3. Dr. Brooks violated Section 54.1-2915A(3), (13), and (16) of the Code of Virginia (1950), as amended ("Code") in his care and treatment of Patient B, a 28-year-old female, during a non-emergent laparoscopic procedure. Specifically:

a. On or about September 12, 2012, Dr. Brooks performed a diagnostic laparoscopy and lysis of adhesions on Patient B.

b. Subsequently, Patient B presented to the emergency room on or about September 13, 2012, complaining of uncontrolled pain. While in the ER, Dr. Brooks ordered a surgical consult to rule out complications from her surgery the previous day. Further, he readmitted her to the hospital for observation while awaiting the results of the surgical consult. Prior to receiving the results of said consultation, Dr. Brooks discharged Patient B later that same day.

c. Dr. Brooks stated to the Board investigator that he later discovered that the consulting surgeon had not completed his evaluation of Patient B prior to herdischarge and acknowledged that he "assumed" the consultant did not suspect an injury, but failed to confirm this information.

d. Patient B expired on September 14, 2012, due to peritonitis secondary to a perforation of the small intestine.

4. As a result of the two adverse events referenced above, Dr. Brooks' medical staff membership at the facility at which these procedures were performed was placed on probation for one year and required to complete a didactic refresher course on laparoscopic surgery and have all