Psychiatric Care: No Discharge Planning, Hospital Liable For Homeless Veteran's Suicide.

The fifty-six year-old patient was admitted to the psychiatric service at the VA hospital following an overdose of heroin and cocaine, stating that he was having suicidal and homicidal thoughts. He began treatment for alcoholism and paranoid schizophrenia.

He was a combat veteran who had picked up addictions to alcohol and drugs in Vietnam which plagued him the rest of his life.

His medical history included chronic drug and alcohol abuse, major depression, diabetes, hypertension, a stroke and prior suicide attempts.

His current social history at the time of admission was that he was unemployed and homeless but was receiving a $900 monthly disability check.

For more than six months the patient received inpatient psychiatric and substance-abuse treatment at the facility, then was phased into a transitional residential setting where he was allowed to leave the hospital on passes in anticipation of discharge into the community.

After six months in the transitional setting he was abruptly discharged because it was felt he no longer fit the criteria for acute inpatient care.

The patient was put out on the street with a one-month supply of his medication and his personal belongings.

He had been in a long-term inpatient program for alcoholism and mental illness.

He returned to the emergency room intoxicated two hours later and asked to be re-admitted. He was told to go find a shelter.

He just sat in the waiting area for seven hours until a security guard found him unconscious slumped over in the chair.

He had committed suicide by ingesting the entire one-month supply of his medication he was given earlier that day.

He was disabled, unemployed and homeless, but his adult children are still entitled to compensation.

UNITED STATES DISTRICT COURT
ILLINOIS
December 10, 2008

Discharge Planning Found Inadequate

According to the record in the US District Court for the Northern District of Illinois, the hospital staff made no effort to find an appropriate community placement for the patient except for some phone calls to a niece which were not returned.

In support of the family's wrongful-death lawsuit, the court accepted expert medical testimony from a psychiatrist that the standard of care for treating a patient like the deceased requires securing a safe environment for the individual where the individual feels comfortable and cared for and has the opportunity to bond with other people.

Without the opportunity to transition directly into such an environment the individual would be expected to suffer anxiety and mental anguish.

Final Emergency Room Visit Was Below the Standard of Care

The family's psychiatric expert went on to state that an individual like the deceased would be expected to experience further feelings of rejection leading to high anxiety from being basically ignored when he went back to the hospital emergency department asking for help.

According to the expert, the patient's death by suicide was caused by the facility's failures, failing to secure a proper discharge placement for him and then ignoring his request for help when he returned the day of discharge. **McKinnis v. US, 2008 WL 5220504 (N.D. Ill., December 10, 2008).**