IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 000531

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**JOY MAREE GUPPY**
Date of birth:	12 January 1956
Date of death:	1 February 2015
Cause of death:	1(a) HYPOXIC ISCHAEMIC BRAIN INJURY 1(b) COMPRESSION OF THE NECK IN THE CIRCUMSTANCES OF HANGING
Place of death:	Alfred Hospital, Prahran, Victoria

HER HONOUR:

Background

1. Joy Maree Guppy was born on 12 January 1956. She was 59 years old when she took her life during an admission as a voluntary patient at the Albert Road Clinic (**the Clinic**), a private psychiatric clinic in South Melbourne.

2. Ms Guppy had a history of major depression and previous suicide attempts.

The coronial investigation

3. Ms Guppy's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

4. The role of a coroner is to independently investigate reportable deaths to find, if possible, identity, medical cause of death and, with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

5. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Ms Guppy's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence. I also sought information from the Clinic as to any subsequent measures it may have taken in relation to access to ligatures and hanging points.

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[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

8. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

9. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Circumstances in which the death occurred

10. Ms Guppy was admitted as a voluntary patient to the Clinic on 9 January 2015 for depression, under the care of psychiatrist Dr Stuart Wild. Upon admission Ms Guppy demonstrated no suicidal tendencies.

11. Ms Guppy's mental health improved somewhat, but she continued to experience anxiety and low mood. She expressed some suicidal ideation, however Dr Wild was reassured by her clear indication that she wished to participate in treatment and did not intend to commit suicide. He therefore did not increase her risk status. As Ms Guppy was not progressing, Dr Wild sought a second opinion and it was decided to commence electroconvulsive treatment (**ECT**).

12. On 31 January 2015, Dr Wild assessed Ms Guppy. She was feeling positive about starting ECT and appeared to be *'forward-looking and problem-solving'*, rather than *'conveying hopelessness or increased suicidality'*.

13. Ms Guppy had difficulty sleeping that night, but was observed apparently asleep at midnight. At approximately 1.50am, nursing staff heard an unfamiliar banging noise. They commenced a ward round, going from room to room. When they got to Ms Guppy's room, she was not in her bed, the ensuite bathroom door was shut and the light was on. She did not respond to knocking, nor open the locked door. It was then noticed that her dressing gown tie was protruding from the top of the door. A duress alarm was sounded and emergency services called. Staff managed to open the door and found Ms Guppy on the ground with the other end of her dressing gown tie around her neck. She was not breathing and had no pulse.

14. Ambulance officers resuscitated and intubated Ms Guppy at the scene, and transported her to the Alfred Hospital.

15. At 3.16am, Ms Guppy was given treatment to support her blood pressure. Computed tomography (**CT**) scans revealed global hypoxic brain injury and bilateral rib fractures consistent with resuscitation.

16. Ms Guppy continued to deteriorate over the course of the day. After consultation between hospital staff and her family members, a decision was made to withdraw active treatment. She was extubated and pronounced deceased at 3.13pm on 1 February 2015.

Identity of the deceased

17. Ms Guppy was visually identified by her brother, Kevin Chamberlain, on 1 February 2015. Identity was not in issue and required no further investigation.

Medical cause of death

18. On 5 February 2015, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of Ms Guppy after reviewing a post mortem CT scan. The autopsy revealed a ligature mark at her neck, blood in the peritoneal cavity, neutrophilic infiltration of the liver, rib and sternal fractures, early hypoxic ischaemic injury, myocardial ischaemic change, thyroid disease and bilateral pleural effusions.

19. Toxicological analysis of ante and post mortem specimens taken from Ms Guppy identified quetiapine, fluoxetine, chlorpromazine, clozapine, and morphine, which were consistent with therapeutic use.

20. After reviewing toxicology results, Dr Francis completed a report, dated 30 March 2015, in which she formulated the cause of death as *'1(a) hypoxic ischaemic brain injury; 1(b) compression of the neck in the circumstances of hanging'*. I accept Dr Francis's opinion as to the medical cause of death.

Access to potential ligatures and hanging points

21. When Ms Guppy was admitted to the Clinic a formal risk assessment was completed by nursing staff and Dr Wild. She was assessed as a *'category 1 (unrestricted)'* patient, which denoted a *'low risk'* of self-harm. Ms Guppy's risk of self-harm was re-assessed at least three times per day by nursing staff, and frequently by Dr Wild. Dr Wild did not consider that Ms Guppy's risk of self-harm altered from *'low-risk'* throughout the period of her

hospitalisation. In the admission form, Dr Wild wrote in the comments section: *'Despite recent suicidal ideas is keen for admission + improvement. No acute suicidal intent'*.

22. I directed the Clinic to provide copies of hospital policies in relation to access to potential ligatures for different patient risk categories. The Clinic advised that it has no specific policy in respect of access to potential ligatures, however audits were regularly undertaken according to the Ramsay Health Care Clinical Governance risk tool (the **risk tool**). Patients were assessed and placed into one of five risk categories set out in the risk tool, ranging from category 1 (unrestricted), indicative of minimal evidence of risk, to category 5 (Intensive Care Unit Specialling), indicative of, *inter alia,* active suicidality. In the case of a category 4 (restricted to ward) assessment, where the patient is considered a *'high risk of self-harm ... belts, shoelaces, plastic bags and any other articles that they may be able to harm themselves with [must be] removed and placed into safe keeping'*. At the time of her death, Ms Guppy was assessed as category 1 (unrestricted). The risk tool made no mention of ligatures or other potentially harmful objects in respect of category 1 patients.

23. The Clinic's response did not otherwise address the issue of ligature removal, instead focussing on potential hanging points. The Clinic asserted there had been no previous suicides by hanging at the facility prior to Ms Guppy's death, although it noted one attempted hanging with a dressing gown cord in September 2013, and two other attempted hangings in April and July in 2015 by other means.

24. The Clinic conducted an internal investigation into the circumstances of Ms Guppy's death. It advised that the possibility of cutting 10mm from each bathroom door was considered (as Ms Guppy's tie had been wedged between the door and door frame), but was dismissed as incapable of full implementation and potentially creating other (unspecified) risks. Instead, the Clinic decided to await the results of a forthcoming full environmental audit.

25. This audit was conducted at the Clinic on 31 March 2016. It consisted of a CEO from another mental health facility owned by Ramsay Health Care inspecting the patient areas at the Clinic and verbally reporting to the Clinic's current CEO about possible anti-ligature measures that could be implemented. There was no written report.

26. On 13 December 2017 the Clinic's solicitor advised that overall, the report was *'favourable'*, however the reporting CEO did note potential areas where harm minimisation measures could be implemented including tapware, drains, rails, blind rollers and doors.

Subsequently, during 2016, the Clinic implemented various 'anti-ligature measures' including:

(a) the windows in patient rooms were reinforced, including the window panes and fittings;

(b) a mesh covering was installed in the balcony area to prevent access to it;

(c) several bathroom towel rails were removed;

(d) the disabled handrail in the intensive care toilet was converted to a closed handrail and the soap holder in the shower cubicle was removed; and

(e) the gap between the handrail and the wall in the central staircase was filled in.

27. Further, the Clinic's solicitor advised that the Clinic was about to undergo an expansion with an expected completion date in April 2018 and that a range of *'proprietary harm minimisation items'* will be installed. The new patient facility will also have *'cut down'* doors with *'piano-like'* hinges on ensuite doors. Once the expansion is completed, the older section of the Clinic will be renovated with new harm minimisation measures, such as *'cut down'* doors (except in shared rooms).

Conclusions

28. The Court's correspondence with the Clinic noted that I had previously investigated the death of a voluntary psychiatric patient at another institution who had hanged herself by jamming her dressing gown cord between the door and door frame of her ensuite bathroom (Finding into Death without Inquest of AWJ, COR 2012 001503[2]). It also highlighted the fact the Clinic's website advises patients preparing for admission to bring with them, inter alia, their dressing gown.

29. Although the Clinic's attention was drawn to the dual issues of hanging points and access to ligatures, the Clinic's response to Ms Guppy's death appears confined to the elimination of hanging points.

30. Like Ms Guppy, AWJ had been assessed as *'low risk'* and had therefore been admitted to the Low Dependency Unit (**LDU**) of the Northern Hospital. Like the Clinic, at that time

[2] De-identified at the family's request.

Northern Hospital policy did not require the removal of potential ligatures from low risk patients (admitted to the LDU). Unlike the Clinic, after the death of AWJ, the Northern Hospital introduced a new policy in relation to the removal of potential ligatures and other hazardous items from all inpatients regardless of their legal status, risk assessment or placement in either the LDU or Intensive Care Area.

31. In my Finding into the death of AWJ, I made comment (footnotes omitted):

> 22. *AWJ was not the first patient in a psychiatric hospital to commit suicide by hanging from an ensuite bathroom door. Indeed, AWJ was not the first patient to do precisely this in the LDU of Northern Hospital. She was also not the first patient to use a dressing gown cord to hang herself.*
>
> 23. *Treatment of the mentally ill is predicated upon the principle that there should be minimum interference with the patient's human rights and dignity. So far as possible, there should be promotion of autonomy and empowerment within a culture of recovery. These principles are now enshrined in the* Mental Health Act *2014 and are consistent with the* Charter of Human Rights and Responsibilities Act *2006.*
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> 24. *The number of deaths of inpatients within psychiatric hospitals demonstrates the obvious tension between the therapeutic benefits of maintaining a minimally restrictive environment and the need to protect patients from self-harm. I accept that assessment and treatment of the mentally ill is a difficult task. I also accept that removal of apparent risks can have unintended consequences, including the possible creation of other risks.*

32. Ironically it may be that inpatients assessed as a low risk of suicide may be more at risk of suicide by the use of ligatures, than patients with a higher risk assessment from whom ligatures are more likely to be removed. I recognise that it is impossible to craft policies for every eventuality, however in my view there is an opportunity to reduce the risk of hanging to low risk voluntary inpatients in a manner consonant with their dignity and privacy. Voluntary low risk patients presumably have their own welfare at heart, at least at the time of their admission. I would expect they would understand at that time the need for measures to protect them should their mental health decline or when risks in the environment are identified.

33. Mental health clinicians and facilities strive to balance patient safety against patient dignity and freedoms. Whilst the balancing exercise is undoubtedly difficult, there are many restrictive rules and procedures routinely employed in hospitals that are practical, necessary, and reasonable for mitigating risks and increasing the safety and security of inpatients and staff. For example, it is routine for the doors of hospitals and wards to be locked each evening; inpatients cannot access their prescribed medications at will and their access to legal substances (such as alcohol, nicotine and often caffeine) is restricted, as is their access to items that can be used as potential weapons or for self-harm (such as knives, hard plastics, metal nail files, and plastic bags). There are also systems in inpatient units that promote safe access to such items, such as lockers and staff managed storage.

34. Restricting access to means is one of the few suicide prevention interventions listed by the World Health Organization as strongly evidence-based. Restricting access to means is applicable at both individual and population levels. Other coronial investigations have identified deaths of people in both public and private psychiatric units using ligatures that have been brought into the unit by the patient, co-patients and/or family and friends.[3] Access to means for hanging in a psychiatric inpatient unit is a modifiable factor by reasonably restricting access to ligatures, as well as ligature points.

35. I acknowledge that it will never be possible to totally eliminate access to potential ligatures, however, what can reasonably be done should be done. In my view, there is no compelling reason why any psychiatric inpatient should be allowed access to obvious ligatures, such as scarves, dressing gown cords, belts, shoelaces or wires. What is wrong with slip-on shoes, robes without cords and pants that do not require belts?

36. Patient safety should be the paramount consideration. It is a tragedy that mentally unwell patients are killing themselves in potentially preventable situations. I do not consider it unreasonable to make it a condition of entry to inpatient psychiatric facilities that patients surrender any obvious potential ligatures and agree to lawful searches on clinical grounds, throughout their stay.

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[3] The Coroners Prevention Unit identified 24 Victorian cases (closed between 2000 and 2017) of ligature involved suicides by voluntary inpatients where the ligatures had been brought into a public or private inpatient unit by the inpatient, co-patient, family, and/or friends. Of these there were 12 cases not involving ligatures made of whole clothing items, installations or bed sheets. The 12 were comprised as follows:
Belt/scarf – 5 cases (20051317; 20095111; 20124587; 20133184; 20144473);
Belts as part of clothing – 4 cases including this one (20061984; 20110660; 20121503, 20150531);
Shoelaces – 2 cases (20053251; 201421780); and
Other non-clothing ligatures – 20073955.

37. I direct that a copy of this Finding be provided to the Office of the Chief Psychiatrist and Safer Care Victoria for consideration of the issues arising from the circumstances of this death.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Joy Guppy, born 12 January 1956;

(b) Ms Guppy died on 1 February 2015 at the Alfred Hospital, Prahran, Victoria, from hypoxic ischaemic brain injury secondary to compression of the neck in the circumstances of hanging;

(c) Ms Guppy intentionally took her own life; and

(d) the death occurred in the circumstances described above.

Recommendations

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. I recommend that the Albert Road Clinic draft a policy for the removal of potential ligatures from all inpatients with due regard to the comments set out above.

I convey my sincere condolences to Ms Guppy's family.

As I have made a recommendation I direct that this finding be published on the internet.

I also direct that a copy of this finding be provided to the following:

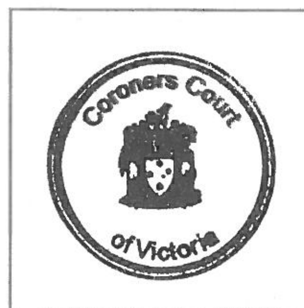
Franz Ahne, Senior Next of Kin

The Chief Psychiatrist

Safer Care Victoria

First Constable Lewis Rapley-Smith, Coroner's Investigator, Victoria Police

Signature:



ROSEMARY CARLIN
CORONER
Date: 1 February 2018