

# Mentally Disabled Young Man Sent to Jail By Hospital Staff With Tragic Results

## Hospital staff conspired to get rid of patient sent to them for medical aid

John Smith (not his real name) had a very hard life. As a young child, he suffered a head injury that permanently damaged his brain, causing severe developmental retardation and epileptic seizures. Seizures are sudden surges of electrical activity in the brain that usually affect how a person thinks or feels for a short time. Sufferers may become unaware of what is going on around them, or may have convulsions and loss of body control. Typically, they are disoriented and have little control over emotions or behavior. One of John's regular medications was Klonopin, used to minimize seizures and relieve anxiety. With medication and family support, John was able to perform the basic functions of daily life, such as brushing his teeth, preparing lunch, writing simplistic words and sentences in both English and Spanish, and playing chess. He had an interest in life around him. Overall, he managed, along with his family, to get through each day.



**Following a family disturbance, a 20-year-old mentally disabled man was taken by police to a nearby hospital for care and restraint under Florida's Baker Act. Instead of providing care, the hospital staff conspired to have him removed from their facility because of repeated past difficulties with him. He was then sent to jail, without his medication or medical records, where he was brutally beaten and suffered further brain damage.**

John's father, James Smith, stood by his son, caring for him and loving him, using the patience, understanding, and affection required of parents of special needs children. Caring for a special needs child can be exhausting and draining, as well as rewarding. On occasion, John would lose control of his behavior and act out, sometimes violently. The situations were not driven by malice or spite, but by John's inability to control his emotions. When John turned 18 years of age, James, knowing that John would never be able to live a normal life on his own, asked authorities to find John mentally incompetent and to name James as John's legal guardian. In 2003, James, John, John's sister Betty, and the children's grandfather Edward, were living together in south Florida. At the end of that year, John's difficult life took a decided and tragic turn for the worse.

On December 17, 2003, 20-year-old John had a violent outburst directed toward his family. John's father, James, recognizing the need to protect the family, called the local police. John was delusional, combative, demanding, hyperactive, and uncooperative. He was experiencing auditory hallucinations. The police recognized immediately that John was incompetent and unable to deal with authority. Instead of taking John to jail, the police decided to take John to the nearest "Baker Act" receiving facility, a nearby local medical center.

The purpose of Florida's Baker Act, passed to recognize and meet the needs of the mentally handicapped people in our society, is to provide a safe haven for people at risk for harming themselves or others. Dignity and human rights are guaranteed for people admitted to mental health facilities under the Act. A receiving facility under the Baker Act is designated by the State and is required to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and short-term treatment. Jail is not an approved Baker Act receiving facility.

Supreme Court Justice William J. Brennan, Jr. once said, "Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment." Society's myths and fears can be just as damaging, or more so, as any physical, mental, or emotional handicap suffered by the patient.

Dr. Jones (not his real name) was the administrative head of psychiatric services at the medical center. Nurse Adams (not her real name) was employed by the medical center and on duty December 18, the morning after the police brought John into the facility. That morning, Dr. Jones conducted a face-to-face evaluation and found that John was incapable of making his own decisions, in need of care and treatment, and should

be admitted as a Baker Act patient. Dr. Jones estimated that John would be admitted for one week. John was also placed under suicide watch.

Behind the scenes, however, personnel in the medical center were already orchestrating rejection of John in an effort to avoid the medical center's obligations under the Baker Act. This was, in fact, not the first time the hospital had tried to reject him from its care. John had been to the same hospital several times before and, like many mentally handicapped persons, he was not an easy patient. A week earlier, on December 9, John was admitted to the same medical center experiencing seizures. During that visit, he allegedly struck a nurse. Following that incident, on December 11 the medical facility tried to get John transferred to a larger hospital in the community. That hospital would not have accepted John if he was already admitted as a patient of the medical center. To make the transfer work, medical center staff prepared a report intentionally omitting the fact that John's transfer was being made by the medical center. In addition, the medical center staff told the police to delete that fact from their own reports of the transfer.

On the morning after John's next visit to the medical center, December 18, Nurse Adams recognized John and told Dr. Jones, "He's here." Medical center personnel renewed their earlier efforts to remove John from their facility, and Sgt. Charles, an off-duty police officer working for the medical center, suggested the medical center charge John with battery for striking Nurse Adams during the encounter one week earlier. The center's staff decided to press charges. John was then discharged into the custody of the police and taken to jail. The medical center records noted, "Discharged to jail."

John was not allowed to take his medications with him. The jail report did not include John's medical records, nor was there any mention of his mental limitations. During his short incarceration, mentally challenged John Smith was so severely beaten by other inmates that he suffered head trauma and fractures of the bones around his left eye. He was found in the corner of his cell having an epileptic seizure. John now suffers even greater brain damage than he had before the incident, and can no longer perform the basic functions he had been able to master earlier. He is no longer a candidate for supervised work programs and will, instead, need 24-hour care.

James Smith, John's father and legal guardian, contacted local attorney Ted Fournaris. Mr. Fournaris prepared the entire case and filed an action in court to hold the medical center and its agents responsible for wrongfully denying John Smith the rights and protections he was entitled to under Florida law, and for forcing him, defenseless, into a savage environment where he was then severely injured. Mr. Fournaris asked SDSBS attorneys **Chris Searcy** and **Brian Denney** to assist in trial.

In an effort to support the medical center's allegation that John assaulted center personnel on December 9, Nurse Adams stated that John jumped on top of her, knocked her to the ground, and struck her several times in the face. John then turned and struck an attending physician, Dr. Michaels (not her real name), several times in the face. The medical center personnel also alleged that a "Code Gray" alert was called. Code Gray is a procedure used by such medical centers when there is an incident such as an assault. A Code Gray Team rushes to the scene, assesses the situation, and determines a proper response. They are accompanied by security personnel.

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During discovery, the medical center was asked to provide copies of the Code Gray Team's report and the security report, to provide copies of surveillance camera film for the day of the incident, and to provide the identification of Code Gray and security team members involved in the incident. The medical center did not provide the information. The medical center's risk management department had not even investigated the allegations of assault on Dr. Michaels and Nurse Adams. In fact, Dr. Michaels later testified that although John had hit her, she had sustained no injuries and had continued working. The security report for December 9 (filed two days later on December 11 by Sgt. Charles, who was not on duty on the 9) stated "no injuries reported." Dr. Jones' report for December 10 stated that John was well-behaved.

The medical center had a responsibility as a Baker Act receiving facility to care for John Smith and to ensure that he was protected. The center had alternatives that could have been used in responding to a belligerent and agitated patient, including physical restraints and medications. Instead, medical center personnel recklessly and deliberately discharged the patient into police custody knowing full well that he would be jailed without necessary medications and without care and treatment. Mr. Fournaris filed an action on behalf of John Smith and his family, charging negligent and wrongful care by the medical center and the personnel involved in the incident. The case went to trial. Shortly after trial began, a confidential settlement was reached. ■