STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF DENTAL EXAMINERS

IN RE:	**)**	
TYLER W. LUDINGTON	**)**	**Docket No. 2022-52**
License No. 016.0119165	**)**	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through Prosecuting Attorney Ultan Doyle, and Respondent Tyler Ludington, by and through his counsel Nicole Andreson, Esq., who hereby stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Dental Examiners (the "Board") has jurisdiction to hear matters involving allegations of unprofessional conduct committed by dentists, dental hygienists, and dental assistants pursuant to 3 V.S.A. §§127, 129, 129a; 26 V.S.A. Chapter 12; the Administrative Rules of the Board of Dental Examiners ("ARBDE"); and the Rules of the Vermont Office of Professional Regulation ("OPR").

Stipulated Facts

2. Tyler W. Ludington, DMD ("Respondent") of Ashburn, Virginia is licensed by the State of Vermont as a dentist under license number 016.0119165. This license was originally issued April 1, 2016, and expires on September 30, 2025.

3. At all relevant times, Respondent was practicing as a dentist at The Health Center (the "Practice") located in Plainfield, Vermont.

Patient 1

4. In 2019, Respondent provided dental treatment to patient D.O. ("Patient 1").

5. On January 3, 2019, Patient 1 damaged tooth #31 and sought treatment from Respondent. Respondent recommended a crown be placed on Patient 1's tooth.

6. On February 8, 2019, after Respondent took an impression of the tooth and Patient 1 had left, Respondent noticed that a mesial undercut and a defect in the impression material made the impression for the crown unacceptable.

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7. On February 13, 2019, Patient 1 returned to the Practice, and Respondent took another impression of tooth #31.

8. On February 25, 2019, Patient 1 returned to the Practice so that Respondent could install a crown on tooth #31. Respondent tried installing the crown on tooth #31, but did not complete the procedure due to an open mesial margin.

9. On March 22, 2019, Patient 1 returned to the Practice, and Respondent took a third impression of tooth #31.

10. On April 5, 2019, Patient 1 returned to the Practice, and Respondent installed another crown on tooth #31.

11. Respondent noted in Patient 1's chart, both before and after the installation, that he verified the crown's margins.

12. However, an x-ray taken of the crown taken on April 5, 2019 showed that this crown also had an open mesial margin.

13. On April 11, 2019, Patient 1 emailed the Practice to complain about a margin in the crown's mesial despite having received confirmation that all the margins had been closed upon delivery of the crown. Patient 1 advised that he was going to seek a second opinion from a dentist in a different practice as a result.

14. On April 18, 2019, Respondent added a note to Patient 1's chart that the x-ray taken on April 5 showed a radiolucent (permeable to x-rays) area on the mesial crown. Because Respondent had not clinically (visually or physically) detected an open mesial margin, he explained in Patient 1's chart that the radiolucent area on the x-ray was a void within the internal aspect of the prepped tooth structure.

Patient 2

15. In 2020, Respondent provided dental treatment to patient D.J. ("Patient 2").

16. On December 7, 2020, Respondent replaced a filling in tooth #2 of Patient 2.

17. Respondent noted in Patient 2's chart that the preparation on #2 was extremely deep and in close proximity to the pulp chamber.

18. On December 22, 2020, Patient 2 returned to the Practice complaining of pain in tooth #2 when he chewed.

19. Patient 2 was seen by another dentist at the practice, Dr. A.L., who noted in Patient 2's chart that tooth #2 had an open margin and an extremely deep composite which appeared to be in the pulp chamber.

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20. Dr. A.L. also noted that Respondent's earlier restoration of tooth #2 was a "defective restoration."

21. On January 7, 2021, Patient 2 returned to the Practice complaining that tooth #2 was sore again.

22. Patient 2 was again seen by Dr. A.L., who referred the patient to an endodontist and agreed to cover the cost of a root canal, build-up and installation of a crown because the issue with tooth #2 was caused by Respondent during his prior restoration of the tooth.

Patient 3

23. In 2020, Respondent provided dental treatment to patient M.D. ("Patient 3").

24. On December 15, 2020, Respondent placed a filling in tooth #14 of Patient 3.

25. There was no medical reason for Patient 3's tooth #14 to be filled.

Patient 4

26. In 2019, Respondent provided dental treatment to patient C.F. ("Patient 4").

27. On July 11, 2019, Respondent restored Patient 4's tooth #15 due to significant decay in the tooth.

28. To restore the tooth, Respondent installed a filling, but did not remove all the decay that was present in tooth #15.

29. On March 18, 2021, an x-ray taken of tooth #15 showed much of the decay that Respondent should have removed was still present in the tooth.

Patient 5

30. In 2020, Respondent provided dental treatment to patient D.F. ("Patient 5").

31. On November 24, 2020, Respondent delivered a crown to tooth #18 of Patient 5.

32. Prior to the crown being cemented, Respondent took x-rays of the crown.

33. After the x-rays were taken, Respondent questioned in Patient 5's chart whether there was an open distal margin.

34. Respondent reseated the crown and checked it clinically.

35. Respondent was unable to detect an open margin.

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36. Respondent took another set of x-rays after which he concluded that the crown's margin was "sufficiently subgingival [below the gumline] and sealed to allow for cementation."

37. Despite the x-rays showing an open margin in the crown, Respondent cemented the crown in place.

38. Respondent noted in Patient 5's chart that he "[r]e-verified occlusion, proximal contacts and margins."

Patient 6

39. In 2019, Respondent provided dental treatment to patient G.R. ("Patient 6").

40. On April 11, 2019, Respondent placed fillings in the following teeth of Patient 6: #a-MO, #b-DO, and #j-MO.

41. On October 23, 2019, x-rays were taken of #a-MO, #b-DO, and #j-MO.

42. On November 15, 2019, Dr. A.L. noted in Patient 6's chart that all of the fillings Respondent installed in Patient 6's teeth had failed due to "defective restoration/loss of restorative material."

43. On November 15, 2019, Dr. A.L. replaced Patient 6's fillings.

Patient 7

44. In 2019, Respondent provided dental treatment to patient U.P. ("Patient 7").

45. On June 19, 2019, during an examination of Patient 7, Respondent noted that x-rays taken of tooth #23 showed the presence of periapical (encompassing or surrounding the tip of the root) radiolucency on the tooth.

46. Patient 7 had received a root canal in tooth #23 over 30 years earlier.

47. Without consulting Patient's 7's prior x-rays and charts, Respondent told Patient 7 that the periapical radiolucency was a byproduct of the root canal.

48. Respondent did not recommend at the time that Patient 7 be evaluated by an endodontist.

49. A.D., a dental hygienist at the Practice, pulled Patient 7's prior dental records.

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50. Respondent reviewed these x-rays of tooth #23 and discovered that the tooth did not have any periapical radiolucency in 1988 and 2003, which meant that Respondent's earlier conclusion about the cause of the periapical radiolucency was incorrect.

51. Upon being presented with this information, Respondent appeared upset that A.D. had questioned his diagnosis.

52. Respondent agreed to speak to Patient 7 about these new findings and give him a referral to an endodontist.

Patient 8

53. In 2019, Respondent provided dental treatment to patient K.S. ("Patient 8").

54. On March 12, 2019, Respondent placed fillings on tooth #14-DO and tooth #15-MO of Patient 8.

55. On April 16, 2019, Respondent placed fillings on Patient 8's tooth #18-MO and tooth #19-DO.

56. On April 16, 2019, Respondent also redid Patient 8's fillings for tooth #14-DO and tooth #15-MO.

57. Respondent noted in Patient 8's chart that the fillings had to be done due to his prior "[d]efective restoration."

58. On November 15, 2019, x-rays revealed that Respondent had performed defective restorations again in Patient 8's teeth #14-DO, #15-MO, and also in #18-MO, and agreed to refill these teeth at no charge to Patient 8.

59. On December 31, 2019, Respondent redid the filling in Patient 8's tooth #14-DO for a second time.

60. On December 31, 2019, Respondent also redid the filling in Patient 8's tooth #18-MO.

Incident on December 16, 2020

61. On December 16, 2020, at approximately 1:00 pm, staff at the Practice found Respondent in the Practice's dental area in a chair. Respondent was initially not responsive to attempts to awaken him.

62. When Respondent came around, his speech was slower than normal and he appeared clammy.

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63. When staff discussed calling an ambulance, Respondent refused and said he would drive himself home.

64. Respondent eventually agreed to undergo an EKG, but would not allow blood testing or any lab workup to be done.

65. Respondent specifically denied to the Practice's staff that he had used any drugs or alcohol that day.

66. Respondent stayed in the Practice's exam room and slept until the end of his shift.

67. Earlier that morning, Respondent had taken 20 milligrams of Lexapro as prescribed, as well as an over-the-counter antihistamine.

68. Respondent had not slept well the night before.

69. During the morning, Respondent saw his patients as normal.

70. Around noon, Respondent left the office and consumed a sandwich and a Heady Topper beer and returned to work for his afternoon appointments.

71. Although Respondent was aware of the side effects of mixing alcohol with Lexapro, it was not foremost in his mind at the time he consumed alcohol during his lunchbreak.

72. When he returned to the Practice, Respondent had approximately 30 minutes before seeing his next patient, so he decided to take a nap.

73. The next thing Respondent remembered was being woken by the Practice's staff.

74. Respondent ended up not seeing any patients for the remainder of the day due to the circumstances.

Violation One: 3 V.S.A §129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.

75. Paragraphs 2 through 74 are incorporated herein.

76. As a dentist, Respondent is required to conform to the essential standards of acceptable and prevailing practice for dentists.

77. Paragraphs 2 through 74 demonstrate that Respondent failed to practice competently and failed to conform to the essential standards of acceptable and prevailing practice

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by failing to adequately deliver crowns; failing to adequately place fillings; failing to adequately read and interpret x-rays; and make necessary referrals for endodontic treatment.

78. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Two: 3 V.S.A. §129a(a)(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

79. Paragraphs 2 through 74 are incorporated herein.

80. As a dentist, Respondent is required to exercise his own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

81. Respondent's conduct in Paragraphs 41 through 74 above demonstrate Respondent's failure to exercise his own professional judgment in the performance of licensed activities when that judgment was necessary to avoid action repugnant to the obligations of the profession by drinking alcohol during his work lunch hour, having taking Lexapro that morning, and then returning to work with the purpose of seeing patients that afternoon.

82. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(15).

Understandings

83. Respondent admits that the facts above are true and that the conditions below are necessary to protect the public.

84. Respondent understands that the Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

85. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced his rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

86. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

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87. Respondent is not under the influence of any drugs or alcohol at the time he signs this Stipulation and Consent Order.

88. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

89. Respondent voluntarily waives the right to a contested hearing before the Board and waives any right to appeal from this Stipulation and Consent Order.

90. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

A. The Board hereby **REPRIMANDS** Respondent's license.

B. The Board hereby **CONDITIONS** Respondent's license **FOR A MINIMUM OF THREE (3) YEARS**. The conditions will be as follows:

1. Re-issuance of License. Upon the commencement of these conditions and the renewal of Respondent's license, Respondent shall be issued a license labeled "conditioned."

2. Length of Time of Conditions Imposed. The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes **a minimum of three (3) years** of supervised practice in which Respondent works at least eighty (80) hours every calendar month as a dentist. Part time hours of fewer than eighty (80) hours every calendar month shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week.

3. Monitoring. The Office of Professional Regulation, through the Enforcement Case Manager, shall be responsible for monitoring Respondent's compliance with these Conditions. All reports or correspondence regarding compliance with these conditions shall be submitted to the Case Manager in accordance with the Conditions listed below.

4. Completion of Substance Abuse Counseling, Treatment Plan, Treatment Reports and Recovery Groups. Respondent shall initiate individual substance abuse counseling with a counselor (the "Treating Professional") and comply with the substance abuse treatment plan until the Treating Professional certifies in writing that such counseling is no longer necessary and Respondent successfully petitions the Board for a modification of this condition. Respondent may be requested to participate in substance abuse recovery group(s) as recommended by the Treating

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Professional and, if so, shall submit **quarterly** reports documenting such attendance on forms issued by the Board, until such time the Treating Professional certifies in writing that such recovery group participation is no longer necessary. Within thirty (30) days of the date of entry of this Order, Respondent shall provide a copy of this Stipulation and Consent Order to the Treating Professional and inform him or her of Respondent's conditional license status and the accompanying conditions. Respondent shall cause the Treating Professional to submit to the Case Manager, on forms provided by the Case Manager, acknowledgement of receipt of the Stipulation and Consent Order along with Respondent's current treatment plan.

Respondent shall authorize the Treating Professional to submit **monthly** reports on forms issued by the Case Manager. Respondent shall authorize the Treating Professional to provide all information requested, either orally or in writing, at any time during the period this Consent Order is in effect.

If Respondent is prescribed medication as part of his substance abuse counseling and treatment, Respondent's monthly treating professional reports must also indicate Respondent's current dosage and whether Respondent is appropriately taking the medication as prescribed. Respondent must continue to take such medications as prescribed, until the Treating Professional certifies in writing that such medication is no longer necessary.

Should Respondent's medications be monitored by someone other than his Treating Professional, Respondent shall cause the prescribing provider to certify in writing, at intervals determined by the Case Manager, whether Respondent is appropriately taking the medication as prescribed. Respondent must continue to take such medications as prescribed until the prescribing provider certifies in writing that such medication is no longer necessary.

In addition, Respondent shall continue to engage in outpatient psychiatric management and outpatient psychotherapy until his treating mental health provider certifies in writing that such treatment is no longer necessary and Respondent successfully petitions the Board for a modification of this condition.

5. Random Drug and Alcohol Testing. Respondent shall submit to random drug and alcohol testing through the designated entity. All testing shall be done on a random, unannounced basis and analyzed by a lab qualified to analyze samples for forensic purposes. All specimens collected for tests shall be collected in an observed setting. All screens shall be negative.

   Failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any test shall cause that test result to be presumed positive. Any positive test result shall constitute a violation of this Order. Failure to check-in to determine whether Respondent is selected for testing on any given day, regardless of whether Respondent is selected to test that day, may be considered a violation of this Order.

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6. Abstain from Drug and Alcohol Use. Respondent shall abstain completely from the consumption or possession of alcohol and drugs.

7. Drug Use Exception. Respondent may take scheduled/controlled medications lawfully prescribed for a bona fide illness or condition by a health care practitioner disclosed to the Board in writing by Respondent within forty-eight (48) hours of the prescription. Respondent's health care practitioner shall inform the Board, in writing and on appropriate letterhead, of knowledge of Respondent's conditional license status within seven (7) days of entering into the practitioner/patient relationship. Additionally, the practitioner shall inform the Board of all scheduled/controlled medications prescribed – and the anticipation of how long such prescriptions will need to be taken – within seven (7) days of the prescription.

   The Board or its designee may request that the practitioner document the necessity for the prescribed scheduled/controlled medications or other medications known to have abuse potential. It is not anticipated that Respondent would be prescribed scheduled/controlled medication during the term of this Consent Order for a period greater than fourteen (14) days, but if so, then the conditions herein may be revoked by the Board.

   Respondent shall provide the Board with a current medication list of any medications taken on a scheduled or as-needed basis on forms issued by the Board within seven (7) days and shall update this list within forty-eight (48) hours of any change in these medications.

8. Notification to Employers. Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a dentist and inform them of Respondent's conditional license status. Within ten (10) days of the date of entry of this Consent Order or of any subsequent employment as a dentist, Respondent shall cause Respondent's immediate supervisor to submit to the Board an employer agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

9. Reports from Employers/Program Director. Within one (1) month of the date of this order or within one (1) month of the commencement of employment as a dentist and **monthly** thereafter, Respondent shall cause every employer Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. These reports shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance (i.e. consistently meeting all standards of dental practice) and attendance.

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10. Practice Under Supervision. Respondent shall practice as a dentist only in a setting where Respondent has on-site supervision for the entire shift by a dentist that is in good standing with the Board.

11. Types of Employment Prohibited. Respondent shall not work in a supervisory role.

12. Interview with the Board or its Designee. Respondent shall appear in person for interviews with the Board or its designee upon request.

13. Notification of Place of Employment/Personal Address/Telephone Number. Within ten (10) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of Respondent's current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment (including resignation or termination), personal address, or telephone number.

14. Notification to Other States. In the event that Respondent is licensed as a dentist in any other state(s), Respondent must inform the dental licensing board of the state(s) in which Respondent is licensed of the conditional status of Respondent's Vermont dental license within thirty (30) days of the date of entry of this Order.

15. License Renewal. This Order does not automatically extend the license and Respondent must comply with the Board requirements for license renewal and/or reinstatement.

16. Release of Information Forms. This Order requires Respondent to authorize drug and/or alcohol treatment providers to report information in verbal and/or written format and/or to discuss Respondent and any and all treatment rendered to Respondent for drugs and/or alcohol with the Board or its designee. Any and all of this information may be provided to the Office of Professional Regulation investigators, and that the information may be used for further prosecutions if so warranted or if the Office of Professional Regulation determines that said information violates the terms of this Order or any rules or laws governing the profession of dentistry.

    Respondent is entitled to revoke this consent at any time. However, any revocation shall be considered a violation of this Order. This consent expires when the conditions are removed from Respondent's dental license.

    This Stipulation and Consent Order shall itself constitute a valid written consent pursuant to the requirements of 42 C.F.R. § 2.31. Respondent understands that Respondent's treatment provider may require Respondent's to sign a separate and distinct consent meeting the requirements of 42 C.F.R. § 2.31.

17. Costs. Respondent shall bear all costs of complying with this Consent Order.

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18. Violation of this Order. If Respondent violates this Order, the Board, after giving Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

19. Completion of Conditioned License Period. After the conditioned license period, the Respondent may petition the Board to remove any and all conditions on his license. Respondent shall have the burden of proof to demonstrate successful completion of the above-stated conditions.

C. Notwithstanding any provision above, the Respondent must continue to meet all Board requirements for maintaining a license, license renewal and license reinstatement.

D. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a).

E. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 3/12/24

By: Ultan Doyle
Ultan Doyle, Esq.
State Prosecuting Attorney

TYLER LUDINGTON
RESPONDENT

Dated: March 12th, 2024

By: Tyler V Ludington
Tyler Ludington

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APPROVED AS TO FORM:

NICOLE ANDRESON
ATTORNEY FOR RESPONDENT

Dated: _3/12/2024_____

By: Nicole Andreson_____
Nicole Andreson, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF DENTAL EXAMINERS

Dated: 3/13/24

By: DocuSigned by: Robert Rulil
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Chairperson

Date of Entry: 3/13/24

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IN RE:	**)**	
TYLER W. LUDINGTON	**)**	**Docket No. 2022-52**
License No. 016.0119165	**)**	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont, by and through State Prosecuting Attorney, Ultan Doyle, and makes the following charges against the Respondent, Tyler W. Ludington:

Authority

1. The Vermont State Board of Dental Examiners (the "Board") has jurisdiction to hear matters involving allegations of unprofessional conduct committed by dentists, dental hygienists, and dental assistants pursuant to 3 V.S.A. §§127, 129, 129a; 26 V.S.A. Chapter 12; the Administrative Rules of the Board of Dental Examiners ("ARBDE"); and the Rules of the Vermont Office of Professional Regulation ("OPR").

Statement of Facts

2. Tyler W. Ludington, DMD ("Respondent") of Waterbury Center, Vermont is licensed by the State of Vermont as a dentist under license number 016.0119165. This license was originally issued April 1, 2016, and expires on September 30, 2023.

3. At all relevant times, Respondent was practicing as a dentist at The Health Center (the "Practice") located in Plainfield, Vermont.

Patient 1

4. In 2019, Respondent provided dental treatment to patient D.O. ("Patient 1").

5. On January 3, 2019, Patient 1 damaged tooth #31 and sought treatment from Respondent. Respondent recommended a crown be placed on Patient 1's tooth.

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36. Respondent took another set of x-rays after which he concluded that the crown's margin was "sufficiently subgingival [below the gumline] and sealed to allow for cementation."

37. Despite the x-rays showing an open margin in the crown, Respondent cemented the crown in place.

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Patient 7

44. In 2019, Respondent provided dental treatment to patient U.P. ("Patient 7").

45. On June 19, 2019, during an examination of Patient 7, Respondent noted that x-rays taken of tooth #23 showed the presence of periapical (encompassing or surrounding the tip of the root) radiolucency on the tooth.

46. Patient 7 had received a root canal in tooth #23 over 30 years earlier.

47. Without consulting Patient's 7's prior x-rays and charts, Respondent told Patient 7 that the periapical radiolucency was a byproduct of the root canal.

48. Respondent did not recommend at the time that Patient 7 be evaluated by an endodontist.

49. A.D., a dental hygienist at the Practice, pulled Patient 7's prior dental records.

50. Respondent reviewed these x-rays of tooth #23 and discovered that the tooth did not have any periapical radiolucency in 1988 and 2003, which meant that

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Respondent's earlier conclusion about the cause of the periapical radiolucency was incorrect.

51. Upon being presented with this information, Respondent was upset that A.D. had questioned his diagnosis.

52. Respondent agreed to speak to Patient 7 about these new findings and give him a referral to an endodontist.

Patient 8

53. In 2019, Respondent provided dental treatment to patient K.S. ("Patient 8").

54. On March 12, 2019, Respondent placed fillings on tooth #14-DO and tooth #15-MO of Patient 8.

55. On April 16, 2019, Respondent placed fillings on Patient 8's tooth #18-MO and tooth #19-DO.

56. On April 16, 2019, Respondent also redid Patient 8's fillings for tooth #14-DO and tooth #15-MO.

57. Respondent noted in Patient 8's chart that the fillings had to be done due to his prior "[d]efective restoration."

58. On November 15, 2019, x-rays revealed that Respondent had performed defective restorations again in Patient 8's teeth #14-DO, #15-MO, and also in #18-MO, and agreed to refill these teeth at no charge to Patient 8.

59. On December 31, 2019, Respondent redid the filling in Patient 8's tooth #14-DO for a second time.

60. On December 31, 2019, Respondent also redid the filling in Patient 8's tooth #18-MO.

Incident on December 16, 2020

61. On December 16, 2020, at approximately 1:00 pm, staff at the Practice found Respondent in the Practice's dental area in a chair, unconscious and unresponsive.

62. When Respondent came around, his speech was slower than normal and he appeared clammy.

63. When staff discussed calling an ambulance, Respondent refused and said he would drive himself home.

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64. Respondent eventually agreed to undergo an EKG, but would not allow blood testing or any lab workup to be done.

65. Respondent specifically denied to the Practice's staff that he had used any drugs or alcohol that day.

66. Respondent stayed in the Practice's exam room and slept until the end of his shift.

67. Earlier that morning, Respondent had taken 20 milligrams of Lexapro as prescribed, as well as an over-the-counter antihistamine.

68. Respondent had not slept well the night before.

69. During the morning, Respondent saw his patients as normal.

70. Around noon, Respondent left the office and consumed a sandwich and a Heady Topper beer and returned to work for his afternoon appointments.

71. Although Respondent was aware of the side effects of mixing alcohol with Lexapro, it was not foremost in his mind at the time he consumed alcohol during his lunchbreak.

72. When he returned to the Practice, Respondent had approximately 30 minutes before seeing his next patient, so he decided to take a nap.

73. The next thing Respondent remembered was being woken by the Practice's staff.

74. Due to Respondent's inability to provide dental care, he ended up not seeing any patients for the remainder of the day.

Violation One: 3 V.S.A §129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.

75. The State re-alleges and incorporates Paragraphs 2 through 54 above.

76. As a dentist, Respondent is required to provide safe and acceptable patient or client care.

77. Paragraphs 2 through 54 demonstrate that Respondent failed to practice competently and performed unacceptable patient care by failing to adequately deliver crowns; failing to adequately place fillings; failing to adequately read and interpret x-rays; and make necessary referrals for endodontic treatment.

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78. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

Violation Two: 3 V.S.A §129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.

79. The State re-alleges and incorporates Paragraphs 2 through 54 above.

80. As a dentist, Respondent is required to conform to the essential standards of acceptable and prevailing practice for dentists.

81. Paragraphs 2 through 54 demonstrate that Respondent failed to practice competently and failed to conform to the essential standards of acceptable and prevailing practice by failing to adequately deliver crowns; failing to adequately place fillings; failing to adequately read and interpret x-rays; and make necessary referrals for endodontic treatment.

82. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Three: 3 V.S.A. § 129a(a)(5) Practicing the profession when medically or psychologically unfit to do so.

83. The State re-alleges and incorporates Paragraphs 2 through 54 above.

84. As a dentist, Respondent is prohibited from practicing the profession when medically or psychologically unfit to do so.

85. Paragraphs 2 through 54 demonstrate that Respondent practiced the profession when medically or psychologically unfit to do when he drank alcohol during his work lunch hour, having taking Lexapro that morning, and then returned to work with the purpose of seeing patients that afternoon.

86. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(5).

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Violation Four: 3 V.S.A. §129a(a)(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

87. The State re-alleges and incorporates Paragraphs 2 through 54 above.

88. As a dentist, Respondent is required to exercise his own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

89. Respondent's conduct in Paragraphs 41 through 54 above demonstrate Respondent's failure to exercise his own professional judgment in the performance of licensed activities when that judgment was necessary to avoid action repugnant to the obligations of the profession by drinking alcohol during his work lunch hour, having taking Lexapro that morning, and then returning to work with the purpose of seeing patients that afternoon.

90. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(15).

Relief Requested

WHEREFORE, the license of Tyler W. Ludington should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 4th day of April, 2022.

STATE OF VERMONT
SECRETARY OF STATE

By: Ultan Doyle

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