

**State of New Hampshire
Board of Medicine
Concord, New Hampshire 03301**

In the Matter of:
Ashley A. Fox, MD
License No.: 16267
(Misconduct Allegations)

SETTLEMENT AGREEMENT

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the New Hampshire Board of Medicine (“Board”) and Ashley A. Fox, MD (“Respondent”), a physician licensed by the Board, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the Board according to the following terms and conditions:

1. Pursuant to RSA 329:17, I; RSA 329:18; RSA 329:18-a; and Medical Administrative Rule (“Med”) 206 and 210, the Board has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by physicians. Pursuant to RSA 329:18-a, III, the Board may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.
2. The Board first granted Respondent a license to practice medicine in the State of New Hampshire on August 7, 2013. Respondent holds license number 16267. Respondent practices Emergency Medicine at Concord Emergency Medicine Associates/Concord Hospital, in Concord, NH.

3. On or about January 27, 2017, the Board received notice of a medical malpractice lawsuit filed in Merrimack Superior Court against Respondent and others. The Plaintiffs in the lawsuit are the parents of a thirteen year old girl (“Patient”) who died from a brain tumor after being treated by Respondent and others at the Concord Hospital and Emergency Department (“ED”) on May 1-2, 2016.
4. In response to this, the Board conducted an investigation and obtained information from various sources pertaining to Respondent’s treatment of the Patient in the ED on May 1, 2016.
5. The Board’s investigation revealed, and Respondent stipulates that, if a disciplinary hearing were to take place, Hearing Counsel would introduce evidence and seek to prove that Respondent engaged in professional misconduct, in violation of RSA 329:17, VI (c) and/or (d), and/or Med 501.01 (a), and/or Med 501.02 (e) (1), based upon the following facts:
 - A. Patient was under Respondent’s care in the Concord Hospital ED starting at 4:00 p.m. on May 1, 2016. Patient had arrived at the ED at approximately 10:15 a.m., and had been evaluated and treated by another emergency physician, who signed her over to Respondent at 4:00 p.m.
 - B. The initial ED physician had diagnosed migraine, and had ordered pediatric doses of migraine medications (Compazine, Benadryl, and Toradol), which were administered to Patient at approximately 11:45 a.m. These medications are known to cause sedation. Patient reported improvement in her headache after receiving these medications but was quite sleepy. A consult with the

pediatric hospitalist on duty had also been requested, and this took place at approximately 3:40 p.m., just before Respondent came on shift.

- C. At around the time of the pediatric consult, the initial ED physician's assessment was that Patient's sleepiness was attributable to the sedating effects of the medications, or was possibly behavioral. The pediatric hospitalist agreed with this assessment and had recommended continued observation in the ED.
- D. Respondent received a report at 4 p.m. from the outgoing emergency physician that Patient had a long history of migraines, that her symptoms with this headache were similar to her prior headaches, but longer in duration, that her initial neurological examination in the emergency department was normal, that she had been up since 3:00 a.m., and had vomited from that time until approximately 10:00 a.m., and that she had been quite sleepy that afternoon after taking medications. Respondent was told that the plan was to allow Patient to rest in the ED and allow her medications to wear off, and for Respondent to then check her, and if her mental status was back to baseline, to discharge her with the plan to have an outpatient MRI in the next 1 to 3 days, and if the patient was still sleepy, to admit her to the pediatric hospitalist service for evaluation and monitoring.
- E. At approximately 6:40 p.m., nursing notes indicated that Patient required "max[imum] assist" when going to and from the bathroom. These notes also indicated that Respondent was updated as to the Patient's status at 7:15 p.m. Nursing notes also indicated that, at 7:30 p.m., Patient was noted to be

“responsive to strong physical and verbal stimuli,” and that Respondent was aware, and was to re-evaluate Patient. The record does not show that nursing staff told Respondent that Patient had worsened or that her earlier condition had significantly changed.

- F. After receiving the update from nursing staff, at approximately 8 p.m. Respondent went to Patient’s bedside, observed Patient, and learned from Patient’s parents that Patient was still quite sleepy, and that there had been no change from previously. Respondent believed Patient’s sleepiness was from the sedating medications and lack of sleep. Respondent contacted the pediatric hospitalist and arranged for the hospitalist to evaluate patient and admit her to the pediatric service for further monitoring. The pediatric hospitalist came to the ED and evaluated the patient at 8:40 p.m., and ordered admission. The pediatric hospitalist’s evaluation did not include a renewed neurological examination. Patient was not actually transferred to the pediatric floor until approximately 10:00 p.m.
- G. During the time that Patient was in the ED and under Respondent’s care, Respondent did not conduct a renewed physical or neurological examination, or take an independent history from Patient or her parents, or seek a consultation with, or to obtain records from, Patient’s outside pediatrician. Although the initial emergency physician was told that Patient had been suffering from migraines for quite some time, the records of Patient’s outside pediatrician did not indicate visits for headache complaints until 2/28/16. Respondent did not

order an emergent brain CT to rule out a neurological cause for Patient's headache and continued somnolence. Respondent was aware that the initial emergency physician had ordered an out-patient brain MRI, to take place within 3 days of Patient's discharge. Respondent did not prepare her own reports or notes regarding her interactions with Patient, Patient's family, or other staff.

H. At approximately 1:30 a.m., while still on the pediatric floor, Patient went into cardiac arrest, and was revived. An emergency CT scan was ordered, which revealed the presence of the brain tumor. Although emergency treatment to reduce the pressure in Patient's brain was undertaken, and Patient was transferred to Dartmouth Hitchcock for brain surgery, she died a few days later.

6. The Board finds that Respondent committed the acts as described above and concludes that, by engaging in such conduct, Respondent violated RSA 329:17, VI (c) and/or (d), and/or Med 501.01 (a), and/or Med 501.02 (e) (1).

7. Respondent acknowledges that this conduct constitutes grounds for the Board to impose disciplinary sanctions against Respondent's license to practice as a physician in the State of New Hampshire.

8. Respondent consents to the Board imposing the following discipline, pursuant to RSA 329:17, VII:

A. Respondent is **REPRIMANDED**.

B. Respondent is required to meaningfully participate in a program of **CONTINUING MEDICAL EDUCATION for eight (8) hours**, split equally between the areas of (a) history taking from, and evaluation, assessment, and

diagnosis of, the headache patient, and (b) history taking and assessment of the emergency room patient. These hours shall be in addition to the hours required by the Board for renewal of licensure and shall be completed within one (1) year from the effective date of this *Settlement Agreement*. Within fifteen (15) days of completing these hours, Respondent shall notify the Board and provide written proof of completion.

- C. Respondent is assessed an **ADMINISTRATIVE FINE** in the amount of one thousand dollars (\$1,000.00). Respondent shall pay this fine in full within thirty (30) days of the effective date of this *Settlement Agreement*, as defined further below, by delivering a money order or bank check, made payable to “Treasurer, State of New Hampshire,” to the Board’s office at 121 South Fruit Street, Suite 301, Concord, New Hampshire, 03301.
- D. Respondent is assessed **INVESTIGATIVE AND PROSECUTION COSTS** in the amount of two-thousand dollars (\$2,000.00), pursuant to RSA 332-G:11. Respondent shall pay these costs in full within thirty (30) days of the effective date of this *Settlement Agreement*, as defined further below, by delivering a money order or bank check, made payable to “Treasurer, State of New Hampshire,” and containing the memo “Investigative costs; RSA 332-G:11,” to the Board’s office at 121 South Fruit Street, Suite 301, Concord, New Hampshire, 03301.

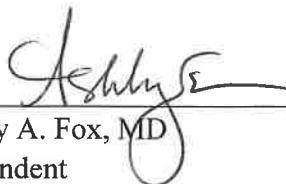
- E. Respondent shall bear all costs of the treatment, evaluation, and reporting required by this *Settlement Agreement*, but she shall be permitted to share such costs with third parties.
- F. The Board may consider Respondent's compliance with the terms and conditions herein in any subsequent proceeding before the Board regarding Respondent's license.
- G. Within ten (10) days of the effective date of this agreement, as defined further below, Respondent shall furnish a copy of the *Settlement Agreement* to any current employer for whom Respondent performs services as a physician or work which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority which licenses, certifies or credentials physicians, with which Respondent is presently affiliated.
- H. For a continuing period of one (1) year from the effective date of this agreement, Respondent shall furnish a copy of this *Settlement Agreement* to any employer to which Respondent may apply for work as a physician or for work in any capacity which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority that licenses, certifies or credentials physicians, to which Respondent may apply for any such professional privileges or recognition.

9. Respondent's breach of any terms or conditions of this *Settlement Agreement* shall constitute unprofessional conduct pursuant to RSA 329:17, VI (d), and a separate and sufficient basis for further disciplinary action by the Board.
10. Except as provided herein, this *Settlement Agreement* shall bar the commencement of further disciplinary action by the Board based upon the misconduct described above. However, the Board may consider this misconduct as evidence in the event that similar misconduct is proven against Respondent in the future. Additionally, the Board may consider the fact that discipline was imposed by this Order as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.
11. This *Settlement Agreement* shall become a permanent part of Respondent's file, which is maintained by the Board as a public document.
12. Respondent voluntarily enters into and signs this *Settlement Agreement* and states that no promises or representations have been made to her other than those terms and conditions expressly stated herein. Furthermore, no improper influence, coercion, or duress has contributed to Respondent's decision to sign this *Settlement Agreement*.
13. The Board agrees that in return for Respondent executing this *Settlement Agreement*, the Board will not proceed with the formal adjudicatory process based upon the facts described herein.
14. Respondent understands that her action in entering into this *Settlement Agreement* is a final act and not subject to reconsideration or judicial review or appeal.

15. Respondent has had the opportunity to seek and obtain the advice of an attorney of her choosing in connection with their decision to enter into this agreement.
16. Respondent understands that the Board must review and accept the terms of this *Settlement Agreement*. If the Board rejects any portion, the entire *Settlement Agreement* shall be null and void. Respondent specifically waives any claims that any disclosures made to the Board during its review of this *Settlement Agreement* have prejudiced her right to a fair and impartial hearing in the future if this *Settlement Agreement* is not accepted by the Board.
17. Respondent is not under the influence of any drugs or alcohol at the time she signs this *Settlement Agreement*.
18. Respondent certifies that she has read this document titled *Settlement Agreement*. Respondent understands that she has the right to a formal adjudicatory hearing concerning this matter and that at said hearing she would possess the right to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on her own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this *Settlement Agreement*, she waives these rights as they pertain to the misconduct described herein.
19. This *Settlement Agreement* shall take effect as an Order of the Board on the date it is signed by an authorized representative of the Board.

FOR RESPONDENT

Date: 10/29/19


Ashley A. Fox, MD
Respondent

Date: _____

Gregory G. Peters, Esq.
Counsel for Respondent

FOR THE BOARD/*

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: November 7, 2019


(Signature)

PENNY TAYLOR
(Print or Type Name)
Authorized Representative of the
New Hampshire Board of Medicine

/* David Conway, MD & Nina Gardner, Board members, recused.

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