**Inquest into the death of Jonathan Clarence Saccu**

On 20 January 2010, Mr Saccu, aged 20 years, absconded from the Mental Health Unit at the Cairns Base Hospital where he was a patient on an involuntary treatment order. He died from multiple injuries due to intentional contact with a train. Mr Saccu had a mental health history of schizophrenia from the age of 15 years.

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 that 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 entrances 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:

The Mental Health Alcohol and Other Drugs Branch agrees with this recommendation to the extent that it is able to issue statewide guidelines (as opposed to policy directives) regarding the physical layout of mental health inpatient units.

The following guidelines apply to managing and monitoring the risk of patients absconding from mental health inpatient units:

- *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.

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 be assessed at admission and at regular intervals for their risk of absconding.