

## **Patient Suicide: Court Finds No Negligence.**

The patient, who was under the VA hospital's ongoing care for chronic pain, came to the same VA hospital's emergency room after he overdosed on his pain medication. He was kept in the emergency room overnight.

The next day a psychiatry resident decided to go forward with an involuntary mental health hold and ordered suicide precautions. A nurse sat with the patient 1:1 until later that afternoon when the staff psychiatrist decided that 1:1 supervision was not necessary and downgraded the patient's suicide precautions to visual checks every fifteen minutes.

The nursing progress notes documented fifteen-minute checks by the nursing staff until shortly after midnight when the patient's nurse found he had hanged himself in his room.

The US Court of Appeals for the Eleventh Circuit agreed with the decision of the lower Federal court to dismiss the case, based on the testimony of the doctors and nurses who cared for the patient that their assessments were appropriate. Ortiz v. US, 2009 WL 4194849 (11th Cir., November 30, 2009).