STATE OF FLORIDA
DEPARTMENT OF HEALTH

Rec'd 11.9.99

BOARD:	Medicine
CASE NUMBER:	1999-59350
COMPLAINT MADE BY:	AHCA
COMPLAINT MADE AGAINST:	Connie Lou Speer, M.D. 1407 M.D. Lane Tallahassee, Florida 32308
DATE OF COMPLAINT:	September 15, 1999
INVESTIGATED BY:	Jill Miraglia; Tallahassee
REVIEWED BY:	John E. Terrel
RECOMMENDATION:	Dismiss PL-99 (4099)

NOTICE OF DISMISSAL/CLOSING ORDER ON RECONSIDERATION

THE COMPLAINT: Violation of Section 458.331(1)(t)(m), Florida Statutes (1999), by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances and failed to keep written medical records justifying the course of treatment of the patient.

THE FACTS: The complaint was submitted by AHCA in regard to Connie Lou Speer, M.D. (Speer) alleging that Speer failed to notify the proper authorities and failed to have Patient A.K., a twenty-four year old female, tested when Patient A.K. claimed to have been raped by an orderly at the Tallahassee Memorial Behavioral Health Center (TMBHC). Patient A.K. was admitted by Respondent on June 25, 1999 for depression. A charge nurse (Webb) was monitoring the patient. On the evening of or about

June 30, 1999, Patient A.K. was raped by an orderly at the hospital. There are no direct witnesses to this incident. The patient reported this to the nurses but they did not believe her. The nursing reports indicate that the patient had revealed that she had been "sexually harassed" and could not remember the details except that the male staff member pulled down his pants. The nurses did not believe her because her boyfriend had visited that evening and the patient appeared disoriented. When Patient A.K. became aggressive because no one would believe her, Speer gave the order for lock door status on Patient A.K., and later when Patient A.K. began beating and kicking the glass, Speer gave the order to restrain Patient A.K. These were telephone orders based on the information Respondent received from the nurses. Patient A.K. also tried to contact the police that evening. A review of the 911 tapes demonstrates that the patient did say she was sexually abused by a staff member. The 911 dispatcher then communicated with Nurse Webb. Nurse Webb told the dispatcher that the allegations were not true, that her male companion had visited her and everything was O.K. Patient A.K. contacted 911 again and said she was raped by an orderly and that the nurses told the police not to respond. The police contacted the nursing staff again and were assured that nothing happened.

PATIENT A.K. was not referred to the emergency room for an examination until the next morning, on or about July 1, 1999, at which time it was confirmed that Patient A.K. was raped. Staff at TMBHC made allegations that Patient A.K. had sex with her boyfriend on the evening of June 30, 1999, but DNA results proved that sperm found in Patient A.K.'s body was that of the orderly.

Speer states that she had been informed by the charge nurse (Webb) that Patient A.K. had told her that Patient A.K. had been sexually harassed. Speer says that she was assured by the supervising nurse that she and her staff had looked into this matter and nothing had happened. Speer states that had she been informed of a sexual assault or rape on Patient A.K., she would have immediately ordered Patient A.K. to the emergency room.

The Department obtained two expert opinions in this case. The first expert, however, had not worked in a similar in-patient facility in five (5) years. The second expert had worked in an in-patient facility and was similarly situated. This expert initially determined that there was a violation of the standard of care. The expert acknowledged that the Respondent was

dependent upon the information she received from the charge nurse. This expert also acknowledged that "nurses represent data collectors for physicians. If the collectors are defective, the medical decisions will suffer." The expert then concluded that there was a violation because Respondent did not immediately respond to the allegation of rape by a staff member.

Probable cause was found on July 18, 2003. On July 24, 2003, the Department filed an administrative complaint against Speer, but now there is reason to reconsider at this time.

The Department conducted extensive discovery and review of the evidence in preparation for sending this case to the Division of Administrative Hearings for a final hearing. A review of the evidence indicates that Respondent was, at best, informed of a patient being sexually harassed and then becoming increasingly agitated. A review of the 911 tapes indicates that Nurse Webb claimed nothing happened when speaking with the police dispatcher. Respondent also maintains that Nurse Webb mislead her concerning the events. Both the police and Respondent were told by Nurse Webb that the incident had not occurred and that the patient's statements were untrue. However, it is clear that a rape did occur. The standard of care issue revolves around what information the data collector (the nurse) told Respondent. The second expert was asked by the Department attorney, telephonically, if a violation occurred under circumstances where the only thing reported is a possible assault or harassment (with the charge nurse denying such an event) and the expert stated that there would be no violation. Therefore, although a rape did occur and the events were egregious enough, there is insufficient evidence to continue this prosecution. Although there was enough evidence to find probable cause, the Department now recommends that this case be dismissed.

Accordingly, the Probable Cause Panel hereby directs that this case be dismissed.

THE LAW: Based on the foregoing, and in accordance with Section 456.073(4), Florida Statutes, the Panel has determined that this case should be dismissed.

It is, therefore, ORDERED that this matter should be and the same is hereby DISMISSED.

DONE AND ORDERED this 31st day of August, 2007.

Chairperson, Probable Cause Panel
Board of Medicine

JET/tgc

PCP: August 31, 2007

PCP Members: El-Bahri, Chizner, & Long

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 1999-59350**

CONNIE LOU SPEER, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Connie Lou Speer, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of Medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the state of Florida, having been issued license number ME 36902.

3. Respondent's address of record is 1407 MD Lane, Tallahassee, Florida 32308.

4. Respondent is board certified in Psychiatry with a subspecialty in Child Psychiatry.

5. On or about June 25, 1999, Patient A.K., a twenty-four (24) year-old-female with a history of depression, bipolar disorder and attempted suicide, presented to the Tallahassee Memorial Behavioral Health Center with depression and thoughts of suicide.

6. Respondent was Patient A.K.'s on-call physician at this facility.

7. Patient A.K. admitted herself as an in-patient to the mental health facility.

8. On or about June 30, 1999, Patient A.K. reported to nurse Faye Webb that a staff assistant within the facility had raped her.

9. Nurse Webb contacted Respondent and advised her that Patient A.K. stated that a male hospital staff member had assaulted her.

10. Nurse Webb informed Respondent that Patient A.K. was acting hostile towards the facility staff and other patients.

11. Nurse Webb opined to Respondent that she did not think that the assault occurred.

12. Without any further evaluation, inquiry or investigation, Respondent recommended that Patient A.K. be placed in a Quiet Room under locked door status because of her increased agitation and hostile behavior towards facility staff.

13. After being placed in a Quiet Room, Patient A.K. began beating on the doors and windows.

14. At approximately 11:00 p.m., Nurse Webb again contacted Respondent about Patient A.K.'s increasing hostile behavior.

15. At approximately 11:30 p.m., Respondent ordered that restraints be placed on Patient A.K. and that she be monitored throughout the night.

16. Respondent never spoke with Patient A.K. or went to the facility to assess Patient A.K.

17. There is no documentation by Respondent indicating an evaluation, conversation, or investigation concerning Patient A.K.'s claim of assault.

18. On or about July 1, 1999, the head nurse, Lora Vitali, responded to the incident after receiving a voice mail message on her phone that morning.

19. On or about July 1, 1999, Nurse Vitali came to the facility to assess Patient A.K.

20. Nurse Vitali immediately transferred Patient A.K. to the Emergency Room for evaluation.

21. An Emergency Room physician determined that there was evidence of semen from a male orderly in Patient A.K.'s vagina.

22. A reasonably prudent physician in similar conditions and circumstances would have evaluated or investigated the alleged rape or would have referred the patient to the emergency room or immediately to a gynecologist.

COUNT ONE

23. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

24. Section 458.331(1)(t), Florida Statutes, provides that failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances constitutes grounds for disciplinary action by the Board of Medicine.

25. Respondent practiced medicine below the acceptable standard of care in one or more of the following ways:

a) By failing to appropriately respond to Patient A.K.'s complaints by failing to personally interview Patient A.K.,

b) By failing to ask Nurse Webb if she had interviewed the orderly,

c) By failing to order the hospital staff to call the Police,

d) By failing to advise and/or order that Patient A.K. be sent to the emergency room or a gynecologist for an immediate examination;

e) By failing to consider talking to the orderly or other involved individuals to determine if Patient A.K. was in an irrational state and find out why she would have made the allegation.

26. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

27. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

28. Section 458.331(1)(m), Florida Statutes, provides that failing to keep medical records that justify the course and scope of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, sets forth grounds for disciplinary action by the Board of Medicine.

29. Respondent failed to keep medical records that justify the course of treatment of the patient, in one or more of the following ways:

a) By failing to document summary notes of the alleged rape;

b) By failing to document any progress notes for the Patient A.K. for the June 30, 1999 incident.

30. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, by failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on

probation, corrective action, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 21st day of July, 2003.

John O. Agwunobi, M.D., M.B.A.
Secretary, Department of Health

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK
DATE 7/24/03

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/JET

Reviewed and approved by: DKK (initials) 5/5/03 (date)

PCP: July 18, 2003

PCP Members: Fuad Ashkar, M.D. (Chairperson), Nabil El Sanadi, M.D., and John Beebe

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NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.