XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
LYNNE K. DOMBROWSKI
Deputy Attorney General
State Bar No. 128080
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3439
Facsimile: (415) 703-5480
E-mail: Lynne.Dombrowski@doj.ca.gov
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MELISSA KELLY EGGE, M.D.** Department of Pediatrics Coleman Pavilion 11175 Campus Street Loma Linda CA 92350-1700 Physician's and Surgeon's Certificate No. A 92826, Respondent.	Case No. 800-2016-021952 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 16, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number A 92826 to Melissa Kelly Egge, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2019, unless renewed.

3. At all times alleged herein, Respondent was Board-certified in General Pediatrics and in Child Abuse Pediatrics. Respondent was one of two physicians designated as a child abuse expert at Santa Clara Valley Medical Center (SCVMC) and was a member of the Suspected Child Abuse and Neglect (SCAN) team. The other SCAN team physician was also the Director of the SCVMC Center for Child Protection.

JURISDICTION

4. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2228 of the Code states:

"The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

"(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

"(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

"(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

"(d) Providing the option of alternative community service in cases other than violations relating to quality of care."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. California Penal Code sections 11164 *et seq.* are known as the Child Abuse and Neglect Reporting Act ("CANRA").

9. California Penal Code section 11165.7, subdivision (a) (21) provides that a licensed physician and surgeon is a "mandated reporter" under CANRA.

10. California Penal Code section 11166 states, in pertinent part:

"(a) Except as provided in subdivision (d), and in Section 11166.05, a mandated reporter shall make a report to an agency specified in Section 11165.9 whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter shall make an initial report by telephone to the agency immediately or as soon as is practically possible, and shall prepare and send, fax, or electronically transmit a written followup report within 36 hours of receiving the information concerning the incident. The mandated reporter may include with the report any nonprivileged documentary evidence the mandated reporter possesses relating to the incident.

"(1) For purposes of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any "reasonable suspicion" is sufficient. . . ."

". . ."

"(3) A report made by a mandated reporter pursuant to this section shall be known as a mandated report.

". . ."

"(h) When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any

member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

"(i)(1) The reporting duties under this section are individual, and no supervisor or administrator may impede or inhibit the reporting duties, and no person making a report shall be subject to any sanction for making the report. . . ."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts; Failure to Comply with CANRA Mandatory Reporting)

11. Respondent Melissa Kelly Egge, M.D. is subject to disciplinary action for unprofessional conduct through gross negligence and/or repeated negligent acts under Business and Professions Code section 2234, subdivisions (b) and/or (c), and/or through failure to file a mandatory report under California Penal Code section 11166, as described herein.

12. On or about July 2, 2015, Patient A, a boy of about two-years-of age, was seen at the Emergency Department ("ED") of O'Connor Hospital ("O'Connor") in San Jose. The patient complained of right elbow pain and was diagnosed with a right supracondylar fracture and buckle fracture of the right distal radius. The examination of the left upper extremity was normal. The parents reported that Patient A fell backward while running on a tile floor. The patient's right arm was splinted and follow-up was arranged with orthopedics.

13. The next day, on July 3, 2015, Patient A returned to the ED at O'Connor with a complaint of left arm pain and swelling of the left upper extremity. The parents said that they were not aware of any new falls and that the left arm swelling had developed about 20 minutes before they arrived at the hospital. The diagnosis was a left supracondylar fracture. A skeletal survey x-ray (a 10-view battered child series of x-rays of the chest, legs, skull) was obtained.

14. Patient A was transported by ambulance from O'Connor to Santa Clara Valley Medical Center ("SVCMC") for pediatric orthopedic care. It was reported that physicians at O'Connor were also concerned about the possibility of non-accidental trauma ("NAT").

15. On or about July 3, 2015 at about midnight, Respondent received a call from a pediatric physician at SCVMC who examined Patient A and reviewed the case for orthopedic

care and for further assessment of the possibility of a non-accidental trauma. Respondent was the on-call child abuse expert for the hospital. After reviewing the patient's known history by telephone, Respondent opined that Patient A's injuries were not likely to be non-accidental trauma, that the described mechanism of fall was consistent with the injuries, and that no report needed to be filed with Child Protective Services ("CPS").

16. Respondent did not adequately document the details of this telephone consultation.

17. Patient A was admitted overnight to the hospital for surgical repair. Repeated x-rays of the bilateral upper extremities were ordered at SCVMC.

18. Prior to Patient A's discharge on July 4, 2015, a SCVMC pediatric hospitalist reviewed the patient's history and contacted Respondent's SCAN team partner, who was the on-call child abuse expert at that time, for another telephone consultation about possible NAT. The other SCAN team physician concluded that Patient A's injuries were most likely accidental trauma and that a CPS report was not recommended. The patient was discharged home with orthopedic followup scheduled. No report was filed with Child Protective Services.

19. On or about July 7, 2015, a SCVMC physician was notified by a radiologist that Patient A's skeletal survey x-rays from O'Connor showed a "late subacute fracture deformity in the distal metaphysis of the left femur." The radiologist noted that: "Combination of acute and late sub-acute or chronic fractures in the pediatric skeleton suspicious for non-accidental trauma. Recommend clinical correlation."

20. On or about July 7, 2015, the SCVMC physician sent an e-mail to the other SCAN team physician regarding concerns about the multiple fractures and about the newly reported femur fracture.

21. On or about July 7, 2015, the SCVMC ED physician called and spoke with the other SCAN team physician, who was the on-call child abuse expert. The advice given by the other SCAN team partner was that, although the femur fracture was not as characteristic an injury for the fall described, he still had an overall low index of suspicion for non-accidental trauma and did not feel that a CPS report was warranted. He recommended that lab studies and screenings be

done to test the patient's bone fragility. The labs were ordered and drawn and the results did not raise any concerns.

22. Sometime in or about July 2015, Respondent learned, during a discussion with the other SCAN team physician, about Patient A's additional femur fracture discovered by the radiologist.

23. On or about November 16, 2015, the Chairman of the SCVMC Pediatrics Department informed Respondent of concerns raised by orthopedic physicians about Patient A's case, the combination of known treated injuries, and the possibility of NAT, and asked that Respondent perform a chart review.

24. On or about November 17, 2015, Respondent reported, after her chart review, that it was her opinion that a report to Child Protective Services ("CPS") was warranted. Respondent discussed the case by email with her SCAN team partner and it was agreed that Respondent's SCAN team partner would file the CPS report. Respondent was told by her SCAN team partner that he would "follow up tomorrow" with the report to CPS about Patient A.

25. On or about November 17, 2015, Respondent notified the Chairman of the Pediatrics Department that her SCAN team partner would report Patient A's case to CPS.

26. On or about December 22, 2015, Respondent discovered that her SCAN team partner had not filed a CPS report on Patient A. Respondent asked the physician to enter a note in the patient's chart.

27. On or about December 24, 2015, Respondent's SCAN team partner posted a note in Patient A's chart in which he stated that "there was a low expectation of non-accidental trauma in this case." He did not mention the occult femur fracture, which had raised concerns and had prompted subsequent review of the case.

28. Neither Respondent or her SCAN team partner filed a report with Child Protective Services about suspected child abuse of Patient A.

29. On or about January 16, 2016, Patient A was found dead at home as the result of a suspected homicide with evidence of physical and sexual abuse.

30. Respondent is guilty of unprofessional conduct through gross negligence and/or repeated negligent acts, under Business and Professions Code sections 2234, subdivisions (b) and/or (c), as follows:

a. Respondent failed to make a mandatory report to the appropriate agency under California Penal Code section 11166 when she had a reasonable suspicion to suspect child abuse or neglect.

b. Respondent failed to follow-up to make sure that a CPS report was filed with regard to Patient A and/or failed to file a CPS report after she became aware that a report had not been filed by the other SCAN team physician.

c. Respondent failed to adequately document her communications and/or consultations regarding Patient A.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Records)

31. Respondent Melissa Kelly Egge, M.D. is subject to disciplinary action for unprofessional conduct under section 2266 for failing to maintain adequate and accurate records with regard to Patient A. Paragraphs 11 through 30 are incorporated herein by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 92826, issued to Melissa Kelly Egge, M.D.;

2. Revoking, suspending or denying approval of Melissa Kelly Egge, M.D. 's authority to supervise physician assistants and advanced practice nurses;

///

///

///

3. Ordering Melissa Kelly Egge, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 11, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2018201557