

STATE OF FLORIDA  
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH, )  
 )  
 PETITIONER, )  
 )  
 v. ) CASE NO. 1997-15802  
 )  
 DAVID IRA MINKOFF, M.D., )  
 )  
 RESPONDENT. )  
 )  
 \_\_\_\_\_ )

**ADMINISTRATIVE COMPLAINT**

COMES NOW the Petitioner, Department of Health, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against David I. Minkoff, M.D., hereinafter referred to as "Respondent," and alleges:

1. Effective July 1, 1997, Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes. Pursuant to the provisions of Section 20.43(3), Florida Statutes, the Petitioner has contracted with the Agency for Health Care Administration to provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate.
2. Respondent is and has been at all times material hereto a licensed physician in the state of Florida, having been issued license number ME 0056777. Respondent's last known address is 129 Garden Avenue, North, Clearwater, Florida, 33755.
3. Respondent is board certified in pediatrics.

4. At all times relevant to this complaint, Respondent was employed by Copenhaver Bell and Associates, an emergency room physicians group, and served as an emergency room physician at Columbia HCA Hospital, New Port Richey, Florida.

5. On or about November 18, 1995, Patient L.M., a 36 year old female, residing in the Fort Harrison Hotel, owned by a religious organization, in Clearwater, Florida, was involved in a minor automobile accident. Paramedics attended the scene of the accident and determined that Patient was not injured.

6. As the paramedics were preparing to leave the scene of the accident, Patient L.M. removed her clothes and told the paramedics that she needed help and needed to talk to someone.

7. The paramedics transported Patient L.M. to Morton Plant Hospital in Clearwater for a psychiatric evaluation. Members of the religious organization came to the hospital, said they would look after her, and Patient L.M. left the hospital with them.

8. Patient L.M. was returned to the Fort Harrison Hotel and was placed in "isolation" (church terminology) for treatment by church staff for a "psychotic break" (church terminology). She remained in isolation until December 5, 1995 under the supervision of church staff.

9. On or about November 20, 1995, Respondent received a telephone call from several members of the religious organization identified as medical liaison officers, including but not limited to David Howton, an unlicensed dentist and Janice Johnson, a physician who was unlicensed in Florida and whose Arizona license had been revoked. Respondent was told that they had a member that was having difficulty sleeping and she needed a prescription to help her sleep. They described her in the organization's terminology as a Type III (psychotic).

10. Respondent called in a prescription for 10 vials of Valium for injections each containing 5 milligrams of Valium. Respondent called in the prescription in the name of David

Howton (spelled Haughton on the prescription) knowing that the drugs were to be administered to Patient L.M. Respondent did not obtain any medical history of Patient L.M., did not perform a physical examination nor had Patient L.M. ever been a patient of Respondent. Further, Respondent failed to document any record of prescriptions or treatment plan for the patient.

11. Valium contains Diazepam, a Schedule IV controlled substance, pursuant to Chapter 893, Florida Statutes. Valium is indicated for the management of anxiety disorders and has the potential for abuse.

12. On or about November 29, 1995, Respondent received another telephone call from Church members, including but not limited to Janice Johnson and David Howton, indicating that Patient L.M. had continued difficulty sleeping. They told Respondent that the patient could not swallow a pill and therefore she needed a liquid medication. Respondent called in a prescription for Patient L.M. for Chloral Hydrate. Respondent did not inquire why the patient could not swallow pills and he prescribed the medication without seeing or examining her. Further, Respondent failed to document any record of prescriptions or treatment plan for the patient.

13. Chloral Hydrate is a Schedule IV Controlled Substance, pursuant to Chapter 893, Florida Statutes. Chloral Hydrate is indicated as a pre-operative sedative to reduce anxiety and has some short term hypnotic effects.

14. On or about 7:30 p.m. December 5, 1995, Respondent received a telephone call from Janice Johnson indicating that Patient L.M. was ill and requesting that he see her at the emergency room at Columbia New Port Richey Hospital. Respondent said he would see her but it was a forty-five minute drive from Clearwater and she should be taken to a closer facility. Johnson said she would prefer to bring her to Respondent.

15. At or about 9:30 p.m. Johnson arrived at the New Port Richey Hospital with Patient L.M. On arrival, Patient L.M. was in cardiac arrest, respiratory arrest, and her pupils were unresponsive. Resuscitation efforts were unsuccessful and the patient was pronounced dead approximately fifteen minutes later by Respondent.

16. An autopsy was performed on Patient L.M. and the autopsy report listed as the immediate cause of death thromboembolus of the left main pulmonary artery (blood clot), thrombosis of the left popliteal vein (blood clot), and severe dehydration and bed rest. In addition to the above, the final anatomic diagnosis reported severe old and recent hematomas (bruises) on the arms and legs.

17. A reasonably prudent physician under similar conditions and circumstances would not prescribe Valium and Chloral Hydrate to a patient without establishing a doctor/patient relationship, without a physical examination and medical history, and without ascertaining the appropriateness of the prescribed drugs and the condition of the patient.

18. A reasonably prudent physician would have documented at a minimum the following: a full physical examination, an adequate medical history, an assessment of psychological function, a treatment plan, records of drugs prescribed, recognized medical indication for the use of a dangerous drugs and controlled substances, and records of consultations.

19. A reasonably prudent physician would not prescribe Valium, a Schedule IV controlled substance, for a third party (David Haughton) when he knew that the drug was to be administered to Patient L.M.

### COUNT ONE

20. Petitioner realleges and incorporates paragraphs one (1) through nineteen (19), as if fully set forth herein this Count One.

21. Respondent failed to practice medicine within the standard of care in that he: prescribed Valium and Chloral Hydrate to Patient L.M. without establishing a doctor/patient relationship, without a physical examination or medical history, and without ascertaining the appropriateness of the prescribed drugs and the condition of the patient.

22. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

### COUNT TWO

23. Petitioner realleges and incorporates paragraphs one (1) through nineteen (19) and paragraph twenty-one (21) as if fully set forth herein this Count Two.

24. Respondent failed to document any aspect of Patient L.M.'s medical records including, but not limited to: an adequate history and physical, an assessment of physical and psychological function, records of drugs prescribed, recognized medical indication for the use of a dangerous drug and controlled substance, and the periodic review of the patient's condition.

25. Based on the foregoing, Respondent violated section 458.331(1)(m), Florida Statutes, by failing to keep medical records 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.

### COUNT THREE

26. Petitioner realleges and incorporates paragraphs one (1) through nineteen (19) and paragraphs twenty-one (21) and twenty-four (24), as if fully set forth herein in this Count Three.

27. Respondent prescribed Valium in the name of a third party knowing that the drug was going to be administered to Patient L.M.

28. Based on the foregoing, Respondent violated 458.331(1)(k), Florida Statutes, in that he made a deceptive, untrue, and fraudulent representation in his practice of medicine.

### COUNT FOUR

29. Petitioner realleges and incorporates paragraphs one (1) through nineteen (19) and paragraphs twenty-one (21), twenty-four (24), and twenty-seven (27), as if fully set forth herein in this Count Four.

30. Respondent excessively and inappropriately prescribed Valium and Chloral Hydrate to Patient L.M. without a physical examination, medical history or psychological evaluation and based on information provided to him by third parties.

31. Based on the foregoing, Respondent violated section 458.331(1)(q), Florida Statutes, by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purpose of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and not in the course of the physician's professional practice, without regard to intent.

32. Based on the foregoing, Respondent violated section 458.331(1)(q), Florida Statutes, by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purpose of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and not in the course of the physician's professional practice, without regard to intent.

#### COUNT FIVE

33. Petitioner realleges and incorporates paragraphs one (1) through twenty (20) and paragraphs twenty-two (22), twenty-five (25), twenty-eight (28), and thirty-one (31), as if fully set forth herein in this Count Five.

34. Respondent prescribed for and treated Patient L.M. without obtaining and/or documenting any consent, either written or oral, from the patient or the patient's legal representative.


35. Based on the foregoing, Respondent violated section 458.331(1)(p), Florida Statutes, by performing professional services which have not been duly authorized by the patient or client, or his or her legal representative, except as provided in s. 743.064, s. 766.103, or s. 768.13.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, the assessment of costs

related to the investigation and prosecution of this case, other than costs associated with an attorney's time, as provided for in Section 455.624(3), Florida Statutes, and/or any other relief that the Board deems appropriate.

SIGNED this 16<sup>th</sup> day of December, 1999.

Robert G. Brooks, M.D., Secretary

  
Kathryn L. Kasprzak  
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Kathryn L. Kasprzak  
Chief Medical Attorney  
Agency for Health Care Administration  
P. O. Box 14229  
Tallahassee, Florida 32317-4229  
Florida Bar # 937819  
RPC/clg  
PCP: December 8, 1999  
PCP Members: Skinner, Zachariah, Cherney

**FILED**  
DEPARTMENT OF HEALTH  
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CLERK *Victoria R. Ellison*  
DATE 12/16/99





STATE OF FLORIDA  
**AGENCY FOR HEALTH CARE ADMINISTRATION**

**INVESTIGATIVE REPORT**

MAY 08 1998

Investigative Case # 97-15802

<b>Office:</b> St. Petersburg		<b>Date of Complaint:</b> 01-07-98		<b>Case Number:</b> 97-15802	
<b>Subject:</b> David L. Minkoff, M.D. 404 Edgewood Ave. Clearwater, FL. 34615 Tel: 813/442-7140			<b>Complainant:</b>  K. D.		
<b>Prefix:</b> ME	<b>License #:</b> 0056777	<b>Profession:</b> Physician	<b>Board:</b> Medicine	<b>Report Date:</b> 05-06-98	
<b>Period of Investigation:</b> 01-29-98 - 05-06-98 intermit.			<b>Type of Report:</b> Final		
<b>Alleged Violation:</b> F.S. 458.331 (1) (m) failing to maintain records justifying the course of treatment; (1) (f) aiding or abetting unlicensed persons to practice medicine; (1) (q) prescribing medications other than in the course of the physician's profession; (1) (t) Practicing below the standard level of care					
<b>Synopsis:</b> This investigation is predicated on a complaint submitted by K.D. alleging during 11-95, Dr. Minkoff prescribed medications to L.M., a 36 year old female without examining or seeing her and prescribed liquid valium to a third party who purportedly was to have given the medication to her at the Ft. Harrison Hotel in Clearwater (Exh. 1).  Dr. Minkoff was notified of this complaint and investigation in a letter dated 01-29-98 (Exh. 2) mailed with a copy of the UCF and complaint letter.  Computer records check indicates Dr. Minkoff was originally licensed on 12-13-89. His license is current (Exh. 3). He stated at a prior deposition that he is a Board Certified Pediatrician  Dr. Minkoff is represented by Attorney Grover C. Freeman of Shear, Newman, Hahn & Rosenkranz, PA, 201 E. Kennedy Blvd., tenth floor, Tampa, Florida, 33602, Tel: 813/228-8530. He requests a copy of the investigative report when complete (Exh. 4). Attorney James Felman (813/229-118) had responded to a subpoena for Dr. Minkoff's records and telephonically advised that he is also representing the physician. (continued)					
<b>Related Case:</b> None					
<b>Investigator/Date:</b> <i>J. P. Pinez</i> 05-07-98 James J. Pinez, MQA Investigator			<b>Approved By/Date:</b> <i>R.L. Mantell</i> R.L. Mantell, Investigator Supervisor		
<b>Distribution:</b> HDQTRS/MQA					

## CONTINUATION

Investigation revealed that on 11-18-95, L.M., while a member of the Church of Scientology, was involved in a minor auto accident in Clearwater. When paramedics were about to leave the scene after discovering she was unhurt, L.M. removed her clothing and informed them she needed help. They transported her to Morton Plant Hospital where members of the Church later arrived and informed the attending physician they did not want her to be seen by a psychiatrist and that they would care for her themselves. The physician had her evaluated without their consent, but, it was determined that she was not a harm to herself or to anyone. She was discharged against medical advice after she conveyed her desire to leave the hospital with her "congregation."

After L.M.'s discharge, she remained in a room at the Ft. Harrison Hotel in Clearwater and owned by the Church of Scientology. Church members remained with her as her mental state failed to improve. Allegedly, the church labeled her condition a "psychotic break" and kept her detained and isolated from the outside world.

On 11-20-95, Dr. Minkoff, a member of the same Church, prescribed liquid Valium to D.H., a third party to inject the drug into L.M. On 11-29-95, he prescribed Chloral Hydrate to L.M. without ever having seen or having examined her. The original prescriptions had been called into Eckerd Pharmacy and were obtained from the pharmacy for this report.

On 12-05-95, Dr. Minkoff, while working in the ER of Columbia New Port Richey Hospital, received a telephone call from a member of the Church, Janice Johnson, M.D. Dr. Johnson is not licensed in Florida or anywhere else, but advised him that L.M. was ill and appeared to be suffering from an infection. She requested, Dr. Minkoff provide her with penicillin, but according to his earlier deposition he refused and although he recommended she take the patient to an ER, Johnson asked him if he would see her. He agreed to do so. A delay in transporting her ensued but during the 45 minute drive to New Port Richey, several other hospitals were passed and when L.M. arrived at the hospital, Dr. Minkoff declared her dead on arrival due to sepsis.

Hospital records confirm the above and Church records suggest L.M. remained in the hotel room from 11-18-95 to 12-05-95 during which time she was provided with medical care by unlicensed individuals including Dr. Johnson who along with the other members, orally and by injection provided her with prescription drugs including sedatives. K.D. asserts that the care or lack of care caused her to become severely dehydrated which caused her death. He also asserts that the Church of Scientology failed to submit records during the last 2-3 days of her life suggesting she expired prior to her being transported to the hospital. Bed rest and dehydration was included as the cause of L.M.'s death, in the autopsy report.

Dr. Minkoff or his Attorneys have yet to respond to the allegations. A submitted copy of his earlier sworn deposition provided to K.D. indicates he admitted to writing the prescriptions in question. He was unaware it was against the law to write the prescription in D.H.'s name whom he feels was or is now a licensed dentist. He stated he also thought Dr. Johnson was a licensed physician, but he was aware she was not licensed in Florida. He acknowledged having never seen L.M. prior to her arrival at the hospital on 12-05-95 nor did he feel it was necessary to inquire of her history prior to writing the prescriptions.

The other persons in her care have yet to be contacted and records appear they are no longer in Florida. One participant was earlier located in Germany. Requests for Official File searches on those involved have been filed. The results will be submitted to legal when received. The State Attorney's office advised that at this time, they couldn't share any information they have obtained concerning this death.

**As this case also involves the activities of unlicensed individuals, an allegation of aiding and abetting such individuals was added to the complaint.**

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\* Contains information which identifies the patient by name and are sealed pursuant to Section 455.241(3) F. S.

\*\* Hospital Records - No copy retained in Regional Office.

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1) **STATEMENT BY K.D. - COMPLAINANT**

K.D. submitted the initial and then a supplemental complaint (**see exhibit one**) advising that on 11-18-95, members of the Church of Scientology began detaining L.M. a 36 year old female at the Fort Harrison Hotel in Clearwater Florida. Later, that same day, she was involved in a motor vehicle accident but had not been injured. When paramedics appeared at the accident scene, L.M. removed her clothing to get their attention advising them, she needed help. She was transported to Morton Plant Hospital in Clearwater where she was psychiatrically evaluated and discharged against medical advice after members of the Church of Scientology arrived stating that they could provide her with the proper care. K.D. maintains that the care was nothing but isolation. He submitted records he feels shows that the church determined, L.M. suffered a "psychotic break", but after 17 days of such isolation, she had lost 45 pounds.

The complaint alleges, during the time of her detention, Dr. Minkoff, a member of the Church of Scientology, prescribed then allowed unlicensed persons to inject L.M. with prescription drugs and to orally give L.M. Chloral Hydrate even though he had never seen the patient. In addition, he wrote a prescription for liquid Valium to D.H. that was to have been given to L.M. D.H.'s name was intentionally misspelled on the prescription in order to disguise his true identity. D.H. is now or intends to be licensed as a Florida dentist. The complaint states that on 12-05-95, L.M. was transported 45 minutes to Columbia New Port Richey Hospital where Dr. Minkof was waiting in the ER. Upon arrival, he pronounced her dead.

**K.D. SUBMITTED THE FOLLOWING RECORDS WITH THE COMPLAINT:**

A copy of a prescription was submitted that appears to have been from Dr. Minkoff indicating that on 11-20-95, he prescribed Valium injection, 5mg for patient D.H. and a computer generated drug printout indicates that on 11-29-95, Dr. Minkoff prescribed Chloral Hydrate 500 for patient L.M. (**Exh. 5**). The original prescriptions were subsequently obtained from Eckerd Pharmacy #28 in Clearwater and are appended as **exhibit 6** (with a receipt for such).

A copy of an autopsy report (**Exh. 7**) with accompanying supplemental investigative reports stating that on 12-05-95, L.M. had been transported to Columbia New Port Richey Hospital by "friends" who had passed several Clearwater Hospitals on the way. An out-of-state physician (Dr. Janice Johnson) was with the group when they arrived at the hospital. She allegedly transported L.M. to that hospital because she wanted Dr. Minkoff to treat her. The autopsy report lists the final anatomical diagnoses as thrombo-embolus-left main pulmonary artery, thrombosis of left popliteal vein, severe dehydration, multiple old and recent hematomas-extremities and an abrasion on her nose. Her vitreous urea nitrogen is listed as having been 300 mg/dl. An accompanying death certificate also lists as a cause of her death, bed rest and severe dehydration.

K.D. submitted a copy of the EMS record dated 11-18-95 describing L.M.'s mental and physical condition after her involvement in a motor vehicle accident along with a typed deposition from one (1) of the EMS Paramedics (**Exh. 8**). The report states that when approached, L.M. advised the paramedics that although she was not physically injured, "I need help, I need to talk to Someone". It also states that as they were leaving the scene, L.M. began walking towards them without her clothing on, stating that she had taken her clothing off to make people think she was crazy. She was described as having a fixed stare and speaking in a programmed and formal manner. They transported her to Morton Plant Hospital in Clearwater.

Both handwritten and typed copies of the Church of Scientology's records chronicling the events during the time L.M. was at the hotel while being cared for by several Scientologists (**Exh. 9**). These records appear to suggest that L.M. was experiencing both medical and psychological problems that required medical intervention. Church members appear to have been attempting to treat her condition(s) by feeding her and by administering medications that included herbs

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and injections of Magnesium Chloride and given Chloral Hydrate by mouth. Records appear to indicate that the injections were given by unlicensed individuals without a physician present. Dr. Johnson, a physician not licensed in Florida also noted that on 12-01-95, she too injected L.M. with Magnesium Chloride and orally gave her Chloral Hydrate. She also noted that L.M. would require 2 liters of fluid when she awoke. The records indicate that while L.M. was being cared for by these individuals at some point, a guard was placed outside the door to the room. The records end on 12-02-95 at which time she could no longer stand and did not know the names of the persons caring for her and "we don't talk to her." She was being fed bananas, a protein shake and "Cal Mag.."

K.D. alleges the records concerning the last three (3) days of her stay at the hotel have been lost, but submitted a typed version of the events which occurred during that time, provided to him by the Church of Scientology (**Exh. 10**). Although the record states it covers the period 12-03-95 to 12-05-95, it does not appear to do so. It consists of a "debrief" or summaries provided by several of the individuals who were caring for her, but does not specifically cover only the last three (3) days of her life. It is also unclear when certain events that are described in the report took place to shed light on the condition she was in during that time.

## 2) INTERVIEW OF K.D.

K.D., interviewed at his office on 04-29-98 stated that the (instant) complaint he filed against members of the Church of Scientology centers on the illegal detention and medical care provided to L.M. while she was being held against her will. She wanted to leave but was unable to do so as members of the organization kept her sedated. Dr. Minkoff, a church member, had written a prescription for Chloral Hydrate, a sedative that was injected into L.M., though he had never seen her. Experts, former Scientologists advised K.D. that the techniques, employed by the organization, including isolation causes people to go "crazy". L.M. only wanted to leave Morton Plant Hospital to go with the members of her "congregation" because she had been conditioned to do so. After being detained, however, she wanted to leave the hotel because she became aware she was experiencing a "slow death." K.D. stated, an examination of the Ft. Harrison records subpoenaed from the Church of Scientology describing the care L.M. received while being detained will show that the records are incomplete. The church lost the records pertaining to the care L.M. received during the last 2-3 days of her life. K.D. believes the loss of such records is inconsistent with the Scientologists strict rules to record an individual's isolation. K.D. believes there are no records because L.M. was in a coma during this time and caused her death by dehydration prior to her being transported to the hospital on 12-05-95. He indicated that the autopsy report shows a urea nitrogen level of 300 mg documenting that she was severely dehydrated. He added, individuals have been known to die from levels of 150-180 mg. She had been in need of dire medical attention for at least three (3) days prior to her death. The medical examiner felt, she had been without fluid for ten (10) days and several expert opinions agree with the autopsy's conclusions.

K.D. stated, Johnson's note dated, 12-01-95, shows she injected her with both Chloral Hydrate and Magnesium Chloride. Magnesium Chloride can only be obtained from a hospital and therefore it is unknown from where the drug came. In addition, on the same note, Johnson orders L.M. receive two (2) liters of fluid when she awoke. L.M., however, never received the fluid.

After honoring his request to provide him with a letter of confidentiality, K.D. submitted a copy of Dr. Minkoff's deposition concerning the matter (**Exh. 11**). K.D. stated the deposition shows Dr. Minkoff acknowledged, the liquid valium he had prescribed to D.H. was intended to be given to the patient and that it was a mistake on his part. He also admitted that Scientologists would agree, it is OK to lie under oath if it is for the good of the (church's) cause. K.D. also submitted a copy of a video tape of the same deposition (**Exh. 12**), as well as a video tape of two (2) video programs he contends were publicly aired concerning L.M.'s death (**Exh. 13**). The

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first program on the tape, aired on Inside Edition on 07-23-97, chronicles the events leading to her death. A Forensic Pathologist, who reviewed the notes and autopsy report concluded that the combination of the vitamin B1, Chloral Hydrate and Magnesium Chloride caused her death as there is no other explanation for her demise. The second program on the tape, aired on Good Morning America on 02-20-97, included the interview of L.M.'s friend in Texas who stated that L.M. had promised her she would leave the church and return to Texas no later than Christmas of that year. It also states that the persons who were with her at the Ft. Harrison Hotel have since left the area and their whereabouts are unknown, but they have retained Attorneys. One individual was located in Germany.

K.D. alleges Dr. Minkoff along with unlicensed individuals caused L.M.'s death because they allowed her to die. The church designated L.M. as a potential trouble source, a PTL, type 3, a psychotic, the worse condition one can be designated (**Exh. 14**). Scientologists believe the treatment plan for such individuals is to place them in total isolation and also believe that sometimes you had to allow them to die. K.D. submitted samples of literature by L.Ron Hubbard, the founder of the Church of Scientology, pertaining to the treatment of psychotics including isolating such people. With the above, he submitted a copy of an excerpt from L. Ron Hubbard's book, Science of Survival, advocating that if other methods fail, to dispose of such individuals quietly and without sorrow (**Exh. 15**). He also submitted an excerpt from the same book which describes the use of certain drugs without a person's consent including Chloral Hydrate to induce a "drug hypnosis" a state whereby the person can receive and obey commands given to him by a "doctor or operator" even after awakening from the drugged sleep (**Exh. 16**).

K.D. submitted copies of the church's amended responses to interrogatories (**Exh. 17**) regarding clarification of certain terms used by the church and the actions taken by members of the church including Janice Johnson during the time L.M. was at the hotel. The questions included a request for Janice Johnson's background, the food given to L.M. while in the room, whether or not she was detained and if she was isolated. The church objected to some of the terminology that was being used in treating her condition. The responses included an advisory that Janice Johnson is no longer available to comment on some of the information requested.

K.D. stated, Dr. Minkoff, although an OT8, the highest operating "thetan" within the organization, informed Dr. Johnson when contacted by her that he did not want the patient taken to New Port Richey Hospital, but, Johnson, also an OT8, ordered him to accept her. Although Dr. Johnson is a physician, she had lost her license to practice medicine after she was accused of abusing drugs. Dr. Johnson received her orders from the case supervisor, Alain Kartuzinski who was in charge of everything.

**Investigator's Note:**

Computer licensing information failed to disclose Dr. Johnson as holding a Florida license to practice medicine. Requests for Certificates of non-licensure were submitted to the Board of Medicine and the Board of Osteopathic Medicine for the individuals who appears to have participated in L.M.'s care including Dr. Johnson and Alain Kartuzinski. The results will be submitted when received.

**3) MEDICAL RECORDS: MORTON PLANT HOSPITAL – 323 JEFFORDS ST., CLEARWATER, FLORIDA 34617 TEL: 813/461-8000**

Copies of L.M.'s medical records were submitted by Attorney K.D.



## CONTINUATION

The records (**Exh. 18**) indicate that on 11-18-95, L.M. presented to that hospital after the auto accident and after she was seen running naked down the street from the accident. A psychiatric nurse's report states, L.M. denied suicidal ideation nor any intention of wanting to harm anyone. She did not want to stay at the hospital and wanted to leave with her "friends" from her congregation. She, however, appeared confused at times and spoke in a monotone with a fixed stare and glassy teary eyed. She stated she took off her clothing to get some attention, but did not want to be arrested.

A report by Dr. Flynn Lovett, the physician on duty indicates that the Scientologists who arrived at the scene informed him that they did not want L.M. seen by a psychiatrist and that they were able to "handle her themselves." He informed them, he needed to obtain such a consult. A psychiatric liaison informed him, because she was not a danger, they could not Baker Act her though they felt she had a psychiatric problem. Dr. Lovett also spoke to an M.D. via telephone who advised him of the same. Dr. Lovett's report states, L.M. denied having been injured in the accident and that there was no evidence of injury. Since she did not wish to remain hospitalized and because the Scientologists stated they would monitor her very closely, L.M. was discharged against medical advice after he diagnosed her condition as no evidence of acute medical problem or injury, behavioral dysfunction.

**4) MEDICAL RECORDS: COLUMBIA NEW PORT RICHEY HOSPITAL – 5637 MARINE PARKWAY, NEW PORT RICHEY, FLORIDA 34656 TEL: 813/848-1733**

Copies of L.M.'s medical records were obtained by patient release mailed with letters of administration on 02-27-98 to Sharon Edinger, Records Custodian (**Exh. 19**).

The records (**Exh. 20**) with a completed verification form, describe L.M.'s presentation when she arrived at 2130 hours (9:30 PM) on 12-05-95. She was accompanied by a friend. The registration indicates, Janice Johnson was to have been notified in case of an emergency. The reason for the presentation was to be evaluated. At that time, L.M. was noted to be unresponsive and her pupils were unreactive. The attending physician in the ER was D.J. Niles. The records indicate, Dr. Minkoff initiated CPR and Dr. Niles intubated the patient. Dr. Minkoff pronounced the patient dead at 2151 hours (9:51 PM). Blood studies were ordered. Her diagnosis was listed as "sepsis".

**5) INTERVIEW OF D.J. NILES, M.D. – COLUMBIA NEW PORT RICHEY HOSPITAL**

Dr. Niles, telephonically interviewed on 4-30-95 stated that he has already given several statements concerning his role in the care of the patient. He stated, contrary to the stamp on the record indicating that he was the attending physician, he, in fact was not the primary care giver and therefore did not generate any reports concerning the care of the patient. Dr. Minkoff wrote and signed the physician care record since he was the attending primary physician during the time the patient was seen. Dr. Niles stated that he (Niles) only assisted Dr. Minkoff by intubating the patient.

**6) STATEMENT BY DAVID MINKOFF, M.D. - SUBJECT**

Since neither Dr. Minkoff nor his representatives have responded to this complaint, Dr. Minkoff's statement was gleaned from the deposition he had given to D.K. on 10-22-97. At the deposition (see exhibit 11) Dr. Minkoff stated, he is a Board Certified Pediatrician who is licensed to practice in both Florida and California. He also has an office at 131 Garden Avenue in Clearwater where he practices nutritional medicine. He first heard of L.M. on 11-20-95, when church members telephoned him for assistance after the church members labeled her a "Type III", a psychotic who was having difficulty sleeping. He couldn't remember if it was Janice Johnson, David Houghton or Alain Kartuzinski who telephoned him regarding the patient. He believes he was called over other physicians in the area because the church trusted him. He was familiar with the church's treatment for such persons because he had read the church's bulletins and was aware that such treatment was not generally accepted in Clearwater or "any place else" (page 47 of

## CONTINUATION

deposition). Treatment included the introspection rundown, part of which advocated keeping the person in isolation. Dr. Minkoff stated however, that there were other members in the room with her but the isolation was only meant to quiet the environment and reduce external stimulation to calm the person down.

Dr. Minkoff stated he thought Janice Johnson was licensed but knew she was not licensed in Florida. He was unaware that she was not licensed in the U.S. He subsequently called in a prescription to Eckerd's pharmacy for Valium, 5 mg. in the name of D.H. to be given to L.M. before sleep. He acknowledged writing the prescription in D.H.'s name because D.H. was going to pick up the prescription. He wasn't aware that it was a violation of a law to write such a prescription and he didn't know the correct spelling of D.H.'s name (page 49-50). He also thinks that at that time, he thought D.H. was a licensed dentist. Although on the prescription, Eckerd's pharmacy identified his practice as Doctor's Walk -In Clinic, Dr. Minkoff stated that at that time, he was not working for such clinic and that there was no such practice at the location. Dr. Minkoff agreed that at the time he wrote the prescription, L.M. was not his patient nor was D.H. his patient (page 52). No one had advised him to put the prescription in D.H.'s name. Dr. Minkoff believes that D.H. has since become a Florida licensed dentist and may have been the other person on the phone who advised him that he would pick-up the prescription for L.M. He also advised he rarely if ever had previously called in a prescription for any church member who was not his patient. He, however, was aware of his obligation to have seen the patient before prescribing a medication for her. He also was aware that although he (Minkoff) was at level 8 in the organization he could have refused to provide L.M. with the injectable liquid Valium without fear of retaliation.

Dr. Minkoff advised that nine (9) days after he had called in the prescription, he received a telephone call from one (1) or two (2) of the three (3) individuals who had initially called him. They now informed him, L.M. was unable to sleep. He then wrote a prescription for Chloral Hydrate, this time in L.M.'s name (page 61). He acknowledged he had never spoken to L.M. nor did he request he see the patient as he didn't believe there was an acute medical problem (pages 73-75). He does not know what the five (5) white pills given to L.M. were nor does he know who gave her the pills. He also denied giving Magnesium Chloride to L.M. He again acknowledged, L.M. was not his patient on 11-29-95 (page 81).

On 12-05-95, at about 7:30 PM, Dr. Johnson telephoned Dr. Minkoff while he was at the hospital wanting authorization for a shot of penicillin to be given to L.M. because she was ill that morning with diarrhea, sore throat and had lost "a lot of weight." Dr. Johnson thought she had strep throat. Dr. Minkoff refused and advised her to transport L.M. to an ER. Dr. Johnson replied that she wasn't that ill and asked whether or not he would be willing to see her. He agreed to see her (page 83). L.M. then arrived at the ER at about 9:30 PM accompanied by Dr. Johnson and perhaps one (1) other unidentified person. When he saw the patient, she was slumped over in a wheelchair and was not breathing. She looked as if she had all the signs of meningococemia. She did not appear to have looked like the person that Dr. Johnson had described to him earlier on the telephone. He felt as though Dr. Johnson misrepresented L.M.'s condition to him and he would have recommended they call 911 if her condition had been accurately described (page 89-90). No temperature was taken of the body nor blood gases tested. Because of the skin hemorrhages and her appearance, he diagnosed her condition as having been an overwhelming infection, septic shock, possibly meningococemia, but he nor anyone else in the ER gave themselves injections to prevent any disease. L.M. also appeared to have been dehydrated. One of the nurses had described her body when seen in the ER to have been dirty. Subsequent blood tests uncovered staphylococcus aureus. Dr. Minkoff stated however, that it wasn't true that when one draws blood from a dead person one will find staph. Dr. Johnson had informed him that she was still breathing half way to the hospital. After he pronounced L.M. dead, he spoke to Dr. Johnson and asked her why she had brought the patient to him. He was very upset with her for having done so. He doesn't recall her answer, but believes that she had taken L.M. to him because he is a Scientologist. He maintains that L.M. died of a staph infection and sepsis.



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Dr. Minkoff explained the reddish/brown marks on L.M.'s arm as having been caused by a leaking blood vessel due to bacteria. He acknowledged that they could have been produced because of restraints. He didn't ask Dr. Johnson any questions concerning L.M.'s condition prior to her (L.M.'s) arrival at the hospital.

Dr. Minkoff was asked what Black Dianetics was and answered that it is dianetics used for harm instead of good, by people who want to create chaos, to harm and suppress people. He denied that drugs could not be used on members of Scientology without the case supervisor's permission (page 118-119). He stated that an "overt" is a transgression against another or oneself and that in Scientology, a lie at times, is not an overt when it is for the greatest good for the greatest number of dynamics. He, however, informed his Attorney that he would not lie to avoid liability in a civil case nor would he lie to avoid liability to the church in such a case. Earlier he had stated that he had spoken to the police and to the State Attorney concerning the incident and that the State Attorney offered him immunity regarding the matter.

**7) MEDICAL RECORDS: DAVID MINKOFF, M.D.**

Copies of L.M.'s medical records were obtained by Subpoena Duces Tecum A-010648 with a patient release and letters of administration mailed on 02-05-98 to his Attorney, James Felman (**Exh. 21**).

The records (**Exh. 22**) duplicate the records obtained from New Port Richey Hospital. They fail to contain any records suggesting that L.M. was a patient of his prior to her presentation at the hospital on 12-05-95 nor does the records contain a copy of the prescription he had written for her.

**8) INTERVIEW OF ATTORNEY MARK MCGARRY – STATE ATTORNEY'S OFFICE (1/813/464-6713)**

After first contacting Sgt. Wayne Andrews at the Clearwater Police Department (813/562-4242 ext. 4310) who directed this writer to the State Attorney's office, 05-05-95, Attorney Mark McGarry stated he had spoken to his superiors regarding the Agency's request for information and since the matter is ongoing, he cannot release any information concerning their investigation at this time.

The confidential Index is listed as **exhibit 23**.