Clinical Neuropsychiatry (2022) 19, 5, 307-313

PERSPECTIVE PAPER

IS HEALTHCARE RESPONSIBILITY IN PATIENTS' SUICIDE PROVABLE BEYOND ALL REASONABLE DOUBT? AN ANALYSIS OF PREVENTING STRATEGIES AND MEDICAL LIABILITY THROUGH A CASE SERIES

Sara Turco, Federica Gori, Luigi Papi, Liliana Dell'Osso, Barbara Carpita, Aniello Maiese, Emanuela Turillazzi, Marco Di Paolo

Abstract

As a result of the duty of care, the healthcare professional has an obligation of surveillance towards the patients that are under their treatment. According to that principle, the Italian Criminal Supreme Court declared a guilty sentence in many cases of psychiatric patients' suicide, recognizing the criminal liability of the healthcare personnel. This is true not only for suicides occurred inside the hospital, but also for the suicide of psychiatric outpatients. Only in a few cases, the Italian Supreme Court acquitted the healthcare personnel. This happened when it was recognized that the suicide event was unavoidable. Despite the fact that suicide risk is often unpredictable, this does not exclude medical liability. In this work we examine the judicial aspects of five cases of suicide of psychiatric patients, considering whether different preventive strategies could have been effective in preventing the suicide event. This work aims to understand whether the suicide of psychiatric patient is effectively preventable and – referring to healthcare responsibility under penal judgment – if that could be proven beyond all reasonable doubt.

Key words: suicide, psychiatric patients, medical liability, prevention

Sara Turco[1], Federica Gori[1], Luigi Papi[1], Liliana Dell'Osso[2], Barbara Carpita[2], Aniello Maiese[1], Emanuela Turillazzi[1] , Marco Di Paolo[1]

[1] Department of Surgical Pathology, Medical, Molecular and Critical Area, Institute of Legal Medicine, University of Pisa, Via Roma n. 55, 56126, Pisa, PI, Italy
[2] Department of Clinical and Experimental Medicine, University of Pisa, Pisa, Italy

OPEN ACCESS

Citation: Turco, S., Gori, F., Papi, L., Dell'Osso, L., Carpita, B., Maiese, A., Turillazzi, E., Di Paolo, M. (2022). Is healthcare responsibility in patients' suicide provable beyond all reasonable doubt? An analysis of preventing strategies and medical liability through a case series. *Clinical Neuropsychiatry, 19*(5)*,* ??-??.

doi.org/10.36131/cnfioritieditore20220506

Funding: None.

Competing interests: None.

Corresponding author
Barbara Carpita
Via Roma 67
56127 Pisa (Italy)
E-mail: barbara.carpita1986@gmail.com
Phone: +393911105675

Introduction

The duty of care and surveillance specifically related to psychiatric patients has always been a highly debated and still current issue. From the legal-medical point of view, there is the need to analyze the type of surveillance prescribed by the medical doctor and the method of carrying out surveillance performed by nurses. According to the WHO, in 2015 800,000 suicides happened worldwide, the majority of them related to psychiatric diseases (Bachman, 2018). According to the literature (Bachman, 2018), a mental illness can increase the risk of suicide tenfold with respect to the general population. In particular, inpatient suicide is considered a sentinel event, defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof" (The Joint Commission, 2013). In Italy it is recommended to report all sentinel events (Labour, Health and Social Politics Ministry, 2009). According to the national report regarding the years 2005-2012, inpatient suicide was the second most common sentinel event (n=295; 15.4%), following patient's falls causing death or severe harm to the patient (n=471; 24.6%). In a previous report (years 2005-2010) inpatient suicide was instead the first most common sentinel event, with 166 suicide events (19%) vs. 147 (16.8%) reports of patient's falls (Italian Ministry of Health, 2015). Inpatient suicide is considered one of the most common sentinel events also in other countries. In the United States of America, inpatient suicide was among the five most reported sentinel events in the years 1995-2010 (The Joint Commission, 2020). Even though in the USA a national registry of suicides is not available, Williams et al. (2018) reported an average number of inpatient suicides of 48.5-64.9. Previously other authors have reported that inpatient suicides were 1500/year(Busch et al., 2003), although Williams and colleagues consider this data as unreliable, stressing that a similar note firstly appeared in a 1986 work and then was cited again in further works with no specific references (Williams et al. 2018).

In Italy the healthcare liability in cases of inpatient's suicide is linked to the duty of care and surveillance towards the patients, whose safety is under the protection of the healthcare personnel taking care of them. This is indicated in the penal code and stated by the Supreme Court in the definition of «position of warranty» (Italian Penal Code, Article 40), which assigns to these subjects the duty to avoid any risks for patients who are under their care. As a consequence, identifying the risk factors of inpatients' suicide and minimizing them is of the utmost importance in order to avoid the occurrence of these events. In this framework, the aim of the present work was to evaluate the judicial aspects of five cases

of suicide of psychiatric patients, providing a brief review of previous Italian Supreme Court sentences in the field and considering whether different preventive strategies could have been effective in preventing the suicide event.

Risk factors of psychiatric inpatients' suicide: an analysis of the current literature

In order to reduce as much as possible the risk of psychiatric inpatients' suicide, the actual risk factors should be identified, providing effective preventative strategies. According to the scientific literature the main inpatients' suicide risk factors are: a history of previously attempted suicide, the consumption of antidepressants, suffering from physical health problems (particularly chronic pain), poor health prognosis, social stressors, hopelessness and drugs abuse (Sakinofsky 2014). Other risk factors are depressed mood (especially in schizophrenic patients), agitation, anxiety (Fawcett, 1988), impulsivity (Fawcett, 2001), trauma- eating- or personality- disorders (Bachmann, 2018). Some categories, such as prisoners, have a higher suicide risk compared with the general population (Milner et al., 2017; Gradus et al. 2013). According to other authors (Hoyer et al., 2009) the suicide risk of inpatients and recently discharged psychiatric patients is higher when the therapy is ineffective. Some authors (Bertolote et al. 2003) found that mental illness and suicide risk were differently correlated between inpatients and outpatients. According to Bertolote, and Colleagues 45% of inpatient suicides were preceded by schizophrenia and organic mental disorders, while 32% of outpatients who committed suicides were depressed or suffered from substance abuse, somatoform, anxiety, and adjustment disorders. The Italian protocol about the prevention of inpatient suicide (Italian Ministry of Health 2008) recommends to evaluate the suicide risk level of each patient immediately after admission and to stratify the suicide risk according to that evaluation. The suicide risk level needs to be shared among all the healthcare personnel and the therapeutic and healthcare program for the patient must be developed and followed taking into account its specific risk, eventually implementing the surveillance measures.

The scientific literature describes 4 observation levels (Reynolds et al., 2005) related to the suicide risk of the patient:

- Level I: General Observation (every 30-60 minutes)
- Level II: Intermittent Observation (every 10-15 minutes)
- Level III: Within Eyesight (continuous)
- Level IV Within Arm's Length (continuous)

Each level corresponds to a specific level of surveillance, from a minimum (Level I), when the location of the patient should be known all times, but there is no need for the patient to be within sight, to the maximum (Level IV) which means that the patient should never be left alone, even when he/she goes to the bathroom.

Another classification cited in the New Zealand Guidelines for the assessment of people at risk of suicide (New Zealand Guidelines Group, 2003) identifies three observation levels specifically required for psychiatric patients in addition to the basic surveillance level:

- Within reach
- Same room sight
- Frequent observation

The first level is required for patients at extremely high risk of suicide, who have already attempted suicide and suffer from unpredictable psychotic states or who could show impulsive behaviours. In these cases, the presence of more than one nurse could also be required. In the second level the risk of suicide is still high, but there is less concern about impulsive self-destructive behaviours. The third level is required for patients at higher suicide risk compared with other psychiatric patients, or with an uncertain risk of suicide. In these cases, the guidelines recommended to modify the time range of monitoring in order to make it less predictable for the patient himself. Despite these recommendations, one of the main issues in the field of mental disorders is related to the frequent unpredictability of suicide events. In particular, when patients are strongly motivated in their purposes, or when they act impulsively, an effective prevention of the suicide event was reported to be almost impossible (Sakinofsky, 2014). Another issue of psychiatric patients' surveillance is related to the actual possibility to perform a "high-frequency-surveillance" in a period of lack of resources and of spending review policies even for the healthcare system. Even though other measures could be used, such as involuntary commitment for the outpatients or restraint measures for the inpatients, those measures should be employed only when necessary (Evans et al., 2002; Frank et al. 1996; Miles, 1993) and are specifically ruled (Law 180/1978, known as "Legge Basaglia" and Italian Constitution, art. 13 and 32). According to Sakinofsky (2014) the most effective strategy for preventing inpatient suicide is based on active surveillance and environmental prevention. According to the US Veteran Department Affair, environmental risk was reported to play a main role in 84% of the inpatients' suicides (Watts et al., 2017), with an estimated 82.4% decrease of inpatients' suicide (from 4,2/100000 to 0,74/100000) after the introduction of the Mental Health Environment of Care Checklist, which addressed the architectural and environmental strategies to prevent suicide in the hospitals. The authors observed a decrease in the number of inpatients' suicides by reducing the environmental risk, while other studies showed that different preventing strategies, mainly based on the healthcare personnel education, were less effective and with discontinuous results (Shtivelband et al., 2015). From a medico-legal point of view, the real issue concerns the grey areas. If continuous surveillance should be considered unrealistic, the gold standard procedure for these cases remains to be clarified. As a consequence, it may be difficult to objectively evaluate when the event can be considered unpredictable – and therefore there is no health responsibility – and when, on the contrary, the event could be attributable to inadequate surveillance. The analysis of clinical record is surely the most important instrument to answer those questions and, on the other side, a detailed and precise clinical record is the most effective defense weapon in case of medical claims or prosecutions.

Psychiatric suicide: a brief review of the Italian criminal supreme court sentences

Italian Supreme Court – Criminal section n° 10430/2004

This case is related to the fall from height of a patient who had been voluntarily admitted to a psychiatric ward to treat depression. During hospitalization she went outside accompanied by a chaperone. While outside of the hospital, the woman committed suicide by jumping from height.

In this case the Italian Supreme Court – Criminal section pronounced a guilty sentence for the medical staff who was taking care of that patient. The Court sentence was based on the failure to inform the chaperone about the suicide risk of the patient. This gap in the informing process gave the chaperone no possibility to prevent the suicide event, absolving him/her from any responsibility, which was instead charged on the ward physician. Thus the ward physician was sentenced because he did not share the suicide risk with the chaperone and he did not choose the most suitable chaperone to accompany the patient outside of the hospital in a safe condition.

Italian Supreme Court – Criminal section n° 13241/2005

This sentence can be compared to the previous one, being related to a lack of sharing the suicide risk level with the healthcare personnel, although in this case the suicide happened inside the hospital.

The case concerns the suicide of a patient who had been involuntarily admitted to a psychiatric ward after an attempted suicide. During hospitalization he managed to commit suicide while going to the toilet without surveillance and taking his life by hanging.

As in the previous case, there was a guilty sentence because the psychiatrist did not communicate properly the high suicide risk of the patient to the nurses who had to provide the surveillance. This error resulted in a lack of adequate surveillance by the nurses and, as a consequence, in the suicide of the patient.

Italian Supreme Court – Criminal section n° 48292/2008

In this case, a psychiatric patient committed suicide by jumping from height while he was voluntarily hospitalized in a psychiatric ward. The Italian supreme court, criminal section, pronounced a guilty sentence against the psychiatrist who was responsible for the care of patients. This sentence refers to the duty of custody and surveillance that the healthcare professional has towards the patients who rely on his care (Italian Penal Code, Art. 40).

Italian Supreme Court – Criminal section n°4391/2011

This sentence is related to the case of an inpatient psychiatric suicide committed by jumping from height from the window of a nursing home. The criminal judge of the Supreme Court confirmed the guilty sentence for the medical chief of that structure, due to the omission of proper therapy, the lack of surveillance, the lack of effective measures to prevent the patient from reaching the window and jumping off and the omission of the patient's transfer to a more adequate structure, such as a psychiatric ward, where patients have less freedom and the level of surveillance is higher.

Italian Supreme Court – Criminal section n°16975/2013

This is one of the rare not guilty sentences among those of the Italian Supreme Court related to healthcare responsibility in cases of inpatients and outpatients suicide. This case is related to the death of a psychiatric patient while she was staying at a center for mental illnesses. The woman absconded and was found in a river near the center where she was staying. A not guilty sentence was pronounced in all the three degrees of judgment. In particular, the Supreme Court judge recognized that the center for mental illnesses is different from a psychiatric ward, and could be considered a sort of rehabilitation structure, where the patients have more freedom and do not need the higher levels of surveillance typical of a psychiatric ward.

Globally, this brief review (see **table 1**) of Italian criminal jurisprudence clearly highlights that in most of the cases that reached the third degree of judgment (Supreme Court) there was a guilty sentence. The reason for that decision was based on the omission of the duty of custody by the healthcare professional charged to take care of patients. According to the Italian Supreme Court the health of the patient needs to be protected from any threat to its integrity, and that duty lasts for the entire work shift (Italian Supreme Court, 2013; 2008; 2005; 2000). Another reason for the guilty sentences was the lack of sharing with all the healthcare team the suicide risk of the patient. As a consequence of this omission, the opportunity to take all the possible actions to prevent the suicide event was missed. As reported above, according to our knowledge there is only one not guilty sentence, the Italian Supreme Court – Criminal section n°16975/2013. In this case, it seemed like the judge accepted an "allowed risk" of suicide for patients affected by mental disorders. This not guilty sentence was based on the impossibility to verify that different medical procedure could have prevented the suicide for sure, or, according to the criminal law statement, beyond all reasonable doubt.

Table 1. *Overview of the Italian criminal supreme court sentences on psychiatric suicide*

Criminal section sentence n°	Type of patient	Mental illness	Type of structure	Type of admission	Suicide method	Sentence
10430/2004	Inpatient	Depression	Psychiatric hospital	Voluntary	Jumping from height (while on leave)	Guilty
13241/2005	Inpatient	Previous attempt of suicide	Psychiatric hospital	Involutary	Hanging	Guilty
48292/2008	Inpatient		Psychiatric hospital	Voluntary	Jumping from height	Guilty
4391/2011	Inpatient		Nursing home		Jumping from height	Guilty
16975/2013	Inpatient		Center for mental illnesses	Voluntary	Drowning	Not-guilty

Our experience with psychiatric patient suicide: clinical cases presentation

CASE 1 – The lack of surveillance and the environmental inadequacy

The first case is focused on a 40 years old woman with severe anorexia treated with antipsychotics, who was voluntarily hospitalized in a psychiatric ward. At the admission she had a weight of 32 Kg, she was 1.62 m tall and her BMI was 12.3Kg/m^2, compared with a normal BMI of 20-25. She reported a history of esophagitis and intestinal mycosis. During the admission procedures, the medical doctors described severe cachexia and vitamin D deficiency. She showed a delusional psychosis with hypochondria symptoms, but she recognized the severity of her somatic conditions. For this reason she agreed to the hospitalization and to the proposed treatments, as well as to the need to be accompanied when going outdoor.

The day after the admission, she started parenteral nutrition and continued her treatment with antipsychotics. During the hospital stay, she developed anxiety related to the effects of parenteral nutrition, complaining about hepatic enlargement and kidney ptosis. As a consequence, the dosages of the antipsychotics were increased. The patient did not follow group therapies but underwent daily interviews in addition to the pharmacological therapy. During the interviews, she expressed the desire to end her life, so the dosage of antipsychotic therapy was further increased. One month later a clinical improvement was clearly observable, the patient's weight increased and she was more positive about future perspectives. However, the next month she had a resurgence of psychotic symptoms and she revealed to have never taken the prescribed drugs. Subsequently, after that day, it was established that the patient had to take the pharmacological therapy in the presence of the healthcare personnel. The patient should also have to be monitored during the meals, as she refused to eat and was found emptying the parenteral nutrition bags into the toilet. Four months after admission the woman tried to injure herself with an insulin needle. Her room was searched and the nurses found a lancet, scissors, and a telephone wire which they suspected had been introduced through the window. The drug therapy was increased again and the staff was also recommended to supervise any visit. After these events, a slight improvement of her psychical condition was progressively observable, and during the interviews the patient expressed the wish to return home and the will to change her behaviour. One night, 5 months and 6 weeks after the admission, the nurses reported in the medical record that the patient went into the toilet several times. At 6 a.m., they didn't find the woman inside the room. They looked for her, but she was disappeared, so they informed the doctor on duty and at 7 a.m. informed the police. Previously, at 4:55 a.m., the railway police had been contacted by a train chief who noticed a human body on the railway tracks at the local railway station. It was a woman, underweight, lying prone with the head on the line and the rest of the body on the ground just beside the track. She had a burst fracture of the cranial bones with avulsion of the cranial vault and brain exposure. The woman was identified as the patient who had escaped from the psychiatric ward. An autopsy was performed, confirming that the cause of death was the severe head injury due to the railway accident. The rest of the body was undamaged, and the pattern of injury was consistent with a railway suicide. As only two trains passed by that station, respectively at 3:08 and at 3:40 a.m., this should be considered the time range of the patient's death. On the basis of the data and considering video surveillance, it was assumed that the patient reached the station after 2.30 a.m. Walking slowly, the patient should have reached the station from the psychiatric ward within 30-60 minutes, so it was assumed that, hypothesizing that she went straight from the hospital to the station, the approximate time of the escape would have been between 1 a.m.-1.30 a.m. Considering that the medical staff noticed the absence of the patient at 6 a.m. and that, according to the protocols of that hospital, patients had to be monitored by nurses every 1-1.5 hours, unless differently stated by medical doctors, a surveillance gap of at least 5-5.5 hours could be proven. In addition, the handle of the window was found with the patient's belongings while, according to the hospital protocols, handles should be hidden and kept safe by the nurses. For all the reasons mentioned above, even if that case has not been sentenced yet, the probability of a guilty sentence for the healthcare professional on duty that night is quite high.

CASE 2 – Suicide on the ambulance

The second case is related to a 34 years old woman with chronic paranoid schizophrenia and a history of several attempts of self-injury. The woman was involuntarily admitted into a psychiatric ward due to a resurgence of the symptoms of the mental disorder. The psychiatrists prescribed a pharmacological therapy based on antipsychotic drugs. Subsequently, when the patient accepted the treatment, they converted the psychiatric treatment into a voluntary hospitalization and they allowed the patient to be transferred into another hospital. During the transfer the patient committed suicide inside the ambulance. The exact means of suicide remained undisclosed. During the first degree of judgment, a not guilty sentence was pronounced towards the medical staff, while the liability of the volunteer who was inside the ambulance with the patient was recognized. The second degree of judgment modified the previous sentence, stating that the volunteer was not guilty, as the transfer needed to be done with medical staff on board. According to this sentence, a negligent conduct of the psychiatrists who treated the woman was detectable, as they dismissed the patient too early, without waiting an adequate amount of time to evaluate whether the treatment had been effective. They were also liable for having allowed the transfer of the patient without a medical doctor on board, and for not having adequately informed the ambulance volunteer about the suicide risk of the patient. The final sentence for this case is not available yet, and the issue of whether liability would be charged to the volunteer or the medical staff is still being debated.

CASE 3 – Can medical restraints prevent inpatient suicide?

This case concerns a 33 years old patient with a history of epilepsy, no mental disorders, and no previous self-injurious behaviours, who was hospitalized at the neurosurgery department to treat a severe head trauma occurred during a car accident. After an initial period of drowsiness, during the hospital stay the patient became agitated, and as a consequence the medical staff prescribed antipsychotic drugs. Despite the drug therapy, the patient tried several times to get away from

the hospital, in a state of mental confusion. To avoid these escapes, the physicians prescribed medical restraints. These devices were sticky paper bands put around the patient's wrists and tied to the bed. A few days after the prescription of restraints, during the night, the nurses administered the pharmacological therapy to the patient, who was quite agitated, and frequently monitored her. The doctor on duty asked the anesthetist for counsel, who prescribed morphine to make the patient rest. As this type of drug requires the informed consent of a capable patient, and the woman was in an upset state of mind, the doctor on duty preferred to increase the dosage of the antipsychotic therapy. According to the last check recorded in the clinical report, the patient was no longer overwrought 20 minutes after. After a few minutes the patient released herself from the medical restraints and jumped out the window of the hospital ward. According to the legal doctor who evaluated this case of healthcare criminal liability, there were no reasons to transfer the patient into a psychiatric ward, as she was receiving urgent treatments for the head trauma. The patient had no history of suicide attempts. The medical staff prescribed an adequate pharmacological therapy. The physical restraints, though inadequate to prevent the patient escape, were the only ones available in that hospital. The main issues related to this case were the advisability to ask for psychiatric counsel, and to increase the patient's surveillance, though we could not know whether these precautions could have avoided the self-defenestration. Even if this case has not been sentenced yet, the liability seems to be related only to the inadequacy of the medical restraints given by the hospital.

CASE 4 – Mental illness of the elderly patient

This case is related to a 75 years old man hospitalized due to a lung infection. He had no history of dementia, nor of psychiatric disorders, but during the hospitalization he developed mental confusion. One night the nurses found him wandering around the ward, in a state of mental confusion. They brought him back to his bed, and monitored him frequently. That night the man called his wife, telling her he felt like a prisoner. The woman tried to calm down her husband, and told that she would have come and visit him in a few hours. During the same night, a nurse, after have monitored the patient, went into another room to continue his work. When passing through the patient's room again, the nurse noticed that he was not in his bed. The window of the room was opened, with the sheets of the bed tied and used as a rope to escape. The man was found lying on the ground floor. He was promptly carried to the Emergency Room, where he died due to the severe polytrauma caused by the fall. A criminal investigation started, and a legal doctor and a psychiatrist were assigned to evaluate the healthcare criminal liability for the death of the patient. According to the psychiatrist evaluation, and based on the study of the clinical record, the man probably developed a form of delirium, which is a frequent occurrence in elderly patients during hospitalization. In this specific case, the delirium remained undiagnosed, and was unveiled with the attempt of escape. As no evident risk factors were detectable, there was no reason to start a specific drug therapy, nor to prescribe medical restraints. The only issue was related to the type of window, which, although not supposed to be opened completely, was damaged, allowing the patient to escape. Healthcare liability in this case could only be linked to the structural inadequacy of the hospital.

CASE 5 – Communication defect between psychiatric facilities

The latest case concerns a 35-year-old female patient with borderline personality disorder. The woman had attempted suicide few years earlier; following this episode she underwent a rehabilitation treatment for substance abuse. She sometimes attempted suicides, mostly defined as demonstrative. One evening, after an argument with her partner, she took a great amount of psychotropic drugs. The next day she was hospitalized in an intensive care unit and subsequently in the psychiatry department : however, she remained there only about twelve hours, in order to be transferred to a local psychiatric facility, where she committed suicide. The doctors of the hospital ward from which the woman had been transferred with assisted discharge were investigated, while the position of the managers of the territorial structure that had received her was archived.

According to the public prosecutor's consultant, communications from the hospital ward were not sufficient, considering that the clinical picture, compared to the planned hospitalization for a detoxification program, had changed due to the attempted suicide. In particular, the risk of suicide was not adequately communicated to the colleagues working in the territorial structure. In addition, the discharge from the hospital was rushed and the few hours of hospitalization, for the consultant, were not sufficient for properly investigating the new state of the patient. The woman was assigned by the doctors of the territorial facility to a department for patients with medium suicidal risk and not to the maximum emergency protocol (with continuous assistance from

Table 2. *Summary of our case series*

	Age	Sex	Psychiatric History	Previous attempts of suicide	Suicidal mode	Healthcare liability
Case 1	40	Female	Severe anorexia, delusional psychosis	Occasional attempt of self-injury	Train collision	Not sentenced yet
Case 2	34	Female	Chronic paranoid schizophrenia	Several attempts of self-injury	Undisclosed suicide on the ambulance	Inadequate discharge
Case 3	33	Female	None	None	Precipitation	Not sentenced yet
Case 4	75	Male	None	None	Precipitation	Not sentenced yet
Case 5	35	Female	Borderline personality disorder	Yes	Hanging	Not sentenced yet

the staff). Although the hospital discharge file reported the substance abuse, highlighting what in technical jargon is called a demonstrative suicide attempt, it also reported that the crisis was subsided. On the contrary, according to the opinion of the consultant, the patient was still in the acute phase. Moreover, this conduct was further aggravated by the fact that the hospital ward did not sent the woman's suitcases. This omission, together with the concomitant relational crisis, could have played a role in increasing the patient's sense of "loneliness and despair" that led her to hang herself at cabinet handles, which were not up to standard according to the consultant. The criminal case related to this event is still ongoing. It should be noted that in borderline personality disorder a high suicidal risk should always be taken into account (Goodman et al., 2012), due to the tendency towards impulsive behaviours, which may lead to suicide attempts sometimes for futile reasons and without warning signs. Excluding this issue, the healthcare liability may be firstly identified in the inadequate communication between psychiatric colleagues regarding the suicidal risk and, subsequently, in the inadequacy of the reception facility.

Discussion and conclusion

In this work we analyzed healthcare responsibility in cases of psychiatric inpatient suicide through a review of preventing strategies and of Italian criminal jurisprudence.

According to the literature the most effective methods for suicide prevention are the reduction of the environmental risk and the increase of the surveillance level (Watts et al., 2017; Shtivelband et al., 2015; Sakinofsky, 2014). The assessment of the suicide risk of the patient is also recommended, and the information must be shared with all the healthcare personnel. An adequate education of the healthcare professionals dealing with these kinds of patients is also mentioned as an effective strategy for inpatient and outpatient suicide prevention, though not as effective and long-lasting as the reduction of the environmental risk, which was reported to be capable of reducing suicide risk up to more than 82% (Watts et al., 2017; Shtivelband et al., 2015; Sakinofsky, 2014).

Despite those measures, the number of inpatient and outpatient suicide is still very high, raising a medico-legal debate related to the role of the healthcare personnel in cases of psychiatric patients' suicides. The scientific literature recognizes suicide as a constitutive part of some mental disorders. However, the Italian Criminal Supreme Court jurisprudence often recognizes the healthcare liability in cases of psychiatric patient's suicide. In particular, in the framework of medical errors related to the failure to adequately take care of patients, according to art. 40 of the Italian Penal Code. That failure makes the healthcare personnel complicit in the suicide event, leading to a charge of culpable homicide. Only a few sentences in the Italian Supreme Court jurisprudence accepted the theory of suicide risk as an allowed risk, relieving the medical staff from a guilty sentence if they had done all they could to prevent the suicide event, though inefficiently, acknowledging that the suicide was unavoidable. As the criminal law needs to prove guilt beyond all reasonable doubt and the risk of suicide is a known and often implicit risk of many mental disorders, we wondered whether the patient's suicide could be realistically considered as effectively preventable or if there should be decriminalization for medical staff involved in such events. Decriminalization seemed to have been introduced with the latest sentences, which focused more on the evaluation of the real possibility of the medical conduct to avoid the suicide, rather than remaining stuck on the duty of custody the physicians are charged with. It is certainly important to evaluate the patient's level of suicidal risk not only at the beginning of the hospitalization, but at every stage of it. Taking into account that suicidal risk is a dynamic variable, the patient's status should be reassessed daily by the medical and nursing staff, through a customized observation, made with the aim to support the patient and recognize the warning signs of a possible suicidal behaviour. The "burden of proof" of having adopted all the precautions required to prevent the occurrence of the harmful event falls on the healthcare facility. Most of the above reported issues are based on the assumption that suicide falls within the spectrum of predictability, that there is a measurable risk and that its assessment can prevent the event itself. The crucial point consists in evaluating when, despite the fact that the healthcare personnel have followed the patient's vigilance and protection obligations, suicide falls within the circumstances of the inevitable. Most of the sentences we analyzed had been pronounced before the introduction of the law 24/2017 that was also meant to reduce the criminal liability of medical staff in cases of culpable crimes. We wondered whether after that law a change will be observable in the jurisprudence leaning in cases of medical responsibility for patient's suicide.

References

Bachmann, S. (2018). Epidemiology of Suicide and the Psychiatric Perspective. *International Journal of Environmental Research and Public Health*, *15*, 1425.

Bertolote, J. M., Fleischmann, A., De Leo, D., & Wasserman, D. (2003). Suicide and mental disorders: Do we know enough? *British Journal of Psychiatry, 183*, 382-383.

Busch, K. A., Fawcett, J., & Jacobs, D. G. (2003). Clinical correlates of inpatient suicide. *Journal of Clinical Psychiatry, 64*(1), 14-19.

Evans, D., Wood, J., & Lambert, L. (2002). A review of physical restraint minimization in the acute and residential care settings. *Journal of Advanced Nursing, 40*(6), 616-625.

Fawcett, J. (1988). Predictors of early suicide: identification and appropriate intervention. *Journal of Clinical Psychiatry, 49*, 7-8.

Fawcett, J (2001). Treating impulsivity and anxiety in the suicidal patient. *Annals of the New York Academy of Sciences, 932*, 94-102; discussion 102-105.

Frank, C., Hodgetts, G., & Puxty, J. (1996). Safety and efficacy of physical restraints for the elderly: review of the evidence. *Canadian Family Physician, 42*, 2404-2409.

Goodman, M., Roiff, T., Oakes, A. H., & Paris, J. (2012). Suicidal Risk and Management in Borderline Personality Disorder. *Current Psichiatry Reports*, 14(1), 79-85.

Gradus, J. L., Shipherd, J. C., Suvak, M. K.; Giasson, H. L., & Miller, M. (2013). Suicide attempts and suicide among Marines: A decade of follow-up. *Suicide and Life-Threatening Behavior, 43*(1), 39-49.

Hoyer, E. H. , Licht, R. W., & Mortensen, P. B. (2009). Risk factors of suicide in inpatients and recently discharged patients with affective disorders. A case–control study. *European Psychiatry, 24*(5), 317-321.

Italian Ministry of Health (2008, March). *Recommendation n. 4., Prevenzione Del Suicidio Di Paziente In Ospedale*. Available online: https://www.salute.gov.it/imgs/C_17_pubblicazioni_592_allegato.pdf.

Italian Ministry of Health (2015). *Protocollo di Monitoraggio*

degli eventi sentinella 5° Rapporto (Settembre 2005-Dicembre 2012). Available online: https://www.salute.gov.it/imgs/C_17_pubblicazioni_2353_allegato.pdf.

Italian Supreme Court, Criminal Section (2000, March 2nd). *Sentence n. 447*.

Italian Supreme Court, Criminal Section (2005 March 11th). *Sentence n. 9739*.

Italian Supreme Court, Criminal Section (2008 November 27th). *Sentence n. 48292*.

Italian Supreme Court, Criminal section (2013, April 12th). *Sentence n. 16975*.

Labour, Health and Social Politics Ministry (2009, Decree December 11th). *Istituzione del sistema informativo per il monitoraggio degli errori in sanità. (10A00120) (GU Serie Generale n.8, 12-01-2010)*. Available online: https://www.gazzettaufficiale.it/eli/id/2010/01/12/10A00120/sg.

Miles S. H. (1993). Restraint and sudden death. *Journal of American Geriatrics Society, 41*(9), 1013.

Milner, A., Witt, K., Maheen, H., & LaMontagne, A.D. (2017). Suicide among emergency and protective service workers: A retrospective mortality study in Australia, 2001 to 2012. *Work*, 57, 281-287.

New Zealand Guidelines Group (NZGG) (2003). *The assessment and management of people at risk of suicide*. New Zealand Guidelines Group.

Reynolds, T., O'Shaughnessy, M., Walker, L., & Pereira, S. (2005). Safe and supportive observation in practice: a clinical governance project. *Mental Health Practice, 8*(8), 13-16.

Sakinofsky, I. (2014). Preventing Suicide Among In patients. *The Canadian Journal of Psychiatry, 59*(3), 131-140.

Shtivelband, A., Aloise-Young, P. A., & Chen, P. Y. (2015). Sustaining the effects of gatekeeper suicide prevention training. *Crisis, 36*(2), 102-109.

The Joint Commission (2013). *Sentinel event data: event type by year 1995–2Q 2012.* The Joint Commission (TJC).

The Joint Commission (2020). A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department. *Sentinel Event Alert, 46*.

Watts, B. V., Shiner, B., Young-Xu, Y., & Mills, P. D (2017). Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide*. Psychiatr Services, 68*(4), 405-407.

Williams, S. C., Schmaltz, S. P., Castro, G. M., & Baker, D. W. (2018). Incidence and Method of Suicide in Hospitals in the United States. *The Joint Commission Journal of Quality and Patient Safety, 44*(11), 643-650.