**NURSING COMPLAINT FORM**

# DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HEALTH PROFESSIONS LICENSURE
OFFICE OF PUBLIC PROTECTION
TEL (617) 973-0865 FAX (617) 973-0985 TTY (617) 973-0988
http://www.mass.gov/dph/boards

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**DPH USE ONLY:**
Entered into Database (date) ____/____/____ Complaint # _____ Initials ____

**Please complete this form as fully as possible. Please TYPE or WRITE LEGIBLY in ink.**

**COMPLAINANT**

☐Mr. ☐Mrs. ☒Ms. Burgess (Your Last Name) Jessica (Your First Name) redacted (Patient's Name (if different)) (Patient's Age)

Your Business Name (if applicable): Barnstable County Sheriff's Office

Business Address: 6000 Sheriffs Place (Street) Bourne (City) MA (State) 02532 (Zip)

Complainant Address: same (Street) (City) (State) (Zip)

Patient's Address (if different): same (Street) (City) (State) (Zip)

Your Primary Phone number: (508) 563-4442 Your Secondary Phone number: redacted Your Email: jburgess@bcsheriff.net

**LICENSEE**

☐ REGISTERED NURSE ☒ LICENSED PRACTICAL NURSE ☐ ADVANCED PRACTICE NURSE

Kozak (Licensee's Last Name) Peter (Licensee's First Name) LN66531 (Lic # (if known))

Business Name: Barnstable County Sheriff's Office Phone #: 508-563-4416

Business Address: 6000 Sheriffs Place (Street) Bourne (City) MA (State) 02532 (Zip)

**COMPLAINT DESCRIPTION**

DATE(S) OF INCIDENT(S): 5/23/14 + prior incidents

DETAILS OF COMPLAINT: Clearly describe the incident(s) leading up to your complaint. If applicable, **attach copies** of documents such as: witness statements, medical records, copies of prescriptions, photographs etc. that support your statements. PLEASE SEND COPIES; originals will not be returned to you. Attach extra paper as needed to complete this section.

Since I have worked as the Assistant Director of Health Svc at the Barnstable County Sheriff's office (3/15) I have had concerns about Nurse Kozak's abilities to provide safe patient care. Documentation will show incompetence in ability to identify emergency equipment, operate emergency equipment, and administer emergency medications when indicated.

Specifically, on 5/23/14, Nurse Kozak failed

**Continue on next page if needed** ➡

DESCRIPTION CONT.

**Details of Complaint continued**

to administer Narcan to an overdosed inmate. The inmate, [redacted] died as a result of the overdose.

Nurse Kozak's employment was terminated. We felt obligation to report to Nursing Board our concerns over his competency/safety.

COMPLAINT DETAILS

Have you discussed this matter with the licensee, the licensee's office or facility? ☒ yes ☐ no

If yes, name and phone number of person contacted: _____

Date of contact: _____ How was contact made? (phone, e-mail, letter, in person) _____

Result of contact: _____

If there are **witnesses** to your complaint, please provide witness name(s) and telephone number(s) (if applicable)

Dr. Steven Descoteaux [redacted] Supt. John Rogorzenski [redacted]

**Have you filed this complaint with any other state or federal agencies?** ☐ yes ☒ no If yes, explain _____

If resolution of this complaint requires it, **are you willing to testify** in person regarding this matter at a formal hearing?

☒ Yes, I am willing. ☐ No, I am not willing.

Only if required

**AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT**

**My signature on this form, or photocopy thereof, authorizes the Department of Public Health Division of Health Professions Licensure to: (1) receive copies of all my health records relating to my complaint; (2) to share the complaint and all records collected by the Division of Health Professions Licensure during the investigation of my complaint with the licensee for the licensee's use in responding to the allegations in this complaint; and (3) to refer my complaint to other regulatory and/or law enforcement authorities for appropriate action.**

**I understand that all complaints are investigated to determine their factual basis.**

**The act of filing a complaint and its receipt and/or investigation by DPH does not mean that disciplinary action will be taken against the licensee.**

**I hereby declare that I am at least 18 years old and affirm under penalties of perjury that the information provided in connection with the foregoing complaint is true and correct to the best of my knowledge, information and belief.**

Susan Burgess MSN, RN — 7/24/14

**Signature of** — **Date**

☒ **Patient or**

☐ **Legal Representative, or**
(attach documentation)

☒ **Complainant**

**Mail this form to:**
Department of Public Health
DHPL Office of Public Protection
239 Causeway Street, 5th Floor
Boston, MA 02114