ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9515
Facsimile: (619) 645-2012
E-mail: Keith.Shaw@doj.ca.gov

Attorneys for Complainant

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

In the Matter of the Accusation Against: **KWI YUN CASSIE YU, M.D.** **6521 Willoughby Avenue** **Los Angeles, CA 90038-2505** **Physician's and Surgeon's Certificate No. C 168614,** Respondent.	Case No. 800-2022-088730 OAH No. **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 22, 2020, the Medical Board issued Physician's and Surgeon's Certificate No. C 168614 to Kwi Yun Cassie Yu, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2026, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

///

///

STATUTORY PROVISIONS

5. Section 2234 of the Code states in part:

"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:

"..."

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

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

"..."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

///

///

///

COST RECOVERY

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care and treatment of Patient A,[1] as more particularly alleged hereinafter:

PATIENT A

10. On or about June 20, 2020, Patient A, a then 8-year-old child, became a patient of Shields for Families (Shields), a contracting agency that provides specialty mental health services. Patient A's mother reported that he had been diagnosed with mild Autism, Attention-deficit/hyperactivity disorder (ADHD), and learning disabilities. On or about September 17, 2020, Shields documented an appointment with Patient A where he expressed feelings of self-harm and suicidal ideation.

11. On or about September 21, 2020, Patient A was referred for a psychiatric evaluation with Respondent, a psychiatrist employed by Shields. However, Respondent did not respond to confirm the appointment that day, so Respondent's evaluation of Patient A was not completed until on or about October 20, 2020. The psychiatric evaluation conducted by Respondent did not document a suicide risk assessment or any review of the suicidal statements that were documented in Patient A's chart the previous month. Respondent initially diagnosed Patient A

[1] The patient listed in this document is unnamed to protect his privacy. Respondent knows the name of the patient and can confirm his identity through discovery.

with ADHD, general anxiety disorder, and social anxiety disorder, but then confoundingly updated the chart to just two diagnoses, generalized anxiety disorder and Major Depressive disorder. Respondent's treatment plan for Patient A included medication therapy to target anxiety and she noted that Patient A's ADHD was profoundly impacting his academic functions.

12. On or about November 13, 2020, a Shields therapist documented a suicide risk assessment in a phone call with Patient A's mother where it was reported Patient A stated he wished he was dead after losing a video game. On or about December 15, 2020, the Shields therapist documented that Patient A again expressed thoughts of self-harm during a telehealth appointment. On or about February 25, 2021, Patient A's therapist noted an assessment for suicide ideation and self-harm after Patient A reported plans for "jumping off" when he goes back to school in-person, rather than remotely due to the pandemic.

13. On or about March 2, 2021, Respondent saw Patient A for the second time. Respondent documented "no safety concerns" without conducting a suicide risk assessment or noting the suicidal statements recently made by Patient A. Between approximately May 2021 and April 2022, Respondent saw Patient A and his mother for psychiatry appointments on six occasions. During this time, Respondent's treatment plan focused on psychotropic medications. At no time was a detailed safety risk assessment performed other than noting "no safety concerns."

14. On or about March 8, 2022, Patient A's new Shields therapist conducted an assessment regarding Patient A's history of suicide ideation. Patient A's mother reported that the last incident of suicide ideation was approximately one year earlier when Patient A stated he wanted to kill himself after she sent him a picture of one his friends doing his homework. Patient A's mother reported that there was another incident previously when Patient A texted his mother that he had procured a small kitchen knife and had tried to cut his hand. Patient A's mother did not observe any visible marks in Patient A's hands when she returned home. Patient A's mother indicated that a third incident occurred when Patient A told her he would rather kill himself than be in a special needs classroom with 15 other students.

///

15. On or about April 21, 2022, Respondent had her final visit with Patient A. Respondent noted Patient A was experiencing increased struggles with controlling his emotions, had been missing more school, and was extremely stressed out. However, Respondent did not note any of Patient A's suicidal ideation documented by his therapist the previous month, nor conduct a suicide risk assessment. Instead, Respondent primarily focused on her medication treatment plan.

16. On or about May 10, 2022, Patient A's mother informed his Shields therapist (an unlicensed family and marriage therapist) that Patient A was in an acute crisis and needed an urgent suicide risk assessment. Patient A's mother relayed to the therapist that Patient A needed to be seen by Respondent urgently and the regularly scheduled appointment in over two weeks was too long to wait. Patient A's mother indicated that Patient A was expressing thoughts of suicidal ideation and self-harm, which were immediately conveyed to Respondent. Respondent then queried the therapist which medications Patient A was currently taking, and the therapist soon after provided this information to Respondent. Instead of scheduling an urgent appointment, Respondent refused to see Patient A and stated the reason was due to Patient A's mother not following the recommended medication instructions provided by Respondent.

17. A Shields licensed clinical social worker (LCSW) intervened and informed Respondent that the treatment team would see Patient A later the same day in order to conduct a safety risk assessment and asked Respondent to be present for this appointment to assist in the safety risk assessment and provided medication instructions. Just prior to the appointment with Patient A, Respondent was again asked by the LCSW if she would be able to join the virtual appointment. Respondent refused to join the appointment with Patient A.

18. Patient A's therapist conducted the safety risk assessment on his own during the appointment. The therapist conducted a safety plan with Patient A's older sister and instructed her to call the Los Angeles Police Department (LAPD).[2] Patient A admitted an actual suicide attempt to the therapist. LAPD officers arrived at Patient A's residence while the therapist was on speakerphone.

[2] Patient A's mother was bedside with her sick mother (Patient A's grandmother) at the hospital during Patient A's safety crisis. Patient A's grandmother soon after passed away.

Patient A told LAPD officers that he wanted to hurt and kill himself rather than going to school. The therapist completed a safety plan to meet with Patient A and his mother both the same day and the following day.

19. On or about May 12, 2022, Shields terminated Respondent's employment. Respondent was advised that she was prohibited from contacting any patients of Shields. However, Respondent continued to prescribe medications to approximately 15-20 patients of Shields for approximately three months following her termination. Moreover, not only did Respondent no longer have a treatment relationship with these former patients, she also did not document this patient care as she no longer had access to Shields patient charts. On or about August 12, 2022, Respondent informed Shields about her continued prescribing to her former patients following her termination. Respondent was again advised to immediately cease and desist contact with all Shields patients.

20. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent, including but not limited to the following:

a) Respondent failed to conduct a suicide risk assessment as part of the initial psychiatric evaluation, during the course of treatment, and/or at the time of a safety crisis for Patient A; and

b) Respondent continued to treat former patients by prescribing medications following her termination from Shields, even though she no longer had a treatment relationship with these patients and did not document these treatments.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts, as more particularly alleged in paragraphs 9 through 20, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

///

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

22. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records, as more particularly alleged in paragraphs 9 through 20, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 168614, issued to Respondent Kwi Yun Cassie Yu, M.D.;

2. Revoking, suspending or denying approval of Respondent Kwi Yun Cassie Yu, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Kwi Yun Cassie Yu, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: FEB 0 6 2025

for

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2024604512
Accusation - Medical Board.docx