Reckless indifference and failure to provide even basic mental health care result in patient's tragic suicide

Care center was unlicensed, unqualified, and not staffed to care for patients at risk for harm to themselves

Bob Green (not his real name) was a young, successful businessman living and working in South Florida. From a young age, Bob and his family recognized that Bob suffered from severe depression, anxiety, and obsessive compulsive disorder. In order to treat his illnesses, Bob met with psychiatrists, counselors, and took prescription medication for over half his life. When Bob was undergoing counseling and being properly treated, Bob flourished in both his professional and private life.

In early 2007, Bob and his wife, Carol (not her real name), had just welcomed the arrival of their newborn son, Bobby, Jr. However, in the months preceding their son's arrival, Bob's illness consumed him. His depression and anxieties became so severe that Bob resorted to using illicit substances to combat his illness. A few months after the birth of his son, Bob's depression and anxiety overcame him and he attempted suicide. He was rescued just in time and taken to a local hospital emergency room for treatment. The next day, he was transferred to a local psychiatric unit for further care. Just two days later, the psychiatric unit discharged Bob, allowing him to go home. The discharge was premature in the opinion of Bob's wife and other relatives.

Knowing that her husband was not of sound mind and that she could not take care of both her baby and seriously ill husband, Carol and her mother-in-law set about to find a protective alternative residence for Bob. Their research settled on XYZ Care Center (not its real name). XYZ convinced Carol that it was capable and qualified to treat Bob's substance abuse and mental health issues. Bob was admitted to their care.

Upon admission, Bob was not properly screened, nor was he evaluated by a physician or seen by a psychiatrist. His antidepressant medication was changed over the phone without the doctor at XYZ having ever evaluated Bob. In fact, during his six days at XYZ, Bob was seen only once in a brief visit with a doctor that lasted approximately 10 to 15 minutes. Adding fuel to the fire, the staff even recognized that Bob was displaying signs of hopelessness and helplessness during his time at the facility, yet no one notified the doctor or asked for further evaluation. Bob was allowed to wander off the premises of XYZ, unattended, in a state of despair and abandonment. On July 5, 2007, Bob took his own life while a patient at XYZ.

Carol Green asked SDSBS attorneys **Chris Searcy**, **Darryl Lewis**, and **Adam Hecht** to represent her and investigate whether her husband received appropriate care and treatment. What was revealed during the investigation of this case was that Bob was a dual-diagnosed patient, in an active phase of withdrawal, with high risk factors for suicide. He had exhibited active suicidal ideation and was considered to be at significant risk of harm to himself and others and should never have been admitted to XYZ. It was not until after Bob's death that Carol learned that XYZ was not licensed, not qualified, and not staffed to accept and treat patients such as her husband.

Plaintiff's attorneys sought the assistance of experts in the field of psychiatry to determine whether Bob received standard care to protect his safety. It was revealed by experts in the field of psychiatry that basic rules and standards were not followed. It was pointed out that mental disorders are one of the leading causes of death in the United States and patients with such illnesses need to be treated no differently than any other patient who has a serious injury or illness. It was further explained by experts in the field that the conduct by the doctor and staff at XYZ was so violative of the basic rules to protect Bob's safety that it rose to a reckless indifference.

In the investigation, plaintiff's attorneys also sought the expertise of a nationally revered toxicologist. They learned that changing Bob's antidepressants actually increased his depression and suicidal ideations which ultimately led to Bob taking his own life.

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In addition, attorneys also asked a highly qualified psychiatric nurse to review all the policies and procedures that governed the XYZ facility to determine if appropriate nursing care was followed in this case. It was concluded that not only did XYZ violate their own internal policies and procedures when they accepted Bob as a patient, they also violated Florida nursing standards for failing to appropriately provide basic and standard treatment for a patient in Bob's condition.

After two weeks of trial, the parties reached a confidential settlement which will enable Carol and Bobby, Jr., to move on with their lives. ◆