QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Steven John HITCHINS and Shawn Bradley Joseph GUDGE**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2014/2764 & 2015/1767
DELIVERED ON:	5 February 2018
DELIVERED AT:	CAIRNS
HEARING DATE(s):	14 April, 22 June, & 24 to 26 October 2016
FINDINGS OF:	Kevin Priestly, Coroner
CATCHWORDS:	Coroners, mental health unit inpatient suicides, environmental risk management, state wide leadership.

REPRESENTATION:

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Office of Chief Psychiatrist	Stephanie Gallagher, Counsel, Corrs Chambers Westgarth, Brisbane.
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Introduction

At about 7.55pm on 3 August 2014, Steven Hitchins (aged 53) was an inpatient in the Low Dependency Mental Health Unit at Townsville Hospital when he was found deceased with a plastic bag over his head. Autopsy confirmed he died due to asphyxiation.

At about 5.32pm on 10 May 2015, Shawn Gudge (aged 23) was an inpatient in the High Dependency Mental Health Unit of Townsville Hospital when he was found unconscious with a ligature made from a bed sheet around his neck. He was unable to be revived and declared deceased. Autopsy confirmed he died due to hanging.

A coroner is required to investigate and make findings about who died, when the person died, where the person died, how the person died and what caused the person to die (the required findings). A Coroner must not include in findings any statement that a person may be guilty of an offence or civilly liable. A Coroner is empowered at inquest to make comments or recommendations to help prevent deaths from similar circumstances in the future.

The information gathered during the coronial investigation was sufficient to make most of the required findings. However, the circumstances of the deaths gave rise to questions about missed opportunities to better manage the risk of inpatient suicide. I investigated an inpatient suicide in an earlier inquest and made recommendations about management of environmental hazards (inpatient means of suicide).

This inquest was convened to better understand the circumstances of the death, if there were any missed opportunities to reduce the risk of inpatient suicide, and to explore what progress was made in considering and implementing my earlier recommendations.

Steven Hitchins

Clinical Narrative

Mr Hitchins was diagnosed with schizoaffective disorder and had suffered from mental illness for around 20 years. He left school in grade 10 and had various jobs as a cleaner, door man, lifeguard and seasonal worker. He was married and had three children. He developed a mental illness and began abusing illicit drugs in the late

1990s. His marriage broke down in 1999, when he left his family and started leading an itinerant life style, travelling up and down the coast between Sydney and Port Douglas.

Mr Hitchins first had contact with psychiatric services when he was admitted to a psychiatric hospital in Sydney after cutting his wrists at a railway station.

In 2006 Mr Hitchins lived in a disused rented boat in Airlie Beach but due to redevelopment of the Airlie Beach Port and Marina, a number of boat owners had to relocate. Mr Hitchins resisted and protested against the local council and port authority. Police forcefully removed him from his boat and the boat was destroyed. Mr Hitchins reported holding a grudge against the police, state and federal governments, and Whitsunday Regional Council, claiming the Mayor had links with the Mafia.

In 2007 Mr Hitchins received a disability support pension on the basis of mental illness. He was admitted to the Cairns Base Hospital Psychiatric Unit in March 2009 in a distressed state. He was agitated, anxious, thought disordered, paranoid and obsessed with fear of the Mafia. He was lost to psychiatric follow up and on admission to the Townsville Hospital in 2014, appeared not to have had any psychiatric treatment since 2010.

In 2012, Mr Hitchins moved to Bowen and lived in a rented public housing unit. However, he believed the Mafia had followed him there. For several weeks prior to his last admission, he stopped going out, except briefly to collect groceries, and remained hypervigilant, without sleep at night, believing this was when the Mafia were most likely to get him.

Around the beginning of May 2014, Mr Hitchins saw the ex-Mayor of Whitsunday smiling on television and took this as a final sign the Mafia were going to kill him. He telephoned Channel Seven reporting he had placed a bomb in Parliament House, Brisbane and it was programmed to explode at any time. Police traced the call and attended his unit. Mr Hitchins refused to admit police and a siege developed. Police eventually broke into the unit on 6 May 2014 and found a replica gun, inflammable material, cannabis and a bong. Mr Hitchins was arrested and transported to the Townsville Watch House.

Mr Hitchins was assessed in custody, found to be floridly psychotic and transferred to the Townsville Hospital High Dependency Unit (HDU) on 9 May 2014, as a classified patient. He was admitted on an involuntary treatment order and started on risperidone antipsychotic medication, 2mg twice daily. He was initially agitated, anxious, thought disordered. He had auditory hallucinations as well as paranoid and grandiose delusions. He was placed on the antipsychotic risperidone but after some akathisia (restlessness), he was commenced on a depot medication, paliperidone 100m monthly. He was also prescribed a relatively small dose of aripiprazole and promethazine (Phenergan) 25mg at night as well as lorazepam. Mr Hitchin's psychotic symptoms gradually settled, he became more organised in his thoughts and cooperative with treatment.

Mr Hitchins was moved to the low dependency unit on 6 June 2014 and was progressing well. In mid-July Mr Hitchins gave permission for his treating team to contact his daughter, sister, ex-wife and housing manager for collateral information for his assessment.

Mr Hitchins had a Mental Health Review Tribunal hearing on 13 June 2014 which caused him stress, as did proceedings in the Mental Health Court, because of the offences he had been charged with following the bomb threat and siege. The Mental Health Court appearance on 2 July 2014 was adjourned until 8 October 2014 for completion of a psychiatric forensic report.

On 24 July 2014 Mr Hitchins became very distressed, reporting he'd heard from his daughter he was going to lose his accommodation in Bowen. The hospital social worker contacted the Whitsunday Housing Company who confirmed that Mr Hitchins was going to lose his tenancy after 8 August 2014 because he would have been absent from the unit for three months. However, it was reported that his personal property would be stored, and he would be eligible to be allocated another unit when he returned to Bowen.

On the evening of 28 July 2014 nurses noticed Mr Hitchins was agitated and paranoid, stating he did not feel safe on the ward, did not trust anyone, something was going to happen, and he wanted to move to another bed. He slept well that night. The next morning, 29 July 2014, he reported feeling better.

On psychiatric review on 30 July 2014, Mr Hitchins was agitated and anxious. He was paranoid, believing people were laughing at him, the Mafia had followed him and disguised themselves as patients, and they were going to kill him on the ward. He said he would kill himself if he had to remain in hospital but denied having any plan. After this review, his risk profile was upgraded from low to medium and he was placed on 15 minute observations. The antipsychotic, aripiprazole, was stopped due to the possibility it was causing agitation and a more sedating antipsychotic, olanzapine, was added to his medication.

On 31 July 2014, a Consultant Psychiatrist reviewed Mr Hitchins and found he remained agitated, hypervigilant, paranoid that something was going to happen, and the Mafia were going to kill him. However, the evening nurses reported he was more settled, he'd been watching television and appeared to sleep well. He was continued on 15 minute observations.

On Friday 1 August 2014, Mr Hitchins was preoccupied with the delusion the Mafia were going to get him. He seemed to improve, but then early in the afternoon complained of chest pains and collapsed to the floor without losing consciousness. Emergency investigations, including an ECG and blood tests, were normal and Mr Hitchins later told his treating team the Mafia would get him "today" and he'd faked the heart symptoms, for which he apologised. He was subdued and low in mood. He was commenced on the antidepressant escitalopram and continued on 15 minute nursing observations.

On Sunday 2 August 2014, Mr Hitchins continued to voice the belief the Mafia were going to kill him. He requested transfer to the HDU and did not go to bed until midnight. He was continued on 15 minute observations.

On 3 August 2014, nurses noticed Mr Hitchins spent most of his time in the TV lounge with other patients. He had a one-on-one session with a nurse, during which he said he was not right in the head, he was paranoid and kept asking people silly questions but couldn't stop himself. Shortly after 7.30pm that evening he was found deceased in his room with a plastic bag secured with a leather belt, over his head,

CCTV footage from a camera in the corridor outside his room revealed Mr Hitchins entered his room at 5pm and nobody entered his room until 7:21pm. Despite this, the

visual observations chart for Mr Hitchins recorded each 15 minute observation as completed from 5:15pm through to 7:15pm inclusive. Clearly, they hadn't been done.

Internal Review

A Health Service investigation into the Adult Acute Mental Health Inpatient Unit (AAMHIU) was conducted by Psychiatrist Dr Tobias Mackinnon, Statewide Clinical Director Forensic Mental Health, Justice Health and Forensic Mental Health Network NSW; and Ms Michelle Eason, Director of Nursing, the Forensic Hospital, Justice and Forensic Mental Health Network NSW.

The Health Service investigation found limited evidence of systematic and policy governance. There was a lack of clarity at all levels (of management and practice) about the interpretation and implementation of state policy and local procedure through to work instructions. Previous relevant root cause analysis (RCA) recommendations were not implemented, or had been implemented and not continued after subsequent practice revisions, and there was limited awareness of these past recommendations.

The Health Service investigation found in the absence of clear policy guidance, local practice had developed idiosyncratically allowing clinical practice, particularly in relation to visual observations, to develop with inconsistent application across teams and units. Management and medical staff expressed the clear expectation that individual professional responsibility would drive good practice, and current nursing practice was not appropriate irrespective of whether policy was outdated. The report authors considered this attitude may have contributed to a lack of policy development and governance structures. The Health Service Investigation found that consequently a culture of non-standard visual observation practices had developed.

The report authors observed that nursing staff considered the number of patients placed on 15 minute observations by medical staff was inappropriate (noting for example that patients were given ground leave while on 15 minute observations) and also onerous for nursing staff. An attitude had developed whereby observations were considered an administrative burden rather than part of good clinical practice.

It was found the nursing staff who had failed to conduct regular 15 minute observations, despite documenting them, had breached professional practice standards and Health Service policy. It was found this was an individual practice failing, but it was noted

these breaches could be considered failings in the context of a workplace culture where non-standard visual observation practices had become routine, rather than an instance of post incident collusion and deliberate falsification.

A number of recommendations were made including; a requirement that policy development occur within a governance structure, that policy clarity be improved and be effectively communicated, that staff be effectively trained regarding policy, and that forms and documents supporting good practice in keeping with policy and practice guidance be developed.

It was also recommended that the Health Service review the staffing establishment of the Unit to ensure multidisciplinary work is feasible; develop clear, consistent and unified handover processes, develop a single method of communicating risk which is standard across all Units, and that orientation and training of new and existing staff introduce staff to the philosophy of the Unit, model of care, and relevant policies and procedures.

External Review

In relation to the appropriateness of the suicide and/or risk assessments, Dr Reddan (a Consultant Psychiatrist, engaged by the court to conduct an expert review of clinical management) noted there is emerging literature demonstrating that risk assessment is of very little or no value whereas active treatment of mental illness is of value and has been proven to reduce suicide rates. She considered Mr Hitchin's deteriorating mental state in late July 2014, was noted by medical staff and responded to appropriately, with an increase in observations and the addition of an antidepressant. She considered, with the benefit of hindsight, there were signs of a depressive disorder early in the admission. However, she considered it very likely that Mr Hitchin's paranoia and his actions in response dominated the clinical picture. She noted Mr Hitchins was diagnosed with schizoaffective disorder, indicating his clinicians realised there was a strong component of mood dysregulation.

Dr Reddan considered the medications and doses administered were orthodox, and noted the treating clinician responded appropriately to the akathisia. She considered the transfer to aripiprazole reasonable given it has fewer of the similar side effects of risperidone and is a widely prescribed antipsychotic that is very helpful for many patients. However, she did note that aripiprazole can exacerbate psychosis in some

individuals and expressed the view that it could have been a factor in his deterioration around 29 July 2014 (although she considered this speculative). She considered the addition of escitalopram on 1 August 2014 was appropriate.

Dr Reddan considered Mr Hitchin's care and treatment from admission and on transfer to Low Dependency Unit (LDU) was appropriate, orthodox and reasonable; and that whilst it is possible he was more depressed that he first appeared (with the benefit of hindsight) it is probable his paranoia dominated the clinical picture.

On deterioration of Mr Hitchin's mental state during late July (around 29 or 30 July), Dr Reddan observed that ordering of a urine drug screen, ceasing the aripiprazole and substituting olanzapine, and increasing observations to 15 minute intervals; was entirely appropriate as was the commencement of the antidepressant on 1 August 2014.

In relation to the lack of 15 minute observations on the evening of Mr Hitchin's death, Dr Reddan suggested that random checking of CCTV footage against observation sheets be considered. She acknowledged that hanging or asphyxiation can be done very quickly between observations and there needs to be a balance achieved with very paranoid patients who can experience close observation as surveillance thereby exacerbating the clinical picture. The greatest value of patient observations was contact with the patient and that risk is best managed through development of a therapeutic alliance by engaging with patients wherever possible.

In relation to environmental hazards, Dr Reddan reiterated that all mental health services, hospitals and correctional services should be built so that there are no hanging points from doors, door handles, railings or other built furniture items. She noted however the need to balance reduction of environmental hazards with the comfort, care and dignity of patients; and that removal of all plastic bags, belts and cords outside of a High Dependency Unit (HDU) or Psychiatric Intensive Care Unit (PICU) environment would not be routinely recommended. However, she thought consideration should be given to increased scrutiny for potential hazards on a case-by-case basis. She did not criticise the access to plastic bags and belts in Mr Hitchin's case considering the length of time he was an inpatient and despite his deterioration in late July.

Remedial Action

Michael Catt, Executive Director, Mental Health Services Group, Townsville, reported that prior to this incident, plastic bag bin liners were removed from patient bedrooms but were present in common areas and kitchens. The bin liner that was used was from the kitchen in the MHU. Following the incident, bin liners were removed from all areas in the Unit. A briefing note was prepared for the Director General of Health reporting on the action taken in removing all bin liners. The Nursing Director of the MHU did a review, as at the date of this death, about the use of plastic bags and allowing patients the use of belts across other Mental Health Units in Queensland, comparable to Townsville's MHU, and found the practices and procedures varied. The action taken by Townsville MHU and the results of its statewide review were sent to the Office of Chief Psychiatrist on 9 September 2014.

In that email, Mr Catt wrote:

> Further to my discussion with you early while we have been working through a solution to the removal of plastic bags from our AAMHIU (as per the attached guidelines) which we only recently realised existed. We identified that most units across Queensland are using plastic bags (as attached). All but 3 are using perforated bags which I still do not think adequately reduces the risk. Townsville have completely removed all bags and are using small wheelie bins that are cleaned daily
>
> I would like to highlight the risks this poses for patients and I recommend that this issue is discussed with the DMH and Chief Psychiatrist and placed on the next Mental Health Alcohol and Other Drugs Branch and Clinical I Executive Directors Meeting.

Mr Catt also sought clarification about progress with implementation of the recommendations from the Inquest into the Death of Justin, and was informed that the guidelines were still being developed.

By email dated 17 September 2014, Mr Catt forwarded the earlier email directly to Dr Allan and Dr Kingswell, Psychiatrists in senior leadership positions in Mental Health at a state level.

The Townsville MHU developed a working party and worked through practicable alternatives to bin liners and developed accompanying policy. A new draft procedure was devised in September 2014, titled "*Plastic Bag Free Unit"*.

Mr Catt reported:

> The description of the procedure included "Removal of all plastic bags from patient areas in the AAMHIU", however, the procedure was predominately in relation to plastic bags bought in to an inpatient unit and searches of patient rooms and property. It does include as a strategy, limiting access to plastic bags throughout the units and as a staff responsibility that all plastic bags included perforated plastic bags are prohibited in all patient areas. This draft procedure was implemented and titled, "*Removal of Plastic Bags*" THHSCLI140853 v1, effective 22 December 2014.

Although I will address what happened at a state level shortly, Mr Catt notes no substantive response to his emails until provided with draft guidelines under cover of a memo from Dr Allan dated 17 June 2016, some 20 months later.

Comment and Analysis

The evidence supports the finding that Mr Hitchins died due to plastic bag asphyxiation and his death was suicide. His clinical care at the Mental Health Unit was appropriate and reasonable except for patient observations.

No visual observations were conducted between 5pm and 7:21pm. I find that the observation conducted at 7:21pm did not include an attempt to view Mr Hitchin's face or engage in discussion. The absence of 15 minute observations was a missed opportunity to engage with Mr Hitchins and assess his general wellbeing. However, even if 15 minute observations were conducted, there was ample opportunity in the periods between observations for Mr Hitchins to end his life in the manner he did. Completion of the observations would have increased the prospect of earlier detection and initiation of CPR. It is impossible to determine if the outcome would have been different.

I accept the Health Service investigation finding that the absence of periodic observations occurred in the context of a workplace culture where non-standard visual observation practices had become routine, rather than the breaches representing post

incident collusion or deliberate falsification. Townsville Mental Health Service Group (MHSG) placed considerable evidence before me about the extent to which it provided guidance to nursing staff about observations, seeking to refute much of the criticism made in the Health Service investigation including serious concerns about the process used in the preparation of that report. I observe that the matter of observations has been problematic for some time (see my findings in the Inquests into the Deaths of Saccu and Black). Other coronial findings support the fact that this is a much visited area where leadership at a state level is required.

Disciplinary action was taken regarding the conduct of the persons involved and a report submitted to the Health Ombudsman on 12 September 2014. Whether or not disciplinary action is warranted is a matter for proceedings in another forum.

Shawn Gudge

Clinical Narrative

Mr Gudge had a history of drug abuse including benzodiazepines, opiates including buprenorphine and morphine, amphetamines including methamphetamine ("ice"), hallucinogens such as mushrooms and cannabis. He first presented to the Emergency Department for assistance on 11 November 2014 but did not wait to be seen. He contacted Alcohol Tobacco and Other Drugs Service (ATODS) several days later and in November 2014 self-initiated a referral to a residential rehabilitation program where he received treatment for approximately four months.

After leaving rehabilitation Mr Gudge lived with his cousin and her boyfriend. Mr Gudge did not abuse any substances for some time but on 3 May 2015 recommenced intravenous methamphetamine abuse.

On 7 May 2015 Mr Gudge was involved in a high speed car chase with police. He was driving with a female passenger. Police intercepted the car. Mr Gudge threatened police and charged at them. Police deployed oleoresin capsicum spray and Mr Gudge was taken to the Ayr Emergency Department, assessed and returned to the watch house.

Mr Gudge was granted police bail early on Friday 8 May 2015 and went to his father's home. He was distressed, agitated and looking for a rope to hang himself. His father took him to the Emergency Department at Ayr Hospital.

Ms Hodder, Clinical Nurse Consultant from the Burdekin Mental Health Team, assessed Mr Gudge. He reported using intravenous amphetamines, mainly "ice", over the past four days. Ms Hodder noted no known past suicide attempts but family reported that Mr Gudge often behaved in an aggressive manner. Mr Gudge was restless and agitated, reporting "I could snap and have a schizo moment and pull that tap off the wall and stab you with it". He reported auditory hallucinations associated with substance use, said if he had a gun he would kill himself and he would attempt to hang himself. He was assessed to have poor impulse control and there was a relative lack of protective factors.

Mr Gudge was detained under the Queensland *Mental Health Act 2000* and transferred to the Acute Adult Inpatient Mental Health Unit at Townsville for further assessment of his mental state, risks and appropriate management. Ms Hodder consulted with Dr Sarah Beaney and it was decided Mr Gudge be transferred to the High Dependency Unit (HDU) due to the risk of aggression. His risk of harm to self or suicide was assessed as high. His intoxicated state was 'highly influencing' his presentation.

For the purpose of safe transfer, Mr Gudge was administered diazepam, lorazepam and olanzapine. On arrival at Townsville Hospital Mr Gudge briefly engaged with staff but appeared sedated and went to bed to sleep. Dr Beaney saw Mr Gudge at 2:30pm but he was sleeping and very sleepy when woken. Dr Beaney completed her initial assessment based on information from Ms Hodder and collateral information obtained through a telephone conversation with Mr Gudge's father.

Dr Beaney determined Mr Gudge was at a medium risk of suicide and aggression on the basis he was admitted to HDU and the period of amphetamine intoxication was likely nearing an end. It was determined Mr Gudge would remain on 15 minute observations. Dr Beaney gave a verbal handover to Dr Jane Hay (the weekend Consultant Psychiatrist on call) and Dr Lawrence Kozlowski (the evening Registrar on call).

On the morning of Saturday 9 May 2015 Dr Hay and Registrar Dr Shu Wen Xu assessed Mr Gudge. Nursing staff informed Dr Hay that Mr Gudge slept overnight but on waking, he'd expressed anger at his admission to the unit. He demanded discharge and threatened to harm staff, patients and himself, or smash up the unit if he wasn't discharged. There was concern by nursing staff that Mr Gudge might become violent.

On meeting Mr Gudge, Dr Hay considered he appeared to be suffering the effects of recent amphetamine use. She observed he was emotionally labile but appeared predominately dysphoric. His affect varied from angry and threatening to distressed and crying to flippant and boastful. He displayed psychomotor agitation, was constantly moving and picking at lesions on his forearms, punching his fist into the palm of his hand, and rocking back and forwards in his chair. Dr Hay noted the interview was difficult and Mr Gudge left the interview room twice before returning.

Mr Gudge gave a disorganised history and account of past events, and presented in an agitated and disorganised manner. He said he recommenced using methamphetamine five days ago to stay awake at night to chase down a "meth head" who owed him money. Mr Gudge acknowledged he was in significant debt and if he didn't pay part of the debt that day his father would be harmed. He said his father was threatened with a firearm by people he owed money to. Mr Gudge said if he couldn't repay the debt, his backup plan was to kill himself to avoid his father being harmed, stating "I'm not afraid of death". He reported making threatening statements to his cousin and her boyfriend whey they asked him to move out. He expressed distress about his long term female friend Tamara, who had been in the car with him (prior to the incident with the police) and whom he had verbally abused and frightened by driving at 185km/h on the wrong side of the road "to show that he was not afraid of death". At the same time, Mr Gudge boasted about a number of other violent acts.

Dr Hay considered the history had a persecutory, grandiose flavour but no other psychotic symptoms were evident. Mr Gudge said he was sleeping well until recommencing amphetamine use a few days earlier and he had not eaten much over the past few weeks. He also reported previous suicidal intent. Dr Hay noted these symptoms may have been indicative of an underlying affective disorder.

Dr Hay concluded Mr Gudge was still displaying the effects of recent heavy methamphetamine use and was a risk to himself and others due to his lability of mood and impulsivity. She decided a longer period of assessment of his mental state was required and collateral information was required from his family about his longitudinal behaviour to ensure there was no underlying psychiatric diagnosis such as a psychotic or mood disorder.

Dr Hay decided Mr Gudge should continue in HDU under the *Mental Health Act* under close supervision and an involuntary treatment order was initiated. Dr Hay informed Mr Gudge he needed to show control over his behaviour and start making some plans for discharge, such as thinking about where he could live, in order to be released from hospital. She asked staff to go through the recovery and resilience workbook with Mr Gudge to assist him in a plan for discharge. He was prescribed lorazepam 1-2mg PRN (pro re nata - as needed), chlorpromazine syrup 100mg PRN and flucloxacillin 500mg for skin infections.

Dr Hay discussed the diagnosis and treatment plan with Mr Gudge's parents. Mr Bernard Gudge reported he saw Mr Gudge regularly over the past few months and felt Mr Gudge was doing well and had no concerns about his mental state, mood or behaviour, before finding him in the yard the previous morning. Mr Bernard Gudge confirmed Mr Gudge was in debt for a large sum of money and he was threatened with an object pointed out the window of a car. He was not sure if it was a gun, stating it might have "just been a pipe or something."

Dr Hay informed Mr Bernard Gudge she believed Mr Gudge's presentation was due to his methamphetamine use and while he was not yet stable enough for discharge, he did not need to be in hospital for long. Mr Bernard Gudge said he thought Mr Gudge was at a high risk of self-harm and should be kept in hospital as long as possible. He also referred to a past event where Mr Gudge discovered a dead body by a railway track and this impacted Mr Gudge's mental health. He reported the recent separation and relocation of Mr Gudge's ex-partner and son was another stressor.

Later that day, Dr Hay spoke with Mr Gudge's mother, Kristene Wood. She provided further collateral information, reporting when Mr Gudge was busy working or fishing, his behaviour was not a problem. But he became very angry and agitated after using

methamphetamine. She reported he had expressed suicidal ideation, just prior to entering rehabilitation and on discharge from the facility. Ms Gudge reported an incident in which Mr Gudge found a dead body near the train tracks but said Mr Gudge got very angry when family suggested he might need counselling. She also reported a separation from his infant son as a recent stressor. Dr Hay informed Ms Gudge that his current risk was directly related to his amphetamine use and he did not require an extended admission. This distressed Ms Gudge who considered he should remain in hospital to deal with addiction and anger issues.

Dr Hay asked both parents report feedback to nursing staff about any contact with Mr Gudge as to whether he seemed to be returning to his normal self and any concerns about his mental state.

The next day, Sunday 10 May 2015, Dr Hay attended the HDU a number of times but did not review Mr Gudge. Nursing staff reported Mr Gudge spent most of the morning in his room and did not display signs of increased aggression or agitation. He did not have any visitors.

After lunch Mr Gudge phoned his stepfather to ask that clothes and food be brought into the ward. At 2pm he asked Registered Nurse (RN) Harding that he be discharged but was advised to wait to see the doctor. He was given 2mg of Lorazepam and settled. During the afternoon, RN Curtis spent time with Mr Gudge looking at the Recovery and Resilience Workbook and formulating a safety plan in preparation for discharge. She considered his mental state was labile but starting to improve. He was cooperative.

Dr Hay discussed Mr Gudge's case with the Clinical Director and decided (given Mr Gudge's positive response to treatment and the family's concerns) he not be discharged over the weekend but would remain in hospital until the community mental health team and treating consultant were back. In her statement to the Court, Dr Hay reported she considered Mr Gudge should stay in hospital until there was further feedback from family regarding his mental state. It was also important he see the drug and alcohol service prior to discharge and be given some clear follow up appointments with mental health clinicians in Ayr. Dr Hay left the hospital around 5pm.

RN's Michael Farrell and Helen Patterson reported there was nothing in Mr Gudge's presentation that evening to indicate an increased level of risk. Mr Gudge was subject to 15 minute observations which occurred as scheduled. Mr Gudge came out of his room when the evening meal arrived and took the meal tray into his room. At approximately 5.15pm RN Patterson went into Mr Gudge's room to collect his meal tray. He was lying on the bed facing the window with his blanket around him. He had eaten his meal and RN Patterson asked him if he was finished and if she could take the tray. Mr Gudge grunted in response, which RN Patterson said was consistent with previous interactions.

Approximately 15 minutes later, RN Farrell took hot drinks to patients. On knocking on Mr Gudge's door there was no response. RN Farrell opened the door and saw Mr Gudge with a rolled, twisted bed sheet wrapped around his neck. The other end was secured by the closed bedroom door. He was unconscious and his body supported by the bed sheet around the neck. Mr Gudge's trousers were around his ankles and his genitals were exposed.

RN Farrell pressed the duress alarm, called for help and tried to lift Mr Gudge. There were some difficulties associated with cutting Mr Gudge down. Two nurses had difficulty releasing the bed sheet from the door due to Mr Gudge's weight. The ligature cutter was not where it should have been, in the staff station; and scissors were not effective. A Medical Emergency Team (MET) call was initiated and the bathroom door was forced open, releasing the end of the bed sheet which was stuck in the top door jam. Mr Gudge was lowered to the ground. Staff commenced CPR.

A MET call was received on the MET pager at 5:36pm, four minutes after Mr Gudge was found. Dr Heng, ICU Registrar, responded. He arrived at 5.43pm with the MET team and found Mr Gudge grey, cold, and asystolic. Intravenous access was established, and adrenaline, saline and Hartmann's solution were administered throughout the resuscitation. Initially an airway could not be established due to the large amount of vomitus which rendered both the suction equipment and the oropharyngeal airway ineffective; however Mr Gudge was fitted with a mask and a bag to assist in oxygenation.

At 5:44pm Dr Heng called Dr Jones, the second ICU Registrar with greater experience in anaesthetics, for assistance. Dr Jones was advised of the situation, particularly that Mr Gudge had pulseless electrical activity since being found. Dr Jones arrived at the outside of the unit at 5.47am however was not able to gain access as she did not have a swipe card that allowed access. Only the immediate MET team had access by swipe entry. Dr Jones was not able to gain access for thirteen minutes. She was eventually let into the unit arriving at Mr Gudge at 6pm.

On attending, Dr Jones saw defibrillator pads attached to Mr Gudge, although one pad had slid off and was re-attached shortly after. No shocks were administered as Mr Gudge was in PEA (pulseless electrical activity).

Dr Jones gave priority to securing a definitive airway to attempt to improve oxygenation as soon as possible. This was difficult due to vomit clogging the airway. Dr Jones reverted to a gloved hand bailing out vomitus until able to confirm a clear view of the vocal cords and placed the endotracheal tube for oxygenation. Mr Gudge continued to remain in pulseless electrical activity despite ongoing bagging with oxygenation. Mr Gudge could not be revived and resuscitation efforts were ceased. Mr Gudge was declared deceased at 6:35pm.

Internal Review

A Root Cause Analysis (RCA) was conducted by a Patient Safety Team pursuant to section 113 of the *Hospital and Health Boards Act 2011.* The report was completed on 28 July 2015.

The RCA team found that the advanced life support provided by the Medical Emergency Team was in accordance with protocols. However, opportunities for improvement were identified, relating to placement of, and access to, emergency response equipment (an anti-ligature device and resuscitation equipment) within the HDU, and improved access to the mental health unit for all staff attending in support of the Medical Emergency Team. However, the absence of a readily available ligature tool and the difficulty the second ICU Registrar experienced in accessing the ward were found not to have contributed to Mr Gudge's death.

In relation to environmental considerations, the RCA team visited the HDU including the bedroom in which the incident occurred. The linen used in the room was standard

hospital linen. Anti-ligature linen was available for use where indicated by risk but was not normally used as it provided less comfort than standard linen. Further, anti-ligature linen was used only in conjunction with anti-ligature clothing, which becomes a consideration for patient dignity in a recovery-focused environment. The RCA team considered each of the risk assessments, engagement and observations conducted by the treating team; and concluded that there was no clinical indication to switch the patient to anti-ligature clothing or linen.

The RCA noted CCTV was located in the common areas of the HDU and provided live feedback to the Health Security Office at the Townsville Hospital but was not used for clinical observation or monitoring. Further, CCTV cameras were not permitted in bedrooms or clinical areas (interview rooms or treatment rooms) to protect the privacy and dignity of patients.

The RCA report noted doorways were significant ligature risk points on inpatient units and that the door used by Mr Gudge in this incident was a standard full length door, opening only into the bedroom, with protruding horizontal handles and standard door hinges. The RCA team re-created the ligature used and found the rolled bed sheet did jam tightly between the door and the door frame when closed, holding a significant weight and rendering the door difficult to open.

There are various anti-ligature design measures that can be incorporated into doorways, for example, the top of the door can be cut down and tapered, preventing the jamming of a ligature between the door and frame. Hinges can run the length of the door preventing a ligature being hung down a side. Handles can be designed to drop or release when pressure is applied or alternatively shaped so that nothing can be secured to them. Pressure sensors are available for the tops of doors to alert staff when any pressure is placed over a door. The RCA team acknowledged that ligature risk cannot be eliminated on an inpatient unit and anti-ligature measures were only one aspect of a safety culture, to be deployed alongside client engagement, assessment and observation. However, it was noted the absence of anti-ligature measures in the doorway of the patient's bathroom facilitated an environment where he was able to enact a high-lethality suicide attempt in the brief period between observations.

The RCA team also considered the efficacy or otherwise of 15 minute observations in guaranteeing patient safety in a HDU. It noted that while the practice of 15 minute observations in HDU was consistent with practices in other HDU wards, such observations are not able to eliminate most of the risks for which they are commonly implemented (self-harm, suicide, absconding and aggressive incidents). It was the opinion of external experts in the analysis group that consideration should be given to the implementation of continuous back-to-base monitoring with threshold parameters to trigger patient safety alerts as occurs in medical Intensive Care and Cardiac Care Units.

Finally, the RCA report noted serious issues about the management of, and communications with, Mr Gudge's family members in the immediate aftermath of Mr Gudge's suicide.

In summary, the RCA identified that the ligature, which was constructed using standard hospital linen and secured in a tightly fitting doorway, was a contributing factor to the death. The absence of anti-ligature measures in the design of the doorway contributed to the effectiveness of the ligature, increasing the likelihood of a high-lethality suicide attempt occurring between regular visual observations. It recommended the Mental Health Service Group undertake a program of works to identify and address ligature points across all inpatient units and develop an action plan to enhance the internal response to medical emergencies and access to clinical areas for all responders to medical emergency calls.

External Review

As part of the coronial investigation process, Consultant Psychiatrist, Dr Jill Reddan was asked to conduct a clinical review of the management of Mr Gudge. Her report was admitted into evidence.

Dr Reddan considered the suicide and/or risk assessments conducted in the HDU were appropriate. However, she noted that any sort of risk assessment should be viewed as a guide to clinical management, rather than as a predictor. She also noted that there was no evidence base to support suicide risk categorisation of mental health patients generally, including psychiatric inpatients, as a useful guide to treatment, particularly over time.

Dr Reddan considered that the level of observations (15 minute observations) of Mr Gudge in the HDU was appropriate. She noted that expressed suicidal ideation has been shown by various studies to be a poor predictor of future suicide. She noted suicide risk categorisation does not have the necessary discriminating power to distinguish groups of higher and lower risk of suicide in a way that provides a useful guide to treatment. Dr Reddan did not consider continuous observations ought to have been in place and noted that continuous observations can cause regression in patient's clinical state while increasing risks to nurses as patients find continuous observation extremely intrusive.

Although Dr Reddan would have chosen a different benzodiazepine to lorazepam, she considered the medications prescribed in this case were reasonable and orthodox. There were no other medications that would have made any difference to the outcome. She considered the medical care and treatment provided to Mr Gudge was reasonable, commending the amount of medical attention and the consultant review of Mr Gudge over the weekend.

In relation to the management of environmental hazards, Dr Reddan reported that anti-ligature linen or clothing should not routinely be used, but an implement sharp enough to rapidly cut a ligature should be readily available. She reported that no mental health service should be built without anti-ligature measures in the built environment, including walls, doors and doorways. In relation to the suggestion of back-to-base monitoring raised as a possibility in the RCA Report, Dr Reddan noted that whilst it would have some utility, unintended consequences needed to be considered, such as the impact on patients of installing it in bedrooms and interview rooms as well as the need for someone to do the monitoring thereby reducing the number of staff available for actual patient interaction.

In relation to the emergency response, Dr Reddan noted the importance of all medical ICU or emergency staff having ready access to mental health units via swipe cards.

Remedial Action

Immediately following this death, Mr Catt inquired of similar units across the state about the use of ordinary linen, resuscitation trolley equipment and checklists, and

observations procedures. He reported that Townsville was equivalent or comparable with the others.

Mr Catt also reported that the recommendations of the RCA report about a program of works to identify ligature points across all inpatient units was already underway at the time of this death. Completion of the Ligature Audit in January 2014 also included completion of a Risk Assessment and Management Plan with an action plan that included reconfiguration of the High Dependency Unit and ligature related repairs.

Mr Catt reported in his statement to the court:

> I understand that the anti-ligature works in the high risk areas such as patient ensuite bathrooms, patient bedrooms, door handles and shower fixtures have been completed. Mr McHugh is progressing funding applications and waiting on further funds to complete low risk areas such as main AAMHIU areas. The redesign of the HDU has been approved in principle and is being progressed, including further submissions being made for additional funding.

In evidence at the inquest, he reported extensive work undertaken in cutting down the tops of doors in the MHU. In August 2015, the revised cost of proposed scope for anti-ligature works was about $1.2 million. Bundles of documents were tendered about the nature and extent of the works undertaken.

What is happening elsewhere in the state in like mental health units? Was there a missed opportunity to make earlier and better progress in managing environmental hazards with state wide leadership and funding?

Comment and Analysis

The overwhelming weight of evidence supports the finding that Mr Gudge died due to hanging and his death was suicide. The possibility of death through misadventure by auto-erotic asphyxiation was considered. Mr Gudge was found with his pants around his ankles and his genitals exposed. He had recently eaten a full meal and this might be thought inconsistent with an intention to take his own life. It was in this context, Dr Reddan raised the possibility of auto-erotic asphyxiation. However, on further investigation, the zip and buttons on his pants were fastened when he was found, his pants were baggy and he was not allowed to wear a belt in ICU. The scene investigation by police did not reveal any semen. I find that possibility unlikely.

The clinical treatment and care provided to Mr Gudge was appropriate and reasonable. I accept the opinion of Dr Reddan that a longer acting benzodiazepine may have been preferable due to Mr Gudge's history of substance abuse. However, the medication regime provided was within the bounds of what a reasonably competent practitioner might prescribe. Further, there is no evidence to suggest the medication regime contributed to Mr Gudge's death.

I accept that the choice of 15 minute observations was reasonable and that there were no clinical features warranting continuous observation. Dr Reddan warned that constant observations can cause regression in clinical state and that some patients find it intrusive and distressing. With the benefit of hindsight, while continuous observations might have prevented Mr Gudge constructing a ligature and hanging himself; his condition at the time of that decision did not warrant continuous observation.

It is of concern that a ligature cutting tool was not immediately available on discovery of Mr Gudge. However, Mr Catt, Executive Director of Mental Health, raised a valid point, namely that standard ligature cutting tools may not cut through a sheet.

There were issues with the MET team response. Access to the mental health unit was one. In a previous inquest into an inpatient death at the Townsville Mental Health Unit (Inquest into the Death of Justin), a similar issue arose about access by a responding MET team. The findings recorded that steps were taken to ensure swipe card access to MET members. The current RCA recommended that all staff attending in support of a MET call have swipe access to the unit. It is a serious concern that further issues arise with access by emergency medical staff. There was a clear missed opportunity by the Mental Health Service Group to consider the possibilities and develop access arrangements to address those possibilities.

However, I find that if Dr Jones attended to Mr Gudge earlier, and obtained airway access and oxygenation earlier, the outcome is unlikely to have changed. On arrival of the MET team, he was "grey, cold and asystolic", CPR started as soon as he was found and continued until further effort was considered futile.

The medical treatment and response provided to Mr Gudge, when located by the nurses in HDU and subsequent MET team was appropriate; save for the issue relating to access to the HDU, which has since been rectified.

While the use of anti-ligature linen (and associated anti-ligature clothing) was not indicated, it is of serious concern that Mr Gudge was able to access a ligature point in the form of the doorway to his bathroom, particularly given there are mechanisms and door designs that can decrease the risk of its use for this purpose.

Inpatient Suicide Risk Management – Environmental Hazards

The deaths of Mr Gudge and Mr Hitchins were facilitated or enabled by access to the physical means to suicide, a ligature and ligature point on the part of Mr Gudge, and the plastic bag on the part of Mr Hitchins. How were such hazards identified and managed? I start with the United States experience and then consider the history of endeavours in Queensland. I also consider the history specific to Townsville Mental Health Unit.

The United States Experience

In 2003, the American Psychiatric Association reported that about 1,500 suicides take place in inpatient hospital units in the United States each year, and that one third of these take place while the patient is on 15 minute observations.

In 2006, Veterans Affairs (VA) National Centre for Patient Safety completed a review of all root cause analysis reports of inpatient suicide and serious suicide attempts. A multi-disciplinary committee was formed and charged with the task of developing a checklist to be used to identify environmental hazards on acute mental health units treating suicidal patients.

The committee developed general guidelines to be applied to all areas of a psychiatric unit and detailed specific guidelines for specific rooms such as bathrooms, bedrooms and seclusion rooms. Drafts of the checklist were extensively piloted in early to mid-2007. In August 2007 the VA leadership decided the use of the *Mental Health Environment of Care Checklist* was mandatory for VA mental health units treating suicidal patients. All 113 mental health units in the VA system were required to form

an inspection team and review the unit on a quarterly basis. The teams were required to submit a list of all identified hazards, along with plans for abatement, to their facility directors and to a national data base. By October 2008, the facilities completed their fourth quarterly review. The results were analysed and published.

The findings included:

- The facilities identified and rated 7,642 hazards and at the end of the first year of the project, 5,834 (76.3%) hazards were abated;
- About 2% of the hazards were identified as critical hazards and another 27% were rated as serious, for a total of 2,192 hazards;
- The most common location of the hazards was bathrooms and bedrooms; and the most common hazard was anchor points (protrusions that could support the weight of a patient attempting to hang himself or herself); and
- The most common suffocation risk was the use of plastic liners in trash cans, while poisoning risk came from access to cleaning products.

The report published in February 2010, concluded it was too early to assess impact of the measures on the suicide rate because many facilities were still in the process of remodelling and abating identified hazards. The cost effectiveness of the measures was not within the scope of the report, the authors noting the overriding goal was that no veteran should ever commit suicide while hospitalized in a VA psychiatric unit.

A further report on progress within VA was published in 2013: "*Inpatient suicide on mental health units in Veterans Affairs hospitals - avoiding environmental hazards".* The authors reviewed root cause analysis reports of suicide or attempts in mental health units at VA hospitals from December 1999 to December 2011. There were 243 reports of suicide attempts and completions: 43.6% (106) were hanging, 22.6% (55) were cutting, 15.6% (38) were strangulation, and 7.8% (19) were overdoses. Doors accounted for 52.2% of the anchor points used for the 22 deaths by hanging; sheets or bedding accounted for 58.5% of the lanyards. In addition, 23.1% of patients used razor blades for cutting. The report provided a breakdown of anchor points used for hanging. Door and door handles accounted for 52% of anchor points. In examining lanyards, sheets and belts were used in the majority of completed suicides. The paper concluded:

> The mental health environment presents many challenges for patient safety. Hanging is the most commonly reported method for inpatient suicide. Many materials can be used as a ligature (e.g., drapery cords, belts, shoe laces, ties, kerchiefs, bathrobe sashes, drawstrings from pants, coat hangers, call cords, privacy curtains, trash can liners, etc.), including clothing (e.g. pajamas) and bed sheets, which can't easily be removed from the unit. Therefore, systematic elimination of usable hanging/anchor points is the most critical step, being sure to include less obvious anchor points and ones that may be below a patient's head or closer to the floor, since complete suspension is not a requirement for suicide by hanging. It is impossible to completely eliminate suicide risk in mental health environments since systems or engineering fixes are not always 100% effective and because there is a delicate balance between safety and maintaining a humane environment that is welcoming and healing for patients (see the VHA Mental Health Design Guide for ideas on how to maintain both a safe and therapeutic environment [20]). Therefore, patient supervision by qualified staff plays a vital role in mitigating risk, along with adequate assessment, observation and therapy [21].

I conclude this topic with some observations about the *Mental Health Environment of Care Checklist* available at http://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp

- Detailed criteria is included about how to assess doors as potential anchor points and modifictions and alternatives that are effective;
- Bed sheets are identiifed as potential ligatures and suggestions made about alternatives;
- Bin liners are identified as potentially hazardous as the means of suffocation and the use of paper liners are recommended;
- The checklist descends into detailed criteria for particular rooms such as bedrooms, bathrooms and seclusion rooms.

I have to record that the existence of this checklist originally came to my attention early into my investigation into an inpatient suicide at Townsville that ultimately went to inquest (Inquest into the death of Justin) through a basic google search. It was listed

on the first page of hits. Clearly, publicly available, and no sophisticated literature review was required to find it.

I now turn to consider the state of knowledge and its application in Queensland in the same area.

The Queensland Experience

What do we know about the Queensland experience with managing environmental hazards in mental health inpatient facilities?

In 2005, a report was published "*Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events"*. The Director General of Health established a committee to review deaths occurring between 2002 and 2003 involving people with a serious mental illness. It involved the review of 23 inpatient suicides and identified a number of systemic issues, including issues associated with visual observations as well as issues associated with environment and means to suicide.

I will let the report speak for itself on the number of topics relevant to these deaths. Firstly, as to environmental hazards:

> Issues related to the environment and access to means of suicide were identified by the Committee in 11 of 23 inpatient suicides and 1 of 7 unexpected deaths. In 8 of the 23 inpatient suicides the Committee identified structural issues relevant to the suicide including 4 cases where the patient jumped from the hospital car park. In the prevention of suicide, important environmental issues include the structure of wards and nearby facilities such as car parks and railway stations, access to the means of suicide such as hanging points and ligatures, and security in inpatient wards.
>
> Of the 7 patients who suicided in mental health wards, 5 used materials that they had brought with them, such as shoelaces, belts and a parka cord. There are detailed provisions in the *Mental Health Act 2000* around the searching of patients and visitors and the Committee supports the development and application of standardised policies on searching and the removal of harmful things whilst preserving the dignity and privacy of patients.

The design of some units was clearly inappropriate, and fixtures and fittings such as door handles in high dependency units require review.

Secondly, as to immediate responses to sentinel events:

The Committee identified problems related to the mental health services' response to the incident in 5 of the 23 inpatient suicides and 4 of the unexpected deaths. Of these the Committee noted that in 3 of the inpatient suicides and 4 of the unexpected deaths following the collapse of a patient, there were problems in gaining access to emergency response services. There were variations among the facilities as to where emergency equipment was located, the ease of access to the required area and the type and working order of the equipment provided.

There was also variation in the communication of deaths to family members, and in providing follow-up to family members. In 2 of the 23 inpatient suicides the Committee noted untimely and/or inappropriate communication with the family after the incident. In the case of suicide, it is well known that surviving family members are considered to be at higher risk of suicide and the Committee believes there should be a process for providing information and support to these family members.

Thirdly, in relation to statewide guidelines:

The Committee supports the standardisation of investigations into future mental health sentinel events in accordance with the *Queensland Health Incident Management Policy 2004* and believes each review team should include a participant who is external to the health service district. Recommendations of sentinel event reviews should be examined at the corporate level to assist district mental health services where there is a need for statewide guidelines or training to address issues that arise.

The recommendations of the report included:

- Remove potential means of suicide wherever possible by implementing searching procedures in accordance with the *Mental Health Act 2000* and correcting potential structural factors in all inpatient mental health units and their immediate environment; and

- Establish an ongoing process for monitoring the results of analysis of mental health sentinel events at the corporate level to determine trends and communicate these to the services.

In update of 7 March 2008, Queensland Health reported on progress with the *Achieving Balance* recommendations, relevantly stating:

> A 12 week project that assesses the suitability of a standardised ligature risk audit tool has commenced in the Central Area Health Service. This is based at the Royal Brisbane and Women's Hospital and is being funded by the Patient Safety Centre. The Senior Project Officer (Bill Parlet) will be auditing all inpatient mental health facilities using the Ligature Risk Audit tool obtained from the United Kingdom National Health Service ('Assessing, addressing and managing ligature risks in in-patient areas, 24 hour off site nursed units and other clinical/ treatment areas'). Following the 12 week project, a final report will be submitted to the Central Area Health Service and Patient Safety Centre for consideration of a modified audit tool that can be standardised throughout Queensland Health and expanded to include potential environmental hazards other than ligature points.
>
> Consultation has commenced regarding the development of an Environmental Design Guide. Modification of an existing US document *'Design guide for the built environment of behavioural health facilities: second edition 2007'* is being considered for Queensland Health. The guide outlines the safe fixtures and fittings that can be introduced into mental health facilities, and lists the local manufacturers that produce them.
>
> The Searches Workgroup has completed the regular meetings for project deliverables regarding development of statewide guidelines. The guidelines are in the process of development and will be released following legislative clarification which remains ongoing.

There was an increasing awareness in Queensland, comparable with the VA experience in the United States, of opportunities to better manage environmental hazards that might be used as the means of inpatient suicide. But there are also emerging differences in approach. Queensland proceeds with ligature audits but

progress on the broader subject of environmental hazards starts to significantly lag behind. What is under discussion in Qld is an environmental ***design*** guide. There is no discussion about what to do with existing hazards in the built environment.

For the moment, I will focus on environmental hazards relevant to the circumstances of Mr Hitchins then return to consider developments specific to ligature risks relevant to the circumstances of Mr Gudge.

On 3 May 2009, Justin died due to choking on a bar of soap while an inpatient in the Psychiatric Intensive Care Unit at the Townsville Mental Health Unit. His death was suicide. There were immediate learnings at the MHU and bars of soap were replaced with small bars that reduced the prospect of obstruction in the throat. On reflection, the death of Justin should have put the broader issue of environmental hazard management back on the radar for Queensland Health. Did any other mental health units in Queensland learn from the experience at Townsville Mental Health Unit? If not, was there a system for statewide dissemination of lessons learnt and how effective was it?

The Inquest into the Death of Justin concluded with findings published in July 2013. The issues addressed in that inquest included the need for improved observations and environmental risk management. During the inquest, Dr Riley, then Clinical Director of the Townsville Mental Health Unit, conceded that there was no systematic approach to identification of hazards (means of inpatient suicide) and assessment of associated risk. I made a recommendation to the State Director of Mental Health to develop and implement an Environmental Risk Management System for the identification of hazards and assessment of associated risks for inpatient suicide. I suggested as a starting point the development of checklists to guide staff conducting routine inspections to identify environmental hazards and to take appropriate corrective action. During the course of that hearing, reference was made to the US VA checklist.

In 2014, the Office of the Chief Psychiatrist advised the Office of the State Coroner that the Coronial recommendations from the Inquest into the Death of Justin would be implemented by way of a guideline.

On 9 September 2014, not long after the death of Mr Hitchins, Mr Catt, an executive member of the leadership team for the Townsville Mental Health Unit, wrote to Associate Professor Allan and Dr Kingswell (both members of the senior leadership team at state level for mental health) asking for an update on the implementation of the recommendation from an Inquest into the Death of Justin. He was told the guideline was still being developed and received no further response.

To recap a few key points relevant to environmental risk management vis-à-vis the inpatient suicide of Mr Hitchins:

- Through the *Achieving Balance* report in 2005, and update in 2008, Queensland identifies the need to remove the means for suicide; a ligature risk audit tool was implemented as a trial and discussion started about an environmental design guide.
- The United States moves ahead with application of its checklists as well as studies into its effectiveness and continues with its efforts over the period 2008 to 2013.
- Justin dies in May 2009 from an environmental hazard (choking on a bar of soap) and Townsville MHU immediately identifies lessons to be learnt and takes appropriate remedial action. But there were no lessons learnt on a statewide basis, and corresponding action on a statewide basis towards a broader environmental risk management guideline.
- In July 2013 I made recommendations directed to State Director of Mental Health to develop and implement an Environmental Risk Management System for the identification of hazards and assessment of associated risks for inpatient suicide.
- In August 2014 Mr Hitchins died due to asphyxiation with a plastic bag.
- The leadership team responsible for Mental Health at a State level is unable to identify any action taken in the interim to advance that recommendation.

I now turn to management of the ligature risk vis-à-vis Mr Gudge.

In 2012, seven years after the *Achieving Balance* report, Queensland Health published the *Guideline for Managing Ligature Risks in Public Mental Health Services*. The guideline applies to all public mental health inpatient facilities, providing a systematic

approach to management of ligature risks through the use of a ligature audit tool in conducting annual ligature environmental audits.

Ligature risks are identified, assessed, and scored. Compensatory factors are identified. Recommendations for remedial action to mitigate the risk are expected to be reported to management. The risk assessment is a function of the type of room or location, the risk profile of consumers who have access, and the prospect of physical risk from the ligature point. Interestingly, the examples given of ligature points include doors in bedrooms, common areas and corridors.

Unfortunately, the Guideline does not provide any assistance about how to mitigate the risk of doors used as a ligature point. Table 4, 'Ligature Point Identification' merely refers to doors without specifics about the features that might present a ligature hazard. Table 6, 'Recommended Courses of Action' refers to suggested actions including 'remove' or 'remove and replace' or 'modify'. No guidance is given statewide about what might practically be done. Contrast that approach with the United States' VA checklist. It might be argued that the Guideline was a good start. However, given the opportunity to learn from the VA checklist, I rate the 2012 Guideline as abysmal in comparison.

Interestingly, VA conducted studies after implementation of its checklist to review impact and effectiveness of that strategy. There was no evidence offered to suggest that Queensland Health monitored statewide implementation for effectiveness or shared lessons learnt during implementation. The Guideline was offered, but not monitored. Why not? Was there concern about the cost implications?

The 2012 Guideline was published in August of that year. Mr Gudge died on 10 May 2015. How did Townsville MHU progress implementation of that guideline in that period?

A two page table resulting from a ligature audit of the High Dependency Unit at Townsville in November 2012 identified a number of ligature points including doors, carried out the risk assessment, arrived at scores, then in respect of recommended remedial action noted, "To be locally managed". No further detail is provided. Clearly,

implementation of the guideline was in its infancy. But given the lack of detail in the guideline, the expectation in terms of outcomes could only have been low.

A report of a ligature audit of the Townsville Mental Health Unit in January 2014 shows a similar table format but starts to discuss substantive remedial action. For example, door handles scored high risk and the recommended remedial action was replacement with pressure drop handles. However, the doors were not identified as ligature points in themselves and therefore no remedial action considered. Contrast that with the United States experience.

The April 2015 ligature audit (now on an excel spreadsheet) is a vast improvement on earlier audits. In respect of bedrooms in the High Dependency Unit, it notes doors open inwards and the recommended remedial action is 'remove/replace'. However, the recommendations were not implemented before the death of Mr Gudge. I accept the scope of work resulting from this audit was major and could not have been expected to be carried out immediately. However, the lag in developing internal knowledge and experience in the auditing process, due to a lack of detailed guidance given in the guidelines, failed Mr Gudge.

In September 2015 I sought an update on progress with implementation of recommendations from the Inquest into the Death of Justin. A status report was provided noting delays had been caused by a restructure of the department and other priority work commitments. It also advised that further work was ongoing including a review of international literature.

It was at this point that the convening of these inquests became necessary.

On 17 June 2016, nine months later, *Draft Guidelines for Managing Ligature Risks in Queensland Public Mental Health and Alcohol and Other Drugs Inpatient Units* were distributed for consultation with feedback required by 1 July 2016. An accompanying memo advised that "The Guidelines provide Hospital and Health Services with guidance on service responsibilities for the routine assessment and management of environmental safety risks including ligature risks within inpatient environments. The guidelines are a complementary package to assist in annual comprehensive assessments of ligature risks and environmental safety risks in inpatient units."

On 18 November 2016, Associate Professor Allan, in his capacity as Acting Executive Director, Mental Health Alcohol and Other Drugs Branch, reported to me that in response to my recommendations Queensland Health had developed two documents (Guidelines and a Checklist) to assist Hospital and Health Services operating public mental health inpatient units to recognise, respond to and mitigate against potential environmental hazards. These documents were titled:

- Managing ligature risks in Queensland public mental health alcohol and other drugs in patient units 2016 (incorporating an audit tool for monitoring ligature risks) (the *Ligature Guidelines 2016*);
- Recognising and managing potential environmental hazard risks in Queensland public mental health alcohol and other drug inpatient units 2016 (incorporating the recognising and managing of potential environmental hazards and facility checklist) (the *Environmental Hazard Guidelines 2016*).

The report of Associate Professor Allan explains that the decision to develop detailed ligature risk assessment guidelines and audit tool, complemented by a broader guideline for the identification and management of environmental hazards was informed by robust literature on ligature risk assessment, the prevalence of death by ligature, consultation with and feedback from Hospital and Health Service clinical units and expert clinical opinion of a working party. According to the report of Associate Professor Allan, the expert working party comprised senior mental health clinicians, patient safety clinicians and CIDU representatives. Ultimately it was decided to retain and amend the existing 2012 Queensland Health *Managing Ligature Risks Guidelines.*

There was little evidence at the inquest, other than the fact of a departmental restructure and higher priority work commitments, as to why it took more than two years for the guidelines to be developed. This delay by Queensland Health to provide comprehensive guidelines was a missed opportunity to ensure environmental safety in Queensland mental health inpatient units.

It also remains unclear to me exactly how the *Environmental Hazard Guidelines* are to be used. The *Ligature Guidelines* include a risk rating matrix whereas the *Environmental Hazard Guidelines* do not. Dr Heffernan gave evidence that the Environmental Guidelines is a broad tool that should be read in conjunction with other

more specific guidelines. He stated *"And so the intent is that this is an overarching document that considers physical, relational and procedural risk and helps clinical services step through the auditing…and that underneath that overarching guideline is a series of guidelines such as the sexual safety guidelines and the ligature audit guidelines ".* Unfortunately this is not clear from the document itself.

The recommendation from Inquest into the Death of Justin was to develop a checklist to guide staff to conduct routine inspections to identify environmental hazards, and take appropriate corrective action. It is not clear that the *Environmental Hazard Guidelines* on its own will serve that purpose. I remain concerned that the Environmental Guidelines alone are not adequate without relevant practical guidelines being developed to assess for and audit specific hazards.

The current guidelines are a product of a working group. Thus, the reasoning for adopting particular approaches to development of the guideline are not immediately transparent or ascertainable. I don't understand the reasoning for different approaches to ligature risk in comparison to other environmental hazards.

During the inquest, I asked Dr Heffernan, the newly appointed Chief Psychiatrist, if he could assure me that bars of soap, plastic bags and doors similar to the door used by Mr Gudge had been removed or modified in other Mental Health Units around the state. He could not give me that assurance. This may be because Dr Heffernan was newly appointed or it may reflect a situation whereby lessons learned from one Hospital and Health Service are not considered centrally by the Office of the Chief Psychiatrist and disseminated to other Hospital and Health Services; with follow up for compliance.

I note the evidence of Dr Heffernan, that there was a distinct change in how the Office of the Chief Psychiatrist operates when compared to the period before 2012. There was a restructure in Queensland Health in 2012 (and the passage of the *Hospital and Health Boards Act 2012)* resulting in some loss of centralised oversight and devolution of responsibility to Health Services for reviewing inquest recommendations, findings of RCAs and critical incidents. Dr Heffernan reported that as a result of recommendations from the recent *Sentinel Events Review Report 2015,* the Office of the Chief Psychiatrist has agreed to take part in a quality assurance committee and the Queensland Government has guaranteed that the committee will be established. This

may be one forum in which to discuss lessons learned from critical incidents, in particular serious critical incidents involving injuries and deaths.

Findings required by s. 45

Steven Hitchins

Identity of the deceased	Steven John Hitchins
How he died –	Mr Hitchins obtained a plastic bin liner from the kitchen area of the facility and use a belt to secure it over his head and asphyxiated himself.
Place of death –	Townsville Adult Acute Mental Health Inpatient Unit, Low Dependency Unit. Townsville Hospital Townsville Queensland 4810 Australia
Date of death–	03 August 2014
Cause of death –	1(a) Plastic bag asphyxiation.

Shawn Gudge

Identity of the deceased	Shawn Bradley Joseph Gudge
How he died –	Mr Gudge used a standard hospital sheet that was on his bed, rolled and twisted it tightly and wrapped it around his neck and then tucked it up under itself. He then secured the other end into his ensuite bathroom door opening and closed the door creating a strong ligature and then proceeded to hang himself.
Place of death –	Townsville Adult Acute Mental Health Inpatient Unit, High Dependency Unit. Townsville Hospital Townsville Queensland 4810 Australia
Date of death–	10 May 2015
Cause of death –	1(a) Hanging

Recommendations

Recommendation 1

I recommend Queensland Mental Health centralise within the State a body, with oversight from the Office of Chief Psychiatrist, tasked with the function of reviewing

and reporting to Hospital and Health Services on lessons learnt and other opportunities for improvement through internal and external investigations (including RCA reports, Health Service Investigation Reports, Health Ombudsman Reports, Coronial findings and recommendations) as well as like reports from other States.

Recommendation 2

I recommend that the Office of the Chief Psychiatrist commission an independent, external audit and review of the extent to which each relevant Hospital and Health Service has implemented the Ligature and Environmental Guidelines as well as the effectiveness of that implementation. The results of that audit and review be shared with each Hospital and Health Service as well as any opportunities for improvement.

I close the inquest.

Kevin Priestly
Coroner
CAIRNS
5 February 2018

Appendix 1: Relevant Resources

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