- County of sentencing
- State inmate identification number
- Dates of: birth; prison admission; prison release; parole discharge; parole eligibility hearing; projected prison release; mandatory prison release
- First and last names
- Demographic information: sex; race; Hispanic origin; education level
- Offense type and number of counts per inmate for a maximum of three convicted offenses per inmate
- Prior time spent in prison and jail, and prior felony convictions
- Total sentence length imposed
- Additional offenses and sentence time imposed since prison admission
- Type of facility where inmate is serving sentence (for yearend custody census records only, the name of the facility is requested)
- Type of prison admission
- Type of prison release
- Whether inmate was AWOL/escape during incarceration
- Agency assuming custody of inmate released from prison (parole records only)
- Supervision status prior to discharge from parole and type of discharge

In addition, BJS is requesting OMB clearance to add the following items to the NCRP collection, all of which are likely available from the same databases as existing data elements, and should therefore pose minimal additional burden to the respondents, while greatly enhancing BJS' ability to better characterize the corrections systems and populations it serves:

- Date and type of parole admission
- Location of parole discharge or parole office
- FBI identification number
- Prior military service, date and type of last discharge

BJS uses the information gathered in NCRP in published reports and statistics. The reports will be made available to the U.S. Congress, Executive Office of the President, practitioners, researchers, students, the media, others interested in criminal justice statistics, and the general public via the BJS Web site.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* BJS anticipates 57 respondents to NCRP for report year 2012: 50 state respondents; the California Juvenile Justice Division; and six separate state parole boards. Each respondent currently submitting NCRP data will require an estimated 28 hours of time to supply the information for their annual caseload and an additional 3 hours documenting or explaining the data for a total of 1,200 hours. For the 15 states which have never submitted data or are returning to NCRP submission following a lapse of several years, the total first year's burden estimate is 933 hours, which includes the time required for developing or modifying computer programs to extract the data, performing and checking the extracted data, and submitting it electronically to BJS' data collection agency via SFTP. The total burden for all 57 NCRP data providers is 2,133 hours for report year 2012. Starting with report year 2013, this burden will decrease to 1,326 hours since all states will have data extract programs created and need only make minor modifications to obtain report year 2013 data. All states submit data via a secure file transfer protocol (SFTP) electronic upload.

(6) *An estimate of the total public burden (in hours) associated with the collection:* There are an estimated 2,133 total burden hours associated with this collection for report year 2013.

If additional information is required contact: Jerri Murray, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street NE., Washington, DC 20530.

Jerri Murray,

Department Clearance Officer, PRA, U.S. Department of Justice.

[FR Doc. 2012–14612 Filed 6–14–12; 8:45 am]

BILLING CODE 4410–18–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under the Clean Water Act

Notice is hereby given that on June 11, 2012, a proposed Consent Decree in *United States* v. *Siemens Industry, Inc., et al.,* Civil Action No. 1:12-cv-00729 was lodged with the United States District Court for the District of Delaware.

The complaint in this matter alleges that defendants violated Section 311 of the Clean Water Act at an oil recycling, storage and distribution facility in Wilmington, Delaware through their failure to prepare and implement an adequate Facility Response Plan, failing to provide an adequate secondary containment system, and failing to prepare and implement an adequate Spill Prevention, Control, and Countermeasure Plan.

The proposed Consent Decree requires defendants to take appropriate actions to comply with Section 311 of the CWA and implementing regulations at 40 CFR part 112, particularly to insure compliance with secondary containment requirements and Spill Prevention, Control and Countermeasure Plan requirements. Defendants will also pay a $300,000 civil penalty.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the proposed Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and either emails to emailed to *pubcomment-ees.enrd@USDOJ.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *Siemens Industry, Inc.,* D.J. Ref. 90–5–1–1–09287.

During the public comment period, the proposed Decree may be examined on the following Department of Justice Web site: *http://www.usdoj.gov/enrd/Consent_Decrees.html.* A copy of the proposed Decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, or by faxing or emailing a request to ''Consent Decree Copy'' (*EESCDCopy.ENRD@usdoj.gov*) fax no. (202) 514–0097, phone confirmation number: (202) 514–5271. If requesting a copy from the Consent Decree Library, please enclose a check in the amount of $8.25 (25 cents per page reproduction cost) payable to the U.S. Treasury or, if by email or fax, please forward a check in that amount to the Consent Decree Library at the stated address.

Robert Brook,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 2012–14664 Filed 6–14–12; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Patrick K. Chau, M.D.; Decision and Order

On August 8, 2011, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, issued an Order to Show Cause to Patrick K. Chau, M.D. (Registrant), of Vancouver, Washington. The Show Cause Order proposed the revocation of Registrant's DEA Certificate of Registration BC1983659, which authorizes him to dispense controlled substances as a practitioner,

and the denial of any pending application to renew or modify his registration, on the ground that his ''continued registration is inconsistent with the public interest.'' GX 3, at 1 (citing 21 U.S.C. 823(f) & 824(a)(4)).

More specifically, the Show Cause Order alleged that between February 20 and March 27, 2009, Registrant had issued prescriptions for alprazolam, a schedule IV controlled substance, to two undercover officers, without a legitimate medical purpose and outside the usual course of professional practice, in violation of 21 CFR 1306.04(a) and Wash. Rev. Code § 18.130.180(4). *Id.* at 1–2. The Show Cause Order further alleged that on October 15, 2009, the State of Washington's Medical Quality Assurance Commission issued an order prohibiting Registrant from prescribing controlled substances and that Registrant is therefore without authority to prescribe controlled substances in the State in which he is registered with DEA. *Id.* at 2. Finally, the Show Cause Order notified Registrant of his right to request a hearing on the allegations or to submit a written statement regarding the matters of fact and law raised in the Order in lieu of a hearing, the procedures for doing either, and the consequences for failing to do either. *Id.* (citing 21 CFR 1301.43(a), (c), (d), & (e)).

As evidenced by the signed return receipt card, the Government accomplished service on or about August 11, 2011. GX 4. Since the date of service of the Show Cause Order, more than thirty days have now passed and neither Registrant, nor anyone purporting to represent him, has either filed a request for a hearing or submitted a written statement in lieu thereof. Accordingly, I find that Registrant has waived both his right to a hearing and his right to submit a written statement in lieu of a hearing. 21 CFR 1301.43(e). I therefore issue this Decision and Order based on relevant evidence contained in the Investigative Record submitted by the Government. I make the following findings.

Findings

Registrant is the holder of DEA Certificate of Registration BC1983659, which authorizes him to dispense controlled substances in schedules II through V as a practitioner at the registered location of 6816 NE Highway 99, Suite 108, Vancouver, Washington. GX 1. While this registration was due to expire on August 31, 2010, on August 30, 2010, Registrant submitted a renewal application. GX 2. Accordingly, I find that Registrant's registration has remained in effect pending the issuance of the Final Order in this matter. 5 U.S.C. 558(c).

Registrant, who is a board-certified psychiatrist, is also the holder of a license to practice as a physician and surgeon issued by the State of Washington. GX 6, at 2. On October 1, 2009, Registrant entered into a Stipulated Findings of Fact, Conclusions of Law and Agreed Order with the State's Medical Quality Assurance Commission (hereinafter, MQAC or Commission); the MQAC accepted the Order on October 15, 2009. *Id.* at 24.

The MQAC's Order contained extensive findings regarding Registrant's prescribing of controlled substances to numerous patients. *See id.* at 3–17. For example, the MQAC found that Registrant had ''violated the standard of care in the following ways'' in treating Patient B, noting that:

> Patient B was on addicting doses of benzodiazepines and opioids when he started seeing [Registrant]. At that point, [Registrant] should have had Patient B detoxified rather than continue to support his treatment, and over time, increased the prescribed amounts of addictive medications.
>
> [Registrant] increased Patient B's already addictive and dangerous doses of opioids and benzodiazepines. In addition, there is no evidence of much, if any, resulting improvement to the patient's condition.
>
> [Registrant's] prescriptions of large amounts of opioids likely caused Patient B to become addicted to narcotics. [Registrant] failed to consider and try Patient B on non-addictive alternatives to treat his headaches.

Id. at 5–6. The MQAC thus found that ''[a]s a result, [Registrant] harmed, or created an unreasonable risk of harm, to Patient B.'' *Id.* at 6.

The MQAC further found that Registrant ''has engaged in a pattern of prescribing high doses and large amounts of addicting medication, particularly benzodiazepines, to new patients who claimed to need ongoing treatment at such doses, but who also provided rationales for transferring their care to [Registrant], such as that they recently moved from another state or part of this state, or that they changed or lost their insurance.'' *Id.* at 7. The Commission then found that in numerous instances Registrant ''did not obtain any records or otherwise verify [a patient's] treatment history.'' *See id.* at 7–13 (Patients D, E, F, G, H, I, J, K, L, M, N, O, P, Q, & R). Moreover, with respect to Patients D through R, the MQAC found that Registration violated the standard of care by:

> Failing to recognize that the patients were on addicting doses of medication and refer them to an appropriate detoxification facility.
>
> Repeatedly providing new patients with three-month supplies of high doses of addictive medications without planning to see the patients for three months.
>
> Ignoring possible drug-seeking and diversion behaviors, and not requesting medical records from other providers or otherwise substantiating the patients' reported treatment and prescription histories. As a result, [Registrant] placed these patients at an unreasonable risk of harm.

Id. at 13.

The MQAC catalogued additional violations by Registrant of the standard of care with respect to several of the patients. With respect to Patient K, the MQAC found that Registrant ''violated the standard of care * * * by prescribing two benzodiazepines, both at addicting doses.'' *Id.* Next, the MQAC found that Registrant ''violated the standard of care in prescribing OxyContin to Patient M and Norco to Patient N because he did not document that they suffered from current pain complaints.'' *Id.* at 14.

With respect to Patient S, the MQAC found that he had told Registrant ''that his symptoms improved when he tried two milligrams of Xanax supplied by 'other people.''' *Id.* Registrant ''prescribed a daily regimen of eight milligrams of Xanax, wrote for a three-month supply, and asked the patient to return in three months. The patient returned one month early * * * at which time [Registrant] increased the prescription to ten milligrams per day and again wrote for a three-month supply.'' *Id.* The Commission also found that approximately two months later, ''Patient S told [Registrant] that he was leaving the area for a summer job in Alaska and that he needed a 90-day supply of Xanax to last him for that period. [Registrant] provided the requested prescription.'' *Id.*

Regarding his prescribing to Patient S, the MQAC found that Registrant violated the standard of care, explaining that:

> He started the patient on an unduly high and addictive dose of Xanax instead of starting at a safer, lower dose and titrating up if warranted. He also disregarded signs that the patient was drug-seeking and possibly diverting. In accepting the patient's claim that he needed a 90-day supply of Xanax because he was going to work in Alaska for the summer, [Registrant] accepted at face value a brief note to that effect that the patient provided. The note was purportedly written by another of [Registrant's] patients.

Id.

Based on these and other findings, the MQAC concluded that Registrant had ''committed unprofessional conduct'' in violation of RCW 18.130.180(4), (8)(a), and (9). *Id.* at 18. The Commission placed Registrant's medical license on probation and prohibited him from

prescribing controlled substances, explaining that it ''will not lift this restriction unless the Center for Personalized Education for Physicians in Denver, Colorado * * * determined that [Registrant] can prescribe safely and with reasonable skill and without posing an unreasonable risk of harm to the public.'' *Id.*

On February 20, 2009, a DEA Special Agent (S/A) made an undercover visit to Registrant. During the visit, which was recorded, Registrant explained that he is a psychiatrist and asked the S/A if he was looking for psychiatric services and that his fee was $140, which the S/A paid in cash. GXs 8 & 9. The S/A told Registrant that he had a friend in Seattle who was giving him Xanax and that his girlfriend had also given him some of the drug. GX 9. Registrant asked the S/A to tell him about his symptoms; the SA replied that he had a friend who gave him a couple of pills, stated that he was really relaxed and ''just more relaxed after'' taking the drug, that ''I feel better after I take the pill,'' and ''I definitely feel better after than before.'' *Id.* Registrant than asked the S/A whether anyone in his family had anxiety; the S/A denied that anyone in his family had ''an anxiety problem.'' *Id.* Registrant then reviewed some type of agreement with the S/A, and after completing this, Registrant stated that ''my diagnosis for you is some sort of general anxiety problem.'' *Id.*

However, at no point during the visit, did the S/A state that he felt anxious. Registrant nonetheless gave the S/A a prescription for 90 tablets of Xanax 1mg. GX 10.

The Government also submitted a recording of a second undercover visit, which was conducted on March 27, 2009 by a different S/A. In his affidavit, the S/A stated that he had paid $140 cash; that he told Registrant that he had been referred by the S/A, who had performed the previous visit; and that Registrant gave him a prescription for 73 tablets of Xanax 1mg. GX 11, at 1–2; *see also* GX 13 (copy of Rx).

During the visit, the S/A told Registrant that he had not seen a doctor in a long time, and after confirming that he lived in Seattle, the S/A denied having a doctor in Seattle, stating that he was ''actually pretty healthy to be honest with you.'' After discussing the S/A's purported job, Registrant asked the S/A to ''tell me about what kind of symptoms you would like me to help you with?'' The S/A answered: ''Well actually * * * I'm not doing bad, I'm doing very good.'' Registrant replied: ''OK,'' and asked the S/A why he wanted to see him. The S/A explained he wanted to get some Xanax and when asked to explain why, stated that ''the only reason I can think of is it makes me feel good when I take it. Can't think of anything else to be honest with you.''

Registrant then asked the SA if he had previously taken Xanax; the S/A replied that he had taken it about two years ago. Registrant asked the S/A why he had then taken Xanax; the S/A stated: ''the same reason really.'' After Registrant asked: ''You feel relaxed''?; the S/A said: ''It makes me feel good,'' and that he had bought it on the street then, but that it was too expensive. After discussing the price the S/A had paid on the street, Registrant asked: ''Can you tell me the benefit when you taking it? Like when you're on it compared to when you're not on it? And the difference to justify the benefit, the reason you pay money to take it?'' The S/A answered: ''It just makes me feel good. I mean in general.''

Registrant then asked if a doctor had ''ever formally prescribe[d]'' the drug; the S/A stated ''No, No, I'll be honest with you.'' Next, Registrant asked if the Xanax helped him sleep; the S/A denied having any problem sleeping. Registrant then asked: ''And in the way you feel good that means you're relaxed? Able to do your job better? Is that right?'' The SA responded: ''I don't know if I could say that. I'm trying to be honest with you. I'm not trying to lie to you.'' Registrant then told the SA to ''try to justify the reason you come to visit me and to get the medication and so there's a reason. It just feels good. If you don't take it, if you feel good also, that might not be really reasonable right?'' The S/A replied ''right,'' and Registrant continued, stating: ''So in order for you to pay that much money and to come all the way to see me you must have some reason you want to do so.'' The S/A stated: ''right, right, right. It just makes me feel better in general.'' Registrant remarked: ''General well-being. So I suppose it takes away some kind of a tense, some kind of anxiety feeling.'' The S/A replied: ''well if we've * * * if that. If we've gotta say that, yes we can say that if we've gotta say that, yes.''

Registrant responded that ''anxiety is not like a panic that comes and goes and for some kind of anxiety that is pervasive always there, and that if the anxiety is being resolved and the people feel liberated from those feelings, that's how you feel better or general sense of well-being.'' The S/A replied: ''I mean if we have to say that, general well-being then you know, let's say that. I thank God I'm doing very good in everything, really, you know.'' Registrant then stated:

> So what I would do since there's not a very severe degree of symptom and may not be as drastic as other people I've had and there's also a considerable benefit like that you tell me that makes you come all the way. So what I would call a middle of the road approach, ok? Of course I believe you are not selling drugs either and not trying to take the medicine from me to go to the streets sell eighty bucks a pill. So I have to trust the best of you. You go to a lawyer, the lawyer have to trust you instead of think that you're bad. Otherwise, won't be a client relationship.

Continuing, Registrant said that in ''this good willing or good faith, I would give you a try, ok, a preliminary trial of medication,'' but that it wouldn't be ''what you get from the street but according to our standard of trial I will start you on a very preliminary dose.'' Registrant then explained his dosing regimen and that he would not give the S/A more than a one-month prescription for a patient that had not been receiving the medication on an ongoing basis from another doctor.

Registrant further said that he was ''fighting the State of Washington over the controversial [sic] of prescribing Xanax and Klonopin because some people doesn't want to, some people says it's excess, but for me its justified for the patient's presentation. Except in your case, we are ambiguous, ambiguity. So I want the patient to use only one pharmacy.'' Registrant then told the S/A that he would have to use a local WalMart pharmacy and required him to sign an agreement for their ''mutual protection,'' which required that he use only one pharmacy, that he was not on methadone or heroin, that he would not divert or sell the controlled substance to others, and that he would not have more than one doctor prescribe the same class of controlled substances.

Subsequently, in between small talk, Registrant asked the S/A whether he had ''any other physical illness'' and whether family members ''have any anxiety problem''; the S/A answered: ''No, they're doing great.'' Registrant then calculated the number of tablets he was prescribing per his dosing regimen and wrote out the prescription, which he then gave to the S/A.

Discussion

Section 304(a) of the Controlled Substances Act (CSA) provides that ''[a] registration pursuant to section 823 of this title to * * * dispense a controlled substance * * * may be suspended or revoked by the Attorney General upon a finding that the registrant * * * has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined under such

section.'' 21 U.S.C. 824(a)(4). In making the public interest determination in the case of a practitioner, Congress directed that the following factors be considered:

(1) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(2) The applicant's experience in dispensing * * * controlled substances.

(3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

21 U.S.C. 823(f).

''[T]hese factors are considered in the disjunctive.'' *Robert A. Leslie,* 68 FR 15227, 15230 (2003). I may rely on any one or a combination of factors and may give each factor the weight I deem appropriate in determining whether to revoke an existing registration or to deny an application. *Id.* Moreover, while I ''must consider each of these factors, [I] 'need not make explicit findings as to each one.''' *MacKay* v. *DEA,* 664 F.3d 808, 816 (10th Cir. 2011) (quoting *Volkman* v. *DEA,* 567 F.3d 215, 222 (6th Cir. 2009)); *see also Hoxie* v. *DEA,* 419 F.3d 477, 482 (6th Cir. 2005) (citing *Morall* v. *DEA,* 412 F.3d 165, 173–74 (DC Cir. 2005)).

With respect to a practitioner's registration, the Government bears the burden of proving by substantial evidence that the continuation of a registration would be inconsistent with the public interest. *Cf.* 21 CFR 1301.44(d).[1] In this matter, I have considered all of the factors and conclude that the evidence with respect to factors one, two, and four supports a finding that Registrant's continued registration would be inconsistent with the public interest.

Factor One—The Recommendation of the State Licensing Board

As found above, on October 15, 2009, the MQAC adopted the Agreed Order which Registrant has previously entered into, pursuant to which Registrant is prohibited from prescribing controlled substances under Washington law. *See* Rev. Code Wash. § 18.130.160(3) (authorizing a ''[r]estriction or limitation of [license's holder's] practice''); *id.* § 18.130.180(9) (providing that ''[f]ailure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority'' is unprofessional conduct).

The CSA defines ''the term 'practitioner' [to] mean [] a * * * physician * * * or other person licensed, registered or otherwise permitted, by * * * the jurisdiction in which he practices * * * to distribute, dispense, [or] administer * * * a controlled substance in the course of professional practice.'' 21 U.S.C. 802(21). Consistent with this definition, Congress, in setting the requirements for obtaining a practitioner's registration, provided that ''[t]he Attorney General shall register practitioners * * * if the applicant is authorized to dispense * * * controlled substances under the laws of the State in which he practices.'' 21 U.S.C. 823(f).

Accordingly, because one cannot obtain a practitioner's registration unless one holds authority under state law to dispense controlled substances, and because where a registered practitioner's state authority has been revoked or suspended, the practitioner no longer meets the statutory definition of a practitioner, DEA has repeatedly held that the possession of authority to dispense controlled substances under the laws of the State in which a practitioner engages in professional practice is a fundamental condition for both obtaining and maintaining a practitioner's registration.[2] *See, e.g., Calvin Ramsey,* 76 FR 20034, 20036 (2011); *Dominick A. Ricci,* 58 FR 51104, 51105 (1993); *Bobby Watts,* 53 FR 11919, 11920 (1988). Because the CSA expressly conditions the holding of a practitioner's registration on the practitioner's being ''authorized to dispense controlled substances under the laws of the State in which he practices,'' *id.,* and also limits the definition of the term ''practitioner'' to a physician who is licensed, registered or otherwise permitted to dispense a controlled substance in the course of professional practice, *id.* § 802(21), and Registrant, by virtue of the Agreed Order, is no longer authorized under his license to dispense a controlled substance, this factor provides reason alone to revoke his registration.

Factors Two and Four—Registrant's Experience in Dispensing Controlled Substances and Record of Compliance With Applicable Laws Related to Controlled Substances

The MQAC Findings

As found above, the MQAC found that Registrant had repeatedly violated the standard of care and committed unprofessional conduct in prescribing controlled substances to numerous patients. More specifically, the MQAC found that Registrant had committed ''[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.'' GX 6, at 18 (citing Rev. Code Wash. § 18.130.180(4)). The MQAC also found that Registrant committed unprofessional conduct by ''[f]ail[ing] to cooperate with the disciplinary authority,'' as well as by ''[f]ail[ing] to comply with an order issued by the disciplinary authority,'' *id.* (citing Rev. Code Wash. § 18.130.180(8) & (9)). However, the MQAC did not find that Registrant had prescribed controlled substances ''other than for legitimate or therapeutic purpose'' or that he diverted controlled substances, in violation of Rev. Code Wash. § 18.130.180(6)).[3] *Id.*

As I have previously acknowledged,[4] numerous federal courts of appeal have held ''the offense of unlawful

[1] As found above, Registrant neither requested a hearing nor submitted a written statement explaining his position on the matters of fact and law asserted. By contrast, in a contested case, where the Government satisfies its *prima facie* burden, as for example, by showing that a registrant has committed acts which are inconsistent with the public interest, the burden then shifts to the registrant to demonstrate why he can be entrusted with a registration. *Medicine Shoppe-Jonesborough,* 73 FR 363, 380 (2008).

[2] To effectuate this requirement, in 21 U.S.C. 843(a)(3), Congress also granted the Attorney General authority to revoke a registration ''upon a finding'' that a registrant ''has had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the * * * dispensing of controlled substances.''

[3] Under a longstanding DEA regulation, a prescription for a controlled substance is not ''effective'' unless it is ''issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.'' 21 CFR 1306.04(a). This regulation further provides that ''[a]n order purporting to be a prescription issued not in the usual course of professional treatment * * * is not a prescription within the meaning and intent of [21 U.S.C. 829] and * * * the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.'' *Id.*

As the Supreme Court has explained, ''the prescription requirement * * * ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, [it] also bars doctors from peddling to patients who crave the drugs for those prohibited uses.'' *Gonzales* v. *Oregon,* 546 U.S. 243, 274 (2006) (citing *United States* v. *Moore,* 423 U.S. 122, 135 (1975)).

[4] I also assume, without deciding, that the facts as found by the MQAC in the Agreed Order do not establish a violation of 21 CFR 1306.04(a). *But see George Mathew, M.D.,* 75 FR 66138, 66146 (2010) (rejecting MQAC's finding that physician had not diverted controlled substances when ''[s]everal Federal courts of appeals have held that conduct similar to what the MQAC found [the physician] to have engaged in by prescribing over the Internet violates the prescription requirement of Federal law and constitutes an unlawful distribution under 21 U.S.C. 841(a)''), *pet. for rev. denied, Mathew* v. *DEA,* No. 10–73480, slip op. at 5 (9th Cir. Mar. 16, 2012).

distribution requires proof that the practitioner's conduct went 'beyond the bounds of any legitimate medical practice, including that which would constitute civil negligence.'" *Laurence T. McKinney,* 73 FR 43260, 43266 (quoting *United States* v. *McIver,* 470 F.3d 550, 559 (4th Cir. 2006)). *See also United State*s v. *Feingold,* 454 F.3d 1001, 1010 (9th Cir. 2006) (The Supreme Court in *United States* v. *Moore,* 423 U.S. 122 (1975), ''based its decision not merely on the fact that the doctor had committed malpractice, or even intentional malpractice, but rather on the fact that his actions completely betrayed any semblance of legitimate medical treatment.'').

However, as the Agency has explained in multiple cases, ''the Agency's authority to deny an application [and] to revoke an existing registration * * * is not limited to those instances in which a practitioner intentionally diverts a controlled substance.'' *Bienvenido Tan,* 76 FR 17673, 17689 (2011) (citing *Paul J. Caragine, Jr.,* 63 FR 51592, 51601 (1998)); *see also Dewey C. MacKay,* 75 FR 49956, 49974 (2010), *pet. for rev. denied* 664 F.3d 808 (10th Cir. 2011). As *Caragine* explained: ''[j]ust because misconduct is unintentional, innocent, or devoid of improper motive, [it] does not preclude revocation or denial. Careless or negligent handling of controlled substances creates the opportunity for diversion and [can] justify'' the revocation of an existing registration or the denial of an application for a registration. 63 FR at 51601.

''Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion.'' *MacKay,* 75 FR at 49974. Likewise, ''[a] practitioner who ignores the warning signs that [his] patients are either personally abusing or diverting controlled substances commits 'acts inconsistent with the public interest,' 21 U.S.C. 824(a)(4), even if [he] is merely gullible or naïve.'' *Jayam Krishna-Iyer,* 74 FR 459, 460 n.3 (2009).

Here, even if the MQAC's findings do not establish that Registrant engaged in intentional or knowing misconduct, they nonetheless establish numerous instances in which he recklessly prescribed controlled substances and that his prescribing practices created a substantial risk of diversion and abuse. More specifically, the MQAC found that Patient B was already on addictive doses of benzodiazepines and opioids when he/she started seeing Registrant and that he should have referred B to detoxification. Yet Registrant increased B's doses, failed to try non-addictive alternatives, and as a result, B likely became addicted. GX 6, at 5–6.

The MQAC further identified numerous other practices by Registrant which created a substantial risk of diversion and abuse. For example, the MQAC found that he ''engaged in a pattern of prescribing high doses and large amounts of addicting medication, particularly benzodiazepines, to new patients who claimed to need ongoing treatment at such doses,'' and who represented that they had either moved or changed/lost their insurance, and yet Registrant ''did not obtain any records or otherwise verify [the patient's] treatment history.'' *Id.* at 7. Indeed, the MQAC identified fifteen patients who obtained controlled substances from Registrant in this manner. *Id.* at 7–13. With respect to each of these patients, the MQAC found that: (1) Registrant failed to recognize that they were on addictive doses and refer them for detoxification; (2) he repeatedly prescribed three-month supplies of high doses of controlled substances ''without planning to see the patients for three months''; (3) he ignored ''drug-seeking and diversion behaviors''; and (4) he did not request the patient's medical records from other providers and otherwise failed to ''substantiat[e] the patients' reported treatment and prescription histories.'' *Id.*

With respect to still another patient (K), the MQAC found that he ''violated the standard of care * * * by prescribing two benzodiazepines, both at addicting doses.'' *Id.* at 13. In addition, the MQAC found that Registrant prescribed OxyContin (a schedule II controlled substance) to Patient M and Norco (hydrocodone, a schedule III controlled substances) to Patient N but ''did not document that they suffered from current pain complaints.'' [5] *Id.* at 14.

Finally, the MQAC found that Patient S had told Registrant that he had obtained Xanax from non-medical sources and yet started him at ''an unduly high and addictive dose'' of eight milligrams a day and wrote him a prescription for a three-month supply. *Id.* Yet, Patient S returned one month early and at this visit, Registrant wrote him another prescription for a three-month supply and increased his daily dose to ten milligrams. *Id.* Moreover, two months later, Patient S returned and said that he was going to take a summer job in Alaska and needed a 90-day supply, and presented a note to this effect. *Id.* Registrant issued the requested prescription to Patient S. The MQAC found that Registrant had accepted at face value Patient S's representation and that Registrant ''disregarded signs that [Patient S] was drug-seeking and possibly diverting.'' *Id.* at 14.

As the forgoing demonstrates, even if Respondent did not intentionally divert controlled substances to any of the patients identified in the MQAC's Order, the Order identified numerous instances in which Respondent recklessly prescribed controlled substances to persons who were likely engaged in either self-abuse or diversion. Respondent's repeated failure to obtain the medical records for his patients, as well as to otherwise verify their treatment histories and other claims, created a substantial risk of diversion and abuse. *MacKay,* 75 FR at 49974.

So too, Respondent's practice of ''[r]epeatedly providing new patients with three-month supplies of high doses of addictive medications without planning to see the patients for three months,'' *id.* at 13, created a substantial risk that the patients were either diverting the drugs or abusing them. As the Supreme Court explained in *Gonzales,* one of the core purposes of the CSA's ''prescription requirement [is to] ensure[] [that] patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse.'' 546 U.S. at 274 (other citation omitted). The MQAC's Order makes clear that Respondent failed to properly monitor numerous patients to ensure that they were not abusing or diverting the drugs he prescribed to them.

Accordingly, I hold that the MQAC's findings alone support findings under factors two and four that Registrant has committed acts which render his registration ''inconsistent with the public interest.'' 21 U.S.C. 824(a)(4). *See also Tan* 76 FR at 17689; *Krishna-Iyer,* 74 FR at 460 n.3; *Caragine,* 63 FR at 51601. I further hold that this finding supports the revocation of Registrant's registration.

The DEA Undercover Visits

As found above, in February and March 2009, two S/As made undercover visits to Registrant and at each visit, obtained Xanax prescriptions. At the first visit, the S/A told Registrant that he had gotten Xanax from both a friend and his girlfriend, and when Registrant asked him to describe his symptoms, the

[5] No explanation was provided by the MQAC as to why these two instances do not constitute violations of Rev. Code Wash. § 18.130.180(6).

S/A reiterated that a friend had given him a couple of pills and that he was just more relaxed after taking the drug, and that he felt better after taking the drug. Significantly, at no point during the meeting did the S/A relate that he had anxiety, and denied that anyone in his family had anxiety.

Registrant then stated that he was diagnosing the S/A with some sort of general anxiety problem. However, given that the S/A stated that he was getting the pills from non-medical sources, and that when asked to relate his symptoms, simply stated that the pills just made him relax and that he felt better after taking the drug, I conclude that substantial evidence supports a finding that Registrant lacked a legitimate medical purpose and violated 21 CFR 1306.04(a) when he prescribed Xanax to the first S/A.[6]

Likewise, when asked to relate what symptoms he wanted Registrant to help him with, the second S/A stated that he wasn't doing badly but was doing ''very good'' and that he actually wanted to get some Xanax. When asked to explain why, the S/A explained that the drug made him feel good when he took it. Subsequently, the second S/A made clear that he had gotten Xanax off the street and that the drug had never been prescribed to him. Upon further questioning by Registrant, the second S/A again said that the drug made him feel good and denied that he had any problem sleeping. Moreover, when asked whether taking Xanax helped him relax and do his job better, the S/A said that he did not know that he ''could say that'' and later added that the drug just made him ''feel better in general.'' Finally, after Registrant explained that the S/A's statement suggested that taking the drug took ''away some kind of a tense, some kind of anxiety feeling,'' the S/A replied that ''if we have to say that, yes we can say that,'' but that he was ''doing very good in everything.'' Subsequently, Registrant stated that the S/A's presentation of his reason for taking Xanax was ambiguous.

However, I conclude that there was nothing ambiguous in the S/A's presentation because he never once acknowledged being anxious, and repeatedly denied having symptoms or problems that would provide a medical justification for prescribing the drug. Indeed, whenever Registrant questioned him, the S/A response was that he took Xanax because it just made him feel better. Accordingly, I conclude that substantial evidence supports a finding that Registrant lacked a legitimate medical purpose and violated 21 CFR 1306.04(a) when he prescribed Xanax to the second S/A.

Registrant's prescribing of Xanax to the two S/As thus provides additional support for my conclusion that he has committed acts which render his registration ''inconsistent with the public interest.'' 21 U.S.C. 824(a)(4). However, as explained above, the findings of the MQAC are, by themselves, more than adequate to reach this conclusion and to support the revocation of his registration.[7]

Sanction

Having found that Registrant lacks state authority to dispense controlled substances, and that he has committed numerous acts which render his registration inconsistent with the public interest, I conclude that the Government has made out a *prima facie* case for revocation. Because Registrant failed to request a hearing or to submit a written statement in lieu of a hearing, and has thus offered no evidence to rebut the Government's *prima facie* case, I will order that his registration be revoked and that any pending application be denied.

Order

Pursuant to the authority vested in me by 21 U.S.C. 823(f) and 824(a)(4), as well as 28 CFR 0.100(b), I order that DEA Certificate of Registration BC1983659, issued to Patrick K. Chau, M.D., be, and it hereby is, revoked. I further order that any pending application of Patrick K. Chau, M.D., to renew or modify his registration, be, and it hereby is, denied. This Order is effective July 16, 2012.

Dated: June 5, 2012.

Michele M. Leonhart,

Administrator.

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BILLING CODE 4410–09–P

[6] While I have considered the audio recordings submitted in this matter, in future cases such evidence must be accompanied by a transcript.

[7] It is acknowledged that there is no evidence that Registrant has been convicted of an offense falling within factor three. However, this is not dispositive of the public interest inquiry. *See MacKay,* 664 F.3d at 817–18 (quoting *Dewey C. MacKay,* 75 FR 49956, 49973 (2010)). I also deem it unnecessary to make any findings under factor five.

DEPARTMENT OF JUSTICE

Federal Bureau of Investigation

[OMB Number 1110–0048]

Agency Information Collection Activities; Proposed Collection: Cargo Theft Incident Report, Revision of a Currently Approved Collection, Comments Requested

ACTION: 30-Day notice of information collection under review.

The Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division (CJIS) will be submitting the following Information Collection Request to the Office of Management and Budget (OMB) for review and clearance in accordance with the established review procedures of the Paperwork Reduction Act of 1995. The proposed information collection is published to obtain comments from the public and affected agencies. This proposed information collection was previously published in the **Federal Register** Number 72, Volume 77, on page 22348, on April 12, 2012, allowing for a 60 day comment period.

The purpose of this notice is to allow for an additional 30 days for public comment until July 16, 2012. This process is conducted in accordance with 5 CFR 1320.10.

Written comments and/or suggestions regarding the items contained in this notice, especially the estimated public burden and associated response time, should be directed to Mr. Gregory E. Scarbro, Unit Chief, Federal Bureau of Investigation, CJIS Division, Module E–3, 1000 Custer Hollow Road, Clarksburg, West Virginia 26306; facsimile (304) 625–3566.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Comments should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who