Hanging by a Thread: How Failure to Conduct an Adequate Lethality Assessment Resulted in Suicide

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This article begins with a legal case exemplar demonstrating how relatively quickly suicide by hanging took place when a medical social worker and an attending physician failed to conduct an adequate suicide risk assessment. The next section examines the lawsuit against the social worker and the physician, the expert testimony, and the outcome of the jury trial. The second half of this article identifies and discusses the importance of utilizing evidence-based suicide assessment protocols, a suicide ideation flowchart, and the 7-stage crisis intervention protocol (Roberts & Yeager, 2005). The authors underscore the importance of understanding proximate cause, shared responsibility, and legal liability issues among all members of hospital-based mental health teams. [Brief Treatment and Crisis Intervention 5:251–260 (2005)]

KEY WORDS: delusion, malpractice, legal liability, suicide, suicide ideation, lethality, risk assessment, proximate cause, suicide ideation.

Mr. Banach came to the United States from Poland looking for a better life, and it seemed like he had found it. He and his wife found a job together and within a year of coming to the States they were able to buy a home for themselves and their two children. Their daughter was in school, their son Michal was working, and Michal’s fiance was able to come from Poland to join them. But Mr. Banach’s journey ended tragically on September 12, 2000, when depression overtook him; the mental health professionals he and his family reached out to failed him and he hanged himself in the basement of his new home.

Confronted with unanswered questions and daunting financial burdens, Mr. Banach’s family turned to the legal system to find answers. What they learned provides important lessons to social workers about (a) the potentially tragic consequences of failing to properly assess patients for risk of suicide and (b) what it
means, legally and professionally, to evaluate patients as part of an interdisciplinary team.

**Ominous Signs and a Needless Death**

In the weeks leading up to his death, Mr. Banach’s behavior changed. He developed a delusion that his testicles were disappearing. A social drinker, he suddenly began to drink heavily the week before he died. On September 11, 2000, he told his wife that he was ill and that they needed to go home early. On the way home he began to shake so badly that his wife asked him to pull over so that she could drive. After they switched seats, Mr. Banach told his wife that it might be better if he hanged himself. When they got home Mr. Banach stripped down to his underwear and began to pace. Alarmed, his family called 911.

Mr. Banach was taken to a nearby hospital where a resident rotating through the emergency room properly concluded that Mr. Banach was a threat to himself and arranged to have him transferred to the nearest state hospital-based mental health facility, Read Mental Health Center. The resident noted on the transfer documents that Mr. Banach was a threat to himself and that he had said that he wanted to hang himself.

Upon his arrival at the state facility a little before midnight on September 11, 2000, Mr. Banach was examined by an internist and then interviewed by an attending physician, Dr. Hien Dang, and a social worker, Chester Scott, through a telephone translator service. As part of discovery in the lawsuit the Banach family later filed against the doctor and the social worker, the Banach family obtained telephone records from that night and confirmed that the entire interpreter-aided interview lasted only 20 min.

After this brief interview, Dr. Dang asked the family if they wanted to take Mr. Banach home. Having failed to make the proper diagnosis of psychosis, depression, and high suicide risk, Dr. Dang explained that Mr. Banach had a drinking problem, which was causing sexual dysfunction, and that he needed to go to a community outpatient facility for a follow-up appointment. He never offered the family the option of admitting Mr. Banach, warned them that Mr. Banach was at risk of suicide, or provided adequate instructions as to how to ensure Mr. Banach’s safety once he left the hospital.

Less than 3 hr after Mr. Banach was discharged from Read Mental Health Center, he hanged himself in the basement of his home. He was pronounced dead at the same hospital where he had been assessed the previous day before his transfer to Read.

After conducting an initial investigation, Mr. Banach’s attorneys sued, among other service providers, the social worker who had seen Mr. Banach at the state mental health facility, Chester Scott. After a jury trial in Chicago, IL, in September 2004, a jury determined that Mr. Scott and Dr. Dang had not provided reasonable medical care to Mr. Banach and awarded the family $750,000 in damages.¹

**Inadequate Suicide Assessment**

**Dr. Roberts’ Analysis of the Care Provided**

One of the experts the jury heard from was Dr. Albert R. Roberts, who testified on behalf of Mr. Banach’s family against Mr. Scott. The family’s attorney, Ted Jennings, of Ball & Jennings, Ltd., in Chicago, IL, did an Internet search and found Dr. Roberts because he is the lead editor on Oxford’s *Social Workers’ Desk Reference*.

¹Mr. Scott and Dr. Dang subsequently settled with the family and dismissed their appeal of the jury verdict.
Dr. Roberts concluded based on his review of the available medical record and the depositions of family members and medical providers who treated Mr. Banach on September 11 and 12 that Mr. Scott deviated from the standard of care applicable to reasonably well-qualified social workers by failing to complete a proper evaluation of Mr. Banach when he arrived at the intake unit of Read Mental Health Center and ensure that adequate steps were taken to provide for his safety. Dr. Roberts concluded that the available records made manifest that the combination of psychosocial stressors on Mr. Banach and the lethality of the means he had threatened to use to end his life were very dangerous and suicide was an imminent threat. Under these circumstances, the standard of care required that Mr. Banach be admitted to the Read Mental Health Center Inpatient Unit for further evaluation and treatment under close one-on-one observation.

Dr. Roberts explained to the jury that according to the American Association of Suicidology, the most serious warning signs for suicide include talking about committing suicide, being specific about a suicide plan or lethal method easily accessible, trouble eating or sleeping, and drastic changes in behavior. The medical record available to Mr. Scott indicated that Mr. Banach had exhibited each of these warning signs. Mr. Scott, nevertheless, concurred in Dr. Dang’s assessment that Mr. Banach was at a “very low risk” of suicide when in fact Mr. Banach was in imminent danger at the time of his admission.

Dr. Roberts testified based on his many years of training and experience that Mr. Scott should have been aware that the threat of suicide by hanging is a particularly ominous warning sign. Hanging is an especially lethal means due to the ready availability of the means. Unlike firearms, every home contains the materials necessary for someone to hang themselves. As a social worker in a facility with an inpatient psychiatric unit, Mr. Scott should have been especially sensitive to the threat of suicide by hanging because such units have to be particularly alert to that threat.

Upon admission at Read, Mr. Scott’s first step should have been to determine whether Mr. Banach was at low, moderate, or high risk of suicide using one of any number of readily available scales used for measuring suicide risk and lethality. There are at least 20 different evidence-based suicide assessment scales available to social workers, and these scales identify the presence of risk factors and their duration and intensity. Mr. Scott did not utilize any such instrument.

Remarkably, Mr. Scott defended himself in part on the basis that the medical records indicate that Mr. Banach at one time indicated that he was suicidal and later denied that he was suicidal during his examination by Dr. Dang and Mr. Scott. But as Mr. Scott acknowledges, a determination might be made that a patient is suicidal even if they deny being suicidal, and a reasonable social worker must take into account the fact that patients frequently try to hide their suicidal intentions and are also ambivalent about their intentions. If an evaluator believes that a client is being dishonest, one tool he can use to assess a patient’s risk to himself is a scale that poses similar questions in different ways to ensure internal consistency. Effective suicide assessment must go much further than taking the patient’s word for the fact that he is not suicidal. To properly assess a client’s risk of committing suicide, an evaluator must gain an understanding of factors such as the client’s hopes and plans for the future, levels of depression and anxiety, psychotic and delusional thoughts, and family members’ reports of suicidal threats or gestures. Mr. Banach’s changing statement that he decided not to hang himself reflected at best ambivalence about his desire to go on living and
more ominously reflected a dangerous willingness to lie to his caregivers. Many individuals who have exhibited suicide threats and gestures are ambivalent during their crisis state, and part of them wants to live and the other feels that there is no way out of feeling miserable except suicide.

Mr. Scott had several pieces of important information he needed to build on. An adequate suicide assessment would have taken at least an hour to an hour and a half; 20 min using a telephone translator was woefully inadequate. It is evident from the available information that a properly performed assessment would have led to the admission of Mr. Banach to the inpatient unit for further evaluation and treatment.

One very important piece of information that Mr. Scott did not identify or take into account during his assessment was Mr. Banach’s conviction that his testicles were disappearing, which was evidence of a transient psychotic or delusional state (according to Dr. Roberts’ testimony), an extremely dangerous condition that greatly increased Mr. Banach’s risk of suicide. In addition to being a significant independent risk factor, that particular delusion would have made Mr. Banach believe that he was likely to face a situation that might cause humiliation or failure, that is, sexual dysfunction and disfigurement of his sexual organs. Being faced with a situation that might cause humiliation or failure is an additional risk factor for suicide, whether based on fact or delusion. In fact, recent literature points to significant anecdotal evidence of a direct link between suicide and the delusion of disappearing organs.

The standard of care also required that Mr. Scott be aware of any language barriers and account for those. Mr. Banach only spoke Polish. His wife likewise spoke no English. Their son, who like them had only been in the United States for a little over 1 year and spoke limited English, acted as translator except for the 20 min that they utilized the telephone translator. Dr. Dang was from Vietnam, the admitting nurse was from the Philippines, and the internist was from Germany; only Mr. Scott spoke English as his first language.

A reasonable social worker in this or a similar situation should have recommended that Mr. Banach be admitted to the hospital for further observation, evaluation, and treatment. Mr. Scott’s failure to act reasonably was by definition negligent and makes him responsible for the damages caused by his negligence.

**Team Approach**

Mr. Scott argued that the evaluation conducted at Read met the standard of care but also defended himself by arguing that only the doctor had admitting privileges at Read and that Mr. Scott, as the social worker, could not be held legally responsible for failing to admit Mr. Banach for further treatment. Neither the judge nor the jury accepted Mr. Scott’s effort to duck responsibility by pointing the finger at his team member. Both Mr. Scott and Dr. Dang testified that they formed an interdisciplinary team and evaluated Mr. Banach together. They further testified that it was the goal of the team to arrive at a consensus regarding disposition decisions and that in this case Mr. Scott concurred in the decision to discharge Mr. Banach.

Dr. Roberts concluded that under the circumstances of this case, Mr. Scott not only had an independent obligation to properly evaluate Mr. Banach but also may have been the team member in the best position to make the proper disposition decision because Mr. Scott had been at the facility far longer than Dr. Dang and spoke English better than Dr. Dang.

**Proximate Cause**

Mr. Scott was not legally exonerated by the fact that Dr. Dang, a physician, was involved in the
evaluation. Both Dr. Dang and Mr. Scott testified that they evaluated patients as a team and attempted to reach disposition decisions by consensus. Mr. Scott, given his years of experience, seniority on the staff, and greater facility with the English language, had an obligation to take a leadership role and do what was in his power to see that Mr. Banach received further evaluation and treatment.

Under the law, a person is responsible if their negligence causes an injury, even if another person or event might have contributed to the injury. In Illinois, where the Banach case was tried, the jury received the following standard instruction:

> When I use the expression “proximate cause,” I mean that cause, which, in natural or probable sequence, produced the injury complained of. It need not be the only cause, nor the last or nearest cause. It is sufficient if it concurs with some other cause acting at the same time, which in combination with it, causes the injury. (Illinois Pattern Jury Instructions 14.01)

Both Mr. Scott and Dr. Dang testified that in the early morning hours of September 12, they formed an interdisciplinary team, as was their custom and practice, and evaluated Mr. Banach together to arrive at a consensus regarding his disposition. Mr. Scott’s failure to properly evaluate Mr. Banach contributed to the team’s failure to make a disposition decision that would provide for Mr. Banach’s safety. Dr. Dang’s concurrent negligence simply meant that Mr. Scott and Dr. Dang were jointly responsible for Mr. Banach.

At trial, Dr. Roberts explained the team approach to suicide assessment and how the social worker and psychiatrist work together toward consensus, explaining that no team worker outranks another and that all team members’ input must be taken together. Under these circumstances, the social worker has an independent obligation to recognize the client’s risk.

On cross-examination, Mr. Scott’s attorneys specifically challenged Dr. Roberts, asking if his belief that Mr. Scott failed to act reasonably was premised on the belief that Mr. Scott had admitting privileges at the mental health facility. But Dr. Roberts reasserted that the basis for his opinions was that Dr. Dang and Mr. Scott worked as a team and shared responsibility for the disposition decision that resulted in Mr. Banach’s death and that the question of who had ultimate authority to admit the patient was irrelevant when the doctor and social worker were acting as a team and the social worker failed to do his job.

Mr. Scott argued to the judge and jury that because he lacked authority to independently admit Mr. Banach without the concurrence of Dr. Dang, he was absolved of any responsibility for his failure to comply with the standard of care when evaluating Mr. Banach. But both judge and jury concluded that had Mr. Scott done his job properly, the team would have admitted Mr. Banach for further evaluation and treatment and Mr. Banach would be alive today. Accordingly, Mr. Scott was jointly liable with Dr. Dang for the damage done to the Banach family by the mistakes they made as a team.”

2Two psychiatrists, Michael Allen, MD, and Ronald Baron, MD, testified that Dr. Dang deviated from the standard of care applicable to doctors performing suicide evaluations. Providing testimony substantively similar to that of Dr. Albert Roberts, summarized at greater length in the article, both Drs. Allen and Baron concluded that Dr. Dang failed to complete a suicide assessment, including inter alia, gathering complete information from the family, and that had he done so Mr. Banach likely would have survived.
Implications for Training Social Workers in Suicide Assessment

All ethical and well-trained social workers should be knowledgeable about the standard of care in terms of suicide risk assessment and crisis intervention protocols. Within the current managed care environment, psychiatric screeners, mental health intake workers, and other social workers are required to assess and determine imminent or high, moderate, and low suicide risk. First and foremost, the intake social workers at a mental health facility or emergency psychiatric unit are required to assess suicide risk—low, moderate, or high—conduct a biopsychosocial assessment; interview family members and other collaterals; consult with the psychiatric resident on duty; and then determine whether or not voluntary or involuntary commitment in an inpatient psychiatric facility is necessary. When the patient is at high risk of suicide, upon arrival at the inpatient facility, the psychiatrist, social worker, and nurse team assign the patient to the most appropriate level of care (Roberts & Yeager, 2005). This may include immediate suicide prevention safety precautions—one-on-one observation for the next 24–72 hr. Implementation of Roberts’ Seven-Stage Crisis Intervention Model (Roberts, 1991) provides appropriate interventions for resolution of moderate and low suicidal ideation immediately after the individual seeks assistance. It is useful to include a suicide assessment checklist as well as several different scales that assess suicide ideation at the worst point in time, depression levels, hopelessness, and any previous psychiatric history. It is important to keep in mind the following checklist:

- Does client have a definite suicide plan, other than vague statement?
- Has specific method been chosen?
- Is method readily available?
- Current or previous psychiatric history
- Is client giving away prized possessions?
- Drug or alcohol use
- Prior suicide attempts
- Recent major stressors such as job loss
- Rate Sense of Worthlessness
- Rate Sense of Hopelessness
- Rate Degree of Social Isolation
- Rate Degree of Depression
- Rate Degree of Impulsivity
- Rate Degree of Anger and Hostility
- Rate Intent or Determination to Die
- Overwhelming or Humiliating
- Environmental Stress
- To what extent is client able to focus on positive future events? (Roberts & Yeager, 2005)

In addition, application of the seven-stage model can provide insight in a nonthreatening manner to assist the patient in the development of cognitive stabilization when completing the initial assessment, and the appropriate clinical pathway is followed. The clinical pathway is discussed below.

Discussion of Suicide Ideation Flowchart and Intervention Protocol

The operation of a crisis intervention program and a time-limited treatment program for persons with suicide ideation is shown by a flowchart. This provides a general description of the different clinical pathways and functions of crisis intervention programs, emergency psychiatric units, inpatient treatment units, partial hospital programs, and referral sources of day treatment facilities in the community.
Person Expresses Suicidal Ideation

Conduct in-depth interview, biopsychosocial and lethality/danger assessment

Person has specific suicide plan; access to lethal means; impaired judgment; psychosis or other serious mental illness and/or chemical dependency; drug-induced psychosis; poor social support network

Person has no access to lethal means; exhibits fair or good judgment; has supportive family or significant other; agrees to sign no-harm contract and, more importantly, to comply with treatment recommendations

Person exhibits no suicide plan or clear intent; willing to talk about stress and problems, and depression; willing to seek treatment; has supportive significant other and transportation

Imminent suicide risk

Moderate suicide risk

Low suicide risk

Arrange for transfer to psychiatric hospital

Crisis stabilization and crisis intervention; Roberts’ 7-stage CI model

Crisis intervention and follow-up; Roberts’ 7-stage model

Observation for 24–120 hr

Continue triage assessment

Continue triage assessment

15-min checks and restricted to unit

Examine dimensions of the problem (e.g., last straw)

Examine dimensions of the problem (e.g., last straw)

Individual and group therapy as tolerated

Encourage exploration of feelings and emotions

Encourage exploration of feelings and emotions

Contract with patient for safety

Explore and assess past coping strategies

Explore and assess past coping strategies

Off-unit privilege (if applicable to program)

Restore cognitive functioning through action plan

Restore cognitive functioning through action plan

One day leave of absence when patient demonstrated stability

Follow-up and case management

Follow-up plan developed

Complete discharge planning/implement discharge plan

Discharge to step-down day treatment program for 4–6 weeks

Discharge to step-down day treatment program for 4–6 weeks

Refer to psychiatrist in private practice for medication management and to case manager and/or vocational rehabilitation counselor or community-supported employment to help prepare for, find, and maintain meaningful employment

FIGURE 1
Crisis intervention, emergency psychiatric services, and suicide prevention programs usually maintain a 24-hr telephone crisis service. This service provides a lifeline as well as an entry point to behavioral health care for persons with major depression or suicidal thoughts and ideation. When the crisis worker answers the cry for help, his or her primary duty is to initiate crisis intervention beginning with rapid lethality and triage assessment and establishing rapport. In essence, crisis intervention and suicide prevention include certain primary steps in an attempt to prevent suicide:

1. Conduct a thorough lethality and biopsychosocial assessment.
2. Attempt to establish rapport and at the same time communicate a willingness to help the person in potential suicide crisis.
3. Help the caller in crisis to develop a plan of action that links him or her to community mental health care and/or inpatient psychiatric facility. The most frequent outcome of depressed or suicidal callers is that they are transported to psychiatric screening and intake at a behavioral health care facility or hospital or addictions treatment program (Roberts, 2005).

The crisis intervention worker assumes full responsibility for the case when they answer the phone or begin to interview a walk-in to the mental health center. The person cannot be rushed and handled simply by a referral to another agency. Crisis intake workers and psychiatric screeners should follow the case until complete transfer of responsibility has been accomplished by some other hospital or agency assuming the responsibility. The crisis worker should complete the state mandated mental health and psychiatric screening report that makes an initial determination as to whether or not the person is a danger to himself or others. This report should be given to the ambulance driver and faxed ahead of time to the intake social worker on duty at the receiving psychiatric unit or hospital. In other cases where there is low suicide risk and a close family member or significant other taking responsibility for the person in crisis, it is important to give the client and the family member telephone numbers to call in an emergency. The ultimate goal of all crises and suicide prevention services is to strive to make a systematic suicide lethality assessment, reduce intense emotional pain and acute crisis episodes, and lead to crisis stabilization while helping to connect the person to a psychiatrist, clinical social worker, and/or clinical psychologist who can help them to develop an intensive treatment plan with the goal of finding positive ways to cope with life.

It is imperative for all crisis clinicians to establish rapport with the person in crisis by listening in a patient, hopeful, self-assured, interested, and knowledgeable manner. The skilled crisis worker tries to communicate an attitude that the person has done the right thing by coming to the emergency psychiatric facility or calling and to convey a willingness and an ability to help. An empathetic ear is provided to the person in crisis in order to relieve his or her intense stress by active listening. The crisis worker should relate to the person in a confidential spontaneous and non-institutionalized manner (Roberts, 1991, 2005).

After listening to the person’s story and asking several key questions, the crisis worker makes a determination as to whether or not the person in crisis has a high suicide risk. If the caller has a lethal method (a firearm or a plan to hang himself or herself) readily available and a specific plan for suicide or has previously attempted suicide, then he is considered as having a high suicide risk. In
sharp contrast, the persons evaluated as low suicide risk still need help, but they may well be primarily depressed and lonely and expressing ambivalent thoughts about what it is like to be in heaven versus hell. They have not yet planned the specific details or method of suicide. Other callers may be persons seeking information for themselves or a family member, social callers with personal problems such as loneliness or sexual dysfunction, or callers needing emergency medical attention.

With regard to inpatient versus outpatient psychiatric treatment, the most important determinant should be imminent danger—lethal means to suicide. It is also extremely important for crisis clinicians and intake psychiatric screeners to make a multiaxial differential diagnoses that determines acute or chronic psychosocial stressors, dysfunctional relationships, decreased self-esteem or hopelessness, severe or unremitting anxiety, living alone, without social support, intimate partner violence, personality disorders (particularly borderline personality disorders), major depressive disorders, bipolar disorder, and comorbidity (American Psychiatric Association, 2003). Making accurate assessments and predicting short-term risk of suicide (1–3 days) have been found to be much more reliable than predicting long-term risk (Simon, 1992). For example, an 80-year-old widow has some symptoms of major depressive disorder and sometimes smokes marijuana—maybe a long-term risk of suicide—therefore, she should be asked every month or two if she has been thinking of suicide. Low risk will increase when this woman learns that she has liver cancer as a result of the 30 years of alcohol dependence. She should then be assessed with a full clinical interview for an escalation of depressive thoughts and drug addiction as well as any suicidal thoughts or plans (Roberts & Yeager, 2005). Other serious clues to increased suicidal risk are when a person has no social support network, poor judgment, poor impulse control, and adamantly refuses to sign a contract for safety.

Conclusion

Mr. Banach’s care provider’s joint failure to adequately assess Mr. Banach’s suicide risk on September 11 and 12, 2000, cost Mr. Banach his life and his family a husband and father and exposed Mr. Scott and Dr. Dang to legal liability. The case is a stark reminder that social workers and other mental health care providers must take the time to do adequate suicide lethality assessments and understand how to do them properly. Although the checklist and algorithms set forth above provide a useful tool, suicide assessment cannot be done out of a cookbook, and health care providers owe it to their patients and themselves to develop the skills necessary to adequately assess patients in crisis. This case is also a reminder that every member of an assessment team shares the responsibility to provide for the safety of the client. Each team member has an independent responsibility to meet the obligations of his or her profession, and nobody can expect to be exonerated by pointing the finger at team members if poor team decisions result in bad outcomes.

References


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