FATAL HOSPITAL FALLS

BY

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The incidence of fatal hospital falls is not high, but the matter deserves notice from the standpoint both of prevention and of the risk of litigation. These aspects are, of course, interdependent. The kind of accident caused by falls on polished floors is well recognized and is not dealt with here. This article is concerned with falls, often suicidal, from windows and roofs.

In six months in the West London Coroner's district six such falls have occurred. The area includes 40 hospitals with roughly 13,800 beds. Postulating an 80% bed occupancy and an average length of stay of 20 days per patient, this gives an annual population at risk of about 100,000. The risk of a fatal fall from a window is therefore about 1 in 8,000. Not all the cases are overtly suicidal, but it is of interest to compare this figure with the current suicide rate of 1 in 10,000 in the general population. The six falls occurring during the six months under review seem to represent an unusually high incidence. Against the factor of closer supervision must be set the nature of the hospital population, consisting as it does of sick people who may be temporarily upset by pain, toxæmia, or biochemical disturbances, to say nothing of psychological troubles. During this time no fatal fall occurred among those occupying the 4,000 beds for mental patients.

Case Reports

Case 1.—Two days after an abdomino-perineal resection of the rectum for carcinoma a man aged 66 climbed out of bed at 6.30 a.m., scaled a radiator, and got out of a narrow opening in a window. He fell to the ground and died of multiple injuries. He had been somewhat mentally confused during the preceding night, but not unduly so for an elderly man recovering from a severe operation. The nurses on duty, quite reasonably, did not consider the possibility of such an athletic action, which was carried out under their eyes with such speed that they could not stop him. He was in an open ward. In view of his disordered mental state it was doubtful whether the conscious intention of self-destruction existed, and an open verdict was returned.

Case 2.—A male hospital employee aged 63, while convalescent from cholecystectomy for gall-stones, developed functional retention of urine, for which he had an indwelling catheter. He was distressed by this. At 12.30 a.m. he was missed from his bed and was found to have made his way to a staircase and thrown himself from a window on the floor above the private room which he had occupied. It was clear that he had deliberately killed himself, and the verdict was in accordance with this.

Case 3.—A woman aged 54, who had had bilateral adrenalectomy for carcinomatosis from carcinoma of the breast, was in hospital, in a private room, to have her cortisone dosage balanced. She had had much distressing treatment and knew she had carcinoma. Superficially she did not seem to have been unbalanced mentally. She had had several attacks in which she had become giddy and had staggered while walking. At 3.30 p.m. she fell from a high-silled window just outside her room door. In view of a history of breathlessness and the giddy attacks it was not possible to exclude accident, and an open verdict was returned.

Case 4.—A woman aged 41 was suffering from alcoholism and had had several epileptiform fits, for which she was being investigated in hospital. She was in a general ward and was described as being rather euphoric and facetious and confused at night. Treatment consisted of large doses of vitamin B, paraldehyde, 5 ml. six-hourly, and phenobarbitone, 3 gr. (0.2 g.) intramuscularly if required. During her third night in hospital she seemed more confused than usual and announced her intention of going home. An extra nurse was detailed to look after her. Early in the morning she got out of bed, gathered her belongings, and said she was going to call a taxi. Despite remonstrance she went down the stairs, accompanied by the nurses, who were still remonstrating with her; suddenly she stopped, threatened the nurses with a piece of iron which she had picked up, and slipped through a staircase window on to a flat roof. Still followed by the nurses, she made her way along the roof and climbed a wall at the end. This was thought to be at ground level, but was in fact some distance above a yard. She fell and was killed. The verdict was accidental death.

Case 5.—A man aged 22 with Crohn's disease had been in various hospitals for several months and had had extensive resection of the ileum. During the course of the illness he developed symptoms of anxiety and depression and was admitted to a mental observation hospital. After a time he was thought fit to return to the general ward for further treatment of his somatic disease. He did not then show signs of mental confusion. At 6.30 a.m. he was seen to go to the lavatory, and bid good morning to one of the nurses quite cheerfully. He was soon missed, and was found lying dead on the pavement several stories below the lavatory window. This window was of the casement variety and so situated that accidental falling was impossible. At the inquest the finding was that he had killed himself.

Case 6.—A man aged 68 had had an operation for implantation of radium seeds for inoperable carcinoma of the pancreas. He had had a previous operation and much medical attention. He was aware of the diagnosis. He had been in hospital 12 days, made no complaint, and suffered no pain. At 6 p.m. he went to the lavatory and threw himself from the window. A note written on the edge of a newspaper was found, making clear his intention. The verdict was that he had killed himself.

Discussion

These six cases show the kind of risk involved. It may be recorded here that the three suicides as found at inquest were the only suicides in hospital during the six-months period. Other methods of committing suicide, such as coal-gas poisoning, drugs, and hanging, are clearly less likely in hospital in view of the practical difficulties, so the window-jump must be regarded as the chief danger. Only a small number of cases are recorded, but they are cited to indicate the risk. Any person with hospital experience could add to them, and no particular hospital seems unduly vulnerable. It is easy to be wise after an event, but reasonable precautions should be taken to avoid this kind of death. The problem should be taken into account in planning the design and layout of new hospitals. No claims were made against the hospitals in which these deaths took place, but it is known that liability has been alleged in similar cases. If a claim is made it would be necessary for the hospital authority to show that a reasonable standard of care had been taken to avoid such incidents. What is reasonable would be assessed by referring to current hospital practice; but this is not inflexible, and would cease to be a guide in the presence of some proved danger. Attention to the following points is suggested.

Perhaps the outstanding feature of these cases is that in no instance was the window-fall expected; and the paucity of such events from mental hospitals, where organization is geared to the ever-present possibility of suicide, indicates the importance of the staff being aware of the risk.

It has been noticed that suicide, including cases of self-destruction that lie on its borderland, is often associated with convalescence from major operations, especially where there has been deprivation of an important viscus. The psychopathology of this is outside the scope of this article. It is suggested that patients who show signs of unusual behaviour in these circumstances, even if it is only slight, should be regarded as possible suicidal risks and be placed in a ward on the ground floor. They certainly should not be left in side wards or private rooms without a special nurse. If a psychiatric opinion has been sought and removal to a mental hospital advised, the usual delay associated with administrative obstacles must be eliminated. It has been noted that the nursing staff can more easily supervise a patient in an open ward; but even this, as shown in Case 1, is no guarantee of security, although the risk is clearly diminished. It is not thought that increase of staffing by night or day would make much difference to fatal falls from windows: the patients in these six cases all fell at a time when ward activity was slight.

Precautions of a structural kind seem more practical, though there would be difficulties where buildings are old and financial resources are slender. It should be impossible to open windows more than 9 in. (23 cm.) at the bottom in upstairs wards, staircases, and corridors. Casement windows could likewise be limited. Where this is not feasible, bars should be fitted to afford at least a temporary obstacle to egress from windows. In the case of lavatories, it should not be possible to bolt the door from the inside. Instead, a large indicator showing "engaged" or "vacant" would be suitable.

In the present state of hospital design and routine it does not seem that any further precautions would be expected by a reasonable person.

Summary

The risk of fatal falls from hospital windows is described and illustrated.

Awareness of the risk is important and should be inculcated in nursing staff.

Simple structural precautions are suggested.

MEDICAL ETHICS IN WARTIME

CODE AND EMBLEM ADOPTED BY W.M.A.

The World Medical Association, at its tenth general assembly last autumn, adopted a "Code of Medical Ethics in Wartime" drafted by a joint committee of the International Red Cross, the International Committee on Military Medicine and Pharmacy, and W.M.A. itself. The World Health Organization was represented on the committee as an observer. W.M.A. also adopted an emblem, recommended by the same committee, for civilian doctors (and others) to wear in wartime. National medical associations are now being asked by W.M.A. to approve and support the code and the emblem. The matter is due to be considered shortly by the B.M.A.

Code of Medical Ethics in Wartime

The provisions of the "Code of Medical Ethics in Wartime" are as follows:

1. Medical ethics in time of war is identical with medical ethics in time of peace, as established in the International Code of Medical Ethics of the World Medical Association. The primary obligation of the doctor is his professional duty; in performing his professional duty the doctor's supreme guide is his conscience.
2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for doctors to: (a) give advice or perform prophylactic, diagnostic, or therapeutic procedures that are not justifiable in the patient's interest;

(b) weaken the physical or mental strength of a human being without therapeutic justification; (c) employ scientific knowledge to imperil health or destroy life.

3. Human experimentation in time of war is governed by the same code as in times of peace; it is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.

4. The forbidding of the medical procedures in points 2 and 3 is mandatory under all circumstances regardless of decisions to the contrary issued by either a *de jure* or a *de facto* authority.

5. In emergencies the doctor must always give the required care impartially and without consideration of sex, race, nationality, religion, political affiliation, or any other criterion. Such medical assistance must be continued as long as necessary.

6. Medical secrecy must be preserved by the doctor in the practice of his profession.

7. Privileges and facilities afforded the doctor must never be used for other than professional purposes.

Rules Governing the Care of Sick and Wounded, Particularly in Time of Conflict

1. Under all circumstances every person, military or civilian, must receive promptly the care he needs without consideration of sex, race, nationality, religion, political affiliation, or any other criterion. Any procedure detrimental to the health, physical or mental integrity of a human being is forbidden unless therapeutically justifiable.

2. In emergencies doctors and associated medical personnel are required to render immediate service to the best of their ability. No distinction shall be made between patients except those justified by medical urgency. Services may be refused if other doctors are rendering their services.

3. The members of medical and auxiliary professions must be granted the protection needed to carry out their professional activities freely. The assistance necessary will be given to them in fulfilling their responsibilities. Free passage will be granted whenever their assistance is required. They will be afforded complete professional independence.

4. The fulfilment of professional duties and responsibilities shall in no circumstance be considered an offence.

5. In fulfilling their professional duties the medical and auxiliary professions will be identified by the distinctive emblem of a red serpent and staff on a white field. The use of this emblem is governed by special regulation.

Medical Emblem

It is clear from the fourth Geneva Conventions and Conferences, states W.M.A., that the protection of the Red Cross emblem applies only to doctors, ancillaries, and medical installations in military organizations. Hence, in time of war, the civilian doctor, his assistants, and civil defence units not under military control are without such protection. The new emblem, suggested by the joint committee and approved by W.M.A., is for them to wear. It consists of a red staff and serpent on a white field. The staff is represented by a vertical line, the serpent by a sinuous line, overlying the vertical line, with two undulations on the left side and one on the right (see diagram).

The ultimate success of this emblem and the Code of Ethics as a guarantee of protection for civilian doctors will largely depend, states W.M.A., on the support they receive from national medical associations.

Dr. W. A. HORNE, medical officer of health of Glasgow, has some remarks to make in his Annual Report for the year 1955 about infestation with bed bugs. In that year 15,000 houses in rehousing schemes were inspected and evidence of infestation was found in 66 (0.44%). Twenty years before the percentage of infested houses was 9.2. The use by the disinfection unit of D.D.T. and "gammexane" is said to give every satisfaction in the eradication of this pest. The total number of "apartments" treated for infestation by bugs in 1955 was nearly 3,000.