Inquest into the death of Mrs B

Mrs B had a long history of mental illness. On 11 March 2008 she was admitted to the emergency department of the Cairns Base Hospital until a bed became available in the Mental Health Unit. In the meantime, she absconded and self-harmed before being returned to the hospital by police. On 13 March Mrs B was transferred to the special purpose area within the low dependency unit of the Mental Health Unit. The following day, immediately following a psychiatric review, she absconded and was found deceased at the Cairns showgrounds on the morning of 15 March. The cause of death was hanging.

Coroner Kevin Priestly delivered his findings of inquest on 2 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

I recommend Queensland Health or the Director of Mental Health investigate and develop a statewide policy about preferred options for managing and monitoring the risk of absconding, including through the physical layout and staffing of reception like facilities at the main entrance to mental health units as a guide to the construction of new units and the modification of existing units.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

In November 2013 the director of mental health issued practice guidelines in relation to the management of involuntary patients while inpatients of authorised mental health services. The guideline states that all involuntary patients must have an assessment of risk of absconding undertaken at admission and regular intervals throughout admission.

The Mental Health Alcohol and Other Drugs Branch has also issued a number of statewide guidelines regarding the physical layout of mental health inpatient units. Each hospital and health service is responsible for applying these guidelines as appropriate to their local circumstances.

The following guidelines apply to managing and monitoring the risk of patients absconding from mental health inpatient units and are available to all hospital and health services:

- Mental health visual observations-clinical practice guidelines, October 2008
- Queensland Government adult acute mental health inpatient unit design guidelines (November 2011)
- National standards for mental health services 2012 implementation standard for safety 2012
- Mental health patient safety strategic plan 2012-2017.