HFS research on NHS Scotland Self-Harm Incidents

following HSE meeting on recent spate of Self-Harm incidents in NHSScotland premises
31 May 2018 (for SFG workshop)

Self-harming in NHSScotland facilities

- **Feedback on discussions with HSE;**
- **Recent incidents and cases;**
- **Discussion on learning and way forward.**

HSE Summary:

1. HSE director Scotland: Barry Baker stated at HFS Conference Nov 2017 'open to challenge' by NHS to ensure safety standards applicable. NHS Scotland on whole not 'high risk' sector for HSE, but can be inconsistent.
2. 12 Apr18 HSE meeting to discuss concerns and future. (NHS: ~12 fatality investigations e.g. GGC @QEUH, @Stobhill; LT @Western; A&A @Crosshouse; TS @MRH; GP @?; F :Whyteman Brae)
3. Health and Safety at Work etc. Act 1974 Section 3(1). HSE Improvement Notices; HSE prosecutions. Conviction incl. unlimited fines as % of income and/or imprisonment. No NHS lists or shared learning
4. Duty to ensure "*persons not in your employment...[i.e.] patients at risk of suicide (in areas where they are not continually supervised), are not exposed to risks to their safety...[i.e.] ligature points identified in your risk assessment including sink pipes, door closers and shower taps, have not been removed where it is reasonably practicable to do so*."
5. HSE consider NHS 'mature' in H&S processes i.e. NOT a target sector; Barry would be happy to work with NHS proactively rather than reactively, to support consistent, long term improvement.

Recent incidents and cases:

6. Scottish Gov's due Summer 2018 Suicide Prevention Action Plan – consultation to replace 2013-16 plan. Includes themes: improved evidence, data & guidance; modernise training; maximise impact of prevention activities; develop social media & online support for people at risk. "SUICIDE IS PREVENTABLE"
7. Scottish Gov's 2017 -27 Mental Health Strategy includes actions supporting suicide prevention, e.g. training
   2. Children; 9. Students; 11. DBI; 12. Rural isolation; 13. Unscheduled care; 14. NHS; 15. Workforce; 38 Profiling.
8. NHS Tayside Public Enquiry announced at parliamentary debate 9 May18. (Dundee: 60% suicide rise in year)
9. NHS Health Scotland leads National Programme for Suicide Prevention. www.chooselife.net ASIST training
10. ISD's Scottish Suicide Information Database (ScotSID) 14 Nov 2017 annual report & summary for 2009 -15
    - In Scotland 5,119 individuals died from suicide between 2009 and 2015. ~15 people per 100,000.
    - Men were ¾ of all suicides. ½ of these are aged between 35 and 54. 70% of all suicides are 'single'.
    - Suicides three times more likely among those living in the most, compared to least, deprived areas.
    - 'Hanging, strangulation & suffocation' at 46% is most common method, then 'poisoning' at 30%.
    - 70% had contact with at least one healthcare service in the 12 months before their death.
    - However, overall suicide risk of any particular healthcare contact is very low: 0.03 to < 1% (Table 1). Therefore prediction of even short-term risk of suicide at the individual level is highly problematic.
    - Most common contact of these 59%, had one or more mental health drug prescription.
    - Next common 26%, had at least one psychiatric inpatient stay or psychiatric outpatient appointment in the 12 months before their death, while 8% had both.
    - Multiple A&E attendances were more common in suicide cohort than in the general population. 2% had ≥4 A&E attendances 3months before suicide, only 0.1% general population in this frequency.
    - 2x chance of a single acute inpatient stay and 46x chance of a single psychiatric hospital inpatient stay, in 12 months before suicide, compared to general population over a similar time period.
    - 300 A&E attendances **excluded,** as likely to be result of suicidal act, not care prior to suicide.
    - 94 MH ward attendances on same day of death included, indicating the individual suicide in hospital, very shortly after, or while absent on pass.

Healthcare service contact	2014 patients who died by suicide in the period after contact	Percent of all patients who died by suicide in 2014 (%)
Mental health drug prescription	643	0.06
A&E attendance	187	0.07
Psychiatric outpatient appointment	136	0.12
Acute hospital inpatient stay	207	0.03
Psychiatric hospital inpatient stay	81	0.56
Specialist drug treatment (initial assessment)	10	0.08

Table 1: Percentage of all patients in contact with particular healthcare services in 2014 who died by suicide after contact

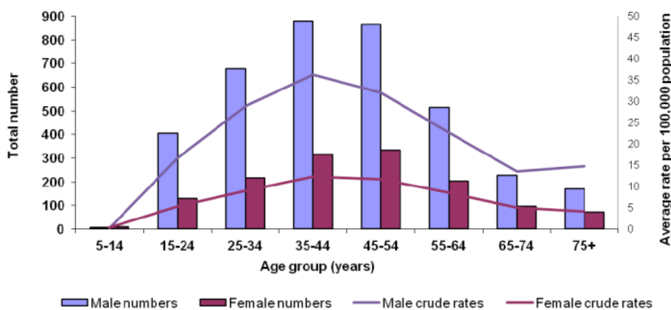


Figure 2: Deaths caused by probable suicide – totals and average rates per 100,000, by age group and sex, Scotland, 2009-15

Number of days	Number	%	% of cohort
0 to 1 days	160	13.7%	3.7%
2 days	79	6.7%	1.8%
3 to 7 days	195	16.7%	4.5%
>1 to <4 weeks	310	26.5%	7.2%
4 to <8 weeks	230	19.6%	5.3%
8 to 13 weeks	197	16.8%	4.6%
Total	1,171	100.0%	27.2%
Number of individuals with no A&E attendances within 3 months of death	3,132	-	
Total deaths caused by probable suicide	4,303	-	100.0%

Table 17: probable suicide –≤3 months after last A&E attendance: -days between attendance & death, Scottish residents, 2010-15

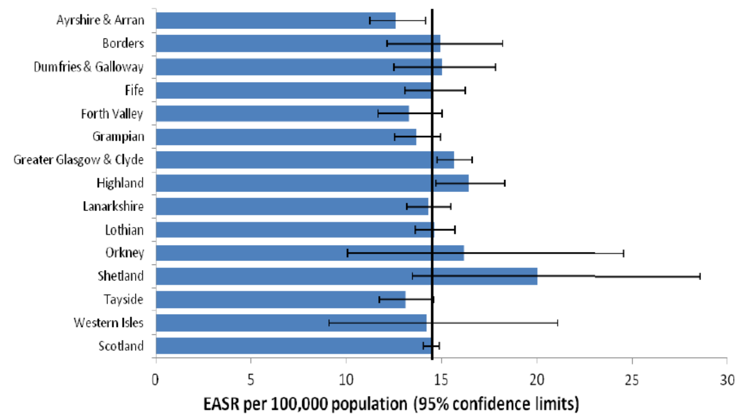


Figure 5: probable suicides – EASRs (inc 95% confidence limits) for persons ≥5 years, by NHS Board in Scotland, 2009-15

Method	Mental health drug prescribing (12 months) Number	%	Specialist contact (12 months) Number	%	A&E (3 months) Number	%	No previous contact Number	%	Total number
Poisoning	955	74.1%	477	37.0%	423	32.8%	212	16.5%	1,288
Drowning & submersion	165	59.8%	99	35.9%	70	25.4%	86	31.2%	276
Jumping or falling from high place	171	55.7%	116	37.8%	83	27.0%	98	31.9%	307
Hanging, strangulation & Suffocation	1,022	51.5%	612	30.8%	444	22.4%	747	37.7%	1,984
Firearm	24	41.4%	10	17.2%	10	17.2%	31	53.4%	58
Other and unspecified	213	54.6%	126	32.3%	141	36.2%	105	26.9%	390
Total	2,550	59.3%	1,440	33.5%	1,171	27.2%	1,279	29.7%	4,303

Table 23: Number and % of the ScotSID cohort in contact with healthcare services before death, by method, 2010-2015

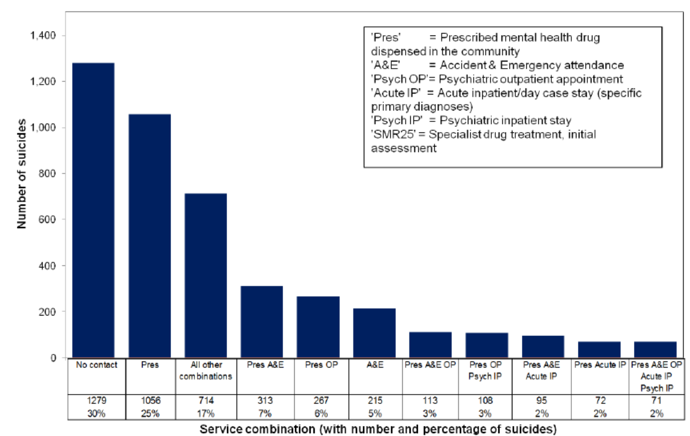


Table 17: Common combinations of healthcare services contacted by the ScotSID cohort, in the periods before death, 2010-2015

"How likely is a patient contacting each service to die by suicide?" ScotSID Main Report Nov 2017 pg 47

"Realism about the challenge of accurately predicting suicide risk at the individual level is also necessary. As shown in this report, even the most powerful risk factors for suicide have poor predictive ability. Gairin et al (2003) take self-harm as an example. Even though an individual with one episode of hospital-treated self-harm has a massively increased risk of future suicide (up to a hundredfold) compared to an individual in the general population who has never self-harmed, most people treated in hospital following self-harm will not die by suicide in the next year. The poor positive predictive value is a consequence of the low specificity of the predictive factor and the low prevalence of the outcome."

"ScotSID is one of the most extensive linked datasets relating to suicide in the world... ScotSID data also reveal the many challenges that remain to be addressed, especially the occurrence of suicide following contact with healthcare services and receipt of medication used to treat mental ill-health... committed to develop programmes..[e.g.] A&E, and developing ways of improving the detection and treatment ...based on ScotSID evidence. Findings ...support the continuation of a broad public health approach to suicide prevention in Scotland, which combines population-based action with interventions targeted at high-risk groups." ScotSID Main Report Nov 2017 pg 53-54

Patient A: Death in Neurology ward following determined effort to defeat window restrictor in upper storey single bedroom. Known history of prior mental health and self-harm, but clinically determined low risk at time.

Patient B: Death in Child & Adolescent Mental Health ward, in ensuite with non 'anti-ligature' tap, when rest of equipment was 'anti-ligature'. Clinically assessed as high risk at time and notes stated 'constant' observation.

Patient C: Death in Mental Health ward using ligature point in an area unable to be easily supervised by staff. Clinically assessed as low risk at time and able to leave ward on a 'day pass'.

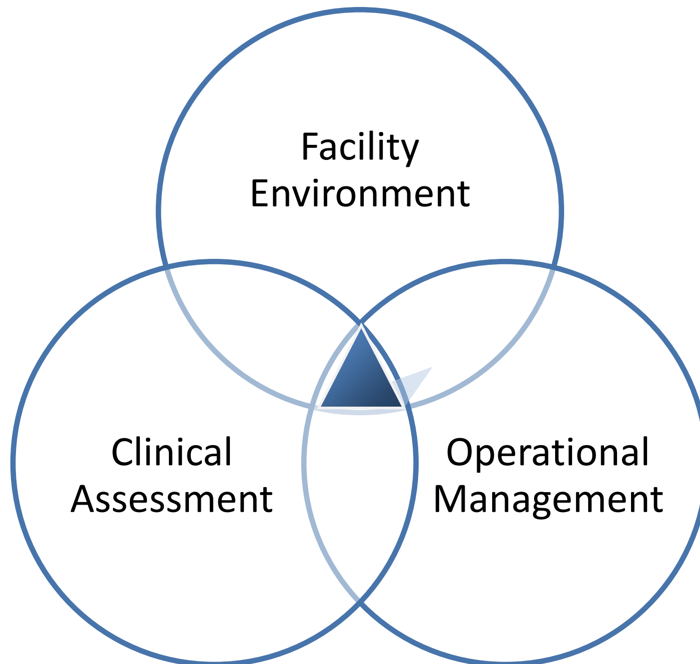
Patient D: Death in general medical ward using coat hook in bedroom/ensuite. Known history of mental health and self-harm, assessed as high risk suicide. However 'regular' observation withdrawn whilst MH ward transfer awaited.

Patient E: Death in Mental Health ward, in ensuite/ bedroom. Clinically assessed as low risk at time. Slow strangulation using ear bud earphone chord with jack jammed in crevice only 200mm from floor.

Discussion on learning and way forward

11. Current NHS Guidance for **NHS Scotland**, includes:
    - HBN 03-01 Mental health - Adult acute units (2013) – applies in NHS Scotland & RofUK NHS
      2.1 The function of an adult acute in-patient unit is to provide safe care in the least restrictive environment,
    - HBN 03-02 Child and Adolescent Mental Health Services (2017) applies in NHS Scotland & RofUK NHS
    - SHTM 55 Windows (2006) – applies in NHS Scotland
      e.g. 2.48 - 2.56 and 3.3 regarding Safety and Security clauses, plus Appendix A -Strength and safety.
      2.56 Project teams must decide on the needs for safety in health buildings. The restriction of opening lights will be required in many rooms or even throughout a building. A restricted opening of not more than 125 mm is recommended for use within reach of patients, particularly in areas for older people and people with learning disabilities or mental illness; a dimension of 100 mm is essential where windows are accessible to children.
    - HBN 00-10 part D (2013) – applies in NHS England; NHS Wales and Northern Ireland
      Evidence showed BS tests for restrictors could not be relied upon to prevent a determined effort.
      it is recommended that, dependent on risk assessments, loads on window restrictors used in healthcare premises are tested using forces in excess of those quoted in BS EN 14351. (page V)
      (Note also that BS EN 13126-5 recommends a opening of ≤89 mm to prevent the passage of small children.)
    - www.cqc.org.uk/sites/default/files/20180404_9001397_briefguide-ligature_points_v1.pdf (England)
12. Current NHS Scotland (also Rof UK NHS) IRIC Safety Alerts:
    - EFA/2013/002 Window Restrictors (Jan 2013)- *restrictors inadequate in preventing a determined effort*
    - HAZ(SC)04/02 Window security (Feb 2004)- *assess risk & fit 2nd restrictor to prevent a defeat if needed*
    - *New EFA 2018 – Following Coroners Report - height of the ligature point is only one of many criteria to consider in the risk assessment of an environment in relation to self harm.*
13. **HSE guidance:** www.hse.gov.uk/healthservices/falls-windows.htm
    - Three broad categories of falls from window etc:
      i- **accidental**: *minority, but occur where people unintentionally fall through or from windows;*
      ii- **confused mental state**: *a significant number occur in health and care facilities; e.g. senility, dementia, mental disorder/ reduced capacity, effect of drink and drugs (both prescribed and illegal); people may try to escape or use a window, believing it to be an exit;*
      iii- **deliberate self-harm or suicide** –a recognised risk for people with certain health conditions, particularly those with a history of self-harm or mental disorder. [i.e. 'determined' efforts.]
      Following a premises risk assessment, HSE state "suitable precautions must be taken". "The opening should be restricted to *≤100 mm*. Window restrictors should only be able to be disengaged using a special tool or key."
14. College Centre for Quality Improvement (CCQI) and NAPICU's (National Association of Psychiatric Intensive Care Units) and DiHMN (Design in Mental Health Network) Guidance, include:
    - napicu.org.uk/wp-content/uploads/2017/05/Design-Guidance-for-Psychiatric-Intensive-Care-Units-2017.pdf
    - www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/picus/ourstandards.aspx
    - www.rcpsych.ac.uk/pdf/RCPsych_Core_Standards_In.pdf
    - DiMHN 'testing and standards' being developed for mental health components with BRE & suppliers

Safe & Therapeutic Care is interdependant on ALL 3 of following, working together



Growing concern for potential for ad-hoc 'reactive' changes to healthcare environments (and guidance) based only on a limited number of recent specific incidents, without either

a) reference to wider context of incident e.g. clinical review, operational management,
b) establish wider statistical trends, e.g. 100 similar self harm 'near misses', or 1 off
c) H&S 'proportionate' application, e.g. NHS test >135,000 windows, how frequently & to what standard?
d) understanding potential for detriment to therapeutic environment, or its associated/unintended consequence to 99% of patient population; an increased length of stay = increased infections, drug use etc

HSE state safety is to be 'managed' via risk assessment and mitigations put in place proportionate to likelihood and severity. Safety can never be 'guaranteed' and all the mitigations in the world could not eliminate ALL risk. So we must accept 'some' risk', but this should be understood by all disciplines and done in an open, considered and consistent/ replicable manner.... perhaps similar to infection control e.g. develop an HAI SCRIBE for Self-Harm?

i. SPAG agreed Nov 2017 a depository of current, historic and draft HSE notices across NHSScotland. e.g. ihub.scot/spsp/mental-health/ or www.nes.scot.nhs.uk/education-and-training/... /mental-health.aspx
ii. a SLWG to identify common issues and priorities, e.g. guidance on how to 'measure' adequacy for various situations in-situ. Potentially interpreted as 'a normal person (surveyor) can overcome with normal/reasonable effort"; i.e. this is to deal with HSE category *i- accidental* and *ii- confused mental state*; but it is not *iii- deliberate* i.e. determined efforts, as no test or guidance exists for this category.
iii. Review of relevant British / European/ ISO 'standards';
iv. Review of relevant research, commission more?
v. Review of NHS Guidance, IRIC safety Alerts, and Clinical Body guidance, identify gaps and prioritise.
vi. Review of current Scottish Government, NHSScotland and Board policies, e.g. Suicide Prevention Strategy 2013-16 (Dec 2013), due for update by Summer 2018
vii. Develop /update NHS Guidance and IRIC Safety Alerts as required
viii. Develop solutions, e.g. 'Repeatable rooms' / 'Standard components' DMHN / BRE 'Component Tests'