Australian
Health Law
Bulletin

Queensland Coroner calls for guidelines to reduce inpatient suicide risk in mental health units — a review of the inquest into the deaths of Steven Hitchins and Shawn Gudge

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Abstract

Following the suicide deaths of two mental health unit inpatients, the Coroners Court of Queensland has handed down its findings and recommendations into minimising environmental hazards in mental health units to reduce the risk of inpatient suicide.

Introduction

On 5 February 2018, Coroner Kevin Priestly delivered findings concerning the deaths of Mr Steven Hitchins and Mr Shawn Gudge.[1]

On 3 August 2014, Mr Hitchins 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. An autopsy confirmed he died from asphyxiation.[2] On 10 May 2015, Mr Gudge 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. An autopsy confirmed he died due to hanging.[3] The Coroner considered if there were any missed opportunities to reduce the risk of inpatient suicide and explored what progress was made in considering and implementing the Coroner's earlier recommendations regarding environmental hazards in mental health units.

The death of Steven Hitchins

Mr Hitchins was diagnosed with schizoaffective disorder and had suffered from mental illness for around 20 years. From 2006 to 2012, Mr Hitchins became increasingly obsessed with fear of the Mafia. Mr Hitchins was admitted to the Cairns Base Hospital Psychiatric Unit in 2009 in a distressed state, and when he was admitted to the Townsville Hospital in 2014, he appeared not to have had any psychiatric treatment since 2010.[4]

In May 2014, Mr Hitchins saw the ex-Mayor of Whitsunday on television and took this as a final sign that the Mafia were going to kill him. On 6 May 2014, Mr Hitchins was arrested for telephoning Channel Seven claiming he had placed a bomb in the Brisbane Parliament House. While in custody, he was assessed as being floridly psychotic and was consequently admitted to the Townsville Hospital High Dependency Unit (HDU) on 9 May 2014 on an involuntary treatment order. Mr Hitchins was moved to the Low Dependency Unit (LDU) on 6 June 2014 and was progressing well.[5]

In July 2014, it became apparent that Mr Hitchins's psychiatric state has deteriorated. In late July, 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.[6]

Shortly after 7.30 pm on 3 August 2014 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 5 pm and nobody entered his room until 7.21 pm. Despite this, the visual observations chart for Mr Hitchins recorded each 15-minute observation as completed from 5.15 pm through to 7.15 pm inclusive.[7]

Internal review

A Health Service investigation found that local practice had developed "idiosyncratically" in relation to visual observations due to "a lack of clarity at all levels", with limited evidence of systematic and policy governance.[8] The report authors observed that nursing staff considered the number of patients placed on 15-minute observations was unreasonably high and therefore the task was too onerous to complete. Consequently, observations were considered to be "an administrative burden rather than part of good clinical practice."

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

- that forms and documents supporting good practice be developed
- that the Health Service review the staffing establishment of the Unit to ensure multidisciplinary work is feasible
- that clear, consistent and unified handover processes be developed
- that a single method of communicating risk which is standard across all Units be developed
- that orientation and training be provided to new and existing staff

External review

An expert review of clinical management concluded that the clinical care and treatment for Mr Hitchins's deteriorating mental state were appropriate. The expert review 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 expert review emphasised that 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.[9]

In relation to environmental hazards, the expert review 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. At the same, it also noted 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 HDU or Psychiatric ICU environment would not be routinely recommended. It concluded that consideration should be given to increased scrutiny for potential hazards on a case-by-case basis.[10]

In Mr Hitchins's case, in considering the length of time he was an inpatient and despite his deterioration in late July, his access to plastic bags and belts was not criticised by the expert review.

The death of Shawn Gudge

Mr Gudge had a clinical history of drug abuse including use of benzodiazepines, opiates, amphetamines and hallucinogens.[11] He had previously presented to the emergency department in November 2014 and engaged in a residential rehabilitation program around the same time. On 7 May 2015, Mr Gudge was involved in a high-speed car chase with the police and returned home after being taken to the Ayr Emergency Department.[12]

The next day, his father took him to the Ayr Emergency Department after Mr Gudge was looking for a rope to hang himself. Mr Gudge was detained under the Mental Health Act 2000 (Qld) and transferred to the Acute Adult Inpatient Mental Health Unit at Townsville and then to the HDU due to the risk of aggression and self-harm or suicide.[13] Mr Gudge was placed on 15-minute observations.

On Saturday 10 May 2015, Mr Gudge did not display signs of increased aggression or agitation. The registered nurse responsible for Mr Gudge considered his mental state was labile but improving and that he was cooperative.[14] Mr Gudge was given dinner and at approximately 5.15 pm a registered nurse collected his meal tray. At approximately 5.30 pm, hot drinks were to be provided to patients. There was no response when his door was knocked on. Upon opening the door, Mr Gudge was found with a rolled, twisted bed sheet wrapped around his neck, the other end of the sheet being secured by the closed bedroom door.[15]

The duress alarm was raised. There were difficulties releasing the bed sheet and the ligature cutter was not where it should have been. The scissors used in substitute were not effective. A medical emergency team (MET) call was initiated while staff commenced CPR. An ICU Registrar attended the scene and called for a second ICU Registrar with greater experience one minute later. The second ICU Registrar arrived at the unit, however she was not able to gain access for 13 minutes, as she did not have the required swipe card. Mr Gudge was declared deceased at 6.35 pm.[16]

Internal review

A root cause analysis (RCA) was completed on 28 July 2015 by a Patient Safety Team, pursuant to the Hospital and Health Boards Act 2011 (Qld).[17] Opportunities for improvement were identified particularly regarding placement of emergency response equipment (an anti-ligature device and resuscitation equipment) within the HDU and improved access to the mental health unit for other staff attending. Despite these recommendations, the RCA did not find that they contributed to Mr Gudge's death.[18]

The RCA team also considered the potential environmental hazards present. The linen used by Mr Gudge was standard hospital linen. The unit did have anti-ligature linen and associated anti-ligature clothing available for use where a patient was at high risk but was only used in exceptions as it provided less comfort to patients.[19] The RCA also noted that CCTV was located in the common areas but was not used for clinical observation or monitoring.[20]

The RCA also noted doorways were signature ligature risk points, with Mr Gudge's door having protruding horizontal handles and standard door hinges. While the RCA noted that ligature risk could not be eliminated entirely, the absence of anti-ligature measures on Mr Gudge's door, including pressure sensors on the tops of doors, facilitated an environment where he was able to enact a high-lethality suicide attempt in a very short period.[21] It recommended that the Mental Health Service Group undertake work to identify and address ligature points across all inpatient units and develop a plan to enhance medical emergency responses.[22] The RCA team also considered the efficacy of 15-minute observations in terms of guaranteeing patient safety in a HDU, noting that such measures are not able to eliminate most of the risks like self-harm and suicide. In this respect the opinion was to consider implementation of continuous back-to-base monitoring to trigger patient safety alerts as occurs in medical intensive care and cardiac care units.[23]

External review

Consultant Psychiatrist, Dr Jill Reddan conducted a clinical review of the management of Mr Gudge. Dr Reddan considered that 15-minute observations were appropriate for Mr Gudge and while she may have chosen different medication to prescribe him, the decisions of the HDU were reasonable.[24]

Dr Reddan also commented on the environmental hazards identified by the internal review. She noted that anti-ligature linen or clothing should not routinely be used, but an implement sharp enough to cut a ligature should be readily available. She also noted that all mental health services should be with anti-ligature measures in doors, walls and doorways. She also noted that CCTV monitoring is a possibility but considerations such as the impact on patients need to be considered.[25] Dr Reddan also commented on the importance of all medical ICU or emergency staff having ready access to mental health units with the use of swipe cards.[26]

Coroner's comments on the deaths of Mr Hitchins and Mr Gudge

Coroner Priestly concluded that the clinical care at the mental health unit was appropriate and reasonable in both Mr Hitchins's and Mr Gudge's cases.[27]

In the case of Mr Hitchins however, the Coroner found that Mr Hitchins' patient observations were lacking, as no visual observations were conducted between 5 pm and 7.21 pm, and the observation conducted at 7.21 pm did not include an attempt to view Mr Hitchins's face or engage in discussion. The absence of 15-minute observations was noted as a missed opportunity to engage with Mr Hitchins and assess his general wellbeing.[28] However, it was also noted by the Coroner that 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 but it was impossible to determine if the outcome would have been different.[29]

The Coroner accepted the Health Service's 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 breaches representing post incident collusion or deliberate falsification.[30] Coroner Priestly observed that the matter of observations had been problematic for some time, and other coronial findings supported the fact that this is a much-visited area, where leadership at a state level is required for Queensland.[31]

In respect of Mr Gudge, the Coroner expressed concern that a ligature-cutting tool was not immediately available and that the MET team experienced difficulty accessing the mental health unit. The Coroner found it was a clear missed opportunity to develop a better response plan to medical emergencies. Despite these findings, the Coroner found it unlikely that the outcome would have changed.[32] The Coroner also found it was of serious concern that Mr Gudge had access to a ligature point in the form of the doorway to his bathroom, especially considering there are mechanisms and door designs that reduce this risk.[33] Also noted of concern were problems with the emergency medical staff's access to the mental health unit, with the Coroner noting that this issue indicated another missed opportunity to the health service to consider such possibilities and develop better access arrangements.[34]

Coroner's findings on environmental hazards and recommendations for systematic change

Coroner Priestly went into significant detail regarding the role environmental hazards play in increasing risk of inpatient suicide in mental health units. He found that the deaths of both Mr Hitchins and Mr Gudge were facilitated or enabled by access to the physical means to suicide, being a plastic bag and a ligature point respectively.[35] The Coroner reviewed the United States's experience before returning to Queensland.

The United States

The Coroner referred to the efforts undertaken in the United States to reduce inpatient hospital unit suicides. In 2006, a multidisciplinary task force was set up and tasked with developing a checklist to be used to identify

environmental hazards on acute mental health units treating suicidal patients. As a result of this process, the Mental Health Environment of Care Checklist (checklist) was established, to be applied to all areas of a psychiatric unit in additional to specific guidelines for certain areas, eg, bathrooms or bedrooms.[36]

By 2008, an analysis was undertaken based on reports provided by individual mental health units. The findings included that:[37]

- 76.3% of hazards were abated.
- The most common locations of hazards were bathrooms and bedrooms.
- The most common hazards were anchor points where patients could attempt to hang themselves.
- The most common suffocation risk was the use of plastic bin liners.

A progress report published in 2013 identified that environmental hazards present many challenges for patient safety and recommended the systematic elimination of usable hanging/anchor points is the most critical step in reducing inpatient suicide risk. The report also noted that patient supervision plays a vital role in mitigation risk, along with adequate assessment, observation and therapy.[38] Coroner Priestly further observed that the checklist gives clear, detailed criteria on how to assess environmental hazards and is easily and publicly available. The Coroner observed the following regarding the checklist:[39]

> - Detailed criteria is included about how to assess doors as potential anchor points as well as modific[a]tions and alternatives that are effective;
> - Bed sheets are identi[fi]ed 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.

Queensland

Coroner Priestly referred to a 2005 report commissioned by the Director-General of Health titled *Report of the Queensland Review of Fatal Mental Health Sentinel Events: Achieving Balance*[40] (report). The report examined 23 inpatient suicides that occurred between 2002 and 2003. The report made the following findings:[41]

- Environmental hazards and access to suicide were present in 11 of the 23 suicides.
- Of the seven patients who suicided in mental health wards, five used materials they had brought with them, demonstrating the need for standardised policies on searching whilst preserving the dignity of patients.
- Problems were identified in the responses to the incidents in five inpatient suicides, including issues with gaining access to emergency response services and equipment.
- There is a need for state-wide guidelines or training to assist district mental health services.

The report also reviewed responses to such events, including communication of deaths to family members and sentinel event report processes. Of the 23 cases reviewed, issues were identified in nine instances.[42] The report also noted that in seven circumstances, there were problems gaining access to emergency response services, as well as inconsistencies among the facilities as to where emergency equipment was located, the ease of access to the area and the type of equipment available.[43] With regard to communication with family, the report found that issues existed in two cases. This was of concern as family members are at a higher risk of suicide and as such a process for providing information and support should be implemented.[44]

The report recommended that potential means of suicide should be removed wherever possible through searching procedures and monitoring and correcting environmental hazards. In addition, it recommended establishing an ongoing process for monitoring results of mental health sentinel events at the corporate level to determine trends and ensure that relevant information is communicated to health services.[45]

Following the report in March 2008, Queensland Health reported progress in this area. It announced that a project regarding ligature risk took place at a number of health services; consultation had occurred regarding development of an environmental design guide based on the United States example and standard guidelines were in the process of development.[46] The Coroner found there was increasing awareness in Queensland at the time but the approach was lacking. The Coroner noted that the Queensland experience focused on a *design* guide rather than an approach on how to minimise existing hazards.[47]

Coroner Priestly referred to the *Inquest into the death of Justin*.[48] Justin died in the Psychiatrist ICU at the Townsville Mental Health Unit due to choking on a bar of soap. Immediately afterwards, bars of soap were replaced with smaller bars. The Coroner found that the death of Justin should have put the broader issue of environmental hazard management back on the radar for Queensland Health.[49]

In the findings into the death of Justin, Coroner Priestly recommended the development of checklists to identify environmental hazards and take corrective action.[50] In 2014, the Office of the Chief Psychiatrist advised the Office of the State Coroner that the recommendations

would be implemented by way of a guideline. In relation to the death of Mr Hitchins, Coroner Priestly found that no action was taken to implement an Environmental Risk Management System between the findings into the death of Justin in 2013 and the death of Mr Hitchins in August 2014.[51]

Regarding the management of ligature risk, Queensland Health published the "Guideline for managing ligature risks in public mental health services"[52] (Guideline) in 2012. Under the Guideline, ligature risks are identified, assessed and scored. However, the Coroner observed that the Guideline does not provide guidance on mitigating the risk of doors used as a ligature point, stating that the Guideline is "abysmal in comparison" to the United States checklist.[53] The Coroner also noted that there is no evidence that Queensland Health monitored the effectiveness of the Guideline.[54]

Returning to the death of Mr Gudge, the Coroner found that the HDU at Townsville identified a number of ligature points and carried out risk assessments in accordance with the Guideline. However, little to no remedial action occurred which the Coroner noted should have been expected given the lack of detail in the guideline.[55] In 2015 a further ligature audit was conducted at Townsville with actions such as "remove/replace" however these were not implemented prior to Mr Gudge's death.[56]

In November 2016, two documents developed by Queensland Health were released:[57]

- 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*).

Coroner Priestly noted there was little evidence at the inquest as to why it took more than 2 years for the guidelines to be developed and the delay was a missed opportunity to ensure environmental safety.[58] In addition, the Coroner noted that it is unclear how the Environmental Hazard Guidelines 2016 are to be used, as they do not include a risk-rating matrix. The recommendation from the *Inquest into the death of Justin* was to develop a checklist to guide staff to conduct routine inspections to clearly identify environmental hazards. The Coroner found that it is not clear how the Environmental Hazard Guidelines 2016 will serve that purpose on their own, and commented that he remains concerned that they are inadequate without relevant practical guidelines being developed.[59] The Coroner recommended Queensland Mental Health and the Office of the Chief Psychiatrist undertake reviews regarding environmental hazard risks and the implementation of the 2016 guidelines.[60]

Comments

The findings from both this inquest and the *Inquest into the death of Justin* clearly demonstrate the need for clear, centralised and consistent environmental hazard management in mental health units in an attempt to reduce the risk of inpatient suicide. This case also highlights the important role of the coronial system in ensuring improved risk management standards to assist in patient safety.

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Footnotes

1. Coroners Court (Qld) *Inquest into the deaths of Steven John Hitchins and Shawn Bradley Joseph Gudge* (5 February 2018) www.courts.qld.gov.au/__data/assets/pdf_file/0017/553310/cif-hitchins-sj-gudge-sbj-20180205.pdf.
2. Above, at 1.
3. Above n 1, at 1.
4. Above n 1, at 1–2.
5. Above n 1, at 2–3.
6. Above n 1, at 4.
7. Above n 1, at 4–5.
8. Above n 1, at 5.
9. Above n 1, at 7.
10. Above n 1, at 7.
11. Above n 1, at 10.
12. Above n 1, at 10.
13. Above n 1, at 11.
14. Above n 1, at 14.
15. Above n 1, at 15.
16. Above n 1, at 15–16.
17. Above n 1, at 16.
18. Above n 1, at 16.
19. Above n 1, at 17.
20. Above n 1, at 17.

21. Above n 1, at 17.
22. Above n 1, at 18.
23. Above n 1, at 18–19.
24. Above n 1, at 19.
25. Above n 1, at 19.
26. Above n 1, at 19.
27. Above n 1, at 9 and 21.
28. Above n 1, at 9.
29. Above n 1, at 9.
30. Above n 1, at 10.
31. Above n 1, at 10.
32. Above n 1, at 21.
33. Above n 1, at 22.
34. Above n 1, at 21.
35. Above n 1, at 22.
36. Above n 1, at 22–23.
37. Above n 1, at 23.
38. Above n 1, at 24.
39. Above n 1, at 24.
40. Queensland Government *Report of the Queensland Review of Fatal Mental Health Sentinel Events: Achieving Balance* (March 2005) http://pandora.nla.gov.au/pan/80033/20080721-1005/www.health.qld.gov.au/mentalhealth/docs/achieving_balance.pdf.
41. Above n 1, at 25–26.
42. Above n 1, at 26.
43. Above n 1, at 26.
44. Above n 1, at 26.
45. Above n 1, at 27.
46. Above n 1, at 27.
47. Above n 1, at 28.
48. Coroners Court (Qld) *Inquest into the death of Justin* (2 July 2013) www.courts.qld.gov.au/__data/assets/pdf_file/0008/203030/cif-justin-20130702.pdf.
49. Above n 1, at 28.
50. Above n 48, at 11.
51. Above n 1, at 28–29.
52. Queensland Health, Guideline for managing ligature risks in public mental health services, August 2012, http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.395.5848&rep=rep1&type=pdf.
53. Above n 1, at 30.
54. Above n 1, at 30.
55. Above n 1, at 31.
56. Above n 1, at 31.
57. Above n 1, at 32.
58. Above n 1, at 32.
59. Above n 1, at 33.
60. Above n 1, at 34–35.