Three patient suicides in a psychiatric hospital in South Savo in the autumn of 2021

T2021-01

FOREWORD

By virtue of section 2 of the Safety Investigation Act (525/2011), the Safety Investigation Authority, Finland (SIAF) decided on 6 October 2021 to launch an investigation into serious incidents that led to the deaths of patients in the South Savo Social and Health Care Authority (Essote) between 9 September 2021 and 3 October 2021. The decision to launch the investigation was preceded by Essote's request for an investigation. Three inpatients in one of Essote's health care units had committed suicide in a short period of time. The purpose of safety investigation is to promote general safety, the prevention of accidents and incidents, and the prevention of losses resulting from accidents. A safety investigation is not conducted in order to allocate legal liability.

Ilona Hatakka, MA, was appointed head of the investigation team, with Riitta Flinck, Master of Health Sciences, Public Health Specialist Jussi Laaksonen, Licentiate of Medicine (until 4 January 2022), and Kari Ylönen, Master of Political Sciences as its members. The investigator-in-charge was Chief Safety Investigator, Adjunct Professor Hanna Tiirinki.

Specialist in Occupational Medicine, Adjunct Professor Alpo Vuorio, MD was appointed as specialist consultant on 10 February 2022.

Professor of Psychiatry Jyrki Korkeila, MD issued an opinion to serve as a separate psychiatric report.

A safety investigation examines the course of events, their causes and consequences, the search and rescue actions, as well as the actions taken by the authorities. In particular, the investigation seeks to establish whether sufficient attention was paid to safety during the activities that led to the accident as well as in the design, manufacture, construction and use of the devices and structures that caused the accident or incident or that were affected by it. The investigation also examines whether the management, monitoring and inspection activities were appropriately arranged and coordinated. Any shortcomings in the rules and regulations concerning safety and the authorities must also be investigated if necessary.

The investigation report includes an account of the course of the accident, the factors leading to the accident and the consequences of the accident, as well as safety recommendations addressed to the appropriate authorities and other operators regarding measures that are necessary to promote public safety, prevent further accidents and incidents, prevent losses, and improve the effectiveness of the operations of search and rescue and other authorities.

An opportunity to comment on the draft investigation report was reserved for those involved in the incident as well as the competent supervisory authorities. Their opinions were taken into account in the finalisation of the investigation report. A summary of the comments is provided at the end of the investigation report. The Safety Investigation Act prohibits the publication of opinions expressed by private individuals.

Swedish and English translations of the investigation report were produced by Semantix Oy.

The investigation report and its summary were published on 31 May 2022 on the website of the Safety Investigation Authority, Finland, at *www.sia.fi*.

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1 EVENTS

1.1 Course of events

Three patients in South Savo Social and Health Care Authority's Moisio Psychiatric Hospital in Mikkeli committed suicide in the space of 24 days in the autumn of 2021.

All three were women aged between 50 and 75 years of age. All of the deaths occurred by drowning, two in a pond on the hospital grounds and one on the ward. One of the deaths occurred in the morning, one in the afternoon, and one in the evening. One of the patients left a suicide note.

Two of the patients had been admitted to Moisio Hospital based on a doctor's referral for psychiatric evaluation. One of these two chose to stay in the hospital voluntarily after the observation period, and the other was committed to care against her will. The third patient had come to the hospital on her own initiative after a suicide attempt.

The patients had been in the hospital for between one week and two months before their death.

Picture 1. Moisio Hospital is located in Mikkeli. The adult psychiatric wards are in building B, marked in green. The hospital is flanked on both sides by a pond. The distance from the wards to the nearest pond is approximately 200 metres on foot. (Background map: National Land Survey of Finland, topographic map series [raster], open data, 11/21. Markings: SIAF.)

1.2 Alarms and rescue activities

In each case the patient had been routinely out of the sight of hospital staff immediately before the incident. Each patient's absence from the ward was noticed relatively quickly, after which a search for the patient was initiated.

In two of the cases, the deceased was discovered by a member of hospital staff. One of the fatalities was discovered by a member of the public who happened to be passing by the pond. Hospital staff had already begun to search for the missing patient at this point, but the search party had not yet made it to the pond. In each case, emergency services were alerted as soon as the patient was found. An attempt was made to resuscitate one of the drowning victims.

All of the emergency calls were answered by the Kuopio Emergency Response Centre (ERC). One of the cases was logged by the ERC as *rescue of a person from water*, the second as *drowning*, and the third as *deceased individual*. The local rescue department attended one of the incidents, paramedics attended two of the incidents, and the police attended all three.

A police officer notified the next of kin of the death in two of the cases. In one of these two cases, the deceased's next of kin was not at home. A senior medical officer from the hospital consequently ended up calling the deceased's next of kin while the police patrol was at their house, and the news of the death was therefore delivered by a doctor. In one of the cases, the deceased's next of kin were notified of what had happened by the hospital's senior medical officer over the telephone.

Hospital staff contacted providers of crisis services in the home towns of the individual(s) whom the patient had identified as their next of kin, and these organisations reached out to the deceaseds' next of kin to offer crisis support. The next of kin were also offered an opportunity to visit the hospital to talk to members of staff.

The staff of the affected wards were invited to a post-crisis debriefing after each incident, and between 10 and 15 members of staff attended each of the sessions.

1.3 Consequences

Three patients in psychiatric inpatient care died by drowning.

2 BACKGROUND

2.1 Operating environment, equipment and systems

The main building of Moisio Hospital was constructed between 1927 and 1930 to serve as a psychiatric hospital. In its heyday, the hospital had capacity for more than 500 patients. Patient numbers have been declining for some time, as the focus has shifted more and more towards outpatient care since the late 1970s.

Parts of the building have suffered from poor indoor air quality. The building was renovated in the 1980s. The South Savo Social and Health Care Authority (Essote), which manages the hospital, adopted an extensive infrastructure renovation programme in 2015, which includes the relocation of Moisio Hospital. A decision was made in 2018 to build new premises for the hospital next to the central hospital in the centre of Mikkeli. Staff and patients are due to move to the new psychiatric and rehabilitation facility in early 2023.

Moisio Hospital has three adult psychiatric wards with capacity for 51 patients in total. Ward 1 is an acute ward with capacity for 15 patients. The ward provides care for patients suffering from symptoms of acute psychosis or who are a high suicide risk. Ward 2 has is an acute ward with capacity for 16 patients, which provides care for patients suffering from mood disorders, such as depression, anxiety and bipolar disorder. Ward 7 is a high-security ward with 20 beds for patients with complex psychosis as well as mentally ill offenders. The wards are located in building B in the western part of the hospital.

Various safety and security improvements have been implemented on the wards in the past 10 years. All locks have been removed from the doors to patient rooms. Windows have been fitted with security film and new key-operated opening mechanisms. Mesh panels have been fitted on top of the railings of the gangway leading to the entrance of building B to prevent falls.

Patient rooms consist of single and twin rooms. The rooms are furnished in a minimalist style, and some have hospital beds. The patients can decorate their rooms with their personal belongings. All staff who deal with patients wear a uniform. The patients can wear their own clothes during inpatient care, and most do. The wards have communal showers and toilets for patients.

The wards are accessed from a stairwell in the middle of the building. A key is needed to open the doors between the stairwell and the wards from both sides. Each ward has its own closed-circuit television (CCTV) system, and there are surveillance cameras both in the communal areas as well as in certain areas outdoors. The camera feeds are displayed on monitors in the ward office.

The hospital is flanked by two ponds: Moisionlampi to the west and Karjalampi to the east. The distance between the ponds and the main building is a couple of hundred metres. The hospital has records of isolated cases of suicide by drowning over the years.

There is a beach on the hospital-side of Moisionlampi, which patients can use for swimming in the summer. Facilities at the beach include a grassy area, an open-sided structure providing shelter, a rescue boat, a dock and a lifebuoy. There is no lighting on the beach. The beach is on the hospital grounds.

Patients can be given permission to spend time outdoors unsupervised as long as they stay in the immediate vicinity of the hospital. Patients with outdoor privileges are provided with a

map of the area and instructed to stick to the marked routes. The beach at Moisionlampi is along one of these routes.

2.2 Circumstances

All three incidents occurred during daylight hours. Nothing unusual was happening on the wards, and there were no staff shortages or extra staff on duty. The wards were at between 80% and 94% occupancy.

2.3 Recordings

The events leading up to the incidents were established with the help of the wards' surveillance camera footage and the ERC's recordings of the emergency calls. The camera footage showed, among other things, the patients' movements on the wards. The ERC's recordings revealed, for example, the times and contents of the emergency calls.

2.4 Persons and organisations related to the accident as well as safety management

2.4.1 Patients

The backgrounds and medical histories of the **suicide victims** were all different.

The **first patient** had a long history of substance abuse and multiple diagnoses. She was on a disability pension. She had long been a client of both social services and mental health and substance abuse services. An attempt had been made a couple of years earlier to get her into psychiatric treatment, but the patient had not been willing. Her doctor at that time had concluded that there were no grounds to commit her to treatment against her will.

A notice of concern[1] about the patient was filed with Essote's social services in May of 2021. The case worker was proactive and tried to get the patient into treatment at the end of June. Contact had already been established with a doctor, but no further steps were taken due to the patient's strong resistance. The situation worsened during July, and several notices of concern were filed about the patient. Towards the end of July, the case worker first contacted a doctor at the local health centre. The doctor was a Bachelor of Medicine who explained that they did not have the authority to make a psychiatric referral, and the case went nowhere. The case worker then contacted an emergency mental health team, and the team's doctor took charge of the case.

The patient was given a referral for psychiatric evaluation in Moisio Hospital. At the end of the observation period, the patient was committed to treatment against her will. The objective of admitting the patient was to help her to regain control of her life, to improve her life management skills and social interactions, and to motivate her to get better. The patient was also treated for somatic illnesses and put on medication. The patient became more engaged during her time in the hospital.

It was not possible for the patient to return to her former home, which is why Essote's social services and the hospital's social worker began to look for a place for her in an assisted living facility. The arrangements proposed by the patient herself were not realistic. A suitable new

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[1] Employees of certain authorities, such as health care services, social services, education services and the police, have a legal duty under the Social Welfare Act (1301/2014) to file, secrecy provisions notwithstanding, a notice of concern with social services as soon as they become aware of an individual who clearly needs the help of social services and is clearly unable to look after himself/herself. Notices of concern can also be filed by other persons regardless of any applicable secrecy provisions.

home was found for the patient in another town. The patient was initially reluctant, but eventually agreed to visit her proposed new home. Arrangements were made for the patient to leave the hospital and move into the assisted living facility. The patient committed suicide two days before she was due to move.

There was nothing about the patient's being suicidal in her records.

The **second patient** had no previous history of psychiatric treatment. She had begun to repeatedly seek medical attention for multiple complaints in the summer of 2021. She was ultimately admitted to psychiatric inpatient care due to her life management skills having deteriorated to a point where she was no longer able to perform daily routines. This was the result of the patient's having lost her zest for life due to loneliness and somatic[2] complaints brought on by ageing. The patient's admission interview included a suicide risk assessment performed by a doctor in training, and the patient was not deemed to be acutely suicidal. It was agreed that the objective of inpatient care would be to rehabilitate the patient both physically and mentally so that she could return home with the support of a home-based carer. The patient was started on medication that was designed to give her a regular circadian rhythm.

The Bachelor of Medicine who was the patient's doctor in the hospital noticed that the patient's spirits were down. The patient was found to be increasingly anxious and struggling to accept the physical changes in her body and her loss of fitness during her time on the ward. The patient was booked an appointment with a doctor due to her somatic symptoms when she was first admitted, but no immediate solutions could be found. The patient appeared to feel uncomfortable discussing her complaints with a male nurse.

As the patient had agreed to stay in the hospital voluntarily after the observation period, there were no restrictions on her spending time outdoors. The patient's physical performance improved on the ward to a point where she was able to go on short walks outside.

A suitable drug regimen was devised for the patient, which was also implemented.

The **third patient** had been a psychiatric outpatient for more than 20 years before she was committed to hospital. She suffered from multiple medical conditions. The patient's health took a clear turn for the worse in the spring of 2020, when her doctor deprescribed her long-term medication. It was discovered at that time that the patient had become dependent on depressants. The patient would have liked to keep taking the medication that she had been prescribed previously, even after her doctor explained the reasons why she had to stop taking it. The patient was not motivated to take her new medication. She repeatedly asked to be put back on her old medication after the switch, claiming that her condition had clearly deteriorated from what it had been and that she had not abused her drugs or developed a tolerance.

The patient told a nurse in the spring and early summer of 2021 that she was having suicidal thoughts. The patient also said that she was feeling guilt and shame over her illness. The patient expressed a wish to kill herself to a nurse towards the end of July 2021. She even described how she would do it. A note about this was added to the patient's rather lengthy medical history. The entry was not flagged as a risk factor. The patient tried to commit suicide by taking an overdose of her prescription medication in mid-August. This was not the method that she had described to the nurse. The patient was moved to the emergency department of

[2] Physical; relating to the body.

the central hospital, from where a doctor referred her to Moisio Hospital for voluntary treatment.

During her admission interview in Moisio Hospital, the patient told a house officer[3] that she had taken the drugs in order to kill herself and that she had been planning this for a while. It was decided that the objective of inpatient care would be to stabilise the patient's mental health. The house officer updated the patient's records during her hospital stay at the end of August, concluding that the patient was not an acute runaway or suicide risk and could therefore be allowed home leave. A Bachelor of Medicine who was acting as senior ward physician at the time assessed the patient in September and concluded that her mental health had not improved. She was still delusional.

The patient had to move wards during her hospital stay, which she found stressful. The move was precipitated by the patient's diagnosis and treatment needs as well as human resourcing on the wards. She asked to be moved back to her previous ward, which she felt was quieter. The patient cheered up when the Bachelor of Medicine acting as senior ward physician promised to move her back. However, it turned out that the move back was not possible, which a senior medical officer communicated to the patient. The patient was disappointed but appeared to accept the situation. She would have preferred to have stayed on her original ward.

Hospital staff were aware of the patient's previous drug overdose but had not noticed the entry that a nurse had made in July about her desire to commit suicide by a different method. The patient killed herself as she had described.

All three suicides came as a surprise to nursing staff.

None of the deceased had any drugs other than their prescription medication in their blood.

2.4.2 Organisations and safety management

The **South Savo Social and Health Care Authority** (Essote) is responsible for providing all social and health care services with the exception of environmental health care, veterinary medical care, occupational health care and certain specialist services for people with intellectual disabilities on behalf of the participating local authorities. Essote was founded in 2017, and it covers nine local authorities, two of which only get their specialised medical care services from Essote and provide their other social and health care services themselves. Essote covers an area with a population of approximately 100,000.

Essote is managed based on rules adopted by its Council of Governors and policies issued by its Board of Directors. Essote's organisation consists of separate divisions for Family and Social Services, Services for the Elderly and Disabled People, Health Care Services, and Group Administration and Services. Moisio Hospital is part of the Health Care Services Division's Department of Mental Health and Substance Abuse Services.

A treatment plan is drawn up for each patient in **Moisio Psychiatric Hospital**. Treatment is provided on a multi-professional basis, which means that patients are seen not only by doctors and nurses but also, for example, therapists and social workers. Pharmacotherapy is an essential part of treatment. The treatment programme includes lessons in life management and social interaction as well as health-related behavioural counselling as required. Patients

[3] 'House officer' refers to a medical student performing practical training as part of their studies. House officers are not qualified doctors and therefore cannot make independent decisions about patients' treatment. They work under the guidance and supervision of other members of staff.

on the acute wards typically spend between a few days and a couple of weeks in the hospital, while patients on the high-security ward can stay from a few months to several years. Patients are offered an opportunity to continue as outpatients after they are discharged.

The **doctors** in Moisio Hospital include two senior medical officers and senior ward physicians. Among the senior ward physicians are general practitioners in training and Bachelors of Medicine, which is why staff turnover tends to be relatively high. One of the senior medical officers is on call whenever a Bachelor of Medicine is on duty. House officers do not have official job titles or job descriptions, and they always work on an internship basis. Moisio Hospital generally expects its psychiatric interns to have completed at least three years of medical school. Medical students who show an unusually keen interest and ability in psychiatry may, in special circumstances, be taken on as house officers on a short-term basis after just two years of studies.

The same **head nurse** was temporarily in charge of all three wards in the autumn of 2021. The morning shift usually consists of between four and six nurses, the evening shift of five or six nurses, and the night shift of between two and four nurses per ward.

Each patient is assigned their own **primary nurse** when they are first admitted. Responsibility for individual patients is divided between the nurses on duty at the start of each shift. The primary nurse looks after his or her own patients when on duty. When the primary nurse is off duty, the nurse who relieves them checks in on each of the patients for whom they are responsible during their shift at least once an hour. If a patient cannot be located, a call is placed to the patient's mobile telephone.

Patients with **outdoor privileges** can spend time outdoors unsupervised. The routes that patients can take when outside are explained to them by their primary nurse at the start of inpatient care. There are no restrictions on the movements of patients who check themselves into the hospital of their own free will. For patients committed against their will, various degrees of restrictions on unsupervised access to areas outside of the ward can be imposed by a doctor and relaxed as deemed appropriate. The nurse who opens the door to a patient wishing to go outside notifies the nurse officially in charge of the patient in question verbally. Time spent outdoors is recorded in the information system if this is deemed relevant in terms of the patient's condition and treatment plan.

There is a **notice board in the office on each ward** that shows each patient's situation on the day in question. The board lists all the patients on the ward, as well as their primary nurses, relief nurses, whether they have outdoor privileges, and all other key issues relating to their daily care. Any talk of death or other signs of suicidal intent are also recorded on the board.

The nurses have access to an emergency button that they can press to alert other nurses in an **emergency.** The nurses on other wards are also automatically alerted to ensure fast access to help.

The hospital applies the relevant Current Care Guideline[4] to **assess and identify suicide risk** in patients. This involves the use of the Safety Planning Intervention (SPI)[5], which is a brief,

[4] Current Care Guidelines are a national set of independent, evidence-based clinical practice guidelines. Current Care Guideline for preventing suicides and treating people who have attempted suicide. Published on 7 January 2020. Revised on 18 February 2022.

[5] The Safety Planning Intervention (SPI) consists of a written, prioritised list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis. The basic components of the SPI include utilising social contacts and social settings as a means of distraction from suicidal thoughts and restricting access to lethal means.

collaborative intervention between a patient and their primary nurse towards the end of their time in hospital. No SPI had been conducted with the patients subject to this investigation.

Suicide risk assessment is based on clinical judgement. When a patient is first admitted, they are asked a series of open and closed questions by a doctor and nurses to assess their situation. There is no specific questionnaire.

There are also no written instructions for assessing suicide risk in the course of inpatient care, and instead staff are advised on this verbally. The assessment is based, among other things, on continuous monitoring of patients by nursing staff, and it therefore relies heavily on professional experience, intuition and instinct. A doctor is called in to assess the situation if any suicidal behaviours are observed.

In the event of a suicide, the on-call psychiatrist must be called to attend immediately if the doctor on duty is not a specialist in psychiatry. All suicides are reported to the police. The deceased's next of kin are given the news over the telephone by a doctor. The doctor also alerts the providers of crisis services in the home town of the individual(s) whom the patient had identified as their next of kin. The aim is to ensure that the deceased's next of kin get the help they need. The next of kin are also encouraged to attend a face-to-face meeting with members of hospital staff. After the meeting, the next of kin are told to call the hospital at any time.

The need to **share the news with other patients who are on the ward at the time** is assessed on a case-by-case basis whenever a suicide or a suicide attempt occurs. The assessment takes into account the scene of the incidents, whether other patients witnessed the incident, and their reactions. If the patient had to be resuscitated on the ward or if another patient witnessed the suicide or suicide attempt, it may be necessary to talk about the incident with a wider group of affected individuals. A decision as to whether or not to share the news is taken by the doctor on duty together with the on-call doctor and later by the senior ward physician. If the patients on the ward appear to want to talk about the incident, their primary nurse and doctor will talk to them.

Essote's client and patient safety plan had been updated in the spring of 2021. The client and patient safety committee reviews the plan at regular intervals and makes updates as required in the course of the annual quality control and management process. The committee is headed by the medical director, and the plan is signed off on by Essote's Managing Director. The plan includes, among other things, procedures for safety risk assessment and management. The plan can be viewed in the safety portal of Essote's intranet.

The client and patient safety committee reviews progress reports received from different sources as well as measures taken and proposed by individual units. The committee draws up proposals of improvements and issues recommendations of actions to increase safety as required. The committee also compiles reports on client and patient safety across the organisation for Essote's Board to include in its report of operations once a year.

Safety priorities in 2021 related to pressure ulcer monitoring, pharmacotherapy plans, follow-up on trips and falls, and the use of therapeutic holding in the child psychiatry outpatient department.

The plan does not mention the identification of suicide risk or suicide prevention during inpatient care or in connection with psychiatric outpatient care.

Essote uses a software tool called HaiPro[6] for **reporting client and patient safety incidents**. Employees are instructed to make a note in the system every time there is an adverse event relating to patient care that caused or could have caused harm to the patient. The system issues an alert about each new entry of this kind to two members of staff who are responsible for the ward's operation – the head nurse and the chief medical officer, for example – who will then process the entry and decide what action should be taken to rectify any shortcomings in the ward's operation that contributed to the incident.

Entries made in the HaiPro system and feedback from patients are reviewed at regular staff meetings openly, constructively and without finger-pointing. Discussing close calls and adverse events together is a learning opportunity and ensures that corrective measures are communicated to everyone. These staff meetings are also an opportunity to spot any gaps in staff's training and competence. The lessons learned are translated to unit-specific and organisation-wide development plans designed to prevent the same mistakes from being repeated in the future.

A summary is compiled of all incidents across Essote and published on the intranet three times a year. The aim is to draw attention to incidents and the chains of events or contributing factors that led to them. This kind of reporting creates opportunities to discuss patient safety at different levels of the organisation so as to improve the patient safety culture without finger-pointing. Regular reporting to higher levels of the organisational hierarchy also helps to emphasise the importance of patient safety in health care decision-making.

Staff in Moisio Hospital made a total of 17 **HaiPro entries concerning suicidal intent or suicide attempts** between 2015 and 2021, which equates to approximately two to three per year. Of the three incidents subject to this investigation, one was in the system.

In nine cases, the person who dealt with the entry suggested that news of the incident should be shared and discussed in order to prevent recurrence. In four cases, it was recommended that the incident be reported to a higher level in the organisation. One of these cases involved a patient breaking a window made of regular glass with no security film, the second involved a patient self-harming with a broken bowl, the third was a patient who committed suicide on the ward, and the fourth involved a patient attempting to leave the ward by breaking the safety glass on the door. The person who dealt with the HaiPro entry proposed corrective measures in two cases. One was to introduce more stringent security checks, and the other was to remove the cords from window blinds. No recommendations were given in the other two cases.

The proposed improvements had not been implemented, and the number of recommendations of corrective measures entered into the system following adverse events was generally low. It appears that nursing staff's motivation to formally report incidents varies. Many consider it a waste of time. They feel that any recommendations they make rarely lead to concrete changes.

According to Essote's client and patient safety plan, all **serious incidents** must be reported immediately to the medical director in the case of health care services and to the senior social welfare officeholder in the case of social services in order to promptly initiate an investigation into the incident and the identification of corrective measures.

A decision on the launching of an investigation and the composition of the investigative team is taken by the medical director or the senior social welfare officeholder. The investigative

[6] HaiPro is a web-based tool for reporting client and patient safety incidents.

team collects all relevant information about the events leading up to the incident and produces an analysis of the incident. The team then uses the results of the analysis to come up with recommendations and viable proposals of concrete measures for preventing the identified risks in the future. The recommendations are implemented in the course of the hospital's regular operational decision-making and management processes.

One case of suicide that occurred in Moisio Hospital in 2019 was investigated as a serious incident.[7]

The next of kin of the patients subject to this investigation have not filed **objections**[8] with Essote.

2.5 Preventive measures by the authorities

Supervising the operation of health care providers is the responsibility of the National Supervisory Authority for Welfare and Health (Valvira) on a national level and Regional State Administrative Agencies on a regional level. The competent regional supervisory authority in Essote's case is the Regional State Administrative Agency for Eastern Finland. Valvira and the Regional State Administrative Agencies have agreed on a division of responsibilities between them. Valvira always takes charge if a patient dies or is extremely seriously injured. Supervision consists of both proactive and reactive controls.

Proactive controls are carried out in accordance with control programmes and plans drawn up by Valvira and Regional State Administrative Agencies together. Proactive controls are based on statutory information gathering exercises or, in some cases, Valvira's own investigations. Enforcement of the maximum waiting times for health care is an example of proactive controls. The priorities of proactive controls are determined by, for example, government policy statements and legislative reforms. One of the current priorities is ensuring the provision of basic-level child and adolescent mental health and substance abuse services. Adult mental health services have not been a priority in proactive controls for years.

Reactive controls are largely based on complaints filed by patients or their families, although the authorities can also instigate controls based on information received from other sources. The Regional State Administrative Agency for Eastern Finland has received a total of 21 complaints regarding the operation of Moisio Hospital since 2018, of which seven have been investigated further. None of these concerned inpatient suicides. A total of 14 complaints led to a reminder procedure. No complaints requiring an administrative response have been filed regarding the hospital since 2019.[9]

In the case of the **deaths under investigation**, the supervisory authorities received no reports from the hospital and no complaints from the patients' next of kin. Valvira decided to instigate reactive controls in Moisio Hospital on the basis of media reports about the incidents. The control settlement has been issued in May 2022.

The supervisory authorities emphasise the importance of service providers' self-monitoring procedures in all their activities.

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7 The investigation is discussed in section 2.8.4.

8 If a patient is dissatisfied with the service, care or treatment they have received, they can file an objection with the head of the relevant service provider or the competent senior officeholder.

9 The competent Regional State Administrative Agency continuously monitors the use of limitations on patients' right of self-determination in psychiatric hospitals such as Moisio Hospital. The Mental Health Act (1116/1990) stipulates that a report on the isolation and tying down of patients must be submitted to the competent Regional State Administrative Agency at two-week intervals.

2.6 The organisations that participated in the rescue activities and their readiness

Pre-hospital emergency medical care in Mikkeli is provided by Essote, and rescue services are provided by the South Savo Rescue Department. Mikkeli is part of the jurisdiction of the Eastern Finland Police Department.

Crisis support for bereaved families in the local authorities that Essote covers is provided by Mikkeli Crisis Centre, which is operated by the South Savo branch of MIELI Mental Health Finland. The next of kin of one of the patients in this case live in the East Savo Hospital District, where the crisis centre operator is the Savonlinna branch of MIELI Mental Health Finland.

2.7 Laws, regulations and guidance

Pursuant to the **Mental Health Act**[10], the provision of mental health services that are regarded as part of the public health system is the responsibility of local authorities, and the provision of mental health services that are regarded as specialised medical care is the responsibility of joint municipal boards for hospital districts. Mental health services must be provided primarily on an outpatient basis and in a manner that promotes patients' seeking help on their own initiative and managing independently.

Doctors employed by a health centre or an emergency department have a legal duty to refer a patient for psychiatric evaluation[11] in a hospital if they find that the patient most likely satisfies the criteria for involuntary admission.

A person can be admitted for observation in a hospital in order to determine whether there are grounds to commit them to treatment against their will. Admission for observation requires that a doctor employed by the hospital concludes that the conditions for committing the patient to involuntary treatment are likely to be met. The doctor responsible for observing the patient must issue a written opinion on their condition[12] no later than on the fourth day after the patient was admitted for observation. The opinion must set out in detail the reasons why the conditions for committing the patient to involuntary treatment are or are not met.

The final decision as to whether or not to commit the patient against their will[13] rests with a senior medical officer in charge of psychiatric care in the hospital. The patient must be allowed to express their views before a decision to commit them is made.

Pursuant to the **Health Care Act**[14], health care services must be of high quality, safe and appropriately provided. Service providers have a legal duty to draw up a plan on quality management and the implementation of patient safety. The plan must set out arrangements for improving patient safety in cooperation with social services.

Pursuant to the **Decree of the Ministry of Social Affairs and Health on the plan on quality management and the implementation of patient safety**[15], the plan must include, for example, procedures for anticipating safety and quality deviations and for identifying and managing safety risks. The plan must also address the identification and reporting of dangerous situations and adverse events, how adverse events are entered into the health care

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[10] 1116/1990.
[11] Form M1.
[12] Form M2.
[13] Form M3.
[14] 1326/2010.
[15] 341/2011.

and social services database and reporting system, and what procedures are in place for other statutory reporting and for implementing corrective measures.

Pursuant to the **Decree on Health Care Professionals**[16], medical students who have completed at least the studies pertaining to the first five years of medical school can, on a temporary basis, work as a doctor, emergency service included, under the direction and supervision of a licensed physician.

Medical students who have completed at least the studies pertaining to the first four years of medical school can work as a doctor under the direction and supervision of a licensed physician in a specialised medical care unit. A further requirement for working as a duty doctor is that the student works directly under the direction and supervision of a licensed physician.

Pursuant to the **Act on the Status and Rights of Social Welfare Clients**[17], documents containing information about clients of social services are classified. Information contained in a classified document can only be disclosed with the client's express consent. If the client prohibits the disclosure of information, the secrecy provisions prevent social services from disclosing any information other than what is necessary to establish the client's care needs. Social services can only share information with health care services in so far as it is clear that a client's health, development or safety is in jeopardy and the client's care needs cannot be established or their treatment initiated by other means.

Pursuant to the **Social Welfare Act**[18], other authorities whose services or support are needed to assess the needs of a client of social services have a duty to assist with the needs assessment and the drawing up of a client plan at the case worker's request.

Pursuant to the **Health Care Act**[19], health care professionals employed by joint municipal authorities for health care whose help is needed to assess an individual's need for services under the Social Welfare Act have a duty to assist with the needs assessment and the drawing up of a client plan at the request of social services' case worker.

Pursuant to the **Decree of the Ministry of Social Affairs and Health on the Prescription of Medication**[20], particular care and caution must be exercised when prescribing medication that can be abused. The prescriber must monitor, where possible, how the medication is actually used in order to prevent the development of drug dependency. A patient suffering from drug dependency must, where possible, be treated by a single physician. Valvira has issued a guideline on the prescribing of benzodiazepines (depressants)[21], and Essote has drawn up its own guidance on that basis in the spring of 2020. The guidance is designed to coordinate the prescribing and repeat prescribing of benzodiazepines and thereby to prevent the potential harms of this class of drugs to patients.

The **implementation plan for the Patient and Client Safety Strategy 2017–2021** emphasises the importance of proactive risk management, ensuring patient and client safety skills, and self-monitoring for patient and client safety.

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16 564/1994.
17 812/2000.
18 1301/2014.
19 1326/2010.
20 1088/2010.
21 Prescribing of benzodiazepines. Revised on 17 June 2020. https://www.valvira.fi/terveydenhuolto/hyva-ammatin-harjoittaminen/laakehoidon-erityistilanteita/bentsodiatsepiinien-maaraaminen

The implementation plan is accompanied by a guide for social welfare and health care organisations on **investigations of serious safety incidents**[22]. The guide provides detailed instructions for the investigation of serious incidents. According to the guide, any recommendations arising from investigations must be communicated to the entire organisation to allow other units to also learn from the experience.

According to the **National Mental Health Strategy and Suicide Prevention Agenda**, the prevention of suicides requires improvements to existing actions and developing new approaches[23]. Mortality trends in different socio-economic groups indicate significant levels of inequality.

The strategy lists 36 proposals for reaching the goals of the agenda, which relate to awareness raising, impacting the means of suicide, early intervention, supporting risk groups, developing care options, increasing media competence, and strengthening knowledge basis and research.

Proposals relating to developing care options include, among others, the following[24]:

- Continued collaboration in organising suicide prevention training for social welfare and health care professionals.
- Developing evidence-based care models for people at risk of suicide, particularly in relation to new electronic approaches. Consolidating care approaches that follow the Current Care Guideline for preventing suicides and treating people who have attempted suicide.
- Providing people at immediate risk of suicide with urgent psychiatric consultation to assess treatment needs and developing a treatment plan that includes safety planning if necessary.
- Strengthening collaboration between experts-by-experience, community organisations, early intervention and health care agencies.
- Facilitating a high-quality management system for a compassionate care culture.

Proposals relating to strengthening knowledge basis and research include, among others, the following[25]:

- Providing research funding for new, digital solutions for suicide prevention.
- Extending accident and incident investigations to include a so-called 'psychological autopsy' in the event of suicides. Initially this will be implemented in relation to young people who have died by suicide, eventually covering all suicides that have occurred during treatment or within a month of discharge.
- The Finnish Institute for Health and Welfare launches a national suicide register for the purpose of monitoring and assessing the quality of suicide prevention actions, and enabling suicide research.

[22] Haavisto, E, Helovuo, A, Kinnunen, M & Peltomaa, K (2012). *Vakavien vaaratapahtumien tutkinta: Opas sosiaali- ja terveydenhuollon organisaatioille* [Investigations of serious safety incidents: a guide for social welfare and health care organisations]. The Finnish Society for Patient and Client Safety. Turku: Multiprint Oy.

[23] The Safety Investigation Authority, Finland investigated a collision between a passenger car and a bus in Karkkila on 4 July 2015 (Y2015-02). It was evident based on the investigation that the accident was a suicide. Following its investigation, the Safety Investigation Authority recommended that the Ministry of Social Affairs and Health launch a new special suicide prevention programme and make it a national health objective to significantly reduce the number of suicides, similar to other Nordic countries.

[24] Proposals 19, 20, 22, 23 and 24.

[25] Proposals 29 to 31.

The **Current Care Guideline[26] for *preventing suicides and treating people who have attempted suicide*** focuses, in respect of suicide prevention, on the role of health care in the treatment of all patients and, in respect of those who have attempted suicide, on psychiatric treatment provided by social welfare and health care professionals.

According to the guidance, a previous suicide attempt is the strongest predictor of a subsequent death by suicide. It is therefore important to talk through the entire chain of events that led to the suicide attempt with the person in question. Asking about a person's suicidal thoughts does not increase the risk of suicide. Any assessment of the need for psychiatric hospitalisation must take into account the severity of the psychiatric disorder and especially whether the person is psychotic, deeply depressed or clearly unstable, presents an immediate risk of suicide, or satisfies the criteria for involuntary admission laid down in the Mental Health Act[27].

Interventions targeting suicidal behaviours can significantly reduce the risk of another suicide attempt. The guidance lists a number of interventions with scientifically demonstrated effectiveness, such as the Safety Planning Intervention (SPI), as well as structured assessments of mental status. According to the guidance, a structured interview has the potential to make the identification of suicidal thoughts and suicide attempts more reliable. The Current Care Guideline explains that, based on the experiences of suicidal patients with a history of psychiatric hospitalisation, factors that help to prevent inpatient suicides include human interaction, a sense of safety, and a controlled environment.

2.8 Other studies

2.8.1 Separate psychiatric report

A separate psychiatric report was drawn up in the course of the investigation based on an evaluation by an expert in psychiatry of the care and medication of the three patients in question as well as the suicide risk assessment measures that had been taken. The expert's opinions have been incorporated into section 2.4 of the report.

2.8.2 Suicides as a phenomenon

Suicides are a serious health problem for society. The World Health Organization (WHO) has prepared a menu of timely, evidence-based and cost-effective interventions for suicide prevention. Suicide is always a rare occurrence even among those suffering from severe mental illness.[28] A previous suicide attempt is the most significant risk factor for suicide.[29]

Finland has a high suicide rate compared to other Nordic countries.[30] Since not all those who attempt suicide end up in treatment as a result of the attempt, the number of suicide attempts can only be estimated. The number of suicides committed in Finland in 2020 was 717, which

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[26] Current Care Guidelines are summaries drawn up by experts of the effectiveness of diagnostics and care of individual diseases. They are not intended to replace the assessment of a doctor or other health care professional regarding the best possible diagnostics, treatment and rehabilitation of an individual patient when making care decisions. The Current Care Guideline for preventing suicides and treating people who have attempted suicide was published on 7 January 2020 and revised on 18 February 2022.

[27] 1116/1990.

[28] Tahvanainen, M, Riipinen, P, Jääskeläinen, E & Halt, A-H (2021). Miten itsemurhariskiä voidaan arvioida? [How should suicide risk be assessed?] *Duodecim Medical Journal* 137(9): 952–932.

[29] Ribeiro, J, Franklin, J, Fox, K, Bentley, K H, Kleiman, E M, Chang, B P & Nock, M K (2016). Self-injurious thoughts and behaviors as risk factors for future suicide ideation, attempts, and death: a meta-analysis of longitudinal studies. *Psychological Medicine* 46(2): 225–236.

[30] Tahvanainen, M, Riipinen, P, Jääskeläinen, E & Halt, A-H (2021). Miten itsemurhariskiä voidaan arvioida? [How should suicide risk be assessed?] *Duodecim Medical Journal* 137(9): 952–932.

was 29 less than in 2019. Suicide mortality, i.e. the number of suicides per 100,000 people, was 13 in 2020; the figure for men was 19, and the figure for women was 7.[31] The most careful estimates put the number of suicide attempts in Finland at approximately 10,000 per year.[32]

The actual number of suicides is higher than what the statistics show. A death is only recorded as a suicide if the person drawing up the death certificate knows for certain that the death was a suicide. If, for example, the possibility of an accident cannot be fully excluded, the cause of death is classified as *undetermined*. The Safety Investigation Authority, Finland has called attention to this fact in connection with, for example, previous investigations into deaths by drowning.[33]

A positive turnaround occurred in suicide mortality approximately 30 years ago during the National Suicide Prevention Project (1986–1996).[34] Suicide mortality has dropped by 30 per cent in the last 10 years, more in relative terms among women than among men.[35] Suicide mortality among men is still higher than among women. Although the Finnish Institute for Health and Welfare compiles statistics on suicides by age group and gender, there are no statistics available on, for example, suicides committed during hospitalisation or institutional care. The COVID-19 pandemic did not increase suicide mortality among Finns in 2020.[36]

Suicidal thoughts have not increased across the adult population as a whole, but especially highly educated women now have more suicidal thoughts. While the percentage of highly educated women who had suicidal thoughts in 2018 was 4.2%, the figure was as high as 7.4% in 2020. According to scientists, this phenomenon is worrying and warrants more research.[37]

There is a strong correlation between suicides and **loneliness**. Loneliness is, above all, a personal experience and therefore difficult to define exactly. Loneliness is a form of stress that makes people more likely to make life choices that are harmful for their health. The causes of loneliness are diverse and intertwined. They often relate to changes in important social relationships, or to loss of physical performance and opportunities to play an active role in society due to, for example, illness.

Loneliness is detrimental to health. Brain and mental health risks brought on by ageing include, among others, loss of mental and physical activity, bereavements, and feelings of loneliness and redundancy. Among the elderly, loneliness is linked with perceived ill health, memory loss, elevated blood pressure, heart conditions, and premature death. A person who feels lonely is more likely than others to use psychiatric medication and health care services as well as to be admitted to hospital on an emergency basis.[38]

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31 Official Statistics of Finland (OSF): Causes of death in 2021.

32 Gaily-Luoma, S (2020). Itsemurhaa yrittäneiden kokemukset ammattilaisen apuna [Service-user experiences of attempted suicide can guide clinicians]. *Finnish Medical Journal* 75(38): 1926–1930.

33 Safety Investigation Authority, Finland (2011). *Deaths by Drowning in Finland between 1 April 2010 and 31 March 2011*. Investigation report S1/2010Y.

34 Vorma, H, Rotko, T, Larivaara, M & Kosloff, A (eds) (2020). *National Mental Health Strategy and Programme for Suicide Prevention 2020–2030.* Publications of the Ministry of Social Affairs and Health 2020: 15. Helsinki: Ministry of Social Affairs and Health.

35 Official Statistics of Finland (OSF): Causes of death in 2021.

36 Partonen, T, Kiviruusu, O, Grainger, M, Suvisaari, J, Eklin, A, Virtanen, A & Kauppila, R (2021). Suicides from 2016 to 2020 in Finland and the effect of the COVID-19 pandemic. *The British Journal of Psychiatry* 220(1): 38–40.

37 Suvisaari, J, Appelqvist-Schmidlechner, K, Solin, P, Partonen, T, Parikka, S, Koskela, T & Ikonen, J. Aikuisväestön mielenterveys ja avun hakeminen mielenterveysongelmiin – FinSote 2020 [Mental health and help-seeking for mental health problems among the adult population – National FinSote Survey 2020]. *Data brief* 42/2021. Helsinki: Finnish Institute for Health and Welfare.

38 The Finnish Medical Society Duodecim (2020). *Aivot ja mieli – terveyden ja hyvinvoinnin edistäminen* [The brain and the mind – promotion of health and well-being]. Consensus statement published at a consensus conference.

A project launched as part of the **Government's analysis, assessment and research activities** resulted in a proposal to introduce a set of indicators for client and patient safety in 2021, which would include descriptions of so-called hotline indicators, or 'never events'. Reporting and tracking of the indicators would help to give those in charge immediate access to information about adverse events and allow them to instigate corrective and preventive measures in a timely manner. The number-one objective is for organisations to learn from adverse events. The proposal recommends including an indicator for *suicides during psychiatric inpatient care* in the new national measurement framework for client and patient safety.[39]

In the context of suicide research, the **Werther effect**[40] refers to a suicidal person's mimicking the suicidal behaviour of someone else. The Werther effect can lead a person to commit suicide after learning about the suicide of a person close to them. In the cases under investigation, the other two patients were already being treated in Moisio Hospital when the first suicide occurred. They may have found out about the incident.

A patient's suicide is a traumatic event for **nursing staff** and can lead to what has been termed the 'second victim' phenomenon.[41] A patient's suicide can be a source of stress for members of nursing staff and cause their work performance to suffer, in addition to which such an event can breed distrust towards colleagues and supervisors across the organisation. A special second victim manual[42] has been produced to deal with such situations.

2.8.3 Assessment and prevention of suicides in psychiatric inpatient care

The ability to assess the risk of suicide is an integral element of a doctor's professional competence. The task is extremely challenging. In assessing a patient's suicide risk the doctor collects and analyses information about the patient's mental status, symptoms and background by interviewing them in respect of both risk factors and protective factors.[43]

A patient's history of attempted suicide and suicide intent can be assessed with the help of structured indicators and assessment tools, such as the Columbia Suicide Severity Rating Scale (C-SSRS) and the Suicide Intent Scale (SIS), which are incorporated into psychiatric care guidelines.

According to the relevant Current Care Guideline, interventions targeting suicidal behaviours can significantly reduce the risk of another suicide attempt. The interventions with scientifically demonstrated effectiveness recommended in the Current Care Guideline include cognitive behavioural psychotherapy, the Safety Planning Intervention (SPI) and dialectic behavioural therapy in connection with borderline personality disorder.

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39 Virkki, M, Leskelä, R-L, Ikonen, T, Haatainen, K, Welling, M, Rauhala, A, Tiirinki, H, Mustonen, P, Jormanainen, V, Rautava, P, Cansel, A, Heikkilä, K, Inkinen, V, Isotalo, J, Kalliokoski, J, Siimar, M, Sorsa, O, Syrjä, V & Ylitalo, P. *Potilas- ja asiakasturvallisuuden tilannekuva ja seurantamenettelyt: Ehdotus seurannan mittaristoksi* [Current situation of patient and client/customer safety and follow-up procedures in Finland: A suggestion for a measurement framework]. Publications of the Government's analysis, assessment and research activities 2021:68. Helsinki: Prime Minister's Office.

40 The phenomenon is named after Goethe's novel *The Sorrows of Young Werther*, in which a young man ends up committing suicide in response to unrequited love.

41 Qinwen, S, Wang, Y, Hou, K, Zha, H & Sun, X (2021). The psychological experiences of nurses after inpatient suicide: A meta-synthesis of qualitative research studies. *Journal of Advanced Nursing* 77(10): 4005–4016.

42 Leskinen, S (2019). Mitä tapahtuu virheen tekijälle? [What about the one who made the mistake?] *Finnish Medical Journal* 74(18): 1108–1109.

43 Tahvanainen, M, Riipinen, P, Jääskeläinen, E & Halt, A-H (2021). Miten itsemurhariskiä voidaan arvioida? [How should suicide risk be assessed?] *Duodecim Medical Journal* 137(9): 952–932.

It is known that suicide prevention requires multi-professional and multi-level cooperation between social services and health care services.[44] Moreover, most suicides are preceded by the suicidal person's having been in contact with someone in health care services. However, these individuals are often not diagnosed with a psychiatric condition. This is why it is especially important for primary health care staff to learn to identify mental illness and suicidal behaviours.[45] Help must be offered proactively especially to patients who openly talk about suicide or who have attempted suicide in the past, as well as to the families and loved ones of suicide victims.[46]

The suicide risk of mental health patients is higher than that of the rest of the population and significantly higher than the average within the first three months after discharge from a psychiatric hospital. The risk is multiplied in patients who are known to have suicidal thoughts or behaviours.[47]

Inpatients must be made to feel safe. Hospitals also should not have means or tools for suicide available.[48] There are nevertheless differences in patient safety cultures between groups of professionals and hospitals. More attention needs to be given to patient safety culture and the factors that influence it in psychiatric hospitals.[49]

Essote has launched an early intervention project called 'Apua Ajoissa!' [50], which is designed to reduce the number of suicides by providing better services for suicidal people and people who have previously attempted suicide. The project also seeks to find new ways to prevent suicides. There are plans to increase nursing staff's competence in the identification and prevention of suicide risk.

The project began with a needs assessment that included an extensive survey among Essote's staff concerning, for example, their personal competence and care processes. According to the responses[51],

- approximately one in three employees encounters suicidal individuals through their work at least weekly,
- almost four-fifths of staff have not been given training relating to the prevention of suicides,
- less than one in three employees considers the way in which suicidal people are referred to treatment in their own unit to be systematic, and

[44] Laukkala, T, Jylhä, P, Isometsä, E, Koponen, H, Marttunen, M, Wahlbeck, K, Laajasalo, T, Vuorio, A & Pirkola, S (2020). Itsemurhaa yrittäneen psykiatrinen hoito – Kysy, kuuntele ja hoida perussairaus [Psychiatric assessment of suicide attempters – ask, listen and ensure appropriate care]. *Finnish Medical Journal* 75(38): 1920–1925.

[45] Pajunen, K (2020). *Itsetuhoisten henkilöiden hoidon kehittäminen julkisella sektorilla – Kuvaileva kirjallisuuskatsaus* [Improving the care of suicidal patients in the public sector – Descriptive literature review]. Bachelor's thesis. Diaconia University of Applied Sciences.

[46] Partonen, T, Kiviruusu, O, Grainger, M, Suvisaari, J, Eklin, A, Virtanen, A & Kauppila, R (2021). Suicides from 2016 to 2020 in Finland and the effect of the COVID-19 pandemic. *The British Journal of Psychiatry* 220(1): 38–40.

[47] Chung, D T, Ryan, C J, Hadzi-Pavlovic, D, Singh, S P, Stanton, C & Large, M (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry* 74(7): 694–702.

[48] Laukkala, T, Jylhä, P, Isometsä, E, Koponen, H, Marttunen, M, Wahlbeck, K, Laajasalo, T, Vuorio, A & Pirkola, S (2020). Itsemurhaa yrittäneen psykiatrinen hoito – Kysy, kuuntele ja hoida perussairaus [Psychiatric assessment of suicide attempters – ask, listen and ensure appropriate care]. *Finnish Medical Journal* 75(38): 1920–1925.

[49] Kuosmanen, A (2021). *Patient Safety Culture in Forensic Psychiatric Hospital Care. Health Care Staff Perceptions*. Dissertation in Health Science. Publications of The University of Eastern Finland. Joensuu: PunaMusta Oy.

[50] The project is set to run for a fixed period in 2021 and 2022, and it is being coordinated and implemented by Essote in cooperation with the South Savo health and social services reform team. The Central Finland Hospital District as well as the Police, crisis centres and regional organisations are also contributing to the project. The project receives funding from the Ministry of Social Affairs and Health. Statistics show that suicide mortality is higher than average in both South Savo and Central Finland.

[51] n = 282.

- just over half are familiar with some or all of the risk scenarios set out in the Current Care Guideline for suicide prevention.

According to the responses collected from staff of the Department of Mental Health and Substance Abuse Services[52],

- 70% of employees encounter suicidal individuals through their work at least weekly,
- two-thirds have not been given training relating to the prevention of suicides,
- almost half do not consider the way in which suicidal people are referred to treatment in their own unit to be systematic, and
- almost three in four are unable to say, or do not know, what peer support models are available.

The needs assessment shows that there are weaknesses relating to both employees' competence and ability to use methods of preventing suicides and the way in which clients are advised.

The Hospital District of Helsinki and Uusimaa carried out a pilot project concerning **inpatient suicide risk assessment and treatment** in Jorvi Hospital in the autumn of 2021. The project involved piloting a new operating model on ward P2, which treats inpatients suffering from acute mood disorders.

The operating model is based on a doctor's assessment of suicide risk in connection with each patient's admission interview based on the patient's current circumstances. There are four risk levels: *low*, *moderate*, *high* and *very high*. The assessment process includes, among other things, questions based on the Columbia Suicide Severity Rating Scale (C-SSRS), such as whether the patient has previously had suicidal thoughts and/or whether they have previously attempted suicide.

Each patient's estimated daily suicide risk level is shown on the notice board in the ward office using a colour-coding system. After the initial assessment, it is the nurse responsible for each patient who plays a key role in reviewing and revising the estimated risk level as required. A change from moderate to high risk can mean, for example, that the patient is no longer permitted to go outside without supervision or that they are moved from a single room to a twin room. High-risk items can be removed and access to certain objects on the ward restricted based on the assessment. Ward safety is continuously monitored by staff members and assessed at least once a year by an external safety expert.

The Safety Planning Intervention (SPI) tool is employed as soon as the patient is well enough. The SPI can be carried out in multiple stages and without an instruction from a doctor. The outcome of the SPI is recorded in the Apotti information system, and a copy is printed out for the patient. The patient can take a picture of the printout and save it on their telephone. Patients must have easy access to their personal SPI results. The pilot project also seeks to emphasise the role of discharge planning in the context of suicide prevention, as suicide mortality is known to increase after discharge from a psychiatric hospital.

There is some variance in the use of **digital solutions** to ensure patient safety between psychiatric hospitals. Surveillance technology is most typically used to control access to individual wards and buildings. Examples of the use of smart technology include smart floors in Niuvanniemi Hospital for the Criminally Insane, which are also used in care services for the

[52] n = 87.

elderly. The floors react to patients' movements. Data from the floors is fed to the office for staff to see.

Digital solutions are also used to some extent in the provision of remote psychiatric consultations and rehabilitative care. Senior ward physicians in Moisio Hospital provide consultations remotely. The Hospital District of Helsinki and Uusimaa's Jorvi Hospital uses remote technology to allow psychiatric outpatients undergoing long-term rehabilitation to participate in ward-based activities.

It appears based on information gathered in the course of the investigation that technology has advantages but is no substitute for physical interaction with nursing staff. There are also certain ethical and legal conditions to the use of digital solutions.

The public health care system is suffering from a **shortage of psychiatrists**. According to the Finnish Psychiatric Association, approximately one-third of psychiatric vacancies are currently unfilled in the Southern Finland catchment areas for specialised medical care, i.e. in Helsinki, Turku and Tampere. The number of unfilled vacancies further east and north in the catchment areas of Kuopio University Hospital and Oulu University Hospital respectively amounts to between approximately 40% and 60%. Many of the filled vacancies are held by doctors in training or part-time staff. One of the core problems is the fact that not enough young doctors choose to specialise in psychiatry to compensate for the loss of retiring psychiatrists. Although the popularity of psychiatry has increased slightly in the last decade, the just under 30 specialists who graduate each year are not enough to satisfy the demand, which currently stands at approximately 45 specialists per year.

2.8.4 Investigations into psychiatric inpatient suicides

Inpatient suicides can be investigated by individual health care units. There is no standardised procedure for sharing the results of investigations carried out by individual health care units with other similar providers, which means that the lessons learned generally only benefit the unit in question or, at the most, the service provider's organisation.

An inpatient in **Moisio Hospital** committed suicide towards the end of 2019. An internal investigation was carried out on the medical director's instructions. The investigation revealed a number of non-compliances and factors that contributed to the incident. The investigation team came up with four recommendations:

- Moisio Hospital needs an operating model that ensures that nurses always know what is going on with the patients for whom they are responsible.
- Toilets must be fitted with alarms that alert staff in the ward office if, for example, a toilet remains occupied for an excessively long time.
- A procedure needs to be introduced that allows staff to check which patients are on the ward and which patients are outside.
- A system of delegation needs to be put in place that determines how patients are handed over to other staff on duty if a nurse is too busy.

The recommendations were discussed in staff meetings after the internal investigation, in addition to which one ward adopted a written policy that addressed the themes of the recommendations.

Valvira is generally only competent to investigate psychiatric inpatient suicides if it receives a complaint concerning the operation of a specific health care unit. Valvira's document management system does not provide detailed enough statistics to search for all cases involving inpatient suicide. Establishing the number of suicides that have led to enforcement

action would require going through all enforcement decisions concerning psychiatric treatment.

Valvira's enforcement decisions are not public documents. Sometimes a summary is produced and made available in the public domain. Valvira occasionally publishes these kinds of **summaries** on its website. One summary published in 2017 concerns an inpatient suicide. In that case, a young woman had been diagnosed with bipolar disorder, and she had previously suffered from alcoholism. The patient had checked herself into the hospital on her own accord. A week later, the patient was doing slightly better, although she had had some suicidal thoughts. Two weeks after checking into the hospital, the woman went for a walk outside and committed suicide.

In its report, Valvira concludes that the patient did not have a diagnosis for acute psychosis that would have warranted committing her to treatment against her will. Her medication was appropriate based on the information that was available at the time, although in hindsight her dose should have been higher. The patient was suffering from intensive compulsions, which may have justified keeping her under closer supervision.

Valvira felt that the patient's care had been appropriately planned, implemented and tracked. Nothing had come to light during the patient's time on the ward based on which her unfortunate suicide could have been anticipated and prevented. Valvira therefore did not find any mistakes or negligence in the patient's care.

2.8.5 Swedish practices in the tracking and investigation of suicides

Suicide statistics from Sweden[53] show a total of 1,168 suicides in 2020, of which 72% were committed by men and 28% by women. The overall suicide rate[54] among people aged 15 years and older was 14, with the figure for men being 20 and the figure for women being 8. Suicides were most common among men aged 85 years or older; the suicide rate in this age group was 44. The lowest suicide rate, just under 4, was recorded among women of the same age group.

The authority responsible for supervising and coordinating patient and client safety in social and health services in Sweden is the **Health and Social Care Inspectorate (IVO)**. IVO carries out risk-based controls based on its own risk analysis. The risk analysis is based on previous findings of IVO's own controls as well as observations made by other operators, such as the Patient Insurance Association, local and regional authorities, patient committees and patient organisations.

Sweden has introduced a reporting procedure for adverse events called **Lex Maria**, which is based on patient safety legislation[55]. Lex Maria requires providers of social and health services to report to IVO all events that have, or could have, caused significant harm to patients. This includes inpatient suicides. However, the legal obligation to report suicides was abolished on 1 September 2017, after which the number of reports made has dropped by approximately one-quarter. Including suicides, a total of 2,070 Lex Maria reports were filed in Sweden in 2020, of which 51 led to further action.

The Swedish authorities have published a manual for the **investigation of serious medical injuries**, which all social welfare and health care units must follow. The manual sets out an investigation procedure and an event analysis methodology. All social welfare and health care

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[53] Sweden has a population of 10.35 million.
[54] Number of suicides per 100,000 people.
[55] Patient Safety Act (659/2010).

incidents with serious consequences must be investigated. The objective of investigation is to establish the course of events and the factors that contributed to the incident as well as to devise a framework of methods that can help to prevent recurrences.

2.8.6 Interviews with experts-by-experience

'Experts-by-experience' are individuals who have personal experience of an illness or injury and who have completed a training course in being an expert-by-experience. The experience-based knowledge that experts-by-experience can contribute has proven invaluable in the development of services. Experts-by-experience also give hope to others who are going through the same issues. Strengthening collaboration between experts-by-experience, community organisations, early intervention and health care agencies is one of the recommended measures included in the national suicide prevention agenda.

Two experts-by-experience were interviewed in the course of the investigation. Both had personal experience of psychiatric hospitalisation and had attempted suicide in the past.

The experts-by-experience emphasised the importance of feeling safe while in a psychiatric hospital. They identified having a good relationship with the primary nurse as the most important source of a sense of safety. It is good for nursing staff to be easily identified based on, for example, a uniform or a photographic ID badge. A feeling of safety is also promoted by staff interacting respectfully with patients, protecting them from their own destructive impulses, and controlling the environment. Suicidal patients need someone else to set boundaries for them.

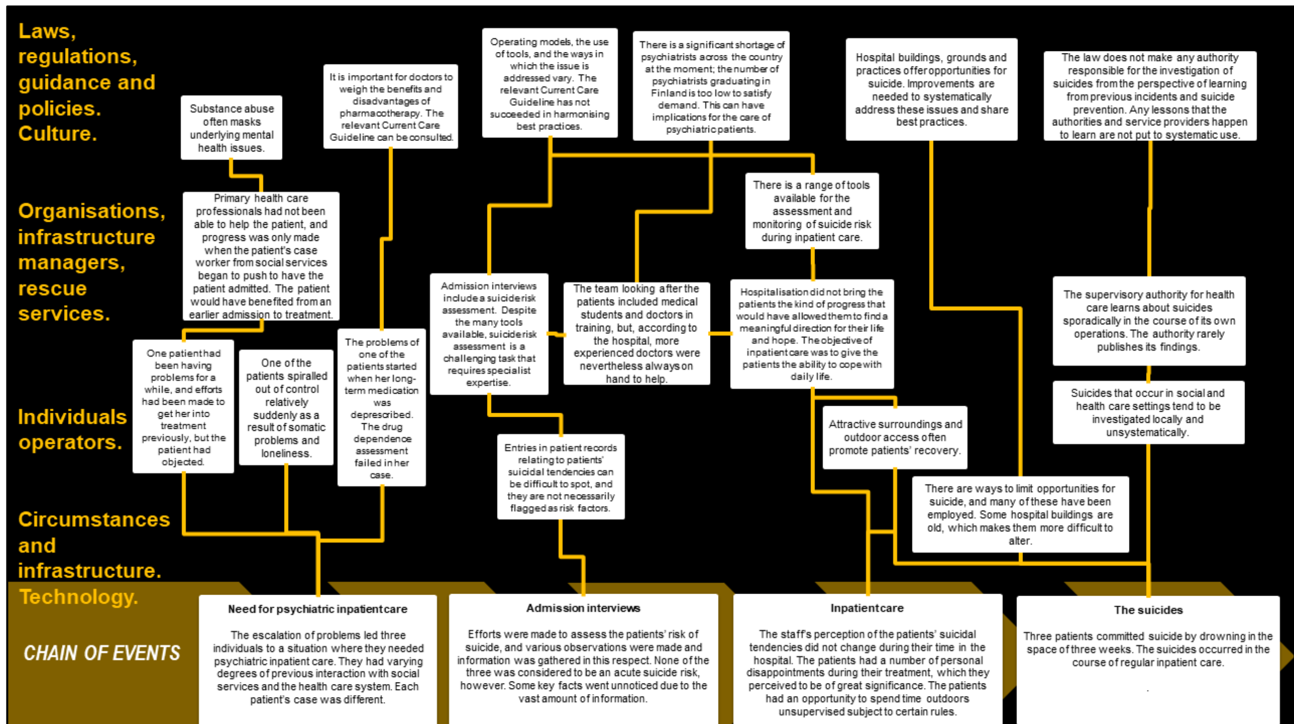
Recovery can also be accelerated by a well-structured ward layout and attractive décor, as well as having opportunities to withdraw from others on the one hand and to spend time with others on the other. Some patients prefer to be in a room on their own, while others want to share a room with another patient. Being allowed to wear their own clothes also makes patients feel safer.

Patients admitted following a suicide attempt lack the resources to deal with everyday misfortunes and can react extremely strongly to disappointment. The situation begins to improve as their recovery progresses. It is important for nursing staff to discuss thoughts relating to suicide with patients despite the fears that the topic can arouse not just in patients but also potentially in members of staff. Suicide as a concept can evoke feelings of guilt in patients. The term 'self-harming' can be used instead. If a patient is otherwise unable to express their feelings verbally, a suicide risk assessment questionnaire can be used. The questionnaire can help staff to better understand how much the patient is suffering. The experts-by-experience welcomed the SPI approach, as it gives patients clear instructions of what to do when suicidal thoughts take hold.

Inpatients need signals that give them hope of recovery and returning home cured. Each patient should be allowed to take part in activities and go outside according to how they are feeling. The experts-by-experience described other patients as peers with whom to share experiences. On the other hand, they had been frightened by the experiences and outbursts of other patients. Keeping in regular contact with family and friends is important. Carefully planning each patient's future care and agreeing on the details is an essential part of treatment, as without them the patient is left in limbo.

3 ANALYSIS

The incidents were analysed using the Safety Investigation Authority's version of the AcciMap[56] method. This analysis is structured according to the AcciMap diagram drawn up during the investigation. The accident is described as a chain of events at the bottom of the diagram. The factors contributing to the chain of events are arranged in the diagram on multiple analytical layers.



Picture 2. AcciMap diagram drawn up by the investigation team. (Picture: SIAF)

3.1 Event analysis

3.1.1 Need for psychiatric inpatient care

Three individuals found themselves in a situation where they no longer had the resources to deal with the escalation of their problems. They needed psychiatric inpatient care. Each patient's case was different.

One had a history of substance abuse and frequent interactions with health care services. Attempts had been made to get her into treatment previously, but she had objected.

Primary health care professionals had not been able to help the patient, and progress was only made when the patient's case worker from social services began to push health care services to admit the patient. The patient would have benefited from an earlier admission to treatment. As a rule, social and health care services have as their aim the promotion of well-being and health in consensus with the client or patient. Committing a person to treatment against their will always requires very strong grounds.

In this case, the patient had been labelled as a substance abuser and troublemaker, which delayed her diagnosis. The patient's medical history focused on her substance abuse issues. It

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[56] Rasmussen, J & Svedung, I (2000). *Proactive Risk Management in a Dynamic Society.* Karlstad, Sweden: Swedish Rescue Services Agency.

appears from her records that little effort had been made to detect other psychiatric illnesses. It is clear that the patient was denied appropriate clinical assessment due to social stigma[57].

Mental illnesses and substance abuse are common among those who attempt suicide. These must be appropriately diagnosed and treated. Substance abuse often masks underlying mental health issues, which can delay access to treatment.

The second patient spiralled out of control relatively suddenly as a result of somatic problems and loneliness. Loneliness is a personal experience and detrimental to health. The causes of loneliness are diverse and intertwined and often relate to changes in social networks and loss of physical performance. Preventing loneliness is an important means of protection against the risk of suicide.

The third patient had had their long-term medication deprescribed 18 months before her admission to the hospital. Despite a new drug regimen to replace her previous medication, the patient began to deteriorate, which led to a suicide attempt and then hospital admission. The patient's earlier medication had been deprescribed because she was found to have developed a dependence on the medication. However, drug dependency cannot be diagnosed solely based on a patient's having taken the same medication for years. It is important for doctors to weigh the benefits and disadvantages of pharmacotherapy. The Current Care Guidelines provide more detailed information about the care practices associated with specific drugs.

3.1.2 Admission interviews

An admission interview, which included a suicide risk assessment, was conducted with each of the patients when they were first admitted. This allowed staff to make observations and gain information about their suicidal tendencies. None of the three was considered to be an acute suicide risk.

The notes concerning one contained an entry about the patient's having previously described a specific method by which they wanted to commit suicide. The entry went unnoticed due to the mass of information in the patient's record. Suicidal tendencies are not necessarily flagged as risk factors in client and patient information systems, which can make the information difficult to find if there is a lot of other information on file.

There is a range of tools available for the assessment of suicide risk, and a list of those with scientifically demonstrated effectiveness is included in the relevant Current Care Guideline. Suicide risk assessment is a challenging task that requires specialist expertise, which is why staff must be given regular training and familiarised with ways to prevent suicides. Asking about a person's suicidal thoughts does not increase the risk of suicide.

3.1.3 Inpatient care

The staff's perception of the patients' suicidal tendencies did not change during their time in the hospital. The patients were, for example, allowed to spend time outdoors unsupervised. The patients encountered a number of personal disappointments during their treatment, which they perceived to be of great significance. Being in hospital is a big change from patients' normal routine and habits. Hospitalisation did not bring the patients the kind of progress that would have allowed them to find a meaningful direction for their life and hope.

Attractive surroundings and outdoor access are known to promote patients' recovery, which is why the threshold for limiting these is high. The objective of inpatient care is for patients to

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[57] Stigma in this context refers to a label that associates a person with a set of unwanted characteristics, leading to shame, suffering and loss of self-esteem.

get better, maintaining their physical performance and giving them the tools to cope with the help of outpatient care after their discharge, i.e. to lead as normal a life as possible.

The team looking after the patients included medical students and doctors in training. According to the hospital, more experienced doctors were nevertheless always on hand to help. The number of psychiatrists graduating in Finland is too low to satisfy demand, and there is a shortage of psychiatrists in the public sector. This can have implications for the care of psychiatric patients.

Suicide risk assessment and monitoring continue after the admission interview throughout inpatient care. Operating models, the use of assessment tools, and the ways in which the issue is addressed vary.

The aim of the relevant Current Care Guideline is to make the prevention of suicides in the health care sector more efficient, but it has not succeeded in harmonising best practices. The implementation of the guidance is not enforced systematically as part of national suicide prevention efforts.

3.1.4 The suicides

Three psychiatric inpatients committed suicide by drowning in the space of three weeks. The suicides occurred in the course of regular inpatient care.

There are ways to limit opportunities for suicide, and many have been employed both in psychiatric hospitals in general and in Moisio Hospital specifically. Some hospital buildings are old, which makes them more difficult to convert into ideal psychiatric facilities.

Hospital buildings, grounds and practices offer opportunities for suicide. Improvements are needed to systematically address these issues and share best practices. Several new development projects are in progress in Finland at the moment, which are designed to incorporate psychiatric wards into central hospitals. However, the use of digitalisation and technological improvements in client and patient safety are largely sector, project or operator-specific. New solutions and best practices are not sufficiently or systematically shared between operators.

Suicides that occur in social and health care settings can be investigated locally by the relevant unit, but there is no obligation to do so. Internal investigations are based on each unit's own judgement and tend to be unsystematic. Any lessons learned from such investigations are only shared within the organisation in question and therefore do not end up benefiting efforts to promote client and patient safety in social and health care services more broadly.

The supervisory authority for health care does not investigate suicides systematically and instead generally only gets involved if a complaint is filed. Summaries of investigations are published in some cases. The supervisory authority holds back information that could be useful for learning.

The law does not make any authority responsible for the systematic investigation of suicides from the perspective of safety and suicide prevention. Any lessons that the authorities and service providers happen to learn are not put to systematic use.

4 CONCLUSIONS

The conclusions include the causes of the accident or incident. A cause means the various factors behind the incident and the direct and indirect circumstances affecting it.

1. Several notices of concern had been filed concerning one of the patients over the years, which were being dealt with by primary health care professionals. Efforts had been made to get the patient into treatment at an earlier time. The patient objected to hospitalisation. The patient would have benefited from an earlier admission to treatment. Progress was only made when the patient's case worker from social services took an active role in the patient's case.

   Conclusion: *Primary health care practices may not have the capacity to respond to the needs of multimorbid patients in a timely enough manner. The best outcome can be achieved when social services and health care services work together.*

2. One of the patients began to deteriorate 18 months before her admission to hospital when her long-term medication was deprescribed. The patient's new drug regimen did not have the desired effect. There is no mention in the patient's notes about anyone ever having considered switching the patient back to her earlier medication.

   Conclusion: *Effective pharmacotherapy is a key element of the treatment of psychiatric patients, and changes in the drug regimen can have a significant impact on a patient's health. A decision to deprescribe medication is not necessarily reviewed even when the patient is showing no signs of improvement.*

3. The notes concerning one of the patients included an entry about the patient's having described in detail how they intended to commit suicide before she was admitted to hospital. The entry had not been flagged as a risk factor and was not communicated to hospital staff. The patient killed herself as she had described.

   Conclusion: *Information relating to a patient's behaviour is not necessarily flagged as a risk factor, which makes it possible for information that would be critical for the patient's care to get lost amid client and patient records.*

4. Assessments made in the course of inpatient care failed to detect the patients' suicidal tendencies. Operating models, the use of tools, and the ways in which the issue is addressed vary. The relevant Current Care Guideline has not succeeded in harmonising best practices. Suicide risk assessment is a challenging task that requires specialist expertise.

   Conclusion: *The structured methods described in the Current Care Guideline are not always employed systematically, and instead assessment often relies on interviews and observation.*

5. The team looking after the patients on the psychiatric ward included medical students, doctors in training, and psychiatrists. According to the hospital, inexperienced doctors always had easy access to the expertise of the more experienced members of staff.

   Conclusion: *There is a shortage of psychiatrists in the public health care system, which is in part due to not enough students wishing to specialise in psychiatry. Psychiatrists and other specialists play a critical role in ensuring the standard of psychiatric inpatient care and patient safety.*

6. Efforts have been made to eliminate opportunities for suicide on psychiatric hospital wards. Inpatients' freedom of movement can only be restricted if their treatment

absolutely requires it. The hospital environment offers opportunities for suicide, and improvements are needed to systematically address these issues and share best practices.

> ***Conclusion:*** *There is no such thing as a risk-free hospital environment, as it is never possible to eliminate all risks. The objective of inpatient care is to enable patients to cope with daily life, and achieving this objective requires patients to have as much freedom as possible. This makes patient-specific risk assessment all the more important.*

7. Service providers can, if they so wish, investigate patient suicides, but any lessons learned from these investigations that could improve safety are generally only shared within the service provider's own organisation. The competent supervisory authority also has an opportunity to investigate patient suicides that occur in social and health care service settings. The authority only sporadically publishes findings of its investigations.

> ***Conclusion:*** *The law does not make any authority responsible for the systematic investigation of inpatient suicides from the perspective of learning from previous incidents and suicide prevention. Any lessons that the authorities and service providers happen to learn are not put to systematic use.*

5 SAFETY RECOMMENDATIONS

5.1 Suicidal tendencies should be flagged as a risk factor in patient information systems

It can be difficult to spot important entries in client and patient information systems among all the information contained in patient records, if these entries are not clearly flagged as risk factors. Flagging risk factors is a key element of the work of social services and health care professionals as well as their efforts to ensure patient and client safety.

The Safety Investigation Authority recommends that

The Finnish Institute for Health and Welfare take it upon itself to ensure that entries relating to suicide risk are flagged as risk factors in its coding service. The recording of information about suicide risk needs to be promoted as part of the information strategy of the new well-being services counties and efforts to improve the recording practices of social and health care services in general in order to ensure that information relating to risks is easy to find and can be used to improve patient safety. [2022-S15]

The Finnish Institute for Health and Welfare's coding service[58] makes it possible to record information so that suicide risk is shown more clearly and logically in the risk factor window of patient information systems. The code sets of the coding service are being revised in 2022.

5.2 Ensuring access to the specialist expertise of psychiatrists

Psychiatric patient care requires specialist expertise. However, there is a substantial shortage of psychiatrists, which means that the teams looking after seriously ill and multimorbid psychiatric patients include not only psychiatrists but also medical students and doctors in training. Psychiatrists play a critical role in ensuring the standard of care and patient safety, even if inexperienced doctors have easy access to the expertise of more experienced members of staff.

There is a range of tools available for suicide prevention and the assessment of suicide risk in psychiatric patients, but using them requires specialist expertise and their use varies. The implementation of the relevant Current Care Guideline is not enforced.

The Safety Investigation Authority recommends that

The Ministry of Social Affairs and Health take it upon itself to ensure that each well-being services county has enough specialist competence and services to offer its clients and patients according to their myriad psychiatric needs. More specialist training is needed on the detection of psychiatric multimorbidity and the prevention of suicides, which must be provided in collaboration with education providers and labour market operators. More psychiatrists are needed in the public health care system. [2022-S16]

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[58] The Finnish Institute for Health and Welfare's coding service is designed to harmonise, on a national level, the data structures used in the electronic patient and client information systems of social welfare and health care providers. Such data structures include, among others, code sets, classifications, terminologies and register entries. The coding service also helps to ensure the standard of data structures as well as their maintenance and development.

It can take years to increase the number of psychiatrists. The timely identification of needs and higher levels of competence can also be promoted by means of basic-level and in-service training focusing on the detection of psychiatric multimorbidity and the prevention of suicides, as well as by sharing best practices and the adoption of new tools and operating models.

5.3 Investigating suicide attempts and suicides that occur in social and health care settings

Finland lacks a clear understanding of suicide attempts and suicides that have occurred in social and health care settings. These incidents are not systematically investigated, and the statistics that do exist are not comprehensive. The big picture is missing. The competent supervisory authority has no obligation to investigate suicides. It rarely publishes reports of its findings, which means that information that could be useful for learning is not disseminated. Whether or not to investigate serious adverse events is mostly left for individual service providers to decide, and the lessons learned from such investigations are not shared with others.

The Safety Investigation Authority recommends that

The Ministry of Social Affairs and Health take it upon itself to ensure that a harmonised operating model for the investigation of patient and client suicides and suicide attempts is introduced across the whole of the social welfare and health care system and kept up to date. Any lessons learned from investigations that could help to improve safety must be shared across and between well-being services counties as part of the efforts to continuously improve the standard of safety management and the implementation of the national patient and client safety strategy. [2022-S17]

The operating model for the investigation of serious adverse events must be incorporated into, for example, each service provider's self-monitoring plan as part of its patient and client safety culture, knowledge management and risk management policies. The national Client and Patient Safety Strategy and Implementation Plan 2022–2026 also emphasises the importance of clear operating models for the investigation, reporting and learning from serious adverse events in every social welfare and health care unit. The strategy makes it the responsibility of the Ministry of Social Affairs and Health to update the guidance on the investigation of serious adverse events.

The National Mental Health Strategy and Programme for Suicide Prevention 2020–2030 recognises the need to establish a national suicide register. This task has been assigned to the Finnish Institute for Health and Welfare, which is the social services and health care registration authority in Finland.

5.4 Measures that have been taken

Essote has launched an early intervention project called 'Apua Ajoissa!', which is designed to improve the services available to previous suicide attempters, suicidal people and their families in cooperation with nursing staff, non-governmental organisations and experts-by-experience. The project team is aiming to finalise its new operating models for suicide prevention by the autumn of 2022. One of the team's recommendations is to always flag a previous suicide attempt as a risk factor in patient records. The team is working in close cooperation with the Finnish Institute for Health and Welfare.

The **Ministry of Social Affairs and Health** published a new national Client and Patient Safety Strategy and Implementation Plan for the years 2022 to 2026 in February 2022. The strategy addresses, among other things, serious adverse events and how they should be handled. Procedures for the handling of serious adverse events of national significance are also being revised under the Ministry of Social Affairs and Health's coordination during 2022.

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Investigation materials

1) Photographs, measurements and other materials from the site investigation
2) Information on weather and other conditions
3) Consultations with the parties involved
4) Patient and client records
5) Interviews with experts-by-experience
6) Examination of the practices of the Hospital District of Helsinki and Uusimaa's Jorvi Hospital
7) Enquires into the digital solutions of Niuvanniemi Hospital
8) Consultation on the opportunities presented by digitalisation with the Finnish Psychiatric Association
9) Recordings of the calls made to emergency services
10) Police reports as well as aerial photographs and video footage of the hospital grounds
11) Emergency services' resource and accident statistics (Pronto)
12) Finnish Institute for Health and Welfare's cause-of-death records and forensic chemistry and forensic medicine findings
13) Finnish Institute for Health and Welfare's records on suicides in Finland between 2016 and 2021
14) Finnish Institute for Health and Welfare's statistics on the health and well-being of Finns

15) Official Statistics of Finland (OSF): Causes of death in 2021
16) OECD's suicide statistics from 2021
17) WHO's suicide records from 2021
18) Suicide statistics of the Public Health Agency of Sweden
19) Statistics of the Swedish Health and Social Care Inspectorate (IVO)
20) Statistics and records of the Swedish National Board of Health and Welfare
21) Findings of controls carried out by the National Supervisory Authority for Welfare and Health (Valvira)
22) Findings of Regional State Administrative Agencies' controls
23) National coding service of the social welfare and health care administration
24) Separate psychiatric report
25) National Mental Health Strategy and Programme for Suicide Prevention 2020–2030
26) National Client and Patient Safety Strategy 2022–2026
27) Patient and Client Safety Strategy 2017–2021 of the Ministry of Social Affairs and Health
28) Client and patient safety plans and guidance on the prescribing of benzodiazepines of the South Savo Social and Health Care Authority (Essote)
29) CCTV footage from Moisio Hospital
30) Entries made by staff of Moisio Hospital in the HaiPro adverse events reporting system as well as guidance and plans relating to safety and risk management
31) Information about the outdoor areas of Moisio Hospital and improvements carried out at the hospital
32) Information on the number of staff required at Moisio Hospital and the hospital's actual human resources as well as staff training documentation and information on staff's qualifications
33) Resources associated with South Savo's 'Apua ajoissa!' early intervention project
34) Current Care Guidelines of the Finnish Medical Society Duodecim

SUMMARY OF COMMENTS REGARDING THE DRAFT INVESTIGATION REPORT

The draft investigation report has been reviewed by the Ministry of Social Affairs and Health, the National Supervisory Authority for Welfare and Health (Valvira), the Finnish Institute for Health and Welfare, the Regional State Administrative Agency for Eastern Finland, the South Savo Social and Health Care Authority (Essote), and the next of kin of the deceased. The Safety Investigation Act prohibits the publication of opinions expressed by private individuals.

The **Ministry of Social Affairs and Health** points out, regarding the first recommendation that concerns the Ministry, that it is aware of the need to train more specialists and is keeping a keen eye on forecasts for the number of medical students in different fields. The shortage of specialists in Finland is set to get worse in the coming years due to retirements. The availability of psychiatrists in particular is already an issue. The Ministry of Social Affairs and Health has launched an intragovernmental programme aimed at ensuring the sufficiency and availability of social services and health care personnel. The Ministry's division for the coordination of specialist training in medicine and dentistry and specific training in general medical practice issues annual recommendations on the number of students that universities should admit in each specialty. The action plan for specialist training in medicine and dentistry also involves increasing national coordination of the various specialties.

Regarding the second recommendation concerning the Ministry of Social Affairs and Health, the Ministry notes that serious adverse events and how they should be handled are addressed in the Client and Patient Safety Strategy published in February 2022. Procedures for the handling of serious adverse events are also being revised under the Ministry of Social Affairs and Health's coordination during 2022. The Client and Patient Safety Strategy emphasises the importance of incorporating clear operating models for the investigation, reporting and learning from serious adverse events into each service provider's self-monitoring plan, along with a clear division of responsibilities. Service providers are also advised to draw up procedures for debriefing and defusing crises and serious adverse events, and all social welfare and health care units must have access to appropriate guidance. The Finnish Centre for Client and Patient Safety has been put in charge of monitoring progress towards the objective.

The **National Supervisory Authority for Welfare and Health (Valvira)** notes in its comments that enforcement decisions contain confidential patient information and cannot therefore be published in full. Valvira's policy is to publish summaries of decisions of public interest on its website. Despite the small number of summaries that are available in the public domain, Valvira regularly consults its previous enforcement decisions and uses the lessons learned from historical cases to, for example, advise and disseminate information to social welfare and health care operators, the Finnish Institute for Health and Welfare, the Ministry of Social Affairs and Health and other interested parties. Valvira intends to step up the rate of publication, but it also has other means by which it shares its knowledge.

Valvira notes on a general level that the risk of suicide can be lowered by the proper identification and appropriate treatment of mental health issues. However, not even the best possible treatment can eliminate the risk of suicide altogether. Even patients receiving standard and appropriate therapy have been known to commit suicide. In any case, patients who are being treated in a psychiatric hospital benefit from the most intensive care and observation available, and the patients themselves as well as their loved ones have a right to expect (especially in the case of involuntary admissions) that the care facility will assume much of the responsibility for identifying and preventing any risk of suicide.

A project called Suicides in Finland investigated every suicide that had occurred in Finland in 1987 (1,397 suicides). Of the victims, approximately five per cent had been inpatients in a psychiatric hospital at the time of their suicide. There appear to have been no subsequent studies of a similar kind in Finland. Since both the rate of psychiatric hospitalisation and the percentage of psychiatric patients who end up in hospital have decreased concurrently with a significant drop in the number of suicides, it should be safe to assume that the number of inpatient suicides has at least not increased. In other words, approximately 95% of suicides are not associated with psychiatric inpatient care, and studies focusing exclusively on inpatient suicides are unlikely to provide a basis on which general conclusions about suicide rates and suicide prevention could be drawn.

Valvira points out that the risk of suicide among psychiatric inpatients is not at its highest during hospitalisation but after discharge from hospital. The risk peaks in the first month after discharge ('post-discharge period'), when it can be as high as 200 times the patient's normal lifetime risk.

Valvira's comments also clarify some of the terminology used in the draft version of the investigation report as well as the parts of the report in which Current Care Guidelines and Valvira's role are discussed.

The **Finnish Institute for Health and Welfare** agrees that inpatient suicides warrant careful investigation and considers it very much justified for the Safety Investigation Authority to have investigated these incidents that resulted in the deaths of three people. The Finnish Institute for Health and Welfare considers the draft version of the investigation report to be well written and clear. In the Finnish Institute for Health and Welfare's opinion, the report is well researched and covers multiple perspectives.

According to the Finnish Institute for Health and Welfare, the investigation of inpatient deaths is in most cases limited to a forensic medical examination and the relevant hospital's internal investigation, and there is currently no rule about investigating inpatient deaths. Investigations are consequently only conducted in some cases, as the decision on whether or not to investigate is at the relevant hospital's discretion. Compared to an individual hospital's internal investigation and a forensic examination of the cause of death, the advantages of a safety investigation include its broader analysis of the course of events and of the circumstances that made it possible for a suicide to occur.

The Finnish Institute for Health and Welfare notes that the draft version of the investigation report does not provide any details or even summaries of police investigations or forensic examinations of the cause of death. An investigation report of this kind would benefit from the inclusion of separate sections dealing with these investigations and examinations. The Finnish Institute for Health and Welfare also notes that the report does not specify the psychiatric diagnoses of the deceased but mentions only that the patients had suffered from multimorbidity, substance abuse issues and drug dependency. More detailed diagnoses could have been provided without compromising the victims' anonymity. The separate psychiatric report was not yet available when the Finnish Institute for Health and Welfare drafted its opinion. The investigation report would benefit from the inclusion of a procedure that doctors would be required to follow in the event of a suicide. The Finnish Institute for Health and Welfare calls attention to the importance of training staff to deal with suicidal patients and of always having the support of more senior colleagues readily available. It appears based on entries made in the HaiPro system in recent years that new procedures instructed on the basis of the reported incidents have not been implemented in practice.

In the Finnish Institute for Health and Welfare's opinion, conducting an investigation in the event of a suicide should not be a choice but an obligation. Reporting cases of suicide to the competent supervisory authority should become routine. Valvira should conduct more investigations on its own initiative and not just when a complaint is filed. Initiating an investigation should be a given; a more systematic approach could potentially be promoted by obligating hospitals or hospital districts / well-being services counties to report incidents to either Valvira or the Regional State Administrative Agency similarly to what is done in Sweden. The Finnish Institute for Health and Welfare proposes making Regional State Administrative Agencies responsible for disseminating the lessons learned from safety investigations, since these agencies already work closely with psychiatric hospitals due to their supervisory role. Deaths resulting from suicides that occur in the closely monitored settings of psychiatric hospitals undermine the public's trust in an element of the psychiatric care system that should be able to protect mentally unstable people in all circumstances.

The Finnish Institute for Health and Welfare points out that admitting a person to a psychiatric hospital for observation and potentially committing them to treatment against their will thereafter are procedures designed for psychiatric emergencies in which the only option is to limit the person's constitutional rights. A person going through such an emergency needs not just appropriate pharmacotherapy and interactive care but also close monitoring, and allowing patients to wander around hospital grounds unaccompanied by nursing staff can hardly be considered a practice conducive to patient safety. The threshold for subjecting patients to locked doors and constant supervision should be low, as the closeness of another human being also makes patients feel safe and gives them an opportunity to engage in social interaction during periods of lucidity. Such an intensive form of psychiatric inpatient care usually requires an additional nurse on two shifts as well as reshuffling of the division of responsibilities among nursing staff accordingly. Any decisions to limit patients' right of self-determination should always be supported not only by a patient-specific clinical psychiatric risk assessment based on interviews with, and knowledge of, the patient in question but also the kinds of structured methods described in the relevant Current Care Guideline. Furthermore, the Finnish Institute for Health and Welfare notes that the resourcing of psychiatric hospitals should be planned and coordinated so as to ensure that every region has enough inpatient capacity per capita, including enough capacity for involuntary psychiatric admissions.

The Finnish Institute for Health and Welfare's comments also clarify some of the terms used in the draft and propose rewording some sections of the report.

The **Regional State Administrative Agency for Eastern Finland**'s opinion focuses on the issue of deprescribing. The draft version of the investigation report does not consider the possibility that the effect of the patient's change of medication was not monitored systematically enough and not reacted to vigorously enough due to the patient's doctor having changed several times within an 18-month period. The role that the nurse at the outpatient clinic played in monitoring the patient's medication was not explored either. More attention could have been given to the programme for the phasing out of benzodiazepines that Essote's Department of Mental Health and Substance Abuse Services has been pursuing for some years.

The Regional State Administrative Agency for Eastern Finland agrees that spotting a patient's potential suicide intent from among the vast amount of information contained in patient records can be difficult and that it is important for professionals to have access to various kinds of tools for the assessment of suicide risk. Suicide risk assessment requires regular staff training and continuous learning, as well as familiarisation with ways to prevent suicides.

The Regional State Administrative Agency for Eastern Finland notes that the role of each patient's designated primary nurse in the care of the patient and the assessment of their situation was not properly explained in the draft version of the investigation report. The Regional State Administrative Agency for Eastern Finland has learned from complaints that have been filed and from other sources that inpatients in Moisio Hospital sometimes feel lonely. Examining the nursing staff's use of time and the standard of the care they are able to deliver would have been useful from this perspective as well. The Regional State Administrative Agency for Eastern Finland notes that having backup support from experienced professionals is no substitute for face-to-face consultations with, and examinations performed by, seasoned specialists. The Regional State Administrative Agency for Eastern Finland points out that a recently concluded enforcement case involving Essote's Department of Mental Health and Substance Abuse Services (ISAVI/6645/2020) revealed a serious shortage of physicians, but the issue has not been addressed and no action has been taken on a national level.

The Regional State Administrative Agency for Eastern Finland agrees with the conclusion expressed in the draft version of the investigation report that psychiatrists and other specialists play a critical role in ensuring the standard of psychiatric inpatient care and patient safety. The Regional State Administrative Agency for Eastern Finland also concurs with the view that the supervisory authority for health care does not investigate suicides systematically and instead generally only gets involved if a complaint is filed. It notes that Regional State Administrative Agencies have stepped up the publication of summaries of enforcement decisions in recent years, but the cases to be published are selected at random. The supervisory authority's lack of resources and the arbitrariness of controls on adult mental health services prevent a more efficient use of enforcement decisions to support efforts to improve patient safety.

The Regional State Administrative Agency for Eastern Finland also agrees that primary health care practices may not have the capacity to respond to the needs of multimorbid patients in a timely enough manner. Furthermore, the Regional State Administrative Agency for Eastern Finland proposes rewording the description of its own role as well as the sections concerning Current Care Guidelines.

The comments of the **South Savo Social and Health Care Authority (Essote)** include amendments to seven sections of the draft version of the investigation report. Essote emphasises that the decision to launch the investigation was preceded by Essote's request for an investigation. Essote thanks the investigators for their cooperation and for the systematic and thorough investigation. Essote intends to use the lessons learned from the investigation to improve patient safety and safety in general across its organisation.