Inquest into the death of SH and AW

On the evening of 25 April 2009, Ms SH, a 25 year old female, was pronounced deceased at the base of the Buranda car park, located opposite the Princess Alexandra Hospital. On the morning of 2 February 2010, Mr AW, a 24 year old male was pronounced deceased at the base of the same car park.

SH and AW were in-patients in the east wing ward of the Princess Alexandra Hospital Mental Health Unit. Both suffered significant chronic mental health issues prior to their deaths.

At the time of their deaths, SH and AW were both under an involuntary treatment order and on 15-minute visual observations and not allowed to leave the ward without an escort. Despite these orders, both frequently left the ward unescorted, including immediately prior to their deaths.

The now Deputy State Coroner John Lock delivered his findings of inquest on 25 January 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. The Department of Health 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

I recommend that Metro South Mental Health Services communicate with the Chief Psychiatrist in relation to the current policy for missing consumers (unauthorised absence) seeking advice as to whether this policy should be altered (anticipating that any change to the current policy may be linked to a review of the *Mental Health Act 2000*). In the meantime metro south is to undertake a review of its current procedures in relation to implementing this policy with particular reference to strategies to assist in the management of repeat absconders, the management of the no smoking procedures within the service and the current escalation processes.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

Following the Department of Health directing that all adult acute mental health inpatient units not currently locked to be locked from 15 December 2013, all consumers/patients are now required to sign in and out of the ward. In addition:

- A briefing is provided to the hospital and health service chief executive when a patient under the *Mental Health Act 2000* is absent without permission from an inpatient facility.
- Fortnightly unauthorised absences under the Mental Health Act 2000 are reported in a standardised report to the director of mental health.

Metro South Hospital Health Service has also reviewed the following two procedures as recommended:

- Missing consumer (unauthorised absence) – mental health
- Smoking management – inpatient mental health units.

This review included update existing procedures as stated above to address recommendations and ensure safety of consumers and staff due to the directive from the Department of Health.

The updated procedures were published to all staff on the intranet in December 2013.

Recommendation 2

I recommend that Metro South Mental Health Services conduct a three month trial of the provision of a leave book or register to be signed by each patient who is leaving the ward to ascertain whether any such changes modify patient behaviour and the capacity of staff to monitor and support the missing persons procedure.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

Following the Department of Health directing all adult acute mental health inpatient units that are not currently locked to be locked from 15 December 2013, all consumers/patients are now required to sign in and out of the ward (the coroner made this recommendation prior to the locking of the adult acute inpatient wards policy).

The implementation of the locked ward policy is reported on a fortnightly basis to the director of mental health and has shown a decrease in the number of consumers absconding from the inpatient units. The impact of the locked ward policy is still being evaluated with respect to consumers, carers, families and staff.

Recommendation 3

I recommend that Metro South Mental Health Services undertake a review into possible technological aides which could be used to assist staff in managing repeat absconders in an open ward environment (that is, providing some form of intermediate supervision between acute observation area/constant observations and an open ward environment).

Response and action: the recommendation was not implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

This recommendation was superseded by the locking of the adult acute inpatient wards.

However, in addition, the Metro South Addiction and Mental Health Services trialled two iPads in the wards. The trial of iPads is to assist the clinicians to have immediate access to the consumer integrated mental health application which provides up-to-date consumer clinical information across service settings. Clinicians utilise the consumer integrated mental health application to view treatment plans and to evaluate service delivery to the consumer.

Recommendation 4

I recommend that Metro South Mental Health Services continue the clinical transformation process which is committed to the development and implementation of strategies to identify and manage the deteriorating patient with respect to their mental and physical health. I note that this process is well advanced and it is expected that a report will be provided to metro south in early

2013. I welcome the offer of being provided a copy of the report and regular advice as to its implementation and training of staff.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

As part of the clinical transformation, strategies were implemented to identify and manage deteriorating patients with respect to their mental and physical health. Part of the strategies included gap analysis of nursing education. The clinical champion program was developed as a foundation training tool for nursing staff that highlighted providing care to vulnerable consumers. This tool will undergo an evaluation and principals of the program have been incorporated into the strategic plan for nursing education.

The registration of nurses with respect to mental health training was altered some years ago. As a consequence there is no specific recognition of mental health nurses by Australian Health Practitioner Regulation Agency, however the implementation of credentialed nurses seeks to enhance the recognition of the role of mental health nurses, increase the number of nurses with specific skills that supports and promote recognition of, and response to, patients whose condition deteriorates in an acute health care facility. This training includes ensuring a patient's deterioration is recognised and appropriate action is taken.

Metro South Addiction and Mental Health Services complete regular internal audits against the national standards for mental health services and national safety and quality health service standards. For example an audit of standard nine of the national safety and quality health service standards, 'recognising and responding to clinical deterioration in acute health care', ensures that a patient's deterioration is recognised and appropriate action is undertaken.

An update of the clinical transformation was provided to the coroner in 2013.

Recommendation 5

It is noted that metro south is awaiting the implementation of a journey board system providing online details with respect to a patient's admission status, expected date of discharge, Mental Health Act status and frequency of visual observations. Pending implementation the director of nursing will be requested to utilise a photographic identification process for patients with the requirement that this be connected to the handover sheet for each nurse, which document is also to include leave entitlements.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

The journey board system is now installed within the acute adult psychiatric unit at Princess Alexandra, Redlands and Logan hospitals and is being used to support clinical handover. Access to the journey board is available across all of Metro South Hospital and Health Service including emergency departments.

Recommendation 6

I recommend that Metro South Mental Health Services ensure any scheduled Mental Health Review Tribunal reviews are entered on the current whiteboard system and ultimately on the proposed journey board.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

Scheduled events such as mental health review tribunal reviews are included in the journey board system which is now installed within the Acute Adult Psychiatric Unit at Princess Alexandra, Redlands and Logan hospitals. Access to the journey board is available across all of Metro South Hospital and Health Service including emergency departments.

Recommendation 7

I recommend that Metro South Mental Health Services review the practicality of providing reception staff with a copy of the visual observation photo board so they are aware of which patients can or cannot leave the ward.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

The Metro South Hospital and Health Service reviewed the practicality of providing a visual photo board for administration staff and does not consider it practicable to implement this recommendation as there would be limited places where photographs could be placed without breaching privacy for each individual.

Following the Department of Health directing that all adult acute mental health inpatient units that are not currently locked to be locked from 15 December 2013, all consumers/patients are now required to sign in and out of the ward. Consumers requesting to leave the ward are required to see nursing staff. Nursing staff review the consumers limited community treatment plan, request information from the allocated nurse for the consumer or the clinical nurse for the shift before granting leave.

To ensure the compliance of the direction capital works are being undertaken at all sites, this has included installing two locked doors at east wing a the Princess Alexandra Hospital. The architects are currently evaluating how an air lock system can implemented in all other areas of the acute inpatient units.

Recommendation 8

I recommend that Metro South Mental Health Services ensure there are specific individual behavioural management plans for excessive alcohol and drug use by those patients, who cannot be discharged. Such individual plans may include the clinical team implementing a structured program of searches, regular breathalysing, and limiting the patient's access to money (where there is a legal entitlement to do so).

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

In October 2014 the illicit substance management procedure was endorsed and ensures the service meets its obligation to the community by endeavouring to prevent criminal activity being conducted in the mental health inpatient units. Addiction services are providing additional consultation liaison services to the acute psychiatric units at Princess Alexandra, Redlands and Logan hospitals.

Recommendation 9

I recommend that Metro South Mental Health Services seek agreement by way of a memorandum of understanding or similar agreement between Metro South Mental Health Services and the Mater Hospital concerning the management of female psychiatric patients giving birth to promote mothers being able to stay with their baby for a reasonable period after the birth of a child.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

The Metro South Hospital and Health Service and the Mater Hospital started to formalise an agreement to address the transfer of mothers and the support of mothers and babies of psychiatric patients who give birth and in February 2015 a perinatal program commenced.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

A memorandum of understanding between Metro South Mental Health Services and the Mater Hospital has been changed to include all services.

Metro South Hospital and Health Service has also adopted a process that identifies and places the majority of women at risk due to mental illness and pregnancy at Logan Hospital Mental Health units. This has commenced as gender specific units have become available and obstetric and mental health services are co-located on one campus.

The memorandum of understanding is expected to be finalised in 2016.

On 12 September 2016 the Minister for Health and Minister for Ambulance Services responded:

A memorandum of understanding between Metro South Mental Health Services and the Mater Hospital will be signed by both parties to include all healthcare services and will promote mothers being able to stay with their baby for a reasonable period after the birth of a child.

On 25 January 2018 the Minister for Health and Minister for Ambulance Services responded:

A memorandum of understanding between Metro South Mental Health Services and the Mater Hospital was finalised and is progressing for the consideration of both parties to include all healthcare services. A perinatal program is already in place where female psychiatric patients giving birth are encouraged to stay with their baby for a reasonable period after the birth of a child.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

In July 2017 a memorandum of understanding was entered into by Metro South Hospital and Health Service, Addiction and Mental Health Services (MSAMHS) and the Mater Hospital. The memorandum of understanding addresses the transition of mothers between MSAMHS and Mater Mothers' Hospital, supporting female psychiatric patients giving birth to remain with their babies for a reasonable period after the birth. Services are provided to the Mater Adult Hospital by Consultation Liaison Psychiatry Services, Metro South Hospital and Health Service.

Recommendation 10

Queensland Health is conducting in 2013 a review of the mental health mortality report. During that process Queensland Health, as well as metro south should review the practical and legal implications for the inclusion of written statements from medical and nursing staff caring for the patient at the time of the death (to assist the root cause analysis process and any subsequent investigations such as a coronial inquest).

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

A meeting was held between the department's Mental Health Alcohol and Other Drugs Branch (MHAODB) and the Patient Safety Unit in May 2015 to discuss the implications of the review and the newly developed mortality reporting process. A key focus of the meeting was to explore opportunities for collaboration and discuss policy and or legislative amendments which may be required to enable hospital and health services to comply with the new process.

A further meeting is scheduled after which legal advice can then be sought. Advice regarding the implications for the inclusion of written statements from medical and nursing staff caring for the patient at the time of the death will also be sought during this consultation. The outcome of this advice will be included within the guidelines.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

A further meeting between MHAODB and the Patient Safety Quality and Improvement Service (PSQIS) was held in June 2015. The MHAODB is developing a mortality reporting process to assist in identifying trends and systems issues related to sentinel[1] events. As recently as November, new collaboration opportunities with PSQIS have resulted in different data sources and analysis opportunities becoming available which can inform the mortality reporting process. The MHAODB are examining legislative and policy implications of the proposed mortality reporting process.

Further consultation on potential enhancements is to be undertaken to inform the development of a suitable mortality reporting process. Advice regarding the implications for the inclusion of written statements from medical and nursing staff caring for the patient at the time of the death, will also be sought during this consultation. The outcome of this advice will be included within the guidelines developed to support an improved mortality reporting process. An update will be provided in the mid 2016 reporting phase.

[1] Any death which was not reasonably expected to be the outcome of incidences of serious harm which occurred to a patient.

On 12 September 2016 the Minister for Health and Minister for Ambulance Services responded:

The Department of Health reviewed and considered the practical and legal implications for the inclusion of written statements from medical and nursing staff caring for patients at the time of their death as part of a mortality reporting process, and considers that no changes are warranted at this time.

Hospital and health services are responsible for ensuring that good quality contemporaneous clinical information is documented in the patient's clinical chart; this would be sufficient information to inform clinical incident analyses, including root cause analyses. Both clinical documentation and the results of clinical incident analyses are accessible to the coroner in the instance where an investigation is undertaken.

The Department of Health wrote to the hospital and health services to emphasise the importance of good quality clinical documentation, particularly as it applies to this recommendation for the recording of critical incidents and care at the time of death. All hospital and health services are also reminded of the medico-legal and ethical requirements of the completion of timely, accurate and comprehensive clinical case notes. Hospital and health services undertaking clinical incident analyses were advised to ensure the analyses take into account the perspective of all members of the treating team at the time of the event. Hospital and health services were reminded that the timely completion of a root cause analysis or other clinical incident analyses within the 90 day period will ensure that the event is adequately documented as recommended by the coroner, to assist with subsequent analysis and investigations, such as a coronial inquest.

The Department's Mental Health Alcohol and Other Drugs Branch and the Patient Safety Quality and Improvement Service will continue to work in collaboration to identify mechanisms to further improve mortality reporting of mental health critical incidents and examine legislative and policy implications of the critical incident reporting process.

Recommendation 11

It is recommended the Queensland Government progress stage two of the mental health plan to provide a medium secure unit for Metro South Mental Health Services.

Response and action: implementation of the recommendation is in progress.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

In October 2014, the Queensland Mental Health Commission launched the five year *Queensland mental health, drug and alcohol strategic plan 2014–19.* The plan brings together individuals living with mental health difficulties or issues related to substance abuse and shapes a new direction for families, carers, members of the community, government and non-government agencies for mental health, drug and alcohol reform.

The Department of Health will lead the development of the *Mental health, drug and alcohol services plan* that will complement and realise the objectives and principles outlined in the commission's strategic plan.

The Department of Health is responsible for the planning, development and implementation of operational plans that align with the strategic priorities and objective. Provision of a medium secure unit for Metro South Hospital and Health Service will be considered as part of this process.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

In May 2015, the Department of Health commenced the development of the *Queensland Health mental health, drug and alcohol services plan* (services plan), to guide service planning and delivery of state funded mental health, drug and alcohol services. The services plan is a key commitment under the *Queensland mental health, drug and alcohol strategic plan 2014-2019* (strategic plan), developed by the Queensland Mental Health Commission which was released in September 2014.

Provision of a medium secure unit for Metro South Hospital and Health Service will be considered as part of this process.

It is anticipated a draft services plan will be provided to the Minister for Health and Minister for Ambulance Services for consideration in 2016.

On 12 September 2016 the Minister for Health and Minister for Ambulance Services responded:

Extensive stakeholder consultation occurred to guide the development of the *Connecting Care to Recovery: A plan for Queensland's state funded mental health, alcohol and other drug services 2016-2021*. A final draft is nearing completion. Provision of a medium secure unit for Metro South Hospital and Health Service is being considered as a part of this process.

On 25 January 2018 the Minister for Health and Minister for Ambulance Services responded:

Connecting Care to Recovery: A plan for Queensland's state funded mental health, alcohol and other drug services 2016-2021 was released in October 2016. Early planning indicates the need for additional secure mental health rehabilitation beds for adults with complex needs.

The Department of Health and relevant hospital and health services commenced discussions with a view to determining the location and cost of enhanced secure mental health and rehabilitation services for Queensland.

The Minister for Health and Minister for Ambulance Services updated:

The Department of Health, in consultation with relevant hospital and health services, is undertaking a project to address the provision of medium secure rehabilitation beds across the state. The project will involve redesigned referral pathways and optimisation of existing skills and abilities as an interim measure, and future capital projects will be identified.

The development of a new unit at the Gold Coast will be considered within this context.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Stage 2 of the mental health plan is superseded by the new *Connecting Care to Recovery 2016-2021: A Plan for Queensland's state-funded mental health alcohol and other drug services* (the plan). Under the plan there is a commitment to reconfigure referral pathways for patients requiring medium secure care. The Department of Health, in consultation with relevant hospital and health services, is progressing development of a detailed business case for development of a new state-wide 40 bed medium secure unit. It is proposed this unit be located at the Gold Coast Hospital and Health Service (a site is available). There is agreement that this unit will cover the Metro South Hospital and Health Service catchment and accept referrals from Metro South Hospital and Health Service.

Consideration of the detailed business case for a new 40 bed secure mental health rehabilitation unit is scheduled in 2018.

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

Government consideration of the detailed business case for capital funding will occur in 2019.

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

Funding for a business case to develop a 40 bed statewide secure mental health rehabilitation unit was secured and a project management contractor appointed in early 2019.

The business case for capital funding will be developed and submitted to the Queensland Health Investment Review Committee for approval in late 2019.

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

The business case to secure capital funding to construct a Gold Coast Secure Mental Health Rehabilitation Unit was prepared and will be submitted for consideration and approval at the next Queensland Health Investment Review Committee.

If successful, it is expected that early works and construction would start by April 2021, with practical completion by Jan 2023 and operational commissioning soon after.

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

The detailed business case to secure capital funding for the Gold Coast Secure Mental Health Rehabilitation Unit was approved by the Queensland Health Investment Review Committee. The approved business case is now awaiting funding approval by the Queensland Government.

Recommendation 12

It is recommended the Queensland Government progress stage two of the mental health plan to include the development of a specialised mother and infant unit for public psychiatric patients.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

The Queensland Mental Health Commission recently undertook community consultation on a discussion paper entitled, Perinatal and infant mental health service enhancement which includes inpatient options for perinatal and infant mental health admissions. A specialised mother infant psychiatric unit is listed as one of the recommended options.

The Department of Health will develop a mental health drug and alcohol services plan to implement the objectives within the Queensland Mental Health Commission's *Queensland mental health, drug and alcohol strategic plan 2014–19* (strategic plan).

During the planning process, consideration will be given to psychiatric inpatient care for mothers and their infants, including the development of a specialised mother and infant unit for public psychiatric patients, as detailed within the Perinatal and infant mental health service enhancement discussion paper.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

The Queensland Mental Health Commission undertook community consultation, and released a discussion paper in June 2015 titled, *Perinatal and infant mental health service enhancement* which listed a specialised mother infant psychiatric unit as one of the recommended options.

In May 2015, the Department of Health commenced the development of the *Queensland Health mental health, drug and alcohol services plan* (services plan), to guide service planning and delivery of state funded mental health, drug and alcohol services. The services plan is a key commitment under the strategic plan, developed by the Queensland Mental Health Commission which was released in September 2014.

During the planning process, consideration will be given to psychiatric inpatient care for mothers and their infants, including the development of a specialised mother and infant unit for public psychiatric patients, as detailed within the perinatal and infant mental health service enhancement discussion paper.

A draft services plan will be provided to the Minister for Health and Minister for Ambulance Services for consideration in 2016.

On 12 September 2016 the Minister for Health and Minister for Ambulance Services responded:

Extensive stakeholder consultation occurred to guide the development of the *Connecting Care to Recovery: A plan for Queensland's state funded mental health, alcohol and other drug services 2016-2021*. A final draft is nearing completion. Consideration is being given to psychiatric inpatient care for mothers and their infants, including the development of a specialised mother and infant unit for public psychiatric patients, as detailed within the perinatal and infant mental health service enhancement discussion paper.

On 25 January 2018 the Minister for Health and Minister for Ambulance Services responded:

Connecting Care to Recovery: A plan for Queensland's state funded mental health, alcohol and other drug services 2016-2021 was released in October 2016. The expansion of perinatal mental health services across specialist community and inpatient services is identified as a priority in the plan.

The Department of Health and the Gold Coast Hospital and Health Service engaged in consultations and planning to provide an additional, four bed inpatient, specialised mother and infant unit for public psychiatric patients.

The Minister for Health and Minister for Ambulance Services updated:

The Lavender Parent and Infant Unit opened at the Gold Coast University Hospital in March 2017. While Queensland's public hospitals provide a range of perinatal mental health services, this new statewide four-bed unit enables mothers diagnosed with acute perinatal disorders to receive treatment and support while continuing to nurture and bond with their baby. The inpatient unit is supported by an outreach community team that provides pre and post admission transition and care.