VIRGINIA:

IN THE CIRCUIT COURT FOR THE COUNTY OF BATH

ROBERT CREIGH DEEDS, ADMINISTRATOR OF THE ESTATE OF AUSTIN CREIGH DEEDS, DECEASED,

Plaintiff,

v.

Case No.

COMMONWEALTH OF VIRGINIA,

JURY TRIAL DEMANDED

Serve: Office of the Attorney General
900 E. Main Street
Richmond, VA 23219

ROCKBRIDGE AREA COMMUNITY SERVICES BOARD,

Serve: John D. Young, Executive Director
241 Greenhouse Road
Lexington, VA 24450

VALIDATE CASE PAPERS
RCPT : 15000002071
DATE : 11/19/15 TIME: 12:48
CASE : 017CL15000056-00
ACCT : DEEDS, ROBERT CREIGH
AMT. : $346.00

and

MICHAEL GENTRY,

Serve: 241 Greenhouse Road
Lexington, VA 24450

Defendants.

COMPLAINT

COMES NOW the Plaintiff, through counsel, and brings this action against the Defendants for wrongful death/negligence, wrongful death/gross negligence, and wrongful death/medical malpractice. Plaintiff seeks compensatory and punitive damages, attorney's fees and costs. In support of these claims, Plaintiff states as follows:

PARTIES

1. Plaintiff Robert Creigh Deeds ("Creigh") is the father of the Decedent, Austin Creigh Deeds ("Gus"), and is a resident of the Commonwealth of Virginia. On the 12th day of March, 2014 the Plaintiff qualified and was duly appointed as the Administrator of the Estate of Austin Creigh Deeds, Deceased, before the Clerk of the Circuit Court of Bath, Virginia, as shown and evidenced by the Certificate of Qualification, a copy of which is attached hereto, marked Exhibit "A" and made a part hereof. Creigh brings this action in his capacity as Administrator of the Estate of Austin Creigh Deeds.

2. The Commonwealth of Virginia Department of Behavioral Health and Developmental Services ("DBHDS") is a department administered by the Defendant Commonwealth of Virginia. DBHDS oversees the provision of emergency services for individuals in mental health crises in the Commonwealth of Virginia. The system is administered by forty community services boards ("CSBs") and/or behavioral health authorities, with guidance, direction and oversight from the DBHDS. DBHDS is responsible for overseeing the administration of the CSBs, and was responsible for providing oversight, guidance and direction to the Rockbridge Area Community Services Board ("RACSB"). DBHDS was also responsible for training and certifying Defendant Gentry at the RACSB. At all relevant times, the Commonwealth of Virginia's employees and/or agents were acting within the scope of their employment and/or agency with DBHDS and the Commonwealth of Virginia.

3. Defendant RACSB was established pursuant to Virginia Code § 37.2-500, and functions as the single point of entry into publicly funded mental health, developmental disabilities, and substance abuse services for individuals in the counties of Rockbridge and Bath,

and the cities of Lexington and Buena Vista. Defendant RACSB was responsible for training, supervising, and overseeing the actions of employees and/or agents of the RACSB, including but not limited to, Defendant Michael Gentry. At all relevant times, the Rockbridge Area Community Services Board's employees and/or agents were acting within the scope of their employment and/or agency with the Rockbridge Area Community Services Board.

4. Defendant Michael Gentry ("Gentry") is a resident of the Commonwealth of Virginia. At all relevant times, Gentry was employed as an evaluator/license eligible mental health professional, LMHP-E, with the Rockbridge Area Community Services Board, and was acting as an employee and/or agent of the RACSB. DBHDS was responsible for providing training and certification to Gentry. Gentry is alternatively sued in Counts I – III in his individual capacity. In Count III, Gentry is sued in his capacity as a health care provider recognized by the Commonwealth of Virginia to provide health care or professional services as an evaluator/mental health professional. Alternatively in Count III, it is alleged that Gentry is not a health care provider and that the provisions of § 8.01-581.15 do not apply.

NOTICE OF CLAIMS

5. Plaintiff has complied with the requirements of Virginia Code § 8.01-195.6 and 8.01-195.7. Plaintiff presented this claim to the Virginia Division of Risk Management. More than six months have passed since the date of the filing of the notice of claim, and Plaintiff now petitions this Court for redress.

VENUE

6. Venue is preferred in this Court pursuant to Virginia Code § 8.01-261(18)(a) as the acts and omissions occurred in the County of Bath.

FACTS

7. On February 28, 2012, the Office of the State Inspector General published Report No. 206-11, *Office of Inspector General Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment.* This report focused on the shortcomings in the state's system for providing emergency services for people in mental health crises in the Commonwealth of Virginia. The Report contained recommendations to alleviate and correct these shortcomings, and particularly highlighted the problems of failed temporary detention orders or "streeting" (the release of people who pose a threat to themselves or others because allegedly no psychiatric facility is available to them), ineffective medical screening and clearance processes for persons restrained for evaluation under emergency custody orders ("ECOs") and temporary detention orders ("TDOs"), and the failure to utilize state operated behavioral facilities as an available resource for individuals assessed as appropriate for inpatient level of care under a temporary detention order. The Report, prepared in the wake of the Virginia Tech tragedy, indicated that the Commonwealth of Virginia maintains a mental health system fragmented among state hospitals, CSBs, and jails. The report indicated a lack of accountability between the CSBs and the Commonwealth.

8. In this report, G. Douglas Bevelacqua, then Inspector General of Behavioral Health and Developmental Services, sounded the alarm over "streeting," and other shortcomings in the state's system of emergency services for those in mental health crises. The report included the following recommendations: tracking unexecuted TDOs; updating the *Medical Screening and Assessment Guidance Materials*; requiring a regional protocol between CSBs and state hospitals

to ensure that no one who meets the criteria for temporary detention is released; appointing someone from each region and the state central office to be responsible for intervening to find a bed when one cannot be found; and creation of a long-promised, web-based psychiatric bed registry.

9. DBHDS failed to implement these necessary changes, despite its knowledge of the significant dangers and consequences of the failure to do so.

10. On November 18, 2013, at 9:10 a.m., the RACSB Clinical Services Director received a call from Creigh, expressing grave concern about his son's (Gus's) behavior. RACSB was familiar with Creigh and Gus and Gus's mental health history, and was aware that Gus struggled with serious mental health issues, including but not limited to previous suicide attempts. Creigh had promised Gus he would not force Gus to be hospitalized again, but on November 18, 2013, based on Gus's recent and acute behavior, Creigh knew that Gus had to be hospitalized. Creigh communicated this to RACSB who stated that if Creigh obtained an ECO, then Gus would be hospitalized.

11. Creigh was advised to obtain an Emergency Custody Order ("ECO") and have local law enforcement transport Gus to the hospital for a preadmission evaluation. RACSB knew at that time that Gus would not go willingly, that he suffered from serious mental health issues, including previous suicide attempts, and that Gus needed to be hospitalized. Creigh traveled to the Bath County Sheriff's Office to petition the magistrate for an ECO.

12. At 11:23 a.m. an Alleghany County Magistrate issued an ECO for Gus, and faxed it to the Bath County Sheriff's Department for assignment and execution. The ECO directed the Bath County Sheriff to transport Gus to Bath Community Hospital for evaluation by a person

designated by the community services board who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by DBHDS in order to assess the need for hospitalization or treatment. The ECO provided that upon completion of the evaluation, the evaluator must promptly report the results of the evaluation to the appropriate judicial officer. The ECO directs the evaluator to conduct the medical evaluation or treatment **immediately** in accordance with state and federal law. (Emphasis added). The portion of the form indicating that the evaluation was completed is missing the time that the evaluation was completed. Gentry is listed as the ES Clinician completing the evaluation. There is no indication on the ECO that Gentry reported the results of the evaluation to the appropriate judicial officer.

13. At 12:26 p.m., the ECO was executed (served) by a Bath County Sheriff's Deputy who took Gus into custody and transported him to Bath Community Hospital ("BCH"). At this point, RACSB knew of Gus's recent behavior, the resulting extreme circumstances facing Gus and Creigh, Gus's previous mental health struggles, including but not limited to previous suicide attempts, and Gus's resistance to treatment. Pursuant to Virginia Code § 37.2-808, after a person for whom an ECO is issued has been taken into custody and transported to a convenient location, an evaluation **must be conducted** to determine whether the person meets the criteria for temporary detention pursuant to Virginia Code § 37.2-809, and to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board ("CSB") who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by DBHDS.

14. Pursuant to Virginia Code § 37.2-809, a person meets the criteria for temporary

detention if it appears that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.

15. The ECO commenced when served and would expire four hours later, at 4:26 p.m. It took approximately 30 minutes to transport Gus to BCH for evaluation. At 12:55 p.m., medical clearance of Gus began with an examination by the BCH nursing staff. At 1:25 p.m. RACSB called BCH about Gus, advising that someone would be coming. At 1:40 p.m., Creigh spoke with the RACSB emergency services supervisor to report that Gus was at BCH, but no one was dispatched to come from RACSB until later. The emergency services supervisor then assigned the CSB evaluator, Gentry. Gentry had been certified as an evaluator/license eligible mental health professional by DBHDS. Gentry was familiar with Gus - he knew and/or should have known of Gus's history of mental illness and struggles including previous suicide attempts. Gentry also knew, or should have known, of Gus's resistance to treatment, including that Gus had previously missed appointments with RACSB, and failed to return RACSB's phone calls. Based on this information, Gentry was acutely aware of the need for hospitalization for Gus to address the severe recent and acute behavioral changes, indicative of the severity of his mental health condition.

16. Gentry arrived at BCH at 3:10 p.m. He initially met with the nursing staff and

attending emergency room physician. At 3:30, Gentry met with Creigh, and Creigh provided a history of Gus's severe recent and acute behavior and thought processes. Creigh conveyed the urgency of the situation to Gentry, and indicated that Gus had been engaged in destructive behavior and that Creigh believed that Gus was a danger to himself and others. Gentry was already familiar, or should have been familiar, with Gus and aware of Gus's history of mental illness as well as the severe recent and worsening of his condition. At 3:45 p.m., the face-to-face preadmission evaluation between the CSB evaluator and Gus began, 3 hours and 19 minutes after the issuance of the ECO, which was only good for four hours. In five minutes with Gus in this face-to-face evaluation, Gentry concluded that Gus met the criteria for hospitalization pursuant to Virginia Code § 37.2-809.

17. The facts alleged herein demonstrate the known and disregarded consequences of the defendants' failure to have implemented the clear directions of the 2012 Inspector General's report.

18. Pursuant to Virginia Code § 37.2-809, an employee or a designee of the local community services board **shall determine** the facility of temporary detention for all individuals detained pursuant to this section. Accordingly, Gentry was required to determine the facility of temporary detention for Gus.

19. At 3:50 p.m., Gentry learned that two private hospitals had reached their staffed capacity and were unable to accept a temporary detention order ("TDO") admission. At 4:01 p.m., the local magistrate extended the ECO for the one permissible two hour period, until 6:26 p.m., leaving defendant Gentry in excess of two and half hours to find a bed for Gus. At 4:21 p.m., Gentry faxed a completed Preadmission Screening Report to a private psychiatric hospital.

At 4:45 p.m., Gentry informed Creigh and Gus that further evaluation was recommended and that a temporary detention order ("TDO") would be pursued. In stating that Gus met the criteria for temporary detention, Gentry had determined that Gus had a mental illness and there was a substantial likelihood that as a result of mental illness Gus would, in the near future cause serious physical harm to himself or others, that Gus was in need of hospitalization or treatment, and that Gus would not voluntarily seek the treatment.

20. At 5:24 p.m., Gus's mother, Pamela Miller Mayhew, spoke with Gentry by telephone. Pam begged Gentry to have Gus hospitalized. Pam told Gentry that Gus was in a very bad place. She told Gentry that Gus would kill Creigh and himself if he was not hospitalized. Gentry responded that Gus was a responsible adult, that he had missed his appointments with the RACSB, that Gentry did not know what more he could do, and that if Gus did kill Creigh, Gus would be institutionalized for a very long time. Pam pleaded with Gentry not to release Gus, and told Gentry that it would be too late in the morning, because Gus was so angry with Creigh that he would hurt Creigh or himself. Pam also told Gentry that Gus was suicidal. Gentry brushed off Pam's pleas. He further failed to include this clinically significant information regarding Pam's warnings of violence on the Preadmission Screening Report, which was sent to potential placement facilities.

21. Gentry had a contact list used by RACSB evaluators which included 26 private inpatient facilities, five crisis stabilization units, and three state facilities. Gentry claimed to have contacted 10 facilities; however, phone records reflect that Gentry contacted only seven facilities. Two of the remaining three facilities Gentry claims to have contacted had beds available on that day. Three state facilities, and nineteen other private inpatient facilities, were

never contacted by Gentry. Western State Hospital was nearby, and it was never contacted. Western State did have a bed available for Gus.

22. Gentry contacted Rockingham Memorial Hospital ("RMH") at 5:57 p.m., but did not connect with RMH's psychiatric admissions team. He faxed the Preadmission Screening Report to RMH twice, but did not follow up with the hospital. The fax number for RMH was incorrectly recorded on the contact information sheet Gentry used, so RMH never received the two faxes. RMH did have a bed available for Gus.

23. The two-hour extension for the ECO expired at 6:26 p.m. Notwithstanding multiple available beds and Pam's dire warnings of violence, Gentry failed to secure a psychiatric bed for Gus. Gentry knew that Gus was a danger to himself and others and was deeply resistant to hospitalization. Gentry's own assessment was that Gus met the criteria for temporary detention, and therefore Gentry knew that Gus should not be sent home with Creigh. Gentry knew that Pam had begged him not to send Gus home with Creigh; had advised him that if he sent Gus home, Gus would commit violence against himself or Creigh; and had warned Gentry that it would be too late if Gentry did not act immediately. Nevertheless, Gentry failed to find a bed for Gus and released Gus into Creigh's custody. Furthermore, Gentry failed to properly establish a safety plan with Gus and Creigh prior to sending Gus home.

24. Virginia Code § 37.2-809(D) provides that an individual does not have to be under an ECO in order for a magistrate to issue a TDO. Gentry should have continued to search for a TDO bed after the ECO expired. Gentry failed to do so.

25. Gus returned to Creigh's home in Bath County, Virginia. The next morning, November 19, 2013, Gus violently assaulted Creigh, stabbing him thirteen times. Severely

injured, Creigh struggled and eventually escaped to get help. Gus then killed himself. Gus was of unsound mind at the time he committed suicide. Creigh was airlifted to a hospital in Charlottesville in critical condition. He was hospitalized for three days, suffering from severe injuries, including severed facial nerves; injuries to his right upper extremity resulting in loss of sensation; knife injuries to his right ear resulting in permanent deformity; and stab wounds which left deep multiple scars on his forehead, left cheek, and torso.

26. At the time of Gus's release, Gentry had made contact with only seven private facilities (not ten as stated in his report). He never contacted the three state hospitals or the other private facilities on the list. At least five area hospitals, including Rockingham Memorial Hospital and Western State Hospital, had beds available at the time that Gus was released by Gentry.

27. The Office of the State Inspector General conducted a Critical Incident Investigation into the events culminating in Gus's attack on Creigh and suicide. In alleging the claims contained herein, Plaintiff has relied in part on the facts as found by the Inspector General and published in the Critical Incident Investigation Report. Plaintiff reserves the right to develop additional facts in these regards through discovery. The Investigation revealed that:

> 1. DBHDS failed to implement the recommendations of Report No. 206-11, *OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment* dated February 28, 2012.
>
> 2. If a web-based psychiatric bed registry had been available, as recommended in Report No. 206-11, the CSB evaluator may have been able to use his time more effectively and connect with one of the facilities that later reported having available beds that afternoon.
>
> 3. There was no coordination among CSBs, law enforcement and assessment facilities.

4. There were no standards of conduct for CSB evaluators. There were no statewide protocols to guide the actions of preadmission screeners or their supervisors when a person is about to be released who has been determined to meet the criteria for involuntary temporary detention.

28. Gus Deeds' violent acts and death could have been avoided if DBHDS had heeded the warnings in the February 28, 2012 report, and acted on the findings.

29. G. Douglas Bevelacqua concluded in his draft of the Critical Incident Report that DBHDS failed to take meaningful action to implement the Recommendations from the OIG's 2012 Report until after November 18, 2013, and that had DBHDS taken timely action on the 2012 Recommendations, it most likely would have produced a different outcome on November 18, 2013. This conclusion was removed from the Report before publication. Mr. Bevelacqua resigned from his position with the Office of the State Inspector General as Director, Behavioral Health and Developmental Services Division, effective March 1, 2014.

30. The Decedent's statutory beneficiaries pursuant to the Virginia Wrongful Death Act are Robert Creigh Deeds (father), Pamela Miller Mayhew (mother), Amanda Jane Deeds (sister), Rebecca Lewis Deeds (sister), and Suzannah Kemper Deeds (sister). The beneficiaries have suffered those losses pursuant to Virginia Code § 8.01-52, including but not limited to, severe mental anguish, sorrow and loss of the solace, society, companionship, comfort, guidance, kindly offices and advice of the decedent, as well as the loss of his company, counsel, and love; and have incurred reasonable medical and funeral expenses.

CAUSES OF ACTION

COUNT ONE - WRONGFUL DEATH/NEGLIGENCE

31. Plaintiff incorporates by reference herein the preceding paragraphs of this Complaint.

32. Defendant Commonwealth of Virginia has a duty to provide emergency services to

people in mental health crises in the Commonwealth. Defendant Commonwealth of Virginia has a duty to ensure that hospital beds are available for people who pose a danger to themselves and others within the Commonwealth. Defendant Commonwealth of Virginia had a duty to provide proper training to RACSB and Michael Gentry. Defendant Commonwealth of Virginia had a duty to provide emergency services and a psychiatric bed to Gus on November 18, 2013, as he was in mental health crisis. Defendant Commonwealth of Virginia had a duty to Gus on November 18, 2013 to provide a qualified and properly trained mental health evaluator, also.

33. The Commonwealth of Virginia breached its duties to Gus when it failed to provide emergency services and a psychiatric bed to Gus on November 18, 2013. The Commonwealth of Virginia breached its duties to provide emergency services to those in mental health crises, including Gus, when it failed to implement the policies and recommendations of the 2012 Inspector General report. The Commonwealth continued to maintain a mental health system fragmented among state hospitals, community services boards, and jails, with no oversight or accountability between the CSBs and the Commonwealth. DBHDS failed to promulgate guidelines and failed to properly oversee the administration of the CSBs. The Commonwealth of Virginia failed to provide proper training for its evaluators; failed to end the practice of "streeting;" failed to update the manual for assessment; failed to establish a regional protocol; and failed to create a web-based psychiatric bed registry. In these regards, the Commonwealth of Virginia breached its duties to Gus.

34. The Commonwealth's breach of the duties owed was a proximate cause of Gus's death.

35. Gentry, RACSB, and its supervisors/employees/and agents (collectively "RACSB"),

had a duty to provide emergency services to individuals in Bath County experiencing mental health crises. Gentry and RACSB had a duty to provide emergency services to Gus, an individual in mental health crisis in Bath County, on November 18, 2013. Gentry and RACSB had a duty to identify a temporary detention bed for Gus prior to the expiration of the ECO. The failure to identify a temporary detention bed presented a high risk of danger to Gus, his family and the public. Gentry and RACSB had a duty pursuant to the ECO to conduct the medical evaluation or treatment immediately in accordance with state and federal law, to assess the need for hospitalization or treatment and to promptly report the results of the evaluation to the appropriate judicial officer. Gentry and RACSB had a duty to properly establish a safety plan with Gus and Creigh prior to sending Gus home, and to continue looking for a TDO bed after the expiration of the ECO.

36. Gentry and RACSB breached their duties to Gus when they failed to provide Gus with the required mental health services within the statutory time frame by failing to identify a temporary detention bed prior to the expiration of the ECO and then releasing Gus. RACSB failed to develop specific protocol to guide or inform Gentry's actions as the ECO approached. RACSB failed to properly supervise Gentry's actions, and failed to have any protocol in place to receive notification when an ECO had been executed, even though RACSB was the sole provider of mental health services at the hospital, and its main office was a 70 minute drive away. Gentry and RACSB failed to assure that Gentry would arrive at BCH in a timely manner in order to provide the mental health services for Gus. Gentry and RACSB knew or should have known as early as 9:10 a.m. on November 18, 2013 that Gus would need to be hospitalized, that he was deeply resistant to voluntary treatment, that he had previously attempted suicide, that he

struggled with mental illness, and that he was a danger to himself and others that day. RACSB agreed with Creigh that Gus would be hospitalized, with the goal of long-term treatment and hospitalization. Gentry failed to contact three state hospitals and nineteen private hospitals in attempting to find a psychiatric bed for Gus. Gentry faxed information to an incorrect phone number, and failed to follow up regarding the facsimile transmission. RACSB failed to provide an evaluator with proper skills and training to accurately assess Gus's danger to himself and others. Gentry and RACSB failed to identify a temporary detention bed prior to the expiration of the ECO, despite the fact that there were multiple beds available. Gentry then released Gus, knowing that Gus met the criteria for temporary detention: Gus had a mental illness and was a danger to others and himself; there was a substantial likelihood that Gus would harm himself or others in the near future; he had previously attempted suicide; he suffered from mental illness; and his condition had not stabilized. Gentry disregarded the known information Pam provided to him-- that if released, Gus would commit violence and that the next morning would be "too late." Gentry failed to properly establish a safety plan with Gus and Creigh prior to sending Gus home, and failed to continue searching for a TDO bed after the ECO expired.

37. These actions of Gentry and RACSB were a direct and proximate cause of Gus's death. Less than fifteen hours after Gentry and RACSB failed to find a psychiatric bed for Gus and released him, despite their own determination and knowledge that he met the criteria for temporary detention, Gus violently attacked Creigh, stabbing him thirteen times. Gus then took his own life. Gus was of unsound mind at the time he committed suicide.

38. As a direct and proximate result of the Defendants' actions, Gus was released and experienced pain and suffering prior to his death; his estate has incurred medical and funeral

expenses due to the injury and death; and his beneficiaries have suffered, and will continue to suffer, sorrow, mental pain and suffering and the loss of Gus's companionship, love and comfort.

39. The acts of the Defendants as set forth above were willful, wanton, shocking, outrageous, and evince a conscious disregard for the safety of others, including but not limited to Gus, and offend generally accepted standards of decency, and as such, entitle Plaintiff to an award of punitive damages as to Defendant Gentry.

COUNT TWO - WRONGFUL DEATH/GROSS NEGLIGENCE

40. Plaintiff incorporates by reference the preceding paragraphs of this Complaint.

41. As previously set forth, Defendant Commonwealth of Virginia and/or its agents and/or employees failed to heed warnings and carry out recommendations of the 2012 Inspector General's report concerning the provision of emergency services to individuals in mental health crises in the Commonwealth of Virginia. The Commonwealth of Virginia was warned in 2012 that the failure to repair the mental health system would result in serious and fatal consequences to individuals requiring mental health services. However, the Commonwealth of Virginia continued to maintain a mental health system fragmented among state hospitals, community services boards, and jails, with no accountability and oversight between by CSBs and the Commonwealth. Despite knowledge of the dangers of releasing people who pose a threat to themselves or others because no psychiatric facility is found or available to them, the Commonwealth did not implement the policies and recommendations contained in its 2012 Report No. 206-11. The Commonwealth deliberately failed to act; these failures include but are not limited to: the failure to end the practice of "streeting;" the failure to update the Manual for Assessment in Psychiatric Cases; the failure to develop a regional protocol between community

services boards and state hospitals to ensure that no one who meets the criteria for temporary detention is released; the failure to develop a web-based psychiatric bed registry; the failure to coordinate CSBs, law enforcement and assessment facilities; the failure to provide standards of conduct for CSB evaluators; the failure to properly train CSB evaluators; and the failure to uncouple the bed search and the clinical evaluation.

42. Gentry, RACSB and its supervisors/employees/and agents (collectively "RACSB") failed to comply with their duty to provide emergency services to a person in their jurisdiction experiencing mental health crises, and to identify a temporary detention bed prior to the expiration of the extended ECO. Gentry and RACSB knew, or should have known, as early as 9:10 a.m. on November 18, 2013 that Gus would need to be hospitalized; that he was deeply resistant to voluntary treatment; that he struggled with mental illness, including prior suicide attempts; and that he was a danger to others and to himself that day. RACSB indicated to Creigh that if Creigh obtained an ECO, then Gus would be hospitalized with the goal of long term treatment and hospitalization. However, no action was taken by Gentry or RACSB at that time. As of 1:25 p.m., RACSB knew that Gus was at BCH, because RACSB contacted the hospital at that time and advised the hospital that someone would be coming. As of 1:40 p.m., Gentry and RACSB were again informed that Gus was at Bath County Hospital awaiting evaluation for temporary detention in a psychiatric facility. By the time Gentry and RACSB began the actual search for a bed it was 3:50 p.m. At that point, the original four hours for the ECO had almost expired, and Gentry and RACSB had just begun to search for a bed. Gentry and RACSB failed to establish ECO notification protocols with BCH and the Bath County Sheriff's Office, thus truncating the prescreening admission process and losing valuable time for finding a psychiatric

bed. The Magistrate extended the ECO for two hours. Even still, Gentry and RACSB failed to contact three state hospitals and nineteen private hospitals for a bed. Gentry faxed information to a number listed incorrectly on the RACSB contact sheet for Rockingham Memorial Hospital. Gentry failed to follow-up on the fax, and thus failed to secure the bed which was available for Gus at Rockingham Memorial Hospital. Gentry failed to secure a bed, of which many were available, for Gus in the six hour time frame. Gentry and RACSB were aware of the very serious risk associated with not hospitalizing Gus, and were aware that Gus had been engaged in destructive behavior and was a danger to himself and others. Nevertheless, in reckless disregard of this information, Gentry failed to contact three state hospitals and 19 private hospitals where beds were available. Gentry and RACSB released Gus, despite Pam's warning that if released Gus would commit violence; despite their own determination that Gus was not stabilized and needed treatment; and despite their assessment that Gus met the criteria for temporary detention, because he was a person with a mental illness who would, in the near future, cause serious harm to himself or others. Gentry brushed off and disregarded Pam's warning of violence. He responded that Gus was a responsible adult who had missed his appointments with RACSB, and that if Gus killed Creigh, Gus would be institutionalized for a long time. Gentry then sent Gus home with Creigh in direct disregard of the warning he had received. Furthermore, Gentry failed to properly establish a safety plan with Gus and Creigh prior to sending Gus home, and failed to continue searching for a TDO bed after the ECO expired.

43. The acts of the Defendants as set forth above were willful, wanton, shocking, outrageous, and amounted to a complete disregard and neglect of the health and safety of Gus, and as such, amount to gross negligence. Defendants acted with utter disregard of prudence

amounting to complete neglect of the safety of Gus. Their deliberate conduct demonstrated want of even scant care and amounts to the absence of slight diligence.

44. The gross negligence of the Defendants and their agents and/or employees in failing to fulfill their duties to Gus, was a direct and proximate cause of Gus's death. Less than fifteen hours after Gentry and RACSB failed to find a psychiatric bed for Gus and released him, despite their own determination and knowledge that he met the criteria for temporary detention, Gus violently attacked Creigh, stabbing him thirteen times. Gus then took his own life. Gus was of unsound mind at the time he committed suicide.

45. As a direct and proximate result of the Defendants' actions, Gus was released and experienced pain and suffering prior to his death; his estate has incurred medical and funeral expenses due to the injury and death; and his beneficiaries have suffered, and will continue to suffer, sorrow, mental pain and suffering, and the loss of Gus's companionship, love and comfort.

46. The acts of the Defendants as set forth above were willful, wanton, shocking, outrageous, and evince a conscious disregard for the safety of others, including but not limited to Gus, and offend generally accepted standards of decency, and as such, entitle Plaintiff to an award of punitive damages as to Defendant Gentry.

COUNT THREE - MEDICAL MALPRACTICE/WRONGFUL DEATH

(Against Defendants Gentry and RACSB)

47. Plaintiff incorporates by reference herein the preceding paragraphs of this Complaint.

48. Gus was under the care and treatment of the employees of RACSB from 12:26 p.m. until 6:26 p.m. on November 18, 2013. RACSB and its employees and/or agents, including but

not limited to Gentry, had a duty to provide Gus with mental health treatment and care in compliance with the standard of care existing in this Commonwealth.

49. Gentry had a duty to render that degree of knowledge, skill, diligence and care to Gus that is rendered by a reasonably prudent similar mental health professional in this Commonwealth.

50. Alternatively, Gentry is not a health care provider under Virginia Code § 8.01-581.15, and the provisions of Virginia Code § 8.01-581.15 do not apply to his conduct.

51. RACSB, Gentry and other agents and employees of RACSB (collectively "RACSB") breached said duties and violated the applicable standard of care. Gentry and RACSB failed to comply with their duty to provide emergency services to a person in their jurisdiction experiencing mental health crises, and to identify a temporary detention bed prior to the expiration of the extended ECO. Gentry and RACSB knew, or should have known, as early as 9:10 a.m. on November 18, 2013 that Gus would need to be hospitalized; that he was deeply resistant to voluntary treatment; that he struggled with mental illness, including prior suicide attempts; and that he was a danger to others and to himself that day. RACSB indicated to Creigh that if Creigh obtained an ECO, then Gus would be hospitalized with the goal of long term treatment and hospitalization. However, no action was taken by Gentry or RACSB at that time. As of 1:25 p.m., RACSB knew that Gus was at BCH because RACSB contacted the hospital at that time and advised the hospital that someone would be coming. As of 1:40 p.m., Gentry and RACSB were again informed that Gus was at BCH awaiting evaluation for temporary detention in a psychiatric facility. By the time Gentry and RACSB began the actual search for a bed it was 3:50 p.m. At that point, the original four hours for the ECO had almost expired, and Gentry and

RACSB had just begun to search for a bed. Gentry and RACSB failed to establish ECO notification protocols with BCH and the Bath County Sheriff's Office, thus truncating the prescreening admission process and losing valuable time for finding a psychiatric bed. The Magistrate extended the ECO for two hours. Even still, Gentry and RACSB failed to contact three state hospitals and nineteen private hospitals for a bed. Gentry faxed information to a number listed incorrectly on the RACSB contact sheet for Rockingham Memorial Hospital. Gentry failed to follow-up on the fax, and thus failed to secure the bed which was available for Gus at Rockingham Memorial Hospital. Gentry failed to secure a bed, of which many were available, for Gus in the six hour time frame. Gentry and RACSB were aware of the very serious risk associated with not hospitalizing Gus, and were aware that Gus had been engaged in destructive behavior and was a danger to himself and others. Nevertheless, in reckless disregard of this information, Gentry failed to contact three state hospitals and 19 private hospitals where beds were available. Gentry and RACSB released Gus, despite Pam's warning that if released Gus would commit violence; despite their own determination that Gus was not stabilized and needed treatment; and despite their assessment that Gus met the criteria for temporary detention, because he was a person with a mental illness who would, in the near future, cause serious harm to himself or others. Gentry brushed off and disregarded Pam's warning of violence. He responded that Gus was a responsible adult who had missed his appointments with RACSB, and that if Gus killed Creigh, Gus would be institutionalized for a long time. Gentry then sent Gus home with Creigh in direct disregard of the warning he had received. Furthermore, Gentry failed to properly establish a safety plan with Gus and Creigh prior to sending Gus home, and failed to continue searching for a TDO bed after the ECO expired.

52. Defendants acted with a complete neglect for the safety of Gus. The negligence of Gentry and RACSB, in breach of duty and violation of the standard of care, as described, was a proximate cause of Gus's death.

53. The acts of the Defendants as set forth above were willful, wanton, shocking, outrageous, and amounted to a complete disregard and neglect of the health and safety of Gus, and as such, amount to gross negligence. Defendants acted with utter disregard of prudence amounting to complete neglect of the safety of Gus. Their deliberate conduct demonstrated want of even scant care and amounts to the absence of slight diligence. The gross negligence of the Defendants and their agents and/or employees in failing to fulfill their duties to Gus, was a direct and proximate cause of Gus's injuries.

54. As a direct and proximate result of the negligent and grossly negligent actions of Defendants RACSB and Gentry, Gus experienced pain and suffering prior to his death; his estate has incurred medical and funeral expenses due to the injury and death; and his beneficiaries have suffered, and will continue to suffer, sorrow, mental pain and suffering and the loss of Gus's companionship, love and comfort.

55. The acts of the Defendants as set forth above were willful, wanton, shocking, outrageous, and evince a conscious disregard for the safety of others, including but not limited to Gus, and offend generally accepted standards of decency, and as such, entitle Plaintiff to an award of punitive damages as to Defendant Gentry.

WHEREFORE, Plaintiff requests compensatory damages, jointly and severally, against all Defendants on all counts, in the amount of five million dollars ($5,000,000.00), and punitive damages against Defendant Gentry in the amount of one million dollars ($1,000,000.00).

Plaintiff further requests attorneys' fees and costs; and such further relief as this Court deems just and proper.

TRIAL BY JURY DEMANDED

Respectfully submitted,

ROBERT CREIGH DEEDS,
Administrator of the Estate of
Austin Creigh Deeds, Deceased

By: _____
Of Counsel

John E. Lichtenstein (VSB # 27048)
jel@vatrials.com
Monica L. Mroz (VSB # 65766)
monica@vatrials.com
LichtensteinFishwick PLC
101 South Jefferson St., Suite 400
Roanoke, Virginia 24011
(540) 343-9711 (telephone)
(540) 343-9713 (facsimile)

CERTIFICATE/LETTER OF QUALIFICATION

Court File No. CWF140000010

COMMONWEALTH OF VIRGINIA

VA. CODE §§ 6.2-893, 6.2-1171, 6.2-1365, 6.2-1367, 64.2-2011, 64.2-506, 64.2-607

Bath County Circuit Court

I, the duly qualified clerk/deputy clerk of this Court, CERTIFY that on March 12, 2014
DATE

Robert Creigh Deeds,
NAME(S) OF PERSON(S) QUALIFYING

duly qualified in this court, under applicable provisions of law, as **Administrator** of the estate of

Austin Creigh Deeds
☒ DECEASED ☐ MINOR ☐ INCAPACITATED

The powers of the fiduciary(ies) named above continue in full force and effect.

$1,000.00 bond has been posted.

Given under my hand and the seal of this Court on

March 13, 2014
DATE

M Wayne Winebriner, Clerk

by M Wayne Winebriner, Deputy Clerk

EXHIBIT

tabbies

A

FORM CC-1625 MASTER 10/12