow-up abnormal findings on electrocardiogram.

7. Approximately seven hours after presentation to the emergency room Patient B became unresponsive with hypotension and cardiopulmonary arrest, after which she was resuscitated. Patient B arrested again the following morning. Resuscitative efforts were not successful. The probable cause of death was sepsis.

8. Respondent failed to maintain a medical record for Patient B which accurately reflects the evaluation and treatment he provided , including patient history and physical, diagnoses and follow-up of test results.

C. On or about July 21, 2004, Respondent treated Patient C, a seven-year-old girl, in the emergency room at Long Island College Hospital in Brooklyn, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to obtain and note an adequate history and physical examination.

2. Respondent failed to include the differential diagnosis of acute appendicitis in his evaluation of Patient C.

3. Respondent failed to order a CT scan of the abdomen or a surgical consultation.

4. Respondent made a diagnosis of urinary tract infection which was not warranted.

5. Respondent's discharge of the Patient was not indicated.

6. Respondent prescribed oral antibiotics which was not indicated.

7. Two days following her discharge from the emergency room Patient C returned. After reviewing an abdominal sonogram which showed a walled off appendicle abscess, an exploratory laparotomy was performed. The post-operative diagnosis was necrotizing ruptured appendicitis with pelvic abscess. Surgery was followed by twelve days of IV antibiotic treatment.

8. Respondent failed to maintain a medical record for Patient B which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for discharge.

D. On or about March 30, 2001, Respondent treated Patient D at Franklin Hospital in Valley Stream, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to appropriately consider and rule out several likely differential diagnoses in his evaluation of Patient D, including myocardial ischemia, cardiogenic shock and obstructive shock.

2. Respondent's working diagnosis of anaphylaxis was not warranted.

3. Respondent failed to order H-1 and H-2 blockers, the routine indicated treatment for the alleged anaphylaxis.

4. Respondent failed to order a basic cardiac work up including an

electrocardiogram for Patient D, who was a known "cardiac" patient.

5. Respondent ordered the administration of magnesium sulfate, as a bolus, which was not indicated or was contraindicated.

6. Respondent, based on the results of an arterial blood gas test, inappropriately and unnecessarily ordered the intubation of Patient D who was otherwise breathing, alert and talking.

7. Respondent failed to evaluate and treat Patient D in accordance with basic principles of airway management. For instance, prior to undertaking to intubate Patient D Respondent should have, but failed to, consult with anesthesia or ENT. Instead Respondent inappropriately administered a paralyzing agent, succinylcholine, and proceeded with intubation without proper preparation.

8. Despite multiple attempts at intubation, the airway was lost and the patient suffered severe brain anoxia and expired.

9. Respondent failed to maintain a medical record for Patient D which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, and follow-up of test results.

E. On or about July 16, 2005, Respondent treated Patient E at Peninsula Hospital Center in Far Rockaway, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Patient E's primary complaints were severe abdominal pain and vomiting. Respondent failed to appropriately evaluate the abdominal pain and failed to re-examine the abdomen prior to discharge.

2. Respondent diagnosis of acute gastroenteritis was inappropriate and without clinical basis.

3. Respondent failed to properly interpret an abdominal x-ray. He missed unequivocal, characteristic findings indicative of small bowel obstruction.

4. Respondent failed to diagnose small bowel obstruction in Patient E.

5. Respondent inappropriately discharged Patient E without attempting to rule out the life threatening condition of small bowel obstruction.

6. Respondent failed to maintain a medical record for Patient E which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for discharge.

F. 1. On or about May 19, 2005, Respondent submitted an application for appointment to the medical staff of Queens Hospital Center in Flushing, N.Y. By answering "No" to the following questions Respondent, with intent to deceive, sought to mislead his prospective employee about the true nature of his professional work history and to conceal from them the fact that as a result of several departures from

acceptable levels of patient care on Respondent's part, Respondent had been forced on May 11, 2005 to relinquish his clinical privileges and membership on the medical staff at Long Island College Hospital:

> "Have you ever been, or have Pending Challenges, or are you currently subject to denial, revocation, suspension, probation, non-renewal, voluntary/involuntary relinquishment/termination, reduction, limitation or diminution of:
>
> -Membership on any hospital staff?
> -Clinical privileges at any hospital/medical facility?"

2. In the same Queens Hospital Center application Respondent, with intent to deceive, falsely answered "No" to the following question in order to conceal from his prospective employer the fact that a complaint had been filed, or would imminently be filed, with the New York State Office of Professional Medical Conduct by Long Island College Hospital regarding the several instances of substandard patient care which were the basis for his forced resignation:

> "To the best of your knowledge, have you ever been or are you the subject of a focused review or under investigation by New York State or one of its designated agencies, e.g., DOH, DSS, etc?"

3. On or about May 30, 2005, Respondent submitted an application for appointment to the medical staff of Peninsula Hospital Center, Far

Rockaway, N.Y. In filling out a portion of this application dealing with the issue of whether the applicant is certified by any American Board and the date of any such certification Respondent, with intent to deceive, entered the following false information:

"American Board of Emergency Medicine (pending)"

In fact Respondent had failed the first part of the American Board of Emergency Medicine test three times and had never taken the second part at all. In no truthful sense could his status be described as "pending".

G. On or about April 25, 2001, Respondent submitted a license registration renewal form for the period July 1, 2001 through March 31, 2003. The form contains several questions which must be answered under penalties of perjury. Respondent falsely answered "Yes" to each of the following questions:

"2. Since you last filed a registration application:

a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?

b. Has any other state or country instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended, or

accepted surrender of a professional license held by you?

c. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?

3. a. Are you under an obligation to pay child support?

b. If you are under such an obligation, do you meet one of the requirements listed in the Child Support Law section below".

H. Physicians in New York State are required to complete and return to the Department of Health a Profile Summary which contains, *inter alia*, information about the physician and the nature of his or her practice. This information is then made available for review by members of the public. On numerous occasions between 2001 and 2005 Respondent, willfully and/or grossly negligently, failed to submit a Profile Summary despite written requests for him to do so.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATION
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following paragraphs:

1. A and A(1) - A(6).
2. B and B(1)-B(7).
3. C and C(1)-C(7).
4. D and D(1)-D(8).
5. E and E(1)-E(5).

SIXTH SPECIFICATION
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following paragraphs:

6. A and A(1)-A(6), B and B(1)-B(7), C and C(1)-C(7), D and D(1)-D(8) and E and E(1)-E(5).

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

7. A and A(1)-A(6), B and B(1)-B(7), C and C(1)-C(7), D and D(1)-D(8) and E and E(1)-E(5).

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

8. A and A(1)-A(6), B and B(1)-B(7), C and C(1)-C(7), D and D(1)-D(8) and E and E(1)-E(5).

NINTH TO THIRTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of the following paragraphs:

9. A and A(7).
10. B and B(1), B(7).
11. C and C(1), C(8).
12. D and D(9).
13. E and E(6).

FOURTEENTH AND FIFTEENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following paragraphs:

14. F(1) - F(3).
15. G.

SIXTEENTH TO EIGHTEENTH SPECIFICATION

FALSE REPORT AND FAILING TO FILE A REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department or by Public Health Law § 2995-a, as alleged in the facts of the following paragraphs:

16. F(1) - F(3)
17. G.
18. H.

NINETEENTH SPECIFICATION

VIOLATION OF PUBLIC HEALTH LAW § 2805-K

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(14) by violating Public Health Law § 2805-k, as alleged in the facts of the following paragraphs:

19. F(1) - F(3).

DATED: March 21, 2006
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct