



DUPLICATE COPY
via FIRST CLASS MAIL
DATE: 12-21-91

COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Medicine

Bernard L. Henderson, Jr.
Director

Hilary H. Connor, M.D.
Executive Director

December 21, 1990

1501 Rolling Hills Drive, Suite 200
Richmond, Virginia 23229-5005
(804) 662-9905
FAX (804) 662-9943

Walter S. Jennings, Jr., M.D.
7149 Jahnke Road
Richmond, Virginia 23225

CERTIFIED MAIL
P 530 104 589

Dear Dr. Jennings:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on Friday, January 25, 1991 at 11:30 a.m. at the Sheraton-Fredericksburg Resort and Conference Center, I-95 & Route 3, Fredericksburg, Virginia. The conference will be conducted pursuant to Sections 54.1-2919 and 9-6.14:11 of the Code of Virginia (1950), as amended ("Code").

An informal conference committee ("Committee"), composed of three members of the Board, will inquire into allegations that you may have violated certain laws governing the practice of medicine in Virginia. Specifically, you may have violated Section 54.1-2915.A(3) as further defined in Section 54.1-2914.A(3), (9), (13) and (14) and Section 54.1-3408 of the Code, in that:

1. Between the period January 27, 1989 and May 11, 1990, you excessively prescribed to Patient A, an individual you knew to be drug and alcohol dependent, the following controlled substances of high abuse potential: 814 dosage units of Xanax 1mg. (Schedule IV), 2240 dosage units of Triavil, concomitantly with 776 dosage units of Ritalin 20mg. (Schedule II), 1775 dosage units of Percodan (Schedule II) and 2178 dosage units of Valium (Schedule IV). Said prescribing was without accepted therapeutic purpose and contrary to sound medical judgement.

2. On July 25, 1988, you provided Patient A with post-dated prescriptions for controlled substances.

In order to protect the privacy of your patient, he has been referred to by letter only. Please see Attachment I of this notice for the identity of the individual referenced above. You may be represented by an attorney at the informal conference. The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing;

2. The Committee may notify you in writing that you are fully exonerated of any charge that might affect your right to practice in Virginia;

Walter S. Jennings, Jr., M.D.
December 21, 1990
Page 2

3. The Committee may reprimand or censure you; or

4. The Committee may place you on probation for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the Committee may direct, evidence that you are not practicing in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of medicine in Virginia.

Should you fail to appear at the informal conference the Board may proceed to a formal administrative hearing in order to impose sanctions. Please inform this office whether you intend to appear at the conference at least ten (10) days prior to the scheduled date above. Also please provide the Board with a telephone number where you may be reached.

Enclosed you will find copies of the relevant sections of the Administrative Process Act, which governs proceedings of this nature, as well as laws relating to the practice of medicine and the other healing arts in Virginia.

If you have questions concerning this notice, please contact Karen D. Waldron, Deputy Executive Director, Discipline.

Sincerely,



Hilary H. Connor, M.D.
Executive Director
Virginia Board of Medicine

KTM:AB1024N1:MED

cc: Franklin J. Pepper, M.D., President
Howard M. Casway, Assistant Attorney General
Karen T. McCaffrey, Legal Assistant
Informal Conference Committee
Division of Investigations (90-00646)
George Wilbur, Director of Public Information
Gloria King, Probation Analyst

Enclosure:

Virginia Code Sections:

54:1-2919
9-6.14:11
54.1-2915
54.1-2914
54.1-3408

Attachment I
Map

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: W. STANLEY JENNINGS, JR., M.D.

CONSENT ORDER

Pursuant to Sections 9-6.14:11 and 54.1-2919 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Dr. Jennings on Friday, April 12, 1991 in Richmond, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the informal conference committee ("Committee") were: Read F. McGehee, M.D., Chairman; Wayne E. Engel, Ph.D.; and Charles N. Van Horn, M.D. Dr. Jennings was present and represented by counsel, Jack B. Russell, Esq. The Board was represented by Howard M. Casway, Assistant Attorney General. The purpose of the informal conference was to inquire into allegations that Dr. Jennings may have violated certain laws governing the practice of medicine in Virginia, as set forth in the Board's notice of informal conference dated December 21, 1990. At the conclusion of the conference, the Committee voted to continue the proceeding pending the receipt of additional information

FINDINGS OF FACT

The Committee deferred making Findings of Fact pending receipt of additional information and upon final determination in this matter.

CONSENT

I, W. Stanley Jennings, Jr., M.D., by affixing my signature hereto, acknowledge that:

1. I have been specifically advised to seek the advice of counsel prior to signing this document;

2. I am aware that without my consent, no legal action can be taken against me, except pursuant to the Virginia Administrative Process Act, Section 9-6.14:1 et seq., of the Code;

3. I have the following rights, among others: the right to a formal fact finding hearing before the Board, to reasonable notice of said hearing, to representation by counsel, and to cross-examine witnesses against me;

4. I waive all such rights to a formal hearing;

5. I admit to the foregoing Findings of Fact; and

6. I consent to the entry of this Consent Order affecting my license to practice medicine in the Commonwealth of Virginia.

ORDER

WHEREFORE, it is hereby ORDERED that the informal conference which met with W. Stanley Jennings, Jr., M.D. on April 12, 1991, be CONTINUED for a period of not more than six (6) months upon the following terms and conditions:

1. Dr. Jennings shall attend the didactic session of the mini-residency sponsored by the University of Medicine and Dentistry of New Jersey entitled "The Proper Prescribing of Controlled Dangerous Substances". Dr. Jennings shall submit to the Board evidence of his attendance and the successful completion of the program.

2. Dr. Jennings shall adhere to and follow the recommendations set forth in the consultant's January 9, 1991 report with respect to his future psychiatric treatment and prescribing of controlled substances of Individual A.

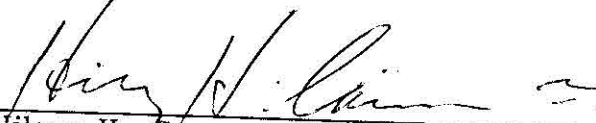
3. Dr. Jennings shall reappear before the informal conference committee within a period of six (6) months. The Committee reserves the right to impose such further terms and conditions as it deems appropriate at that time. The Committee shall serve as an instrument of the Board responsible for approving and reviewing all information relative to the terms and conditions of this Consent Order.

4. Dr. Jennings shall maintain a course of conduct in his practice of medicine commensurate with the requirements of Chapter 29, Title 54.1 of the Code.

Violation of this Consent Order shall constitute grounds for the revocation of the license of W. Stanley Jennings, Jr., M.D. In the event Dr. Jennings violates any of the terms and conditions of this Consent Order, a formal administrative hearing shall be convened to determine whether the license of Dr. Jennings, shall be revoked.

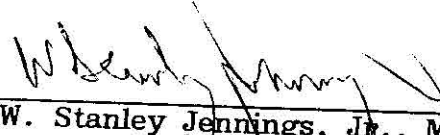
Pursuant to Section 9-6.14:14 of the Code, the signed original of this Consent Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD:


Hilary H. Connor, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 5-9-91

SEEN AND AGREED TO:


W. Stanley Jennings, Jr., M.D.

COMMONWEALTH OF VIRGINIA
COUNTY/CITY OF Richmond, to wit:

Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia at large, this 3 day of May, 1991 by W. Stanley Jennings, Jr., M.D.

My commission expires: 3-13-93

Rebecca A. Janda
Notary Public

RECEIVED: May 14, 1991

Bernard L. Henderson, Jr.
Bernard L. Henderson, Jr., Director
Department of Health Professions

KTM:AB041701:ORDERS



COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Medicine

Bernard L. Henderson, Jr.
Director of the Department

William H. Connor, M.D.
Executive Director of the Board

1601 Rolling Hills Drive, Suite 200
Richmond, Virginia 23229-5005
(804) 562-9908
FAX (804) 562-9943

March 24, 1992

Walter S. Jennings, Jr., M.D.
7149 Jahnke Road
Richmond, Virginia 23225

CERTIFIED MAIL
P 741 100 057

RE: License No. 0101-034383

Dear Dr. Jennings:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on Thursday, April 30, 1992 at 9:30 a.m. at the Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia. The conference will be conducted pursuant to Sections 54.1-2919 and 9-6.14:11 of the Code of Virginia (1950), as amended ("Code").

An informal conference committee ("Committee"), composed of three members of the Board, will review your compliance with the terms and conditions imposed upon your license to practice medicine in Virginia as set forth in a Consent Order of the Board entered May 9, 1991.

You may be represented by an attorney at the informal conference. The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, or in the event of a violation of the terms of the Consent Order, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing; or

2. In the event the Committee finds that you have violated the terms of the Consent Order, the Committee may reprimand or censure you; or


3. The Committee may modify the terms and conditions of the Consent Order for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the Committee may direct, evidence that you are not practicing your profession in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of medicine and other healing arts in Virginia.

Should you fail to appear at the informal conference, the Committee may proceed to a formal administrative hearing in order to impose sanctions. Please inform this office whether you intend to appear at the conference at least 10 days prior to the scheduled date above. Also please provide the Board with a telephone number where you may be reached.

Notice to Walter S. Jennings, Jr., M.D.
March 24, 1992
Page 2

Please find enclosed for your reference copies of relevant statutes and the Board's May 9, 1991 Consent Order. Should you have any questions regarding this notice, please contact Karen W. Perrine, Deputy Executive Director, Discipline.

Sincerely,


Hilary H. Connor, M.D.
Executive Director
Virginia Board of Medicine

KTM:KB0317N1:ORDERS

cc: Bernard L. Henderson, Director, Department of Health Professions
Tony C. Butera, D.P.M., President
Howard M. Casway, Assistant Attorney General
Karen T. McCaffrey, Legal Assistant
Jack B. Russell, Esquire
Informal Conference Committee
Division of Investigations (90-00646)
George Wilbur, Director of Public Information
Gloria King, Probation Analyst

Enclosure:

Virginia Code Sections:

54.1-2919

9-6.14:11

Consent Order dated May 9, 1991

Map



COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Medicine

Bernard L. Henderson, Jr.
Director of the Department

Hilary H. Connor, M.D.
Executive Director of the Board

June 15, 1992

1601 Rolling Hills Drive, Suite 200
Richmond, Virginia 23229-5005
(804) 662-9908
FAX (804) 662-9943

Walter S. Jennings, Jr., M.D.
7149 Jahnke Road
Richmond, Virginia 23225

CERTIFIED MAIL
P 741 100 106

RE: License No. 0101-034383

Dear Dr. Jennings:

This letter is official notification of the decision of the informal conference committee ("Committee") of the Virginia Board of Medicine, which met with you on April 30, 1992 in Richmond, Virginia to make a final determination with respect to the allegations contained in the Board's notice of informal conference dated December 21, 1990 and to review your compliance with the terms and conditions of the Board's May 5, 1991 Consent Order.

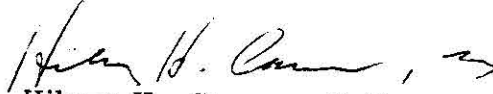
After considering the evidence and testimony presented, and with respect to allegation No. 1 of the December 21, 1990 notice of informal conference, the committee found that between the period January 27, 1989 and May 11, 1990, you prescribed to Patient A, an individual you knew to be drug and alcohol dependent, a large number of controlled substances of high abuse potential. However, the Committee recognized that there were extenuating circumstances surrounding your treatment of this extremely difficult patient. With respect to allegation No. 2 of the notice, the committee found that you had violated Section 54.1-3408 of the Code of Virginia (1950), as amended, by having provided mis-dated prescriptions for controlled substances to Patient A on July 25, 1988.

In addition, the committee found that you were in compliance with the Board's Consent Order and since meeting with the committee on April 12, 1991, and as required by Term I, you successfully completed the mini-residency sponsored by the University of Medicine and Dentistry of New Jersey entitled "The Proper Prescribing of Controlled Dangerous Substances". Furthermore, the committee acknowledged that you have actively worked to increase the awareness of your fellow physicians regarding the proper prescribing of controlled substances.

In conclusion, the committee voted to dismiss the matters before the Board and to take no further action regarding the Board's December 21, 1990 notice of informal conference. The committee's decision will become a part of the public record of the Board of Medicine. Should you reject the Committee's decision, you must within 30 days of receipt of this letter, request a formal administrative hearing in this matter.

Questions regarding the Committee's decision may be referred to Karen W. Perrine, Deputy Executive Director, Discipline at (804) 662-9929.

Sincerely,



Hilary H. Connor, M.D.
Executive Director
Virginia Board of Medicine

KTM:KB0504N1:NOTICES

cc: Charles F. Lovell, M.D., President
Bernard L. Henderson, Jr., Director, Department of Health Professions
Frank W. Pedrotty, Assistant Attorney General
Jack B. Russell, Esquire
Karen T. McCaffrey, Legal Assistant
Division of Investigations (90-00646)
Wayne J. Farrar, Director of Public Information
Gloria King, Probation Analyst



COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

Department of Health Professions
6603 West Broad Street, 5th Floor
Richmond, Virginia 23230-1712

www.dhp.virginia.gov
TEL (804) 662 9900
FAX (804) 662 9943
TDD (804) 662 7197

June 29, 2007

Walter Stanley Jennings, Jr., M.D.
1000 Boulders Parkway, Suite 202
Richmond, Virginia 23225

CERTIFIED MAIL
7160 3901 9849 4240 3604

RE: License No.: 0101-034383

Dear Dr. Jennings:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Thursday, September 6, 2007, at 9:00 a.m., at the Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Richmond, Virginia.** The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

A Special Conference Committee ("Committee") will inquire into allegations that you may have violated certain laws governing the practice of medicine in Virginia in your treatment of Patient A, a psychiatric patient for whom you also provided pain management. Specifically, you may have violated Section 54.1-2915.A(3), 54.1-2915.A(13) and 54.1-2915.A(16), in that, from approximately December 2004 to December 2005, you prescribed injectable ketamine (Schedule III), to be diluted and taken orally, and methadone (Schedule II) for Patient A's chronic pain due to scoliosis and a skin disorder; however, despite the patient's history of medication overdoses and pharmacological self-experimentation, you failed to properly monitor the patient's use of these medications and their effects on the patient, and failed to properly respond to signs of possible misuse of other medications and developing cognitive problems.

Please see Attachment I for the name of the patient referenced above.

After consideration of all information, the Committee may:

1. Exonerate you;
2. Place you on probation with such terms it deems appropriate.
3. Reprimand you; and
4. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

Further, the Committee may refer this matter for a formal administrative proceeding when it has failed to dispose of a case by consent pursuant to Section 2.2-4019 of the Code.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. Further, if you retain counsel, it is your responsibility to provide the enclosed materials to your attorney.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Renee S. Dixon, Discipline Case Manager, Virginia Board of Medicine, 6603 West Broad Street, 5th Floor, Richmond, Virginia 23230-1717, by **August 3, 2007**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Virginia Scher wish to submit any documents for the Committee's consideration after **August 3, 2007**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

You may be represented by an attorney at the informal conference. If you obtain counsel, you should do so as soon as possible, because absent good cause to support a request for a continuance, the informal conference will be held on September 6, 2007. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by **July 17, 2007**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **July 17, 2007**, will not be considered

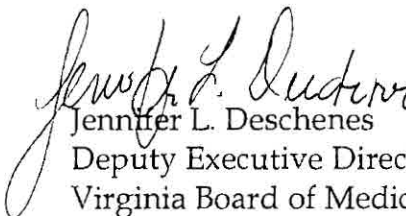
Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at <http://leg1.state.va.us>. To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

In its deliberations, the Committee may utilize the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at <http://www.dhp.virginia.gov/medicine>. You may request a paper copy from the Board office by calling (804) 662-7009.

Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Virginia Scher, Adjudication Specialist, at (804) 662- 7593.

Sincerely,


Jennifer L. Deschenes
Deputy Executive Director, Discipline
Virginia Board of Medicine

Vas/Jennings81NIC.DOC

Enclosures:

Attachment I
Informal Conference Package
Map

cc: Stephen E. Heretick, J.D., President, Virginia Board of Medicine
Sandra Whitley Ryals, Director, Department of Health Professions
Reneé S. Dixon, Discipline Case Manager, Board of Medicine
Virginia Scher, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Vicki Gwaltney Garrison, Pharmacy inspector [106481]

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: WALTER STANLEY JENNINGS, JR., M.D.
License No.: 0101-034383

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Walter Stanley Jennings, Jr., M.D., on October 19, 2007, in Richmond, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Malcolm L. Cothran, Jr., M.D., Chairman; Claudette Dalton, M.D.; and Stephen E. Heretick, J.D.

Dr. Jennings appeared and was represented by legal counsel, Rodney K. Adams, Esquire. Virginia Scher, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions.

The purpose of the informal conference was to inquire into allegations that Dr. Jennings may have violated certain laws governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated June 29, 2007.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law:

1. Walter Stanley Jennings, Jr., M.D., was issued license number 0101-034383 by the Board to practice medicine in the Commonwealth of Virginia on June 17, 1982. Said license is currently active and will expire on May 31, 2008, unless renewed or otherwise restricted.

2. Dr. Jennings violated Sections 54.1-2915.A(3) and (13) of the Code in his treatment of Patient A, a psychiatric patient for whom he also provided pain management. Specifically, from approximately December 2004 to December 2005, Dr. Jennings prescribed injectable ketamine (Schedule III), to be diluted and taken orally, and methadone (Schedule II) for Patient A's chronic pain due to scoliosis and a skin disorder; however, despite the patient's history of medication overdoses and pharmacological self-experimentation, Dr. Jennings failed to properly monitor the patient's use of these medications and their effects on the patient, and failed to properly respond to signs of possible misuse of other medications and developing cognitive problems.

3. Dr. Jennings admitted to the Committee that he did not obtain a complete history of Patient A. For example, Dr. Jennings did not determine: whether Patient A had any history of prior substance abuse; current and prior medications taken by Patient A and how she responded to those medications; or prior non-narcotic treatments for pain. Further, Dr. Jennings did not try any non-narcotic remedies for Patient A's pain, and failed to document that he asked Patient A to sign a release so he could obtain records from her other treating physicians.

4. Dr. Jennings admitted to the Committee that he did not perform a physical examination of Patient A. Additionally, he stated he does not perform physical examinations on any patients, even though he is treating approximately ten pain management patients. Dr. Jennings stated he cannot perform physical examinations because he has no examination table or equipment, and that his office is not suitable for conducting physical examinations.

5. In response to the Committee's questions about a note in the record referencing Patient A's admission for a barbiturate overdose in September 2005, Dr. Jennings stated he did not see that note in the record and had he seen it, he would have fired Patient A. Dr. Jennings attributed his missing of this note to practice management issues in the office.

6. In explaining the paucity of records related to Patient A, Dr. Jennings stated to the Committee that the records were thinned by office staff. He further stated it takes weeks to months for documents to reach patient files.

7. Dr. Jennings stated to the Committee that he had no prior experience with the use of ketamine as a pain management modality, and the initial information he did have was supplied by Patient A.

8. Dr. Jennings admitted that despite the fact that Patient A was not completely truthful with him, he trusted her and that was the reason he did not order the urine drug screens he documented in his treatment plan.

9. Dr. Jennings provided the Committee with a sample copy of the contract he had with Patient A, entitled "Management Rules for Controlled Dangerous Medications". In spite of claiming to have had a contract in place, Dr. Jennings failed to hold Patient A accountable to the terms of the contract. For example, Dr. Jennings allowed Patient A, through written permission on a prescription blank, to obtain pain medications from other physicians.

10. Although Dr. Jennings stated his goal was to decrease the dosages of Patient A's medications, pharmacy records reflect that the dosages were increasing in the several months prior to Patient A's death.

11. The Committee determined that Dr. Jennings did not have a clear understanding that his role was to determine and outline treatment for Patient A, rather than to allow Patient A to take on that responsibility.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that the license of Walter Stanley Jennings, Jr., M.D., be, and hereby is, placed on INDEFINITE PROBATION and subject to the following TERMS AND CONDITIONS:

1. Upon entry of this Order, Dr. Jennings shall be prohibited from prescribing Schedule II and Schedule III controlled substances, with the exception of central nervous system stimulants, i.e. Ritalin.

2. Within thirty (30) days of entry of this Order, Dr. Jennings shall make arrangements to transfer his current pain management patients to other treatment providers. Further, Dr. Jennings is prohibited from accepting any new patients for pain management.

3. Within twelve (12) months of entry of this Order, Dr. Jennings shall successfully complete Board approved continuing medical education ("CME") courses consisting of at least 20 hours in each of the following subjects: (i) medical recordkeeping; (ii) proper prescribing of controlled substances; and (iii) in pain management, to include addiction. The courses shall be approved in advance of registration by the Deputy Executive Director for Discipline of the Board. Any CME hours obtained in compliance with this term shall not be used toward licensure renewal requirements.

4. Within twenty-one (21) days of completion of the CME required by Term #3, Dr. Jennings shall submit a certificate or other evidence, satisfactory to the Board, of completion of all CME required by this Order.

5. Within six (6) months of entry of this Order, Dr. Jennings shall evaluate and review the maintenance of patient medical records to ensure that his patient records are complete and accurate and that medical information is updated in a timely manner. Additionally, Dr. Jennings's shall develop a written protocol, which defines the process for the maintenance and handling of his patient records. The written protocol shall be maintained at the practice location for review.

6. Upon completion of Term #3 of this Order, Dr. Jennings' practice shall be subject to an unannounced inspection by an inspector/investigator of the Department of Health Professions. Said inspection shall be conducted during normal business hours and shall include, but not limited to, determining compliance with Term #5 and obtaining copies of ten (10) of Dr. Jennings' patient records randomly selected by the inspector for review by a Special Conference Committee.

7. In approximately eighteen (18) months from entry of this Order, a probation report shall be prepared and submitted to the Board regarding Dr. Jennings compliance with the terms outlined in this Order. Subsequently, Dr. Jennings shall be noticed to appear before a Special Conference Committee ("Committee") of the Board for review of his compliance. Said Committee shall provide the ongoing monitoring of Dr. Jennings Order, determine the frequency of further appearances by Dr. Jennings before it, and shall serve as the instrument of the Board responsible for reviewing and approving all information relative to the terms and conditions, except as otherwise noted herein.

7. Dr. Jennings shall maintain a course of conduct in his practice of medicine commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

8. Dr. Jennings shall cooperate with the Virginia Board of Medicine and the Department of Health Professions in the investigation or inspection of his practice to verify that he is in compliance with this Order.

9. Dr. Jennings shall notify the Executive Director of the Board, by certified mail, of any change of address within ten days of such occurrence.

10. Dr. Jennings shall notify the Board immediately, in writing, should he intend to change the location of his practice.

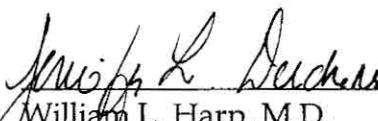
Violation of this Order may constitute grounds for suspension or revocation of Dr. Jennings' license. In the event that Dr. Jennings violates this Order, an administrative proceeding may be convened to determine whether his license shall be revoked.

Pursuant to Section 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Dr. Jennings may, not later than 5:00 p.m., on December 10, 2007, notify William L. Harp, M.D., Executive Director, Board of Medicine, Perimeter Center, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on December 10, 2007; unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

for 

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 11/5/2007



COMMONWEALTH of VIRGINIA

Department of Health Professions

Sandra Whitley Ryals
Director

Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

www.dhp.virginia.gov
TEL (804) 367- 4400
FAX (804) 527- 4475

October 28, 2008

Walter Stanley Jennings, Jr., M.D.
1000 Boulders Parkway, Suite 202
Richmond, Virginia 23225

CERTIFIED MAIL
7160 3901 9845 1839 9423

RE: License No.: 0101-034383

Dear Dr. Jennings:

This letter is official notification of the decision of a Special Conference Committee ("Committee") of the Virginia Board of Medicine which met on October 23, 2008, in Richmond, Virginia, in order to review your compliance with the Board's Order entered November 5, 2007. Members of the Board serving on the Committee were: Jane E. Piness, M.D., Chair, and Valerie L. Hoffman, D.C.

After careful consideration of the information presented, the Committee determined that the indefinite probation and terms imposed on your license should be **TERMINATED** effective this date. Based on this decision, the record of the Board has been updated to reflect that you have a full and unrestricted license in the Commonwealth of Virginia.

Pursuant to §54.1-2400.2 (F) of the *Code of Virginia*, a signed copy of this letter shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

The Board wishes you well in your future endeavors.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

SCC Closure Letter – W. Stanley Jennings, Jr., M.D.

October 28, 2008

Page #2

cc: Renée S. Dixon, Discipline Case Manager [106481]
Jennie Wood, Administrative Assistant
Susan Brooks, Office Manager, APD



COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

Department of Health Professions

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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TEL (804) 367- 4400
FAX (804) 527- 4475

December 9, 2011

Walter Stanley Jennings, Jr., M.D.
1000 Boulders Parkway, Suite 202
Richmond, Virginia 23225

CERTIFIED MAIL

7160 3901 9848 6289 0201

RE: License No.: 0101-034383

Dear Dr. Jennings:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Wednesday, January 18, 2012, at 1:30 p.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Henrico, Virginia.** The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019, and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

A Special Conference Committee ("Committee") will inquire into allegations that you may have violated certain laws and regulations governing the practice of medicine and surgery in Virginia in your care, treatment, and management of Patient A from approximately March 2005 through March 2009. Specifically:

1. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code in that, on or about June 25, 2004, you diagnosed Patient A with "bipolar depression," a diagnosis which is not generally accepted and which is not found in the Diagnostic and Statistical Manual IV text revision (2000) ("DSM IV"). During the course of the patient's treatment, you failed to refine the diagnosis to a specific bipolar diagnosis found in the DSM IV. Additionally, although you supervised a nurse practitioner with regard to Patient A's care for several years and you co-signed Patient A's progress notes authored by the nurse practitioner during that time period, you failed to ensure that changes to the patient's diagnosis made by the nurse practitioner were sufficiently supported in the medical record. For example, on or about February 19, 2008, the nurse practitioner, who regularly treated the patient at office visits at that time, changed Patient A's diagnosis to "major depression," without any explanation in the record for such a change. Likewise, on or about February 3, 2009, the nurse practitioner changed the diagnosis to "bipolar depression, anxiety," again without a documented explanation.

2. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code in that, on or about June 25, 2004 you prescribed 60 dosage units of Topamax (topiramate) 25 mg tablets to Patient A to be taken one tablet by mouth twice daily, without noting the prescription in the patient's progress notes, documenting informed consent, or documenting a patient assessment or rationale for the medication. Additionally, no other prescriptions for Topamax appear in the patient's file, so it cannot be determined from the record when or why the prescription was discontinued.

3. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code by inadequately managing Patient A's lithium therapy as follows:

a. On March 17, 2005, during the appointment at which you initially prescribed lithium to Patient A, you failed to obtain and/or document having obtained informed consent from the patient regarding the potential risks and benefits of the medication. Additionally, you failed to evaluate and/or document the patient's current symptoms, your diagnosis, or an assessment/treatment goals related to the lithium prescription. Finally, you failed to evaluate and/or document a mental status examination, including the presence or absence of suicidal ideation, prior to providing the patient with a prescription for 60 dosage units of 450 mg Eskalith CR.

b. Prior to initiating lithium therapy in March 2005, you failed to order, obtain, and/or review diagnostic laboratory tests or studies, including but not limited to renal function, electrolyte levels, and thyroid function, nor did you note whether the patient had a history of cardiac problems. Moreover, during the approximate four-year period during which you oversaw Patient A's care, neither renal function nor thyroid tests were periodically ordered although lithium continued to be prescribed through early 2009.

c. Although Patient A was prescribed lithium per your approval on a continuous basis through approximately March 2009, her serum lithium levels were only obtained once, on or about March 21, 2005. Following Patient A's May 10, 2005 telephonic complaints relating to lithium, she was seen by the nurse practitioner on May 12, 2005, where she complained of hand tremors, slurred speech, and sedation. The nurse practitioner instructed Patient A to discontinue lithium until the patient returned to the office on May 16, 2005, at which time Patient A was restarted on lithium at a lower dosage. Although you co-signed Patient A's progress notes authored by the nurse practitioner on May 12, 2005 and May 16, 2005, you failed to ensure that a proper evaluation was performed relating to the patient's reported side effects. Moreover, you failed to ensure that the patient's lithium level was obtained at that time.

d. You indicated to the Board's investigator that Patient A's lithium dosage was held at 225 mg (one-half of one 450 mg tablet daily) after her dosage was changed in May 2005. However, as indicated below, some progress notes and pharmacy records from June 2006 forward indicate that the patient was being prescribed 450 mg of lithium per day (one 450 mg tablet daily):

- June 29, 2006: Eskalith 450 1 q day
- July 16, 2007: Eskalith CR 450 Tab ER #30 (Sig: 1 tab(s) orally once daily), Refills: 3
- February 19, 2008: Eskalith 450 q[s?]
- May 19, 2008: Eskalith CR 450 mg Tab ER #30 (Sig: 1 tab(s) orally once daily), Refills: 3
- August 20, 2008: Eskalith CR 450 mg Tab ER #30 (Sig: 1 tab(s) orally once daily), Refills: 3
- October 20, 2008: Eskalith 450
- December 1, 2008: Eskalith 450

4. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code in that, from approximately August 2004 to February 2009, while Patient A was under your care, a thorough substance abuse history was not taken prior to the patient receiving prescriptions for multiple benzodiazepenes, including alprazolam, diazepam, and temazepam. Additionally, the patient's ongoing cognitive complaints, such as poor concentration and memory, were not adequately addressed or documented in progress notes during this time.

5. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code in that, while you were supervising the treatment of Patient A by a nurse practitioner and you co-signed Patient A's progress notes authored by the nurse practitioner, from approximately July 2007 through November 2007 you failed to address the concomitant prescribing of Celexa and Lexapro to Patient A, although the concomitant use of two such SSRI antidepressants is not standard therapy for bipolar-spectrum illness, as it may result in mania induction and/or serotonergic toxicity.

Please see Attachment I for the name of the patient referenced above.

After consideration of all information, the Committee may:

1. Exonerate you;
2. Place you on probation with such terms it deems appropriate;
3. Reprimand you; and
4. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

Further, the Committee may refer this matter for a formal administrative proceeding when it has failed to dispose of a case by consent pursuant to Section 2.2-4019 of the Code.

The Board has engaged the services of Bill J. Forte, M.D., whose curriculum vitae and written report are included in the material enclosed with this letter. Dr. Forte will be present at the informal conference to serve as an expert regarding your care and treatment of Patient A.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. These materials have been provided this date to your counsel, Gerald C. Canaan, II, Esquire.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Reneé S. Dixon, Discipline Case Manager, Virginia Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia, 23233, by **January 4, 2012**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Tracy Robinson wish to submit any documents for the Committee's consideration after **January 4, 2012**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

Absent good cause to support a request for a continuance, the informal conference will be held on January 18, 2011. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by **December 20, 2011**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **December 20, 2011**, will not be considered.

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at <http://leg1.state.va.us>. To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

In its deliberations, the Committee may utilize the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at <http://www.dhp.virginia.gov/medicine>. You may request a paper copy from the Board office by calling (804) 367-4513.

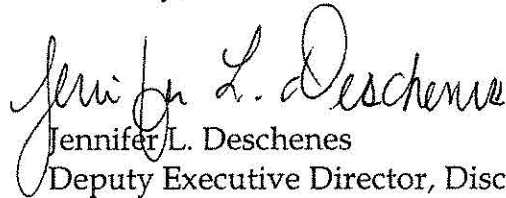
December 9, 2011

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Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Tracy Robinson, Adjudication Specialist, at (804) 367-4694.

Sincerely,



Jennifer L. Deschenes
Deputy Executive Director, Discipline
Virginia Board of Medicine

Enclosures:

Attachment I
Informal Conference Package
Map

cc: Tracy E. Robinson, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Gerald C. Canaan, II, Esquire [w/enclosures]
Gayle Miller, Senior Investigator [130256]

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: WALTER STANLEY JENNINGS, JR., M.D.
License No.: 0101-034383

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019, and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Walter Stanley Jennings, Jr., M.D., on March 22, 2012, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Deeni Bassam, M.D., Chair; Valerie Lowe Hoffman, D.C.; and William H. Epstein, M.D. Dr. Jennings appeared personally and was represented by Gerald C. Canaan, II, Esquire. Tracy E. Robinson, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions.

The purpose of the informal conference was to inquire into allegations that Dr. Jennings may have violated certain laws governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated December 9, 2011.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law:

1. Walter Stanley Jennings, Jr., M.D., was issued license number 0101-034383 by the Board to practice medicine and surgery in the Commonwealth of Virginia on June 17, 1982. Said license is currently active and will expire on May 31, 2012, unless renewed or otherwise restricted.

2. Dr. Jennings violated Sections 54.1-2915.A(3) and (13) of the Code in his care, treatment, and management of Patient A from 2004 through 2009 by inadequately managing Patient A's lithium therapy as follows:

a. On March 17, 2005, during the appointment at which Dr. Jennings initially prescribed lithium to Patient A, he failed to obtain and document having obtained informed consent from the patient regarding the potential risks and benefits of the medication. Additionally, Dr. Jennings failed to evaluate and document the patient's current symptoms, a diagnosis, or an assessment/treatment goals related to the lithium prescription. Finally, Dr. Jennings failed to evaluate and document a mental status examination, including the presence or absence of suicidal ideation, prior to providing the patient with a prescription for 60 dosage units of 450 mg Eskalith CR.

b. Prior to initiating lithium therapy in March 2005, Dr. Jennings failed to order, obtain, or review diagnostic laboratory tests or studies, including but not limited to renal function, electrolyte levels, and thyroid function, nor did he note whether the patient had a history of cardiac problems. Moreover, during the approximate four-year period during which Dr. Jennings oversaw Patient A's care, neither renal function nor thyroid tests were periodically ordered although lithium continued to be prescribed through early 2009.

c. Although Patient A was prescribed lithium per Dr. Jennings' approval on a continuous basis through approximately March 2009, her serum lithium levels were only obtained once, on or about March 21, 2005. Following Patient A's May 10,

2005 telephonic complaints relating to lithium, she was seen by the nurse practitioner on May 12, 2005, where she complained of hand tremors, slurred speech, and sedation. The nurse practitioner instructed Patient A to discontinue lithium until the patient returned to the office on May 16, 2005, at which time Patient A was restarted on lithium at a lower dosage. Although Dr. Jennings co-signed Patient A's progress notes authored by the nurse practitioner on May 12, 2005 and May 16, 2005, he failed to ensure that a proper evaluation was performed relating to the patient's reported side effects. Moreover, Dr. Jennings failed to ensure that the patient's lithium level was obtained at that time.

d. Dr. Jennings indicated to the Board's investigator that Patient A's lithium dosage was held at 225 mg (one-half of one 450 mg tablet daily) after her dosage was changed in May 2005. However, as indicated below, some progress notes and pharmacy records from June 2006 forward indicate that the patient was being prescribed 450 mg of lithium per day (one 450 mg tablet daily):

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- August 20, 2008: Eskalith CR 450 mg Tab ER #30 (Sig: 1 tab(s) orally once daily), Refills: 3
- October 20, 2008: Eskalith 450
- December 1, 2008: Eskalith 450

3. Dr. Jennings stated that despite the fact that the documentation and the patient's refill intervals could suggest that she was taking a full tablet of lithium per day, the

patient was only prescribed one half tablet per day, which the patient confirmed during the course of her care.

4. Dr. Jennings stated that the standard of care prior to initiating lithium is some measure of thyroid and kidney function, and "some" evaluation of cardiac status. He admitted that he did not check the patient's creatinine, but stated that he checked her lithium level and TSH level within four days of starting Patient A on lithium. His experience is that lithium does not affect the thyroid that quickly, so obtaining baseline levels within four days of beginning the medication was sufficient. Dr. Jennings acknowledged that he did not have a baseline BUN when he began providing lithium to Patient A.

5. The Committee heard from an expert retained by the Board and Dr. Jennings' expert, each of whom rendered opinions regarding the aspects of care and treatment provided by Dr. Jennings to Patient A.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Dr. Jennings be and hereby is, issued a REPRIMAND.

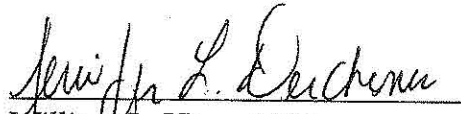
Dr. Jennings shall maintain a course of conduct in his practice of medicine commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Dr. Jennings may, not later than 5:00 p.m., on May 1, 2012, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on May 1, 2012; unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD:

for 

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 3/27/2012