

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

**In the Matter of the First Amended
Accusation Against:**

Manolito Velasquez Castillo, M.D.

**Physician's & Surgeon's
Certificate No. A 67937**

Case No. 800-2017-039398

Respondent.

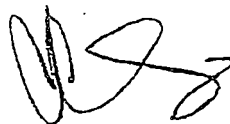
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 09, 2023.

IT IS SO ORDERED: October 11, 2023.

MEDICAL BOARD OF CALIFORNIA



**Laurie Rose Lubiano, J.D., Chair
Panel A**

1 ROB BONTA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 LYNETTE D. HECKER
Deputy Attorney General
4 State Bar No. 182198
California Department of Justice
5 2550 Mariposa Mall, Room 5090
Fresno, CA 93721
6 Telephone: (559) 705-2320
Facsimile: (559) 445-5106
7 *Attorneys for Complainant*

8
9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

13 In the Matter of the First Amended Accusation
Against:

14 **MANOLITO VELASQUEZ CASTILLO, M.D.**
15 **2111 O Street**
Merced, CA 95340

16 **Physician's and Surgeon's Certificate No. A 67937**

17 Respondent.

Case No. 800-2017-039398

OAH No. 2021010703

18
19 **STIPULATED SETTLEMENT AND**
20 **DISCIPLINARY ORDER**

21 In the interest of a prompt and speedy settlement of this matter, consistent with the public
22 interest and the responsibility of the Medical Board of California of the Department of Consumer
23 Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order
24 which will be submitted to the Board for approval and adoption as the final disposition of the
25 First Amended Accusation.

26 **PARTIES**

27 1. Reji Varghese (Complainant) is the Interim Executive Director of the California Medical
28 Board (Board). He brought this action solely in his official capacity¹ and is represented in this

¹ William Prasifka was the Executive Director of the Board when this action was filed.

1 matter by Rob Bonta, Attorney General of the State of California, by Lynette D. Hecker, Deputy
2 Attorney General.

3 2. Manolito Velasquez Castillo, M.D. (Respondent) is represented in this proceeding by
4 attorney Michael F. Ball, whose address is: 7647 North Fresno Street, Fresno, CA 93720-8912.

5 3. On or about April 2, 1999, the Board issued Physician's and Surgeon's Certificate
6 No. A 67937 to Respondent. The Physician's and Surgeon's Certificate was in full force and
7 effect at all times relevant to the charges brought in Accusation No. 800-2017-039398, and will
8 expire on June 30, 2024, unless renewed.

9 JURISDICTION

10 4. The First Amended Accusation No. 800-2017-039398 was filed before the Board, and
11 is currently pending against Respondent. The initial Accusation and all other statutorily required
12 documents were properly served on Respondent on December 8, 2020. The First Amended
13 Accusation and all other statutorily required documents were properly served on Respondent on
14 March 3, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

15 5. A copy of the First Amended Accusation No. 800-2017-039398 is attached as
16 "Exhibit A" and incorporated herein by reference.

17 ADVISEMENT AND WAIVERS

18 6. Respondent has carefully read, fully discussed with counsel, and understands the
19 charges and allegations in First Amended Accusation No. 800-2017-039398. Respondent has
20 also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated
21 Settlement and Disciplinary Order.

22 7. Respondent is fully aware of his legal rights in this matter, including the right to a
23 hearing on the charges and allegations in the First Amended Accusation; the right to confront and
24 cross-examine the witnesses against him; the right to present evidence and to testify on his own
25 behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the
26 production of documents; the right to reconsideration and court review of an adverse decision;
27 and all other rights accorded by the California Administrative Procedure Act and other applicable
28 laws.

1 8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
2 every right set forth above.

3 **CULPABILITY**

4 9. Respondent understands and agrees that the charges and allegations in First Amended
5 Accusation No. 800-2017-039398, if proven at a hearing, constitute cause for imposing discipline
6 upon his Physician's and Surgeon's Certificate.

7 10. Respondent does not contest that, at an administrative hearing, Complainant could
8 establish a *prima facie* case or factual basis with respect to the charges and allegations in First
9 Amended Accusation No. 800-2017-039398, that he has thereby subjected his Physician's and
10 Surgeon's Certificate, No. A 67937 to disciplinary action, and Respondent hereby gives up his
11 right to contest those charges.

12 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
13 discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the
14 Disciplinary Order below.

15 **CONTINGENCY**

16 12. This stipulation shall be subject to approval by the Medical Board of California.
17 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
18 Board of California may communicate directly with the Board regarding this stipulation and
19 settlement, without notice to or participation by Respondent or his counsel. By signing the
20 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
21 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
22 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
23 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
24 action between the parties, and the Board shall not be disqualified from further action by having
25 considered this matter.

26 13. The parties understand and agree that Portable Document Format (PDF) and facsimile
27 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
28 signatures thereto, shall have the same force and effect as the originals.

1 14. In consideration of the foregoing admissions and stipulations, the parties agree that
2 the Board may, without further notice or opportunity to be heard by the Respondent, issue and
3 enter the following Disciplinary Order:

4 **DISCIPLINARY ORDER**

5 **A. PUBLIC REPRIMAND**

6 IT IS HEREBY ORDERED that Respondent, MANOLITO VELASQUEZ CASTILLO,
7 M.D., Physician's and Surgeon's Certificate No. A 67937, shall be and is hereby Publicly
8 Reprimanded pursuant to California Business and Professions Code section 2227, subdivision
9 (a)(4). This Public Reprimand is issued in connection with Respondent's care and treatment of
10 one patient, as set forth in First Amended Accusation No. 800-2017-039398.

11 **B. PRESCRIBING PRACTICES COURSE**

12 Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a
13 course in prescribing practices approved in advance by the Board or its designee. Respondent
14 shall provide the approved course provider with any information and documents that the approved
15 course provider may deem pertinent. Respondent shall participate in and successfully complete
16 the classroom component of the course not later than six (6) months after Respondent's initial
17 enrollment. Respondent shall successfully complete any other component of the course within
18 one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense
19 and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of
20 licensure.

21 A prescribing practices course taken after the acts that gave rise to the charges in the First
22 Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of
23 the Board or its designee, be accepted towards the fulfillment of this condition if the course would
24 have been approved by the Board or its designee had the course been taken after the effective date
25 of this Decision.

26 Respondent shall submit a certification of successful completion to the Board or its
27 designee not later than 15 calendar days after successfully completing the course, or not later than
28 15 calendar days after the effective date of the Decision, whichever is later.

1 **C. MEDICAL RECORD KEEPING COURSE**

2 Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a
3 course in medical record keeping approved in advance by the Board or its designee. Respondent
4 shall provide the approved course provider with any information and documents that the approved
5 course provider may deem pertinent. Respondent shall participate in and successfully complete
6 the classroom component of the course not later than six (6) months after Respondent's initial
7 enrollment. Respondent shall successfully complete any other component of the course within
8 one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense
9 and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of
10 licensure.

11 A medical record keeping course taken after the acts that gave rise to the charges in the
12 First Amended Accusation, but prior to the effective date of the Decision may, in the sole
13 discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the
14 course would have been approved by the Board or its designee had the course been taken after the
15 effective date of this Decision.

16 **D. EDUCATION COURSE**

17 Within 60 calendar days of the effective date of this Decision, Respondent shall submit to
18 the Board or its designee for its prior approval educational program(s) or course(s) which shall
19 not be less than 40 hours. The educational program(s) or course(s) shall be aimed at correcting
20 any areas of deficient practice or knowledge and shall be Category I certified. The educational
21 program(s) or course(s) shall be at Respondent's expense and shall be in addition to the
22 Continuing Medical Education (CME) requirements for renewal of licensure. Following the
23 completion of each course, the Board or its designee may administer an examination to test
24 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
25 hours of CME of which 40 hours were in satisfaction of this condition.

26 **E. INVESTIGATION/ENFORCEMENT COST RECOVERY**

27 Respondent is hereby ordered to reimburse the Board its costs of investigation and
28 enforcement, including, but not limited to, expert review, amended accusations, legal reviews,

1 investigation(s), and subpoena enforcement, as applicable, in the amount of \$25,815.94 (twenty-
2 five thousand eight hundred fifteen dollars and ninety-four cents). Costs shall be payable to the
3 Medical Board of California. Failure to pay such costs shall constitute unprofessional conduct and
4 grounds for further discipline.

5 Payment must be made in full within 30 calendar days of the effective date of the Order, or
6 by a payment plan approved by the Medical Board of California. Any and all requests for a
7 payment plan shall be submitted in writing by respondent to the Board. Failure to comply with
8 the payment plan shall be considered a violation of probation.

9 The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to
10 repay investigation and enforcement costs, including expert review costs (if applicable).

11 **F. FUTURE ADMISSIONS CLAUSE**

12 If Respondent should ever apply or reapply for a new license or certification, or petition for
13 reinstatement of a license, by any other health care licensing action agency in the State of
14 California, all of the charges and allegations contained in First Amended Accusation No. 800-
15 2017-039398 shall be deemed to be true, correct, and admitted by Respondent for the purpose of
16 any Statement of Issues or any other proceeding seeking to deny or restrict license.

17 **G. ENFORCEMENT**

18 Failure to timely complete the courses outlined above shall constitute unprofessional
19 conduct and is grounds for further disciplinary action

20 **ACCEPTANCE**

21 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
22 discussed it with my attorney, Michael F. Ball. I understand the stipulation and the effect it will
23 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
24 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
25 Decision and Order of the Medical Board of California.

26
27 DATED: _____

28 _____
MANOLITO VELASQUEZ CASTILLO, M.D.
Respondent

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2 five thousand eight hundred fifteen dollars and ninety-four cents). Costs shall be payable to the
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7 payment plan shall be submitted in writing by respondent to the Board. Failure to comply with
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13 reinstatement of a license, by any other health care licensing action agency in the State of
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16 Issues or any other proceeding seeking to deny or restrict license.

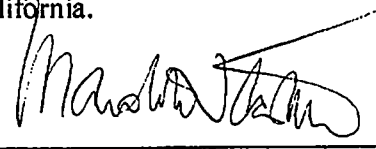
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24 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
25 Decision and Order of the Medical Board of California.

26
27 DATED: 2/17/23




MANOLITO VELASQUEZ CASTILLO, M.D.
Respondent

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I have read and fully discussed with Respondent Manolito Velasquez Castillo, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 2/17/2023 
MICHAEL F. BALL
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: _____

Respectfully submitted,
ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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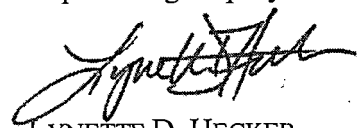
DATED: _____
MICHAEL F. BALL
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 2/17/2023

Respectfully submitted,
ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General


LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2017-039398

1 ROB BONTA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 LYNETTE D. HECKER
Deputy Attorney General
4 State Bar No. 182198
California Department of Justice
5 2550 Mariposa Mall, Room 5090
Fresno, CA 93721
6 Telephone: (559) 705-2320
Facsimile: (559) 445-5106
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13 In the Matter of the First Amended Accusation
Against:

14 **Manolito Velasquez Castillo, M.D.**
15 **2111 O Street**
Merced, CA 95340

16 **Physician's and Surgeon's Certificate**
17 **No. A 67937,**

18 Respondent.

Case No. 800-2017-039398

OAH No. 2021010703

FIRST AMENDED ACCUSATION

19
20 **PARTIES**

21 1. William Prasifka (Complainant) brings this First Amended Accusation solely in his
22 official capacity as the Executive Director of the Medical Board of California, Department of
23 Consumer Affairs (Board).

24 2. On or about April 2, 1999, the Medical Board issued Physician's and Surgeon's
25 Certificate Number A 67937 to Manolito Velasquez Castillo, M.D. (Respondent). The
26 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
27 charges brought herein and will expire on June 30, 2024, unless renewed.

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1 **JURISDICTION**

2 3. This First Amended Accusation is brought before the Board, under the authority of
3 the following laws. All section references are to the Business and Professions Code (Code)
4 unless otherwise indicated.

5 4. Section 2227 of the Code states:

6 (a) A licensee whose matter has been heard by an administrative law judge of the
7 Medical Quality Hearing Panel as designated in Section 11371 of the Government
8 Code, or whose default has been entered, and who is found guilty, or who has entered
9 into a stipulation for disciplinary action with the board, may, in accordance with the
10 provisions of this chapter:

11 (1) Have his or her license revoked upon order of the board.

12 (2) Have his or her right to practice suspended for a period not to exceed one
13 year upon order of the board.

14 (3) Be placed on probation and be required to pay the costs of probation
15 monitoring upon order of the board.

16 (4) Be publicly reprimanded by the board. The public reprimand may
17 include a requirement that the licensee complete relevant educational
18 courses approved by the board.

19 (5) Have any other action taken in relation to discipline as part of an order
20 of probation, as the board or an administrative law judge may deem proper.

21 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
22 medical review or advisory conferences, professional competency examinations,
23 continuing education activities, and cost reimbursement associated therewith that are
24 agreed to with the board and successfully completed by the licensee, or other matters
25 made confidential or privileged by existing law, is deemed public, and shall be made
26 available to the public by the board pursuant to Section 803.1.

27 **STATUTORY PROVISIONS**

28 5. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with
unprofessional conduct. In addition to other provisions of this article, unprofessional
conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or
abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent
acts or omissions. An initial negligent act or omission followed by a separate and
distinct departure from the applicable standard of care shall constitute repeated
negligent acts.

1 (1) An initial negligent diagnosis followed by an act or omission medically
2 appropriate for that negligent diagnosis of the patient shall constitute a single
3 negligent act.

4 (2) When the standard of care requires a change in the diagnosis, act, or
5 omission that constitutes the negligent act described in paragraph (1),
6 including, but not limited to, a reevaluation of the diagnosis or a change in
7 treatment, and the licensee's conduct departs from the applicable standard of
8 care, each departure constitutes a separate and distinct breach of the standard
9 of care.

10 (d) Incompetence.

11 (e) The commission of any act involving dishonesty or corruption that is
12 substantially related to the qualifications, functions, or duties of a physician and
13 surgeon.

14 (f) Any action or conduct that would have warranted the denial of a certificate.

15 (g) The failure by a certificate holder, in the absence of good cause, to attend and
16 participate in an interview by the board. This subdivision shall only apply to a
17 certificate holder who is the subject of an investigation by the board.

18 COST RECOVERY

19 6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
20 administrative law judge to direct a licensee found to have committed a violation or violations of
21 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
22 enforcement of the case¹, with failure of the licensee to comply subjecting the license to not being
23 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
24 included in a stipulated settlement.

25 DEFINITIONS

26 7. Acetaminophen (Tylenol®) is a pain reliever and a fever reducer. It is used to treat
27 many conditions including headache, muscle aches, arthritis, backache, toothaches, colds, and
28 fevers. Acetaminophen is not a controlled substance.

8. Ativan® (lorazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is
a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,
subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

¹ As of November 18, 2021, Section 125.3 of the Code has been amended to remove
subsection (k), which precluded the Board from collecting costs. The Board may collect
investigation, prosecution, and other costs incurred for a disciplinary proceeding against a
licensee beginning January 1, 2022.

1 When properly prescribed and indicated, it is used for the management of anxiety disorders or for
2 short-term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of
3 Ativan® with opioids “may result in profound sedation, respiratory depression, coma, and death.”
4 The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Ativan®,
5 as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

6 9. Benzodiazepines are a class of agents that work on the central nervous system, acting
7 on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain.
8 Valium, diazepam, alprazolam, and temazepam are all examples of benzodiazepines. All
9 benzodiazepines are Schedule IV controlled substances and have the potential for abuse,
10 addiction, and diversion.

11 10. Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative
12 that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,
13 subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.
14 When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders.
15 Concomitant use of Klonopin® with opioids “may result in profound sedation, respiratory
16 depression, coma, and death.” The Drug Enforcement Administration (DEA) has identified
17 benzodiazepines, such as Klonopin®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide
18 (2011 Edition), at p. 53.) Klonopin® has a half-life of 20-50 hours such that twice daily dosing is
19 usually sufficient to prevent a build-up of bioavailable medication. Caution is advised when
20 prescribed in combination with hydromorphone due to an increased risk of respiratory depression.

21 11. Hydromorphone (Dilaudid®), an opioid analgesic, is a Schedule II controlled
22 substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous
23 drug pursuant to Business and Professions Code section 4022. When properly prescribed and
24 indicated, it is used for the treatment of moderate to severe pain. The Drug Enforcement
25 Administration (DEA) has identified hydromorphone, such as Dilaudid®, as a drug of abuse.
26 (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The Federal Drug
27 Administration has issued black box warnings for Dilaudid®, which warn about, among other
28 things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress.

1 The warnings also caution about the risks associated with concomitant use of Dilaudid® with
2 benzodiazepines or other central nervous system (CNS) depressants.

3 12. Invega Sustenna® (paliperidone palmitate) is used to treat certain mental/mood
4 disorders (such as schizophrenia, schizoaffective disorder, bipolar disorder). Paliperidone is an
5 antipsychotic drug (atypical type). It works by helping to restore the balance of certain natural
6 chemicals (neurotransmitters) in the brain. Among others, known side effects include drowsiness,
7 dizziness, lightheadedness, fainting, slow heartbeat, seizures, difficulty swallowing, restlessness,
8 muscle spasms, interrupted breathing during sleep, and difficulty breathing.

9 13. Morphine is a non-synthetic narcotic, derived from opium, which is used for the
10 treatment of pain. Morphine's effects include euphoria and relief of pain. Chronic use of
11 morphine results in tolerance and physical and psychological dependence. Morphine use results
12 in relief from physical pain, decrease in hunger, and inhibition of the cough reflex. Overdose
13 effects include: cold and clammy skin; lowered blood pressure; sleepiness; slowed breathing;
14 slow pulse rate; coma; and possible death. There are known risks associated with concomitant use
15 of morphine with benzodiazepines or other central nervous system (CNS) depressants. Morphine
16 is a Schedule II narcotic under the Controlled Substances Act. The Drug Enforcement
17 Administration has identified morphine, as a drug of abuse. (Drugs of Abuse, A DEA Resource
18 Guide (2017 Edition), at p. 45.)

19 14. Ondansetron (Zofran®, Zofran ODT®, Zuplenz®) is a medication that blocks the
20 actions of chemicals in the body that can trigger nausea and vomiting. It is used to prevent
21 nausea and vomiting that may be caused by surgery, cancer chemotherapy, radiation treatment, or
22 other medications. Ondansetron is not a controlled substance.

23 15. Bioavailability is the proportion of a drug or other substance which enters the
24 circulation when introduced into the body and so is able to have an active effect on the person.

25 16. The half-life of a drug or medication is the amount of time that it takes for half of the
26 drug to be metabolized and eliminated from the body. Or, put another way, the half-life of a drug
27 is the time it takes for it to be reduced by half. For example, a drug that is to be taken every four
28

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1 hours, such as ibuprofen; generally has a half-life of two hours – half of it will have been
2 metabolized in the first two hours.

3 17. Bipolar disorder, formerly called manic depression, is a mental health condition that
4 causes extreme mood swings that include emotional highs (mania or hypomania) and lows
5 (depression). When one who is bipolar becomes depressed, they may feel sad or hopeless and
6 lose interest or pleasure in most activities. When their mood shifts to mania or hypomania (less
7 extreme than mania), they may feel euphoric, full of energy or unusually irritable. These mood
8 swings can affect sleep, energy, activity, judgment, behavior and the ability to think clearly.
9 Episodes of mood swings may occur rarely or multiple times a year. While most people will
10 experience some emotional symptoms between episodes, some may not experience any.
11 Although bipolar disorder is a lifelong condition, mood swings and other symptoms can be
12 managed by following a treatment plan. In most cases, bipolar disorder is treated with
13 medications and psychological counseling (psychotherapy).

14 18. Long Q-T syndrome (LQTS) is a heart rhythm condition that can potentially cause
15 fast, chaotic heartbeats. These rapid heartbeats might trigger the sufferer to suddenly faint. Some
16 people with the condition have seizures. In some severe cases, LQTS can cause sudden death.
17 LQTS may occur because of a genetic mutation (congenital) or it may be caused by certain
18 medications, mineral imbalances or medical conditions (acquired).

19 19. Sleep apnea is a potentially serious sleep disorder in which breathing repeatedly stops
20 and starts. One who snores loudly and feels tired even after a full night's sleep might have sleep
21 apnea. The main types of sleep apnea are: obstructive sleep apnea, the more common form that
22 occurs when throat muscles relax; central sleep apnea, which occurs when the brain doesn't send
23 proper signals to the muscles that control breathing; and complex sleep apnea syndrome, also
24 known as treatment-emergent central sleep apnea, which occurs when someone has both
25 obstructive sleep apnea and central sleep apnea.

26 20. Polypharmacy is the practice of administering many different medicines, especially
27 concurrently, for the treatment of a single disease. It is also the concurrent use of multiple

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1 medications by a patient to treat usually coexisting conditions and which may result in adverse
2 drug interactions.

3 21. Respiratory depression (hypoventilation) is a breathing disorder characterized by
4 slow and ineffective breathing. During a normal breathing cycle, one inhales oxygen into his/her
5 lungs. Blood carries the oxygen around the body, delivering it to body tissues. The blood then
6 takes the carbon dioxide, a waste product, back to the lungs. The carbon dioxide exits the body
7 when one exhales. During hypoventilation, the body cannot adequately remove carbon dioxide.
8 This can lead to poor use of oxygen by lungs. The result is a higher level of carbon dioxide and
9 too little oxygen available to the body. Symptoms of respiratory depression vary. Mild or
10 moderate symptoms may include: tiredness; daytime sleepiness; shortness of breath; slow and
11 shallow breathing; and depression. Respiratory depression can occur as a side effect of certain
12 medications and large doses of central nervous system depressant drugs may slow down the
13 respiratory system. Medications that can have this effect on the body include: alcohol;
14 barbiturates; sedatives; opioids; and benzodiazepines.

15 22. Seen on a prescription, p.r.n. means "as needed." It is an abbreviation for "*pro re*
16 *nata*" which in Latin means as needed. The abbreviation p.r.n. is sometimes written without a
17 period either in lower-case letters as "prn" or in capital letters as "PRN."

18 23. Seen on a prescription, b.i.d. means "twice (two times) a day." It is an abbreviation
19 for "*bis in die*" which in Latin means twice a day. The abbreviation b.i.d. is sometimes written
20 without a period either in lower-case letters as "bid" or in capital letters as "BID."

21 24. Seen on a prescription, t.i.d. means "three times a day." It is an abbreviation for "*ter*
22 *in die*" which in Latin means three times a day. The abbreviation t.i.d. is sometimes written
23 without a period either in lower-case letters as "tid" or in capital letters as "TID."

24 25. Seen on a prescription, q.i.d. means "four a day." It is an abbreviation for "*quater in*
25 *die*" which in Latin means four times a day. The abbreviation q.i.d. is sometimes written without
26 a period either in lower-case letters as "qid" or in capital letters as "QID."

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1 patient's visit to the CRMC-ED two days earlier she had verbalized that she had lost the will to
2 live. Respondent further noted that the patient remained depressed and anxious when Respondent
3 saw her and indicated to Respondent that she still had suicidal thoughts. Respondent noted the
4 patient's current medications as: Gabapentin, lithobid, propranolol, cogentin, Wellbutrin XL,
5 Hydroxyzine, and Invega Sustenna. Respondent either did not realize that his list of the patient's
6 current medications differed from those listed by the MNP, or did nothing to reconcile the
7 differences. Respondent did not conduct a review of the patient's records from her visit to the
8 CRMC-ED that preceded her admission to CBHC. Respondent did not convert the patient's
9 status to a 5150⁴ psychiatric involuntary hold, nor did he make any notation that a change in her
10 status should be considered upon any transfer/discharge.

11 31. Later, on or about that same day, August 17, 2017, an RN documented that the patient
12 claimed she lost consciousness before walking to the nurse's station, but that it was unwitnessed.
13 The RN notified the MNP who had examined the patient earlier that day and the MNP ordered the
14 patient be sent out for medical clearance. The patient was transported by ambulance to CRMC-ED
15 ED. There was no communication between Respondent and the MNP regarding whether the
16 patient should be transferred/discharged to CRMC-ED on voluntary status or if she should be
17 converted to a 5150 involuntary psychiatric hold due to suicidal ideation reported on admission
18 and psychiatric evaluation. Consequently, the patient was only on a voluntary status at CRMC-
19 ED and was not on a 5150 involuntary psychiatric hold. While in CRMC-ED, at or about
20 approximately an hour before midnight, the patient decided that she wanted to go home. Though
21 nursing staff requested she wait for the physician to see her, the patient left against medical
22 advice as she was not being monitored for safety under a 5150 involuntary psychiatric hold.

23 32. The next morning, on or about August 18, 2017, in the early morning hours, at or
24 about 1:20 am, the patient returned to CBHC to obtain her personal items. An RN evaluated the
25 patient, found her not to be a danger to self or others, and allowed her to obtain her personal items
26 and leave. That day when Respondent became aware of the patient's discharge, he did not take
27

28 ⁴ California Welfare and Institutions Code section 5150 allows an adult experiencing a
mental health crisis to be detained for a 72 hour psychiatric hospitalization.

1 any actions to ensure the safety of the patient either by confirming her safety in a treatment
2 setting, or by providing information to law enforcement to substantiate a 5150 involuntary
3 psychiatric hold for danger to self and to request that the patient be brought to a 5150 receiving
4 facility for psychiatric evaluation.

5 33. Later that same day, on or about August 18, 2017, the patient attempted suicide by
6 ingesting 50 Tylenol, and was taken to the Emergency Department at St. Agnes Medical Center
7 (SAMC).

8 34. After medical stabilization, on or about August 21, 2017, the patient was readmitted
9 to CBHC directly from SAMC on a 5150 involuntary psychiatric hold and Respondent was again
10 assigned as her attending physician.

11 35. On or about August 21, 2017, the MNP who had examined the patient back on or
12 about August 17, 2017, conducted the intake of the patient and deferred history and physical
13 exam since "done within 30 days." The MNP noted the patient's attempted overdose with
14 acetaminophen and that the patient had subsequently been having severe liver pain. The MNP
15 prescribed hydromorphone, 4 mg q 6 hrs PRN for the patient on or about August 21, 2017. The
16 admitting physician ordered vital signs to be followed per routine frequency. Respondent was
17 assigned as the patient's attending physician again and, on or about the next day, he examined the
18 patient, prescribed clonazepam 1 mg TID for her, and continued her other medications.
19 Respondent did not review the risks and benefits with the patient of clonazepam before he
20 prescribed it for her. Respondent did not order a change in vital sign monitoring frequency.
21 Respondent either neglected to review or reviewed and dismissed the nurse practitioner's
22 prescription of an opioid for the patient when he decided to prescribe clonazepam at the dose he
23 prescribed. Respondent did not consider any of the patient's unique factors that may have
24 changed with medical co-morbidities and concurrent medications. Respondent did not implement
25 a safety protocol for the combined prescribing by himself and the MNP, nor did Respondent ask
26 the MNP if the hydromorphone was essential or if there was a safer alternative when Respondent
27 wanted to add a psychotropic medication, clonazepam, to the patient's medications. Respondent
28 did not conduct a review of the patient's records from her stay at SAMC that preceded her

1 admission to CBHC. Respondent did not reconcile the patient's medications from her stay at
2 SAMC with those ordered for her to receive at CBHC.

3 36. On or about August 22, 2017, late in the evening, the patient appeared at the CBHC
4 nursing station crying, indicating that she was awakened by severe pain in her abdomen,
5 specifically in her upper right quadrant. Her vital signs were taken and the MNP on call ordered
6 the patient be transferred to the emergency department for medical treatment due to her recent
7 Tylenol overdose with unresolved liver pain despite treatment with hydromorphone. The patient
8 was taken by ambulance to CRMC-ED. The patient's 5150 hold was given to ambulance
9 personnel.

10 37. The patient remained at CRMC for medical treatment until the next morning. During
11 her time at CRMC, the patient was administered morphine 8 mg intramuscular injection and
12 ondansetron 4 mg orally at 1:08 am and lorazepam 1 mg orally at 4:09 am.

13 38. Less than two hours later, at or about 5:45 am, on or about August 23, 2017, the
14 patient was transferred back to CBHC where an RN documented that she was cooperative and
15 requesting pain medication, but that she understood the need to get her back in the system and to
16 notify her attending physician, Respondent, of her return to review medication. Approximately
17 35 minutes later, at or about 6:20 am, an MNP ordered the patient's medications from her
18 previous admission at CBHC be continued – including the hydromorphone prescribed by the prior
19 MNP and the clonazepam previously ordered by Respondent. The vital sign order was similarly
20 updated to the prior level frequency, per routine. The MNP also ordered 15-minute checks,
21 which was authorized by the admitting physician. Respondent did not conduct a review of the
22 patient's records from her stay at CRMC that preceded this re-admission to CBHC. Respondent
23 did not reconcile the patient's medications from her stay at CRMC with those ordered for her to
24 receive at CBHC in this re-admission.

25 39. A little over an hour later, at or about 6:58 am, the patient approached an RN at the
26 nursing station and requested her pain medication. The RN assessed the patient, administered
27 pain medications as ordered, and endorsed the oncoming shift to reassess for effectiveness.

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1 40. That same day, at or about 8:10 am, the patient went to the nurse station to get her
2 medications from the RN. She denied pain and discomfort and took her scheduled medications.
3 Later that same day, the patient requested to be excused from groups because she did not sleep
4 the prior night. The patient was encouraged to join the groups, but when the RN attempted to ask
5 her assessment questions, the patient declined to respond, indicating she just wanted to go to
6 sleep. At or about 9:40 am that same day, a clinical nurse assistant (CNA) called the patient from
7 the door of her room to attend a goal group therapy session. The patient was on her bed. She
8 opened her eyes, looked at the CNA, and went back to sleep. At or around 10:20 am, an RN went
9 to check on the patient. She was snoring in her sleep with a wedge in place, her respirations were
10 unlabored, and no distress was noted. At or about 11:00 am, the patient was called for group
11 therapy by the therapist who peeked in the patient's room and called for group. In response, the
12 patient merely mumbled something and went back to sleep. A CNA observed the patient sleeping
13 and snoring in her room at or about 11:15 am. At or about 11:30 am, Respondent entered the
14 patient's room to interview her and found her pulseless and not breathing. He initiated a code
15 blue and a 911 call, leading to ambulance transport of the patient to a local medical hospital
16 where she did not recover. Respondent did not conduct a review of the patient's records from her
17 stay at CRMC that preceded her final admission to CBHC. Respondent did not reconcile the
18 patient's medications from her stay at CRMC with those ordered for her to receive at CBHC.

19 **FIRST CAUSE FOR DISCIPLINE**

20 **(Gross Negligence)**

21 41. Respondent is subject to disciplinary action under section 2234, subdivision (b), of
22 the Code, in that he engaged in act(s) or omission(a) amounting to gross negligence. The
23 circumstances are set forth in paragraphs 27 through 40, which are incorporated here by reference
24 as if fully set forth. Additional circumstances are as follows:

25 42. The standard of care requires that a review of medical records be included in a
26 psychiatric evaluation. This is required to ensure, in part, that medication is ordered with
27 considerations for contraindications such as an allergy or dosing modifications due to co-morbid
28 medical conditions such as an impairment in liver functioning that might alter metabolism of

1 medication. In addition, every time a patient initiates a new contact with a medical provider,
2 regardless of whether the patient is a new patient or a continuing patient who may have a
3 concurrently prescribing medical provider, the process of medication reconciliation is required to
4 ensure accurate and safe prescribing of medication. The process of medication reconciliation
5 includes documenting a list of medications from medical records and reviewing each medication
6 with the patient at the time of evaluation to determine if each medication is being taken or not and
7 when the last dose was taken as well as adding any missing medications and subtracting any
8 incorrect or obsolete medications. The purpose is to provide a current, accurate list of medication
9 to inform a safe, appropriate treatment plan moving forward including both psychotropic and
10 non-psychotropic medication. The clinical outcome magnifies, but is not essential to rendering an
11 opinion on a departure from the standard of care regarding medical record review and medication
12 reconciliation. Respondent's repeated failure to review the medical record on three occasions
13 (the patient's first CBHC admission on or about August 16, 2017; her second CBHC admission,
14 on or about August 21, 2017 after her attempted suicide by overdosing on Tylenol; and her return
15 to CBHC, on or about August 23, 2017, from a six-hour emergency medical evaluation due to
16 severe abdominal pain) constitutes gross negligence. Similarly, Respondent's repeated failure to
17 reconcile medications both from outside facilities and between concurrent prescribers within the
18 same episodes of care constitutes gross negligence.

19 43. The standard of care for prescription of psychotropic medication requires informed
20 consent. Informed consent for psychotropic medication includes discussing the diagnosis, risks
21 and benefits of medications, alternatives to treatment, and likely results of not receiving the
22 treatment. It is the responsibility of the physician to accurately represent how the risks may be
23 different between patients based on unique factors such as medical comorbidities and concurrent
24 medications. Respondent's choice to initiate a high dose and high dosing frequency for
25 clonazepam (a medication with a long half-life), his lack of attention to medical risks when^{sion}
26 prescribing clonazepam to a patient with a recent medical evaluation for "liver pain" and
27 concurrently prescribed an opioid medication, and his lack of documented discussion of risks,

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1 benefits, and alternatives culminating in obtaining of the patient's signature on an informed
2 consent document, resulted in inadequate informed consent, which constitutes gross negligence.

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Repeated Acts of Negligence)**

5 44. Respondent is subject to disciplinary action under section 2234, subdivision (c), of
6 the Code, in that he committed repeated acts of negligence. The circumstances are set forth in
7 paragraphs 27 through 40, which are incorporated here by reference as if fully set forth.

8 Additional circumstances are as follows:

9 45. Admitting a patient to a psychiatric hospital on a voluntary status meets the standard
10 of care irrespective of whether the patient also meets the criteria for a 5150 involuntary
11 psychiatric hold for danger to self (suicidal), danger to others (homicidal), or grave disability
12 (unable to provide or utilize provided food, clothing, shelter) which would be required if the
13 patient met these criteria but declined to voluntarily consent for services. Nevertheless, when a
14 voluntary patient is transferred/discharged from a psychiatric hospital, the standard of care
15 requires the attending psychiatrist at the time of transfer/discharge to conduct a risk assessment to
16 determine that the patient is safe from a psychiatry perspective for transfer/discharge and does not
17 meet criteria for a 5150 involuntary psychiatric hold. This applies whether the patient requests a
18 transfer/discharge or is recommended for transfer/discharge by the psychiatrist either routinely or
19 emergently such as when a patient has a medical emergency that cannot be treated in a psychiatric
20 hospital. Based on a risk assessment at the time of transfer/discharge, the standard of care for a
21 patient who was admitted on a voluntary status would be to initiate a 5150 involuntary psychiatric
22 hold for danger to self to be re-evaluated by a psychiatrist following the resolution of the medical
23 emergency. Upon discovering that his patient had been discharged from CBHC, on or about
24 August 17, 2017, by a non-psychiatric colleague without an indicated risk assessment for suicide,
25 Respondent's failure to ensure that the patient receive this risk assessment constitutes negligence.

26 46. The standard of care requires increased monitoring when prescribing medications that
27 in combination increase the risk of respiratory suppression. This monitoring would include
28 increasing the frequency of vital sign checks and a sedation protocol to decrease the risk of a

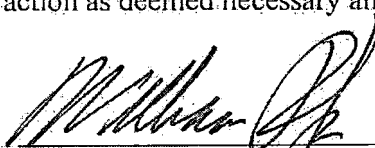
1 patient falling asleep and stopping breathing. Respondent's failure to initiate increased
2 monitoring of a patient at risk for respiratory suppression, particularly when he prescribed
3 clonazepam while the patient was already receiving hydromorphone that had been prescribed by
4 the MNP, constitutes negligence.

5 PRAYER

6 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
7 and that following the hearing, the Medical Board of California issue a decision:

- 8 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 67937,
9 issued to Manolito Velasquez Castillo, M.D.;
- 10 2. Revoking, suspending or denying approval of Manolito Velasquez Castillo, M.D.'s
11 authority to supervise physician assistants and advanced practice nurses;
- 12 3. Ordering Manolito Velasquez Castillo, M.D., to pay the Board the costs of the
13 investigation and enforcement of this case incurred beginning on January 1, 2022, and if placed
14 on probation, to pay the Board the costs of probation monitoring; and
- 15 4. Taking such other and further action as deemed necessary and proper.

16
17 DATED: MAR 03 2022

18 
19 WILLIAM PRASIFKA
20 Executive Director
21 Medical Board of California
22 Department of Consumer Affairs
23 State of California
24 Complainant

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