FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
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DATE MAY 29 2012

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2011-09782**

ALBERTO SANT ANTONIO, M.D., amended complaint

RESPONDENT.

______________________________________/

AMENDED ADMINISTRATIVE COMPLAINT

The Petitioner, Department of Health, by and through the undersigned counsel, files this Amended Administrative Complaint before the Board of Medicine against Respondent, Alberto Sant Antonio, M.D., and in support thereof alleges:

1. The Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 82484.

3. Respondent's address of record is 2665 Executive Park Drive, Unit 1, Weston, Florida 33331.[1]

4. At all times material to this Complaint, Respondent was certified in advanced cardiac life support ("ACLS").

5. At all times material to this Complaint, Respondent practiced at Alyne Medical Rejuvenation Institute ("Alyne"), an office surgical center located at 2665 Executive Park Drive, Weston, Florida 33331.

6. Alyne is not registered as an office surgical center for the performance of Level II and Level III surgeries and is not registered under Chapter 395, Florida Statutes.

7. On or about June 11, 2011, Patient M.S., a 38-year-old female, presented to Respondent to undergo a liposuction procedure and a fat graft procedure.

8. Liposuction is a cosmetic procedure in which excess fatty tissue is removed from a specific area of the body. Fat graft is a cosmetic procedure in which a patient's fat tissue is injected into a subcutaneous area of the body.

[1] Respondent's alternative address is 16111 Emerald Estates Drive, Weston, Florida, 33331.

9. Patient M.S.'s liposuction procedure was associated and directly related to the fat graft procedure and was, therefore, a Level II surgery.

10. The liposuction and fat graft procedures for which Patient M.S. was scheduled had a maximum planned duration of greater than five minutes.

11. Prior to the procedures, Respondent administered, or ordered the administration of, lidocaine as the local anesthetic for the procedures.

12. Respondent was not assisted during the procedures by an anesthesiologist, certified registered nurse anesthesist, a physician assistant qualified under Rule 64B8-30.012(2)(b)6, Florida Administrative Code, or a registered nurse.

13. Respondent did not use a cardiac monitor during the procedures, nor did he have personnel monitor the patient's cardiac rhythm, blood pressure, or respiration.

14. Respondent did not have a crash cart in the room when the procedures commenced.

15. Respondent did not adequately monitor Patient M.S. or have the patient adequately monitored during the procedures.

16. During the liposuction procedure, Respondent removed approximately 500 cc of fat from Patient M.S.'s back.

17. During the fat graft procedure, Respondent injected approximately 500 cc of fat into M.S.'s buttocks.

18. Respondent did not aspirate the injection cannula prior to the injection of fat into M.S.'s buttocks during the fat graft procedure to assure that he was not in the vascular space.

19. During the fat graft procedure, Respondent erroneously injected fat tissue into Patient M.S.'s vascular system.

20. During the fat graft procedure, Patient M.S. had difficulty breathing, was unresponsive, and went into full cardiopulmonary arrest.

21. Respondent failed to adequately diagnose and treat Patient M.S. when she went into cardiopulmonary arrest.

22. Respondent failed to initiate ACLS procedures, including assessing or diagnosing the patient's heart rhythms, establishing an airway, establishing intravenous ("IV") access to provide fluids and medication, and attempting to diagnose the patient's condition.

23. Respondent and his staff initiated cardiopulmonary resuscitation ("CPR").

24. Respondent instructed his staff to bring a crash cart into the procedure room and to call 9-1-1.

25. Patient M.S. was in cardiopulmonary arrest for approximately ten (10) minutes when Emergency Medical Services ("EMS") arrived and instituted ACLS.

26. Patient M.S. subsequently expired due to a pulmonary artery adipose tissue embolism (a clot in the pulmonary artery).

27. The artery adipose tissue embolism which caused Patient M.S.'s death resulted from Respondent's injection of fat into M.S.'s vascular system during the fat graft procedure.

28. A reasonably prudent physician would have taken measures to ensure that fat was not injected into the patient's vascular system.

29. A reasonably prudent physician would have taken measures to adequately monitor the patient during the liposuction and fat graft procedures.

30. A reasonably prudent physician would have initiated ACLS procedures, including assessing or diagnosing the patient's heart rhythms, establishing an airway, establishing IV access, and/or attempting to diagnose the patient's condition.

31. Respondent failed to keep legible medical records by failing to adequately document the resuscitative efforts or course of treatment after Patient M.S. went into cardiopulmonary arrest and ultimately expired.

COUNT I

32. Petitioner realleges and incorporates paragraphs 1 through 31 as if fully set forth herein.

33. Section 458.331(1)(t), Florida Statutes (2010-2011), subjects a physician to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2010-2011).

34. Section 456.50(1)(g), Florida Statutes (2010-2011), defines medical malpractice as "the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure."

35. Section 456.50(1)(e), Florida Statutes (2010-2011), defines the level of care, skill, and treatment recognized in general law related to

health care licensure as the standard of care specified in Section 766.102, Florida Statutes (2010-2011).

36. Section 766.102(1), Florida Statutes (2010-2011), defines the "prevailing professional standard of care for a given health care provider" as "that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."

37. Respondent failed to meet the prevailing standard of care in his treatment of Patient M.S. in one or more of the following ways:

a. Respondent failed to take precautions to ensure that fat tissue was not injected into the Patient M.S.'s vascular system;

b. Respondent injected fat tissue into Patient M.S.'s vascular system;

c. Respondent failed to establish an airway when Patient M.S. went into cardiopulmonary arrest;

d. Respondent failed to establish IV access when Patient M.S. went into cardiopulmonary arrest;

e. Respondent failed to assess or diagnose Patient M.S.'s cardiac rhythm;

f. Respondent failed to use a cardiac monitor during the procedures;

g. Respondent failed to have personnel monitor Patient M.S.'s vital signs; and/or

h. Respondent failed to have personnel monitor Patient M.S.'s respiration.

38. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes (2010-2011), by committing medical malpractice with respect to his treatment of Patient M.S.

COUNT II

39. Petitioner realleges and incorporates paragraphs 1 through 31 as if fully set forth herein.

40. Section 458.331(1)(nn), Florida Statutes (2010-2011), subjects a physician to discipline for violating any provision of Chapters 456 or 458, Florida Statutes, or any rules adopted pursuant thereto.

41. Rule 64B8-9.009(4), Florida Administrative Code, sets forth the standards for office surgeries, in part, as follows:

(b) Standards for Level II Office Surgery.

3. Equipment and Supplies Required.

a. Full and current crash cart at the location the anesthetizing is being carried out. The crash cart must include, at a minimum, the following resuscitative medications:

* * *

4. Assistance of Other Personnel Required. The surgeon must be assisted by a qualified anesthesia provider as follows: An Anesthesiologist, Certified Registered Nurse Anesthesist, or Physician Assistant qualified as set forth in subparagraph 64B8-30.012(2)(b)6., F.A.C., or a registered nurse may be utilized to assist with the anesthesia, if the surgeon is ACLS certified. An assisting anesthesia provider cannot function in any other capacity during the procedure. If additional assistance is required by the specific procedure or patient circumstances, such assistance must be provided by a physician, osteopathic physician, registered nurse, licensed practical nurse, or operating room technician. A physician licensed under Chapter 458 or 459, F.S., a licensed physician assistant, a licensed registered nurse with post-anesthesia care unit experience or the equivalent, credentialed in Advanced Cardiac Life Support or, in the case of pediatric patients, Pediatric Advanced Life Support, must be available to monitor the patient in the recovery room until the patient is recovered from anesthesia.

* * *

42. Respondent performed a Level II surgery on Patient M.S.

43. Respondent failed to meet the standards for Level II office surgeries in one or more of the following ways:

a. Respondent failed to have a full and current crash cart at the location the anesthetizing was being carried out; and/or

b. Respondent failed to have adequate assistance from an anesthesia provider during Patient M.S.'s procedures.

44. Based on the foregoing, Respondent violated Section 458.331(1)(nn), Florida Statutes (2010-2011), by violating Rule 64B8-9.009(4), Florida Administrative Code.

COUNT III

45. Petitioner realleges and incorporates paragraphs 1 through 31 as if fully set forth herein.

46. Section 458.331(1)(nn), Florida Statutes (2010-2011), subjects a physician to discipline for violating any provision of Chapters 456 or 458, Florida Statutes, or any rules adopted pursuant thereto.

47. Rule 64B8-9.0091(1)(a), Florida Administrative Code, sets forth the requirements for the registration of office surgery clinics, in part, as follows:

> Every licensed physician who holds an active Florida license and performs Level II surgical procedures in Florida with a maximum planned duration of more than five (5) minutes or any Level III office surgery, as fully defined in Rule 64B8-9.009, F.A.C., shall register the office with the Department of Health. It is the physician's responsibility to ensure that every office in which he or she performs Levels II or III surgical procedures as described above is registered, regardless of whether other physicians are practicing in the same office or whether the office is non-physician owned.

48. Respondent is a licensed physician in the State of Florida.

49. Respondent performed a Level II surgical procedure with a planned maximum duration greater than five minutes on Patient M.S. at Alyne.

50. Respondent failed to register Alyne with the Department of Health.

51. Based on the foregoing, Respondent violated Section 458.331(1)(nn), Florida Statutes (2010-2011), by violating Rule 64B8-9.0091(1)(a), Florida Administrative Code.

COUNT IV

52. Petitioner realleges and incorporates paragraphs 1 through 31 as if fully set forth herein.

53. Section 458.331(1)(m), Florida Statutes (2010-2011), subjects a physician to discipline for failing to keep legible, as defined by department rule in consultation with the Board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including,

but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

54. Rule 64B8-9.003(3), Florida Administrative Code, sets forth standards for adequacy of medical records, in part, as follows:

> The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

55. Respondent failed to keep legible medical records in one or more of the following ways:

a. By failing to adequately document the amount of fat removed from each section of Patient M.S.'s body; and/or

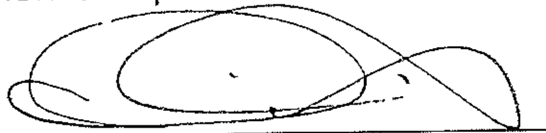
b. By failing to adequately document the resuscitative efforts or course of treatment of Patient M.S. once the patient went into cardiopulmonary arrest and ultimately expired.

56. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2010-2011), by failing to keep legible medical records.

WHEREFORE, Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 25 day of May, 2012.

JOHN H. ARMSTRONG, MD
State Surgeon General and Secretary of Health
Florida Department of Health



Alicia E. Adams
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, FL 32399-3265
Florida Bar No. 0065248
(850) 245-4640 Phone
(850) 245-4662 Fax

PCP: May 25, 2012
PCP Members: Dr. Miguel, Dr. Stringer, Mr. Levine

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

FLORIDA DEPARTMENT OF HEALTH

STATE OF FLORI[DA]
Rick Scott, Govern[or]

RECEIVED BY: NOV 19 2012

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

cosmetic
transfer
death.

done.

I. OFFICE INFORMATION

Medical Cosmetic Center
Name of office

2101 Northside Dr #403
Street Address

Panama City / 32405 / Bay
City / Zip Code / County

850-872-1777
Telephone Cell 850-896-3509

Vincent Ivers, MD
Name of Physician or Licensee Reporting

ME65165
License Number & office registration number, if applicable

8401 Tradewinds Dr
Patient's address for Physician or Licensee Reporting
Port St Joe, Fl 32456

Wilcumo

III. INCIDENT INFORMATION

Candy Lynn Bunch
39 yoa

tumescent lipo/local

11/2/12
Incident Date and Time

death.

Location of Incident:
☐ Operating Room ☐ Recovery Room
☐ Other Clinic

Note: If the incident involved a death, was the medical examiner notified? ☑ Yes ☐ No
Was an autopsy performed? ☑ Yes ☐ No

~~loose skin~~
dermatochalasis
smartlipo laser

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Patient is a [redacted] BMN except for having Liposuction to [redacted] abdomen previously [redacted] had several treatments with skin tightening lasers ⇒ Cutera Titan / SmartSkin CO_2. [redacted] main concern was some loose skin after previous Lipo procedure. On 11/2/12 [redacted] was scheduled for a skin tightening procedure using the SmartLipo Laser. [redacted] was prescribed Lortab 7.5 and Keflex 500mg to be started.

spec: Int med
HP: Yes
DC: NO

PAC: JC ∅
SF ∅
HC ∅

LoTab 7.5
Keflex 500mg

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

- ☑ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☐ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g. death, brain damage, observation only
Name of facility to which patient was transferred: Gulf Coast Hospital

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Patricia Mathews MPN 1128001
Dana Padilla LPN PN5146338
Vincent Ivers MD ME65165

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Patricia Mathews LPN => 850-872-1777 or 850-297-7070
Dana Padillo LPN => 850-872-1777 or 850-297-7070

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

* Acute anaphylactic reaction to Lidocaine

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Install Video cameras in procedure rooms, have Lipid infusion in the room, I have also brought on two Risk managers Dr Robin Lilquist and Dan Cogey + Drug test before procedure

V.
Vincent Ivers MD
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME65165
LICENSE NUMBER

11/15/12
DATE REPORT COMPLETED

5PM
TIME REPORT COMPLETED

* the day before the procedure.
On 11/2/12 [redacted] arrived around 10 A.M and had [redacted] pictures taken.
The procedure and potential were again explained. Informed consent was obtained.
[redacted] was given a sedative, but by the time we were to start the procedure [redacted] wide awake and actually stated [redacted] was "ready to start." At about 12:15 [redacted] was in the minor procedure room where I showed the small fiber from the Smart Lipo Laser and proceeded mark the area that I would be focusing on [redacted] skin tightening. I marked of [redacted] mid to lower abdomen in 5cm square areas, and explained that I would proceed with the small laser fiber to tighten her abdomen ⇒ especially the lower abdomen where [redacted] had the loose skin.
After marking the areas I proceeded to mix two bags of Saline with ① Lidocaine 1%
② Epinephrine (1:1000) and ③ 50cc Sodium Bicarb 8.4%
Two bags were mixed, but only one bag was actually used.

1 L NS bag ↓

↓

Composition of tumescent fluid, lidocaine (lignocaine) 0.1%, epinephrine (adrenaline) 1:1000000

- 50 mL of 2% plain lidocaine (1000 mg)
- 1 mL of 1:1000 epinephrine from ampule (1 mg)
- 10 mL sodium bicarbonate (8.4% sodium bicarbonate solution)
- 1 L normal saline (0.9% NaCl solution)

I calculated that even if I were to use Lidocaine 2% the recommended maximum total tumescent fluid calculated at 2.7 Liter. I would not use anything near that amount. After the Calculation I discarded one of the Saline bags, and decided to just use one Liter bag. I started infusing ██ Lower abdomen and than a small amount to her upper abdomen. In total I used approximately 700-800cc of fluid. Again I infused the abdomen at the slowest rate our infuser goes and the patient was talking to me and the nurses during the whole infusion process. Than just as I was about to start the skin tightening with the fiber SmartLipo fiber ██ had a short seizure. ██ then went into a semi postictal state ⇒ ██ vitals remained stable sats/BP/HR were continuously monitored. I grabbed a vial of Valium in case ██ were to start seizing again. Within minutes ██ had another short seizure and at that point ██ vitals started dropping. I had one of the nurses call 911.

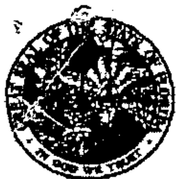
use 1L bag x 1 only

was already on O_2 N.C. →
I therefore rev'd vitals. They dropped rapidly from Sats in the 90s, HR 80s, and a stable BP to a dramatic drop
I started ventilating the patient with an Ambu bag, Amp of Narcan, and ~~and~~ dose of Epi was given. This while one of the nurses placed an IV. The paramedics soon arrived attempted to intubate x 2 s̄ success, another paramedic was able to intubate. CPR / ventilation was continued. Rev'd for vital / Telemetry unable to pick up HR/BP/sats. CPR continued enroute to Gulf Coast Hospital.

On the following day I had a long discussion with the investigator from the Medical Examiners office, [redacted]

[redacted] I have also called to talk to the medical examiner [redacted] I will call [redacted] again to discuss the details of this case, since Lidocaine is something we use on a daily basis. I have used concentrated doses on elderly patients remove large skin cancers, repair large Lacerations without any problems. Also to note is that Candy Burch had a previous Liposuction with tumescent mixture without problems

[signature]



STATE OF FLORIDA
DEPARTMENT OF HEALTH

#3 death lipo.

INVESTIGATIVE REPORT

Office: Fort Lauderdale	Date of Complaint: 06/16/2011	Complaint Number: ME 2011-11371
Subject: **ALBERTO SANT ANTONIO, M.D.** 16111 Emerald Estates Drive Weston, Florida 33331 (954) 446-6464 (Office)	Source: **DOH/ISU/FORT LAUDERDALE**	

Prefix: ME	License #:82484	Profession: Medical Doctor	Board: Board of Medicine	Report Date: 02/22/12

Period of Investigation: 01/26/12 through 02/22/12	Type of Report: FINAL

Alleged Violation: 458.331(1)(g)(t)(nn) Grounds for disciplinary action; action by the board and department.— (1)The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2): (g)Failing to perform any statutory or legal obligation placed upon a licensed physician. (t)Notwithstanding s. 456.072(2) but as specified in s. 456.50(2): 1.Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to require more than one instance, event, or act.2.Committing gross medical malpractice.3.Committing repeated medical malpractice as defined in s. 456.50. (nn)Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

Synopsis: This investigation is predicated upon a report from Investigator KATHERINE ROSENBLATT, DOH/ISU/FORT LAUDERDALE field office, in regards to SANT ANTONIO, that patient K.L.H., 32 y/o/female, expired on 02/14/2010 after SANT ANTONIO performed a liposuction procedure at Alyne-Rejuvenation Center at 2665 Executive Park Drive, Weston, Florida. On 02/13/2010, ANTONIO administered Lidocaine and Oxycodone, during the procedure. K.L.H. expired at Jackson Memorial Hospital on 02/14/2010. The immediate cause of death was Poly-Drug Toxicity (Lidocaine and Oxycodone) complicating elective cosmetic surgery, according to the Death Certificate.

Kellee Lee Howard.

ANTONIO was notified of the investigation by a letter dated 01/16/2012 (Exhibit #2), and was provided a copy of the initiating documents (Exhibit #1).

A check of Department of Health computer records revealed SANT ANTONIO is a Medical Doctor. The license has an emergency restriction and is active. According to the DOH practitioner's profile, SANT ANTONIO is specializes in General Surgery, but is not board certified (Exhibit #3).

Notification letter was sent to family of J.L.H., dated 09/22/11 (Exhibit #4).

SANT ANTONIO is represented by attorney, ARIEL SOFRO, of the law firm of LUBELL & ROSEN, 200 Andrews Avenue, Suite 900, Fort Lauderdale, Florida 33301 (954) 755-3425.

As of February 22, 2012, there has been no response.

my last report to 1/2010

Related Complaint: None	
Investigator/Date: February 22, 2012 **KATHERINE F. ROSENBLATT,** **Medical Malpractice Investigator LI-77**	Approved By/Date: February 22, 2012 **PATRICIA A. CALLAHAN,** **Investigation Manager LI-96**
Distribution: HQ/ISU	

RECEIVED-LEGAL 12 FEB 23 PM 2:01

Received Investigative Services FEB 23 2012 DOH/MQA Tallahassee HQ

33907

After 2 Deaths, Health Dept. Orders Surgeon To Stop Operating

1 Death Remains Under Investigation

Author: Roger Lohse

Published On: Oct 12 2011 04:19:57 PM EDT | Updated On: Jul 18 2011 11:44:38 AM EDT

WESTON, Fla. - A cosmetic surgeon has been ordered by the Florida Department of Health to stop performing surgeries in his office after two of his patients died.

Dr. Alberto Sant Antonio works at the Alyne Center for Cosmetic Surgery. He refused to speak to Local 10's Roger Lohse, who tried to ask him about accusations that his cosmetic surgery center is not safe.

One of those claims was made by the family of Kelle Lee Howard.

"It's so hard without Kelle," said James Howard, her husband.

It has been a year and a half since Kelle Lee Howard died on the couch in their home just hours after having a lipo-sculpture procedure by Sant Antonio, according to a lawsuit filed by her family.

"Just to look over there at her, her being motionless, not moving, it was just like, I know this is not happening to my world," James Howard said.

The autopsy shows his wife died from a lethal mix of lidocaine and oxycodone.

"There was too much anesthesia given in the wrong combination," said Howard's attorney, David Singer.

Singer said he was shocked to read in a newspaper last month that another Alyne patient had died, as well. Maria Shortall, a 38-year-old mother of two, died after a similar lipo-sculpture procedure.

Shortall had 22 incisions on her body, according to her family's attorney, Daniel Harwin. The medical examiner is still waiting for toxicology tests to determine why she died.

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