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Bulletin

Coronial comments on the need for systematic assessment of potential ligature points in psychiatric units

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Introduction

The death of Phillip William Michell following an attempt to take his own life at Ballarat Health Services' (BHS) Adult Acute Unit (AAU) has led to the Coroner to call for rigorous assessment and consideration of potential ligature points within psychiatric inpatient units and improved supervision procedures for the uniquely vulnerable patients who reside within them.

Background

Phillip William Michell was 25 years old at the time of his death. He had been living in Ballarat, Victoria with his wife Toni Michell and had a history of depression and anxiety.[1]

Phillip and Toni's relationship began in 2009. In her statement to the court, Toni acknowledged that Phillip had exhibited signs of depression and anxiety from early on in their relationship.[2] Phillip had been left traumatised after being sexually assaulted as a child at his primary school, and Toni believed that his mental health issues largely stemmed from this trauma. While Phillip's mother Linda acknowledged how traumatic this incident had been for Phillip, her statement to the court rejected any suggestion that this event had led to her son's untimely death.[3]

According to Phillip's friend, Trevor Snowball, "Phillip was very quiet in nature and did not like crowds".[4] Following a noticeable decline in Phillip's mental health in 2013, Toni stated that Phillip became reclusive, stressed and would avoid activities that required him to leave the house. She described Phillip's behaviour as two extremes: either extremely clingy or very distant.[5] She also stated that Phillip had acknowledged thoughts of self-harm throughout their relationship.[6] The statements made by Toni and Trevor stand in stark contrast to that of Phillip's mother, who stated that her son had never evinced any signs of suicidal ideation and the statement of Phillip's brother-in-law, Jonathan Young, who stated that he was unaware of Phillip's suffering from any mental health issues.[7] Despite being aware that Phillip had been in need of professional mental health assistance for several years, Toni was unable to convince him to seek help.

In March 2014, Phillip attended the Eureka Medical Centre with Toni and spoke to the general practitioner about his extreme anxiety. Upon recommendation from the general practitioner, Toni took Phillip directly to the emergency department of Ballarat Base Hospital where they spoke with a registered nurse. In his statement to the court, the nurse described Phillip as having a long-term history of lowered mood and social anxiety.[8] Phillip was discharged from the emergency department later that day after being prescribed medication and provided with a risk management plan.

Phillip continued to see the nurse at the Youth Mental Health Community Service between March and June of 2014. Throughout this time, he was weaned off his medication, as it was only intended for short-term use. Despite the nurse's attempts to refer Phillip to a psychologist, Phillip insisted he would proceed on his own and consider his options. Phillip never made an appointment with a psychologist despite Toni's urging,[9] and his mental health continued to progressively deteriorate in the lead up to his death. Phillip and Toni's relationship also deteriorated, with Toni stating that Phillip became increasingly controlling of both her physical movements and her spending. She stated that "it felt as though Phillip was always angry with her for no apparent reason."[10]

The circumstances surrounding death

In June 2015, Toni and Phillip argued and Phillip shoved Toni hard on the shoulders which caused her to stumble backwards onto their couch. She was deeply upset and stated that this was the first time Phillip had been physical with her. This incident prompted Toni to seek a separation from Phillip.

Toni left the home the couple shared on 25 June 2015. A few hours later, Phillip attended Toni's mother's house where Toni was staying. He had blood on his pants and hand and told Toni that he had punched a window and resigned from his job. Phillip returned home and then called Toni from what sounded like a bathroom. She was immediately concerned and called both the police and Phillip's parents to check on him. Phillip was found by

his father, who stated that Phillip was bleeding from a cut to his left wrist and had just gotten into a full bath. Phillip was taken to the emergency department at Ballarat Base Hospital and admitted to the AAU as an involuntary patient subject to a temporary treatment order under s 46 of the Mental Health Act 2014 (Vic).

After being transferred to the AAU, Phillip was reviewed by a doctor who stated that Phillip denied any further suicidal ideation and appeared very genuine.[11] However, given his recent attempt to take his own life, he was assessed as being at high risk of deliberate self-harm and therefore subject to 15-minute visual observations. The staff at the AAU arranged for the Nursing Observation Category (NOC) checks to be completed at 15-minute intervals, with a registered nurse completing the checks from 10 pm to 12 am on 26 June and 4 am to 6 am on 27 June.[12]

The Nurse Unit Manager (NUM) of the AAU stated that the BHS' "Randomised NOC Inpatient Units — Mental Health Services" protocol for nursing observations sets out random nursing observation categories and specifies the types of observations to be undertaken. For patients requiring 15-minute visual observations, the protocol sets out that the nurse must sight the patient every 15 minutes and communicate as required. This observation should also include a behavioural comment and location.[13]

The NOC chart from 26 June 2015 indicated that Phillip was observed to be asleep at observations made between 12.45 am and 4 am. At 4.15 am and 4.30 am, Phillip was observed to be resting in bed and at 4.45 am, Phillip was observed pacing the lounge.[14] While the NOC chart largely indicated that Phillip was observed at 15-minute intervals, a review of the CCTV footage in the unit indicated that nursing observations were largely undertaken at intervals greater than 15 minutes. In fact, there were several points where there was a greater than 40-minute gap between observations. Further, the observations made by the nurses were found to be of inadequate form and quality.[15] In certain observations, nurses could be seen leaning in and looking around the door, while keeping one foot in the hallway. At another occasion, a nurse was seen looking through a crack in Phillip's door, for between 1 and 2 seconds.[16]

At 5.25 am, a nurse left the office to begin another round of visual observations. She recalled that Phillip's door was completely shut whereas on previous observations, it had been slightly ajar. She observed that the ceiling light was off, as it had been throughout all checks that night but that the desk light was on, as it had been since checks from 4 am onwards. She observed that the motion-sensor light in the bathroom was on. She assumed that Phillip was in the bathroom so she called out to him but received no response. She walked into the bedroom and located Phillip hanging from the bathroom door facing the bedroom. The nurse immediately pressed her duress alarm and yelled out for the other nurses and was joined by another nurse who helped her to remove Phillip from the ligature point and commenced CPR. The nurses proceeded to make a Medical Emergency Team (MET) call followed by a Code Blue alarm.[17]

Phillip was found in the bathroom with a small desk stool. He had created a noose by tying his cargo pants to the hook on the back of the door. The hook was identified as a Yewdale Kestrel K508 Flexible Coat Hook which was designed to fall if someone attempted to hang themselves. Phillip had knotted the pants onto the hook on the inside of the door and then thrown the trousers over the door towards the inside of the bedroom. And this angle meant that the hook was being pulled up rather than down, a process that created a firm anchor.

Recommendations

Anti-ligature system safety

The placement of the hook on the back of the door was of significant interest to the Coroner, as documents obtained from the architects who undertook the refurbishment of the unit in 2008–9 indicated that the hooks were originally scheduled to be placed on the en suite wall rather than the door. The Coroner was unable to establish how the coat hooks came to be positioned on the door[18] and stated that the hospital's inability to advise him as to how or why the hooks were placed there, was concerning.[19]

The Coroner noted that Phillip was not the first psychiatric inpatient to take his life at the AAU. He referred to the Coronial inquest following another death in 2009, and noted that the prior case had examined a number of issues in that investigation including ligature points and nursing observation practices at the AAU. Notably, the Coroner in the prior case held the patient "should not have had the means (access to his bed as a ligature point) or the opportunity (infrequent observation) to hang himself that morning."[20] Alarmingly, a reference was made to a search of the National Coronial Information System and the Victorian Suicide Register which identified 53 deaths by hanging in inpatient psychiatric units at 33 different Victorian hospitals between 2000 and 2015. Common ligatures used were pieces of clothing and the most common ligature point was the top of a door, being used in 24 of the 53 deaths.[21]

The Yewdale Kestrel K508 Flexible Coat Hook, used as a ligature point by Phillip, was promoted as having been developed in response to "repeated requests from hospital staff"[22] and had been specifically marketed for

use in mental health facilities and prisons. The hooks were installed in the AAU as part of the refurbishment of the facility. The Coroner was unable to establish whether the hooks were risk assessed, who purchased and installed them, and whether any testing or maintenance was required.[23]

In 2011, the chief psychiatrist in Victoria conducted an investigation into inpatient deaths from 2008–10 and made a number of recommendations regarding the design of planned and current inpatient units.[24] Specifically, the chief psychiatrist recommended "the removal of ligature points, wherever possible, including in en suite bathrooms, should be undertaken".[25] Following the release of this report, the Office of the Chief Psychiatrist released a self-evaluation tool in November 2012. The tool was designed to assist mental health services to evaluate their response to the recommendations contained in the 2011 report.[26] One of the self-evaluation "indicators" in relation to the above recommendation was "an environmental safety audit including assessment of the ligature points on the unit is conducted on a regular basis and a plan developed for eliminating or managing these risks."[27]

The Coroner expressed surprise that despite the chief psychiatrist's recommendations in relation to anti-ligature actions and the creation of a self-assessment tool, anti-ligature points did not seem to be front of mind for BHS prior to Phillip's death. The Coroner did, however, acknowledge the concessions made by BHS regarding the placement of the coat hooks and further commended their prompt response to the incident by removing all the hooks from en suite doors in the AAU by 30 June 2015.[28]

An email sent on behalf of BHS to the court conceded that the hospital had relied on the hooks being anti-ligature. They had not identified that the hook could be used as a reverse anchor ligature point in situations where the hook was pulled upwards and the noose was placed over the en suite door. Despite BHS having followed the information outlined in the Yewdale Kestrel Fitting Guide (which did not contain any specific warnings about placing the hooks on doors,), BHS conceded that the hooks should not have been on the doors. They also conceded that ligature audits should have been conducted more frequently. Although, BHS submitted there is no certainty that an increased number of audits would have identified the hook placement as a ligature risk.[29]

Whilst he was wary of hindsight bias and the lack of warning about hook placement in the manufacturer's documentation, the Coroner stated that: "Phillip's death has illustrated the devastating consequences of allowing items to remain in the AAU without deliberate consideration and rigorous assessment."[30] He acknowledged the submission of BHS that an increased number of audits would not have necessarily identified the risk, but concluded that the "lack of regular audits indicate a concerning lack of rigour with regards to this issue."[31]

The infrequency and inadequacy of nursing observations

While the Coroner acknowledged that it was the placement of the coat hook that ultimately allowed Phillip to self-harm, he found that the breakdown in BHS' prescribed policies and procedures for NOC checks enhanced that opportunity.[32]

It was established that throughout observations, the nurses had not made direct contact with Phillip, and it was possible that Phillip had not had any staff contact in the AAU for 10.5 hours. Phillip was observed resting (as opposed to sleeping) from 6.45 pm to 10.45 pm, yet the oncoming shift staff did not make an effort to introduce themselves to him despite this being considered minimum standard practice.[33] The Coroners Prevention Unit conducted a review of Phillip's death and found it highly concerning that the internal review conducted by BHS had found that all of his care complied with their policies and procedures.[34]

The nursing observations as shown in the CCTV footage were found to be largely inadequate in both form and frequency. The failure of nurses to step with both feet into Phillip's room, as well as the observation made of him through a crack in the door, were of particular concern to the Coroner.[35]

While it is impossible to say that stricter compliance with policies and procedures would have definitely prevented Phillip's death, the significant gaps between monitoring in combination with their inadequate form, afforded him more opportunity to self-harm without being discovered. Phillip's family was entitled to believe that while in the AAU, he would be closely monitored and safe from harm.[36]

Conclusion

The death of Phillip William Michell at the BHS' AAU has highlighted the need for mental health services to be hypervigilant in the assessment and removal of potential ligature points within their facilities. It also serves as a morbid reminder to employees of inpatient facilities, to ensure that there is strict compliance with the policies and procedures regarding visual observations and checks on patients.

BHS' initial review into Phillip's death identified that there was compliance with all policies and protocols. However, it became apparent that this conclusion was reached through a "root cause analysis" that failed to include a review of the CCTV footage. The Coroner's

investigation identified a lack of compliance with policies and protocols as well as a number of systemic failures. The conflicting conclusions reached by BHS and the Coroner raised concerns about the probative value of the root cause analysis procedure at BHS and serve as a reminder for organisations to ensure that they have analytical processes in place to effectively identify gaps in procedures and other systemic failures.

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Footnotes

1. Coroner's Court (Vic), *Finding into Death with Inquest — Inquest into the Death of: Phillip William Michell* (6 September 2017) para 1 www.coronerscourt.vic.gov.au/resources/028ff85b-f612-4bec-89b2-f641f51c10c9/phillipwilliammichell_343715.pdf.
2. *Inquest Brief* at 26, Statement of Toni Michell dated 24 September 2015.
3. Above n 2, at 46, Statement of Linda Michell dated 15 October 2015.
4. Above n 2, at 77, Statement of Trevor Snowball dated 10 November 2015.
5. Above n 1, para 22.
6. Above n 1, para 22.
7. Above n 2, at 74, Statement of Jonathan Young dated 30 September 2015.
8. Above n 2, at 144, Statement of Clive David Asplen dated 27 July 2016.
9. Above n 1, para 24.
10. Above n 1 para 26.
11. Above n 2, at 109, Statement of Dr Abu Baker dated 27 July 2016.
12. Above n 1, para 38.
13. Above n 1, paras 44–5.
14. Above n 1, para 49.
15. Above n 1, para 50 and Findings at 36.
16. Above n 1, para 51.
17. Above n 1, paras 42–3.
18. Above n 1, para 89.
19. Above n 1, Comment 2 at 33.
20. Coroner's Court (Vic), *Finding into Death with Inquest — Inquest into the Death of Matthew Spalding* (March 2012) at para 145 and above n 1, para 60.
21. Above n 1, para 61.
22. Kestrel Magnetic Anti-Ligature System Brochure (2012) at 7 cited in above n 2, at 41; above n 1, para 68.
23. Above n 1, para 69.
24. Above n 1, para 70.
25. Above n 1, para 70 citing Office of the Chief Psychiatrist *Chief Psychiatrist's Investigation of Inpatient Deaths (2008–2010)* (January 2012) Recommendation 2 at 2 www2.health.vic.gov.au/about/publications/researchandreports/Chief-Psychiatrists-investigation-of-inpatient-deaths-2008-2010.
26. Above n 1, para 70.
27. Above n 1, para 70.
28. Above n 1, Comment 4 at 34.
29. Above n 1, para 99.
30. Above n 1, Comment 2 at 33.
31. Above n 1, Comment 3 at 33–4.
32. Above n 1, Comment 5 at 34.
33. Australian Commission on Safety and Quality in Health Care *Standard 6 Clinical Handover — Safety and Quality Improvement Guide* (October 2012) www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf and above n 1, para 68.
34. Above n 1, para 67.
35. Above n 1, Comment 6 at 34.
36. Above n 1, at 36.