

Inquest into the death of Steven John Hitchens and Shawn Bradley Joseph Gudge

On 5 February 2018, Coroner Kevin Priestly delivered his findings into the deaths of Steven Hitchens and Shawn Gudge.

Mr Hitchens was an inpatient in the Low Dependency Mental Health Unit at Townsville Hospital when he was found deceased on 3 August 2014 with a plastic bag over his head. Autopsy confirmed he died due to asphyxiation. Mr Gudge was an inpatient in the High Dependency Mental Health Unit of Townsville Hospital when he was found unconscious on 10 May 2015 with a ligature made from a bed sheet around his neck. Autopsy confirmed he died due to hanging.

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

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.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

Recommendation 1

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 root cause analysis reports, health service investigation reports, health ombudsman reports, coronial findings and recommendations) as well as like reports from other states.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

On 5 September 2018, the director-general approved the establishment of the Mental Health Alcohol and Other Drugs Quality Assurance Committee (MHAOD QAC), with oversight from the Office of the Chief Psychiatrist. The function of the MHAOD QAC relevant to this recommendation is to monitor and review qualitative and quantitative clinical and other information, including investigation documents (for example coronial reviews), as required, from relevant departments and entities to identify trends and system level improvements.

Committee members were selected via invited expressions of interest for suitably qualified and trained individuals from across Queensland public mental health services and consumer and carer representatives.

Recommendation 2

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.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health is working with hospital and health service (HHS) clinical governance units to review the effectiveness of the implementation of the guidelines *Managing ligature risks in public Mental Health Alcohol and Other Drug inpatient services* and *Recognising and managing potential environmental hazards in Queensland public Mental Health Alcohol and Other Drug services*.

To ensure appropriate mental health expertise and increase objectivity, HHS clinical governance (from outside mental health services) will lead the review and include a senior mental health clinician from another HHS. This will also facilitate sharing of practical lessons across the state.

Results of all HHS reviews will be aggregated by the Office of the Chief Psychiatrist and presented to the Mental Health Alcohol and Other Drugs Quality Assurance Committee (MHAOD QAC) to inform dissemination of lessons across Queensland Health mental health services.

The project reviewing the implementation of environmental safety guidelines within authorised mental health service inpatient units is undergoing final planning and will be tabled for approval by the MHAOD QAC. Subject to approval, the review process as described above will commence in late 2018.

On 2 June 2019 the Minister for Health and Minister for Ambulance Services responded:

Based on feedback gained from trial stakeholders, a revised methodology was developed for the statewide review into the effectiveness of the implementation of ligature and environmental safety guidelines.

Implementation of the review will commence once materials are refined. On completion, the findings will be collated by the Office of the Chief Psychiatrist and presented to the MHAOD QAC to inform dissemination of lessons across Queensland Health mental health services.

On 11 December 2019 the Minister for Health and Minister for Ambulance Services responded:

Following a trial of the review methodology, all support materials were approved by project sponsors. Three briefing sessions for stakeholders were held 4 – 8 March 2019, with the review commencing 11 March 2019.

A local review and report will be completed by each participating hospital and health service. Findings from all participating sites will be collated into one report for presentation to the Mental Health Alcohol and Other Drugs Quality Assurance Committee to inform dissemination of lessons and opportunities for improvement across Queensland Health's mental health alcohol and other drug services.

On 3 June 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services responded:

Hospital and health services completed local reviews, and individual site reports are progressing via hospital and health services clinical governance structures for approval. Hospital and health boards are clearing/acknowledging reports prior to submission to the Department of Health.

Hospital and health services are reporting local process and environmental improvements that have occurred as a result of local reviews.

The Mental Health Alcohol and Other Drugs Branch commenced the development of a statewide report which will be finalised when all hospital and health services reports have been received.

The statewide report will be submitted to the Mental Health Alcohol and Other Drugs Quality Assurance Committee to inform dissemination of lessons across HHSs.

On 2 October 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services responded:

The Mental Health Alcohol and Other Drugs Branch is collating contributions from hospital and health services and finalising the statewide report on the review of the implementation of the safe environment guidelines. The report summarises the review's findings, lessons learnt and opportunities for improvement.

When finalised, the report will be submitted to the Mental Health Alcohol and Other Drugs Quality Assurance Committee for approval. It is anticipated the committee will disseminate lessons learnt from the review to all hospital and health services by the end of the year.

On 8 July 2021 the Minister for Health and Ambulance Services responded:

The report on the Review of the Implementation of the Safe Environment Guidelines is complete and has been endorsed by the Mental Health Alcohol and Other Drugs Quality Assurance Committee.

The review demonstrated that the implementation of the safe environment guidelines has overall been effective, highlighting a strong safety and learning culture in hospital and health services. Some additional safety initiatives were identified through the review, many of which were actioned during the course of the review.

The summary of lessons learnt from the review was disseminated to all hospital and health services. The summary provided an overview of the review and shared successful safety initiatives undertaken by hospital and health services.