

May 1, 2008

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Rebuttal:

I would like to respond to the conclusion and investigation conduct by the Office of Healthcare Inspections Dallas Regional Office and the Office of Medical Investigation. The OMI have made several inaccurate statements related to the investigation and me.

After reading the report, I notice that there were some inconsistencies with this report relating to the investigation, which appears to be faulty and bias. The Office of Medical Investigation stated that they had an ongoing communication with me during the investigated process. However, they never contacted me nor informed me that they were in the investigated stage. I do not know what type of communication the OMI had with the Office of Special Counsel. The OMI stated that they contacted the Albuquerque medical center prior to beginning their investigation and gave them a heads up on what they was looking for and when they were coming in to inspect.

Complaint #1 and 2

There is no indication the investigators spoke to Dr. Irene Ortiz, nor a review of her report related to the investigation conducted into the suicide, which led to her filing a complaint with New Mexico Psychologist Examiners Board. She was directed by the hospital Chief of Staff to investigate this event. The report states that the veteran overdosed on prescription medication, which he hoarded over an extended period. Additionally, it states that the veteran did not receive individual nor group treatment during his stay except for one encounter. The report states that the Director of the SARRTP did not receive proper supervision. Dr. Ortiz was assigned as Jennifer Rielage supervisor sometime following this event. As of this date, Jennifer Rielage is not licensed in the state of New Mexico or any other state. The director and associate director of behavioral health were reprimanded for failure to provide proper and adequate training and supervision to staff members. The associate director reviewed the notes but failed to do them in an appropriate and timely manner going on most occasions two to three weeks before reviewing and signing off on the supervisee notes.

The statement of finding an empty syringe in a trashcan is a little suspicious. When someone overdoses on opiates, the needle is still in his or her arm or whatever part of the body the drug was injected. There is no mention of any other drug paraphernalia in the room or in his vehicle. The statement is inconsistent with someone who was supposedly a heavy long-time heroin and cocaine user. The statement is also inconsistent about not being suicidal when it states that the veteran had previously attempted suicide by cutting his wrist and overdosing with drugs. This was a clear signal that this veteran had major issues that were not addressed adequately by providing a suicidal watch and insuring that he took his medication and swallowed it in front of the provider. The veteran overdosed on prescription medication due to his hoarding them over a period and ingesting them all at once.

Complaint #3

December 2006, a killed a family member. The investigation states that several individuals was spoke to including the Medical Center's supervisor in relation to this incident and stated that they had no knowledge of this event. It is not clear whom the investigators spoke with but the social worker (Armando Pollock) who received the call and attempted to contact Dr. Jeffery Katzman is no longer working at the Medical Center. He was forced to quit due to the constant abuse and harassment. The investigator never spoke with Dr. Leo Kreuz, whom filed a complaint against Dr. Katzman for his failure to respond to the incident and later attempt to blame him for the incident due to Dr. Kreuz begin the veterans primary doctor. Dr. Kreuz was on vacation during that time and Dr. Katzman was the Psychiatrist on-call that day. Dr. Kreuz and Dr. Ortiz brought this to the attention of George Marnell, hospital Director, around March 2007. Shortly afterward, Dr. Katzman resigned. Most of the staff did not know about the event related to the death. Moreover, the statement that 16 social worker field calls and provides triage is inaccurate. Each clinic has it own on call pager and one person is assigned that pager to respond to emergencies. Behavioral Health care has a pager as a whole, which rotates from clinic to clinic each day of the week.

Complaint #3

First, the note was written around the December 20, 2006 and Milton Lasoski added his addendum to the note around December 26. I sent a letter to Dr. Waldorf and a copy going to Jeffery Katzman, Milton Lasoski, and Dr. Thomas Vosburgh addressing this issue. The investigator stated the supervisor knew who the patient was and provided them with a copy of the progress note written. In Addition, a copy of the Psychiatrist medication management note written by the Psychiatrist was provided. The investigator states that the supervisor asked me to add an addendum to my notes, which never happened, based on the new information found in the medical record. I have to ask, when this new information was found. It was not in the patient medical record when I left the medical center on April 19, 2007 and nothing was ever communicated to me about my letter addressing this issue.

I find it hard to believe that the investigators never spoke with or mentioned that they spoke with Psychiatrist (Thomas Vosburgh) whom is the subject of my complaint. I find it hard to believe that Milton Lasoski knew right away, whom the veteran was after nearly a year had past and I had to search through tons of documentation to recall the name of the veteran. I find it hard to believe that the investigators accepted documentation without truly knowing who the veteran was and accepting this as fact. The investigators never contacted me to confirm the identity of this veteran.

The investigators stated that they asked the same interviewees if they ever had any experiences with patients, requesting refills for medication, which they were unable to find, ordered, or documented in the patient's treatment record by a corresponding note from the ordering Psychiatrist/Physician. First, the report only mentioned one interviewee and second, not everyone deals with patients requesting medication refills. I did because I was the point of contact for the PTSD (posttraumatic Stress Disorder) clinic.

I believe this investigation was flawed from the beginning once OMI got involved. OMI provided the agency with advance notice that they were coming to investigate. They failed to interview key people in their fact-finding. The OMI stated that it had constant communication with me throughout the

investigation but failed to contact me and ask for my help in the investigation. I did not find out about the investigation until March 2008. The only other person I had brief communication with was a Patricia Murray and that was back in late July and early August 2007. During that time, I provided her with documentation related to all the complaints. There was no further communication between her and me. I did meet and speak with investigators from the Phoenix office related to another issue but never spoke with anyone from the Washington D.C. office other than the brief communication with Patricia Murray.

Milton Lasoski made statements presented inaccurate documentation relating to incident in complaint 3. Mr. Lasoski has on previous occasions written and falsified patients progress notes. This led me to file an ethical complaint to the New Mexico Psychologist Examiners Board. Enclosed is a copy of Mr. Lasoski progress note on a patient and supporting documents that shows that Mr. Lasoski wrote fraudulent documents to cover up his mistake and neglect relating to patient care. If any additional information is needed, I am willing and ready to provide whatever assistance I can to help in this investigation.


Darryl Young

Enclose:

Progress notes related to Mr. Chancer Smith

Letters written to Virginia Ann Waldorf

Complaint Letter to New Mexico Board of Psychologist Examiners

Paper work showing veteran (Elmer Martinez) request for Percocet refill