

**FILED**

Department of Health  
Angela Hall, AGENCY CLERK

By: Steph Ann J. W. W.  
Deputy Agency Clerk

STATE OF FLORIDA  
DEPARTMENT OF HEALTH

BOARD:	Medicine
CASE NUMBER:	95-11786
COMPLAINT MADE BY:	AHCA
DATE COMPLAINT RECEIVED:	August 2, 1995
COMPLAINT MADE AGAINST:	Fernando Pino, M.D. 8600 SW 92nd Street Suite 203 Miami, FL 33156
INVESTIGATED BY:	Georgina T. Jorge/Miami
REVIEWED BY:	John E. Terrel/tc
STAFF RECOMMENDATION:	Close (PL-82)

NOTICE OF DISMISSAL/CLOSING ORDER

THE COMPLAINT: Complainant alleges that the Subject practiced below the standard of care, in violation of 458.331(1)(t), Florida Statutes; and failed to maintain adequate medical records, in violation of 458.331(1)(m), Florida Statutes.

THE FACTS: Subject's treatment of patient S.W., a four year old male, was initiated on May 27, 1995, after patient's admission to the Charter Hospital in Miami when the Subject diagnosed S.W. with Intermittent Explosive Disorder, after further studies corrected to Bipolar Manic-Depressive Disorder, manifested through aggressive behavior, fighting with parents, head banging, sexual acting out, self-induced vomiting, and alleged molestation of an eight (8) year old boy. Subject's treatment of S.W.'s condition included Orap, Mellaril, Halidol, Elavil, Depakote, Atarax, and Lithium.

Patient S.W. was discharged from the hospital on June 20, 1995, and subsequently continued to be treated at the Charter Hospital's day care center, while spending the nights with his parents.

On July 26, 1995, while in his parents' care, patient S.W. died. The case was reviewed by an expert for the Petitioner who in his expert report, filed on January 30, 1996, noted that Subject failed to properly monitor S.W.'s Lithium level, alleged that Lithium is non-traditional treatment for a four-year old child, failed to adequately monitor S.W.'s condition, failed to refer him to a neurologist, and failed to keep adequate medical records.

In March/April 1997, during the case litigation, a large volume of additional medical records for patient S.W. were obtained by Petitioner through supplemental investigation which were referred to another expert for the Petitioner. In May 1997, after reviewing the complete medical records, the second expert completely exonerated the Subject of the violations alleged in the AC. Specifically, the expert indicated that S.W. had died from Encephalitis, the Lithium levels were appropriate, Lithium was not an extreme treatment method for the patient and Subject's treatment plan was appropriate. The expert further opined that the records indicated that Subject did refer S.W. to the Johns Hopkins for additional examination and for examination for neurological tests, and that Subject's medical records accurately and completely reflect the course of treatment and its justification.

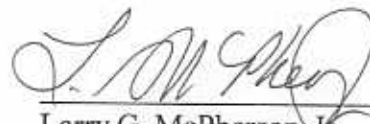
In August 1997, Petitioner received a letter from Subject's counsel summarizing the opinions of Subject's expert, a noted specialist from Boston in children psychiatry and psychopharmacology. His opinions coincide with the opinions of Petitioner's second expert.

THE LAW: There is sufficient evidence for the Panel to have found probable cause in the case. However, based upon information obtained during trial preparation of this case, the Department, by and through the Agency of Health Care Administration, pursuant to the provisions of Section 20.43(3), has determined that there is insufficient evidence to support the prosecution of allegations of violations of Chapter 458, Florida Statutes, or the rules promulgated therein. Therefore, pursuant to Section 455.621(2), Florida Statutes, this case is DISMISSED.

It is, therefore, ORDERED that this matter should be and the same is hereby DISMISSED.

DONE and ORDERED this 1 day of June, 1998.

James T. Howell, M.D., Secretary



Larry G. McPherson, Jr.  
Chief Medical Attorney

AP/tc  
PCP: May 22, 1998