Woman commits suicide just hours after being released from Baker Act hospital admittance

The woman was brought to an emergency room and Baker Acted after attempting to commit suicide by overdosing on sedatives.

Tragedy followed efforts to protect a patient under the Baker Act. The hospital staff failed to follow evaluation procedures. The Florida Baker Act allows doctors, mental health professionals, judges, and law enforcement to commit a person (voluntarily or involuntarily) to a mental health treatment center for up to 72 hours if they display certain violent or suicidal signs of mental illness. The purpose of the Act is to allow time for an evaluation and de-escalation of a crisis to protect vulnerable people from harm. It is imperative that facilities that receive Baker Act patients follow procedures to ensure these individuals are protected.

In February 2020, Kate Doe (not her real name), a vibrant 51-year-old woman, was brought to a Florida hospital emergency room and Baker Acted after an attempt to commit suicide by overdosing on sedatives. After Kate was admitted, nurses noted that she appeared to be at risk for physical injury, medication misuse, and suicide. Their nursing care plan was limited. There was no nursing narrative or behavioral assessment and a Suicide Risk Assessment Screening was not performed.

Kate reportedly was consulted by a psychiatrist. That consultation was completed and documented at the very time the nursing staff had reported that Kate had been asleep. The psychiatrist did not draft his consultation with his own review of Kate's history and physical intake. Instead, he copied and pasted the history and physical intake that had been written by the emergency room doctor just a few hours earlier. The psychiatrist's consultation included comments Kate made to the emergency room doctor earlier that she had "made a mistake." The psychiatrist's consultation document indicates that he had conducted his own examination, finding that Kate exhibited a "roller-coaster mood," disrupted sleep patterns, and poor insight and judgment. He also noted that she had been under psychiatric care and had not been taking her medications.

Despite the emergency room doctor's evaluation information and very clear warning signs of risks, the psychiatrist indicated that Kate could have the Baker Act restriction lifted because "she doesn't currently meet criteria, and there are other less restrictive treatment options." Among those options, the psychiatrist noted, was that Kate had an outpatient psychiatrist as well as community support – information he never verified. The psychiatrist concluded his notes by stating that he would be signing off on the case.

At 1:00 p.m., before the psychiatrist signed his consultation document, he signed a form releasing Kate from the involuntary status of her Baker Act admission. On the form, he checked that Kate had met the criteria for release because she had not refused placement in the Baker Act facility, and because there were "less restrictive treatment alternatives" for her condition. The alternatives, according to the psychiatrist, were that Kate's doctor believed that Kate was "future-oriented and regretted taking the overdose." At 2:51 p.m., with no further evaluations, the hospital ordered Kate discharged to her home, the same place where she had just tried to take her life. Her only instruction was to follow up with her primary care physician within a week. About 3:00 p.m., a hospital employee made a note that Kate was "medically clear and Baker Act lifted." He added, "Patient declines any referrals for [mental health/substance abuse] services," and simply encouraged Kate to call 211 or the suicide hotline in case of crisis.

Although the psychiatrist had noted that his reason for the Baker Act release was because he felt outpatient treatment was the better alternative, he neither discussed Kate's discharge plans nor took any steps to assure she would transition into a safe mental health environment. To the contrary, Kate had declined any such referrals as she was still in an extremely fragile emotional state. Kate was discharged home about 5:30 p.m. with no nursing evaluation ever performed and no instruction provided for follow-up psychiatric care.

The hospital presents itself as "home to a full-service, inpatient behavioral health unit [that is] a Baker Act receiving facility and provide[s] adult psychiatric care to people who need it most. Our patients begin their mental health treatment in an intensive, medically monitored environment." During her brief hospital stay, the psychiatrist and the hospital initiated no mental health treatment for Kate, let alone delivered such treatment in an "intensive, medically monitored environment." ***(Continued on page twelve.)***

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(Continued from page three.)

The psychiatrist and the hospital obtained no records of Kate's prior medical and psychological care, sought no information from any collateral sources, and isolated Kate from any contact with her family while hospitalized. Without initiating any follow-up care and without any treatment plan, she was then released from the hospital into the same emotionally-charged environment that had served as the acute trigger for her suicide attempt the day before. Within hours of that release, Kate would be dead.

With no support system and no treatment in place for stabilizing her acute mental health condition, Kate tragically ended her life just hours after being sent out of the hospital where the physician who had initiated her Baker Act admission had pointed out the substantial likelihood that Kate would cause serious harm to herself without care or treatment. Kate's surviving family member reached out to attorney **Brian Denney** and asked for help. Mr. Denney instituted proceedings to hold the hospital and the physician accountable. The case was settled for a confidential amount. ◆

988
SUICIDE & CRISIS LIFELINE

VETERANS CRISIS LINE
Dial 988
Then press 1 or text 838255

CRISIS TEXT LINE
(text HELLO to 741741)

211
HELPLINE AND CRISIS HOTLINE
(PB and Treasure Coast)

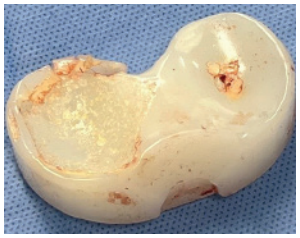
800-273-8255 (talk)
NATIONAL SUICIDE PREVENTION LIFELINE

Exactech Medical Device Update

A lot has happened since we last wrote about the Exactech litigation. Exactech, a medical device company based in Gainesville, Florida, produces a variety of surgical instruments and software but has specialized in orthopedic implant devices for joint replacement surgery – hip, knee, and ankle. Over the years, it has focused its sales efforts within Florida. As a result, Florida has become "ground zero" for litigation involving the requirement of the company to recall these devices due to oxidation, degradation, and delamination of the polyethylene components in the implants. Implant patients were experiencing a high rate of revision surgery necessary to avoid the danger and pain of joint failure. The company has faced litigation for many years on several different issues. The most recent recall involves its production of GXL hip liners.

Since the beginning of this year, many cases have been filed in the Eighth Judicial Circuit Court, Alachua County, Florida. Recently, Judge Donna Keim ordered all cases to be coordinated before her. She conducted several hearings and scheduled monthly case management conferences. There is currently a GXL hip liner case scheduled for trial in 2023. Despite Exactech's best efforts to get that case continued, Judge Keim refused to move the trial date. As the cases were coordinated, Judge Keim appointed leadership counsel similar to what is often used in federal multi-district litigation proceedings. Searcy Denney partner **Cal Warriner** was appointed co-lead counsel. A protective order has been entered, and Exactech is now producing documents which are currently being reviewed.

The more our attorneys study Exactech's recalled devices, the more we are convinced the products are defective... leading to oxidation and degradation of the plastic in the body, known as "poly wear disease".



In September 2022, we appeared before the Judicial Panel on Multi-District Litigation (JPML) in St. Louis, Missouri. Plaintiffs argued for coordination in the Eastern District of New York. Exactech agreed to coordination but wanted the cases coordinated in either Louisiana or South Carolina. This drew laughter from the panel since Exactech is based in Florida and took the position that a venue in Florida was inconvenient. Following the hearing, the JPML ordered coordination before Judge Nicholas Garaufis in the Eastern District of New York. Judge Garaufis scheduled the first case management hearing for November 16, 2022, and has indicated interest in quickly appointing leadership.

The more our attorneys study Exactech's recalled devices, the more we are convinced the products are defective. The design and manufacturing of the polyethylene (plastic) spacers in both the hip and knee implants is bad. Poor design and packaging lead to oxidation and degradation of the plastic in the body. Known as "poly wear disease," plastic particulates cause bone and soft tissue to die. Patients frequently experience swelling and pain in the affected joint. The only option is to remove and replace the device.

Our referral partners have been sending us a steady stream of cases. We now have hundreds of Exactech clients. We are committed to doing our part to make the litigation successful. Please contact us if you have any questions regarding this litigation. ◆