

Inquest into the death of Justin

Justin was admitted to the acute Mental Health Unit at the Townsville Hospital two months before his death. He had a history of depression.

At about 10am on 3 May 2009, Justin was found unresponsive in the Psychiatric Intensive Care Unit with a bar of soap in his mouth. Attempts to resuscitate Justin failed and he was pronounced deceased. Justin died on from choking due to the impaction of soap in the airway.

Coroner Kevin Priestly delivered his findings of inquest on July 2013.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported. Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 1

The director of mental health in Queensland Health (or chief psychiatrist) develop and implement an environmental risk management system for the identification of hazards and assessment of associated risk for inpatient suicide and suicide attempts within psychiatric intensive care units. The starting point might be the development of checklists to guide staff conducting routine inspections to identify environmental hazards and to take appropriate corrective action. Periodic auditing of the outcome of inspections will facilitate the capture and dissemination of lessons to be learnt.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Mental Health Alcohol and Other Drugs Branch already has in place a number of guidelines to assist hospital and health services to maintain a safe environment within mental health inpatient units. These include:

- *Mental health visual observations- clinical practice guidelines*, October 2008
- *National standards for mental health services*, 2010- implementation standard for safety, June 2012
- *Guideline for managing ligature risks in public mental health services*, August 2012, which provides a systematic approach to the management of ligature risks and use of the ligature audit tool, 2011
- *Searches in authorised mental health services-clinical practice guidelines*, December 2008
- *Guideline for the operation of high dependency units*, previously known as psychiatric intensive care units, in mental health services.

The Mental Health Alcohol and Other Drugs Branch will collaborate with mental health services across Queensland to develop an additional guideline regarding routine inspections to identify environmental hazards and the appropriate corrective action to enhance the management and monitoring of vulnerable mental health services. Hospital and health services will be responsible for implementing the guidelines and utilise their local quality and safety governance mechanisms to undertake periodic audits and to disseminate lessons learnt.