QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jonathan Clarence Saccu**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO:	2010/266
DELIVERED ON:	2 July 2013
DELIVERED AT:	Cairns
HEARING DATE(s):	26 June; 16 July; 17 August; 6 September; 8 - 10 October, 2012
FINDINGS OF:	Kevin Priestly, Coroner
CATCHWORDS:	Inquest, absconding from Mental Health Unit, suicide, management of risk of absconding, diagnosis and treatment, periodic observations, physical layout and proximity of reception to main entrance to Unit

REPRESENTATION

Counsel Assisting:	Ms S Williams i/b Office of Northern Coroner
Mrs Saccu:	Mr P Feeley i/b McInnes Wilson Lawyers
Cairns & Hinterland Hospital & Health Service:	Ms S Gallagher i/b Cairns & Hinterland Hospital & Health Service
Ms E Johnson:	Ms S Robb i/b Roberts & Kane Solicitors
Mr P De Vere:	Mr J Trevino i/b Minter Ellison
Mr D Wellington:	Ms S Betzien, Minter Ellison

Introduction

Jonathon Clarence Saccu was 20 years of age and had a mental health history of Schizophrenia from the age of 15. He was admitted to the Mental Health Unit at Cairns Base Hospital on 18 January 2010 following deterioration in his condition. At about 6pm on 20 January 2010, Mr Saccu absconded from the Unit. At about 9pm, a freight train departing Cairns struck and killed Mr Saccu. An inquest was convened to determine the circumstances of his death. I considered the immediate circumstances surrounding his death on the railway and how it was that Mr Saccu came to abscond from the Mental Health Unit. This involves a closer consideration of his clinical history and management. I then consider what measures were in place to manage the risk of absconding, what lessons might be learnt and what opportunity exists to avoid any similar deaths.

Immediate Circumstances

At about 9pm on 20 January 2010 Mr Ken Vaughan, together with co-driver Mr Dale Wellington, departed Portsmith, Cairns at the controls of a diesel locomotive towing 22 mostly empty freight carriages headed in a southerly direction for Townsville. The train was about 370m in length and weighed about 470 tonnes. It gradually accelerated out of Portsmith along a straight section of line running parallel with the Southern Access Road. The track then gradually veers left before entering a straight section, about 400-500m in length, running parallel with the Bruce Highway at Woree.

At this point the posted speed changes from 80kph to 50kph. Mr Vaughan reported the train was travelling at 45-50kph on entering the straight. He was seated in the right seat and Mr Wellington was in the left seat. As the train lights lit the straight section of track, both saw someone lying across the tracks. Mr Vaughan immediately activated the Claxton horn. There was no immediate movement by the person on the tracks. Mr Vaughan activated the emergency brakes. He realised there was no way of stopping the train in time. Mr Vaughan saw the male person lying with his neck on the track and his body facing towards the adjacent highway. There was no movement. Mr Vaughan then felt and heard the train impact with the body. The control room was contacted via radio and emergency services asked to attend. Mr Wellington and Mr Vaughan climbed down from the locomotive but, understandably, avoided witnessing the trauma that they knew must have been caused to the body of the person struck.

Police officers attended the scene. Members of the Forensic Crash Investigation Unit conducted a scene and follow-up investigation of the incident. The deceased was found lying adjacent to the ninth carriage on the western side of the track. The body was intact but had sustained severe trauma. The train was inspected, in particular, the ‘cow catcher’ at the front. No apparent contact points were discernable. A black watch and CD player was found on the tracks at about the point of impact. The watch was stopped at 9.16pm. The distance from the deceased to the front of the train was 145m.

The FCU investigation as well as the Queensland Rail investigation were thorough and did not identify any aspects of the management of the train or its mechanical condition that contributed to the incident.

Interrogation of the data logger from the train revealed that immediately prior to activation of the emergency brake, the train was travelling at 42kph and slowly decelerating. The emergency application of the brake stopped the train in 169m and took 23 seconds. This information corroborates the versions the drivers provided. The train's impact with the deceased was unavoidable.

The deceased was later identified as Jonathan Saccu.

Dr Paull Botterill, Forensic Pathologist, conducted an autopsy and confirmed that the deceased died due to multiple injuries due to contact with train. Toxicology testing of blood samples taken at autopsy revealed the presence of a sedative (diazepam and metabolite) and prescribed antipsychotic agent (flupenthixol) at therapeutic levels.

However, at the time of his death, Mr Saccu was a patient of the Mental Health Unit of the Cairns Base Hospital pursuant to an involuntary treatment order. Investigations revealed he absconded from the Unit shortly after 6pm. He was recorded as present on the observation sheet based on purported sightings until his absence was detected about 9.30pm.

I am required to make findings about who, when, where, what caused the death (medical cause of death) and how the person died. It is immediately apparent that that most of the required findings can be made on the available information. However, Mr Saccu's mental health status was such that he required involuntary admission to the Mental Health Unit. Therefore, relevant to the issue of 'how' he died, is how the risk of absconding and suicide was managed during his admission. In pursuing this course, I am mindful that a Coroner is precluded from including in his findings any statement or comment that a person is or may be guilty of an offence or civilly liable for something (s.45(5) and s.46(3) of the Coroners Act 2003).

In addition to making the required findings, I am mindful that a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to public health or safety and ways to prevent deaths from happening in similar circumstances in the future. My comments take the form of recommendations at the conclusion of the findings.

Before I attempt to frame the issues any further, there is a context to the issues that should be understood and it includes the mental health history of Mr Saccu, the functioning of the Mental Health Unit at Cairns Base Hospital including patient security and observations, and the clinical narrative.

Mental Health History

Mr Saccu's mental health history started in 2004 at the age of 15. His symptoms included social withdrawal, declining academic performance,

religious preoccupation, disorganised and bizarre behaviours, decreased concentration, auditory hallucinations, thought insertion and formal thought disorder. In July 2004 he was admitted to Royal Brisbane Hospital adolescent mental health unit. His treatment included antipsychotic medication and eight electroconvulsive therapy treatments which stopped following cardiac side effects. In October 2004, he was commenced on a trial of Clozapine, an effective antipsychotic medication which requires close monitoring for life threatening side-effects. However, Mr Saccu experienced sedation and postural hypotension. His mother withdrew her consent for Clozapine and asked for her son to be discharged. The intensive treatment order was continued. Mrs Saccu and her son returned to Charters Towers on 21 October, 2004. Mr Saccu continued his treatment in the community and Mrs Saccu took him to Townsville Hospital when required.

In June 2006 there was another episode of serious deterioration in the mental health of Mr Saccu. He spent five days lost in the bush and on admission to hospital, presented as guarded, distressed and verbally aggressive when medication was mentioned. He reported thinking people were trying to kill him including Queensland Health.

He was further admitted to hospital in July 2008 with a self-inflicted wound to the scalp against a background of deterioration in mental health.

In December 2009 he was further admitted due to persecutory beliefs that others were trying to kill him. He is reported to have attacked a security guard on 3 December and threatened suicide.

In reviewing Mr Saccu's mental health history, Dr McVie, Consultant Psychiatrist, reported to the court on his clinical management including his history, which she analysed and summarised:

> Mr Saccu's illness was characterised by poor self-care, formal thought disorder, minimal insight, non-compliance with oral medications and predominant persecutory delusions in recent years. He had a history of aggression during previous admissions, a history of poor impulse control when unwell, and several incidents of absconding (from 2004). Substance abuse was not a feature of his presentation.

In summarising his last admission, Dr McVie reported:

> Mr Saccu was seen by Dr Van Meer (consultant psychiatrist) on 18/1/10 and considered to be high risk of suicide, preoccupied with thoughts of death but no specific plans for suicide. He absconded after that interview on 18/1/10, and later returned himself, saying he had left the unit as he was afraid he would be "locked up". On 19/1/10 he talked of his delusional beliefs that others were trying to torture and kill him. He also talked of "being at one with the universe" and that he would "like to put the universe right".

She later reported:

> In summary, Mr Saccu suffered with a severe treatment resistant schizophrenic illness with onset in his early teens. He was plagued by disturbing persecutory delusions for at least four years prior to his death. His lack of insight, non-compliance with oral medication and delusional fears about previous treatments compromised his full engagement with his treating team. Though he had reported suicidal ideation and was assessed as being psychotic, a high risk of suicide and a high risk of absconding; his final method of death is suggestive of an impulsive, rather than a planned act.

The Mental Health Unit at Cairns Base Hospital

This facility is situated at the south eastern corner of the hospital complex, adjacent to Lake and Kerwin Streets. The main entrance is located on Lake Street. As you enter the Unit, there is a hallway that gradually opens towards the body of the Unit. There is a nurse's station with reasonable line of sight of persons passing to and from the entrance. At night, the entrance is locked against entry but retains its exit capacity. It was through this entrance that Mr Saccu departed the Unit on the night of his death.

The 38 bed Mental Health Unit comprises a Low Dependency Unit (LDU) consisting of 25 beds, a Special Purpose Unit within the LDU consisting of another 5 beds, and the locked Psychiatric Intensive Care Unit (PICU or high dependency unit) consisting of eight beds. There were three shifts; the early shift from 7am to 3.30pm, the late shift from 2.30pm to 11pm, and the night shift from 10.45pm to 7.15am. The overlaps allow for nursing handovers.

Dr Bayley is the Clinical Director of Cairns and Hinterland Mental Health Service. She started with Cairns Base Hospital in 1998 when the Unit moved into its current location. It then had 30 beds and averaged an occupancy rate of about 75%. She described the environment as spacious and therapeutic, an easy unit to manage. Dr Bayley started as Clinical Director in 2003 and reported that in 2004/2005 there started a trend of increasing numbers of patients, 'general emergency department presentations have gone sky high over the years and mental health presentations have consequently also gone up'. She said that the Unit now had 38 beds in the same footprint with occupancy rates of 106%. Dr Bayley told the court:

> We have a very difficult situation where we're managing trying to provide the best service we can to our patients who are ill with an under resourced system, so we have a number of patients awaiting beds in ED at any one time, and it's - it's regrettable. It's actually quite stressful now. So around about - a couple of years before Mr Saccu came in it started to get quite busy, and the staffing was - we were always trying to play catch-up with the amount of staff that we had. And it's also been incredibly difficult to get permanent, well-trained staff, you know, medical and nursing, in a regional area.

Patient Security and Patient Observations

Patient security was managed by an escalating range of security measures from virtually absent in low risk situations (periodic visual observations every 30 minutes in an open unit) to very intense and strict in a high risk situations (constant visual observation in a locked unit). There are three levels of observations:

- category A – constant visual observations – one to one observations by special nurse appointed;
- category B – intermittent visual observation every 15 min; and
- category C - intermittent visual observation every 30 min.

The level of observation of each patient is reviewed on a daily basis.

The observations are conducted by nursing staff. A Clinical Nurse will allocate each nurse a specific time during their shift to complete and record visual observations of all patients over a two hour period. The nurse conducting the observations is required to identify each patient at least once within each period of observation, and then note at the end of that half hour period that they have conducted that observation.

Mr Sweeney, Director of Nursing, reported in his statement:

> "Properly conducting the observation necessarily requires that the staff member identify the consumer the subject of the observation. Most consumers are photographed upon admission and a copy of the photograph is contained in the patient file. If a staff member is unsure about the identity of any consumer then that staff member can refer to the photograph for confirmation. Occasionally, a consumer will refuse to be photographed. In that event, the staff member conducting observations would be required to inspect the consumer's admission bracelet to confirm his or her identity.
>
> The conduct of observations is not intended to be a passive undertaking. Indeed, staff are encouraged to have interactions with consumers when performing the observations…"

The mental health unit has CCTV cameras positioned at the front door, communal areas, courtyard and PICU. There are four monitors, two located on the wall of the nurse's station and two located on a wall in the PICU office. All monitors are divided into four sections to simultaneously show four different areas of the mental health unit on one screen. They are positioned so that they can be viewed only by staff members and not by the public or patients.

Clinical Narrative from 17 January to 20 January 2010

At about 2.45pm on 17 January 2010, Mr Saccu presented to the Emergency Department of Cairns Base Hospital with his mother, Mrs Clarice Saccu, reporting suicidal thoughts and recent past attempts.

At about 3.15pm, an Emergency Department doctor reviewed Mr Saccu, noting a background of paranoid schizophrenia and recent attempts at suicide. It was also noted that Mr Saccu threatened suicide if sent home and experienced persecutory delusions. The reviewing doctor noted the need for admission and referred Mr Saccu to the Acute Care Team for assessment.

Registered Nurse Emma Duffy from the Mental Health Unit at Cairns Base Hospital did a nursing assessment, recording more detail about recent history including suicide attempts and plans. She conducted a Mental State Examination and concluded that Mr Saccu was at a high risk of self harm. The Psychiatric Registrar on call, Dr Tervitt, was asked to conduct a psychiatric assessment to consider the possibility of changing the Involuntary Treatment Order category from community to in-patient.

Dr Tervitt was familiar with Mr Saccu, having reviewed him on three occasions during an admission in July, 2008 (14, 15 and 18) as well as two occasions during an admission in December 2009 (12 and 13). He noted Mr Saccu expressed overt and repeated suicidal threats. The detail was consistent with that noted in the earlier nursing assessment. Mrs Saccu corroborated the circumstances of recent attempts at suicide. Dr Tervitt recorded that Mr Saccu's thoughts were in order, noting Mr Saccu to say he was 'not psychotic', 'just something I need to deal with' and he needed 'a safe place'. Dr Tervitt also noted Mr Saccu did not want to kill himself and didn't want to hurt his mother. Mr Saccu reported poor sleep and ruminating about hating the universe, it's an evil place and themes of torture. He also reported poor food and fluid intake. Dr Tervitt concluded that Mr Saccu presented less psychotic and more ordered than previously but he was still unwell with overt suicidal thoughts. He planned to admit Mr Saccu as an inpatient to the closed Psychiatric Intensive Care Unit (PICU), where the only bed was available and prescribe Valium and Zyprexa on an 'as required' basis.

The relevant paperwork to admit Mr Saccu was prepared including a Consumer Assessment completed at a nursing level that included a risk screen. In that section, his history of high 'AWOP' (away without permission) risk was noted. He was admitted to the PICU at 7.45pm. Nursing notes record that Mr Saccu quickly settled in the unit. However, it was noted he expressed fears of having ECT and sought reassurance that he was safe. It was further noted: "Has been dreaming or and appears pre-occupied with the evil universe and themes of torture".

During the course of the morning of 18 January, Social Worker Alexandra Liddel had a telephone discussion with Mrs Clarice Saccu, clarifying aspects of Mr Saccu's recent suicidal history. Mrs Saccu reported to Ms Liddel that Mr Saccu left the family home the preceding Thursday night with his music to sit in the rainforest with the intent of dehydrating and dying. He returned home on Friday night about 6pm and left again for the rainforest about 9pm with the same plan. He returned home on Saturday, reporting to Mrs Saccu that he was emotionally too weak to follow through with his plan. However, he went back to the rainforest, telling her he was going to die. Mrs Saccu reported a significant change when on Sunday he went to her shop, stating he was going

to hang himself with chain from a bridge. She reported discussing with her him the need for help and he agreed, as he couldn't stop the urges. It was then they decided to present to Cairns Base Hospital and did so that afternoon.

During the morning ward rounds, Consultant Psychiatrist Dr Van Meer and Registrar Dr Armstrong reviewed Ms Saccu. He gave an account of recent suicidal attempts and thoughts consistent with the account given to Dr Tervitt. It was noted that Mr Saccu did not express any suicidal thoughts in hospital, he was happy to stay and felt safe. He also reported fears about Electro Convulsive Therapy and that thoughts of ECT made him suicidal. He reported bad dreams of people torturing him which made him feel he wanted to die. But since his admission, he had no bad dreams or thoughts of dying. He reported no voices. A Mental State Examination resulted in no significant abnormalities except pre-occupation with thoughts about death. Dr Van Meer concluded that Mr Saccu was not currently at risk of suicide and that his current treatment plan should continue. His plan included transfer from the PICU to the open Low Dependency Unit.

At about lunchtime, Psychiatric Registrar Dr Armstrong transferred Mr Saccu to the open Low Dependency Unit.

Unfortunately, at about 5pm, Mr Saccu was not able to be located during observation rounds and an Authority to Return was completed and faxed to the Police Service to facilitate and authorise a search and his detention. However, Mr Saccu telephoned the MHU stating he left because he thought he would be locked up. He agreed to return to the ward. On return, he denied any thoughts of self harm or homicidal ideation. His mood was noted as brighter and reactive. He was returned to the Low Dependency Unit where he slept throughout the night.

At 12pm on 19 January, the nurse responsible for the care of Mr Saccu recorded the following observations:

> Jonathan has been settled on the unit this morning. He has been in isolation this morning alternating between lying in bed and up in the day room. Jonathan's mood appears low and displays a restricted affect. He expresses deep feelings of paranoia about some dreams he has been having recently. In these dreams he states that people whom he can't describe, are torturing him. He believes that these details are also going to kill him. He also expressed delusional content about being at one with the universe. He says it is in a hell of a state but he can learn to live with that. He would like to put the universe right. Jonathan also expressed how he felt sorry for plants and animals and how they must feel pain. Jonathan says he had a girlfriend (whom he never went out with, and knew only at a distance) had let him down and he couldn't cope with this. Yesterday, Jonathan stated he had insight into his predicament and said it would be utterly futile to kill himself, as it would achieve nothing. However, today he now states he may still want to kill himself even if it achieved nothing. He states that it

> is the universe being all wrong that he is driving to this decision. Jonathan is still very much insightless and thought disordered. He is experiencing delusions with a paranoid content.

Psychiatric Registrar Dr Armstrong reviewed Mr Saccu and noted that he presented "much as he did yesterday". There was no formal thought disorder although paranoid delusions persisted as did his overactive sense of compassion. Mr Saccu was noted as having "seen the face of God on the moon" and "seeing square ripples on a pond like a mirage, but it was real". He showed partial insight, acknowledging; "I know it sounds crazy" and "you are going to think I am crazy". Dr Armstrong noted Mr Saccu denied suicidal thoughts but this might change if he were to go home, "I would be okay for a little while, then I would get scared". Dr Armstrong noted an impression that Mr Saccu was psychotic, compliant and had poor insight.

At 7.10pm, the following nursing observations were made: –

> Jonathan presents as pleasant and polite on approach, good eye contact. Grandiose ideas expressed relating to spiritual beliefs, admits he is God and can have powers. Expresses magical thinking and preoccupied with all matters surrounding him, overvalued. Jonathan appears insightless and exhibits poor judgement. Mood labile and tearful at times. Reports "feeling rejected by others when other people don't validate his beliefs". Observed to be isolative. Sitting alone. Mother came in to visit and brought in clothes and earphones. Jonathan feels safe on the ward but does not want to go home.

Mr Saccu slept during all nursing rounds overnight.

On 20 January, nursing observations noted at 12.45pm:-

> Jonathan presents isolative, has spent the majority of the morning sleeping in bed, appears drowsy, declined ADLs. Jonathan voiced nil delusions or perceptual disturbances, appears very distracted and dissociative in behaviour, mood euthymic. Reports feeling safe. Await further review by Van Meer.

A new shift of nursing staff started at 2.30pm and the handover was completed at 3.15pm. Rostered on this shift were:

- Registered Nurse Rose Hallpike, (Acting Clinical Nurse and Team Leader of the shift);
- Registered Nurse Eloise Johnson
- Registered Nurse Alexandra Maran;
- Registered Nurse Laine McNally;
- Registered Nurse Paul De Vere;
- Enrolled Nurse Elizabeth Kukacka;
- Endorsed Enrolled Nurse Siudee Dix;
- Student Nurse Kristina Curtin;

EEN Dix was assigned to undertake constant category A observations in PICU. The Registered and Enrolled Nurses were each assigned a number of patients (5 or 6) for whom they were responsible over the shift. In addition, some of the nurses was allocated a two hour period for which they were responsible for conducting category B (15 minute) or category C (30 minute) observations. During each observation period, nurses were expected to identify and make contact with each patient, not just those allocated to them, to check on their presence and wellbeing.

At about the time of completion of the handover, nurses were informed that a recently discharged patient was on the footpath at the front of the facility, consuming her medications 'one by one'. RN McNally and EN Kukacka left the Unit to check on the wellbeing this person. RN Hallpike made inquiries about this patient's immediate history. RN Johnson remained at the nurse's station to monitor the unit and to assist where possible.

Normally, patients were allocated to nurses immediately after handover. However the activities of the recently discharged patient on the footpath delayed the allocation of patients. At about 3.45pm RN Johnson was allocated her patients including Mr Saccu. RN Johnson was also allocated the duty of medications nurse for the shift, becoming responsible for medicating 30 patients during rounds at 6pm and 8pm. RN Maran was allocated to assist her, a means of ensuring that the correct medication and dosage was administered to patients. At handover, RN Johnson was informed that Clozapine, required for several psychotic patients, was ordered in the last shift but had not arrived.

From 4pm, a number of events take place, the timing and sequence of which overlap to some degree:

- At 4pm, RN Johnson contacts the hospital Pharmacy to enquire about the whereabouts of the earlier ordered Clozapine and was told there are no medications outstanding or to be collected;
- A patient approaches the nurse's desk, reporting pain and demanding morphine. RN Johnson seeks out the Team Leader and together, they attend the drug cupboard and sign out the required medication. The order was then checked, the medication drawn up and administered (about 4.50pm).
- RN Hallpike again queried with RN Johnson the absence of the Clozapine. RN Johnson went to the Pharmacy to collect the drug herself. Again, the Pharmacy says no order was placed or outstanding. She returned to the ward without the medication.
- At about 5.15pm, RN Johnson took a 15 minute tea break and on her return, went through the medication charts of patients in preparation for the 6pm medication round.
- The serving of dinner started between 5.30 -5.45pm.
- RN Johnson remembers Mr Saccu approaching the nurse's station and requesting $7.50 to go to the shop. He was reminded that he was on an Involuntary Treatment Order, he had not been granted leave and he could not go to the shop. Mr Saccu said he was going to get someone to go to the shop for him. RN Johnson gave the money to him and that

was the last time she saw Mr Saccu. Although RN Johnson reported in her statement that this conversation happened sometime between 6 and 8pm, it is a fact that Mr Saccu left the unit shortly after 6pm. For reasons that will become apparent, it is unremarkable that RN Johnson was unable to fix the time any better. RN Johnson does recall she had the medications trolley at the time. Therefore, this event is likely to have occurred about 6pm.

- At 6pm, RN Johnson started dispensing the medications. That took about 45 minutes to 1 hour.
- Shortly after 6pm, Mr Saccu left the unit (confirmed on CCTV footage of the entrance to the Unit).
- RN Maran completed periodic observations from 5pm to 7pm including cycles finishing at 6.30pm and 7pm. She marked Mr Saccu as “A” meaning awake and present.
- Similarly, RN De Vere completed periodic observations from 7pm to 9pm including cycles finishing 7.30pm, 8pm, 8.30pm and 9pm; and marked Mr Saccu as “A” meaning awake and present.
- At about 6.45pm to 7pm, RN Johnson went on her meal break. On her return, she prepared for the 8pm medications round and completed dispensing at about 9pm.
- At about 8.10pm Student Nurse Curtin took a phone call at the nurse’s station from a sister of a patient wanting to speak with that patient. On paging the patient and getting no response, the caller then reported that her sister was with her and had been for about 15 minutes. SN Curtin reported the call to RN Hallpike who advised that the patient was a voluntary admission. However, following this interaction, SN Curtin had a conversation with other patients who reported the absence of two other patients.
- At about 8.30pm, RN Johnson recalls a conversation with SN Curtin reporting two female patients had absconded from the ward. The On-Call Doctor was called and RN Johnson completed the absent without permission (AWOP) paperwork and faxed it to the Police.
- At about 9.15pm, SN Curtin noted the patients allocated to her were asleep and offered to assist with observations, taking over the next round of observations due to be conducted by RN Hallpike. On her first round of observations, she detected the absence of Mr Saccu.
- At about 9.40pm, SN Curtin reported that Mr Saccu was unable to be found on the ward. A search was conducted and he remained missing. The On-Call Doctor was contacted and AWOP documentation completed by RN Kukacka at about 10.55pm. The paperwork was left for execution and faxing to police by the next shift, 11pm to 7am.

Managing the Risk of Absconding and Suicide

Although one of the issues for investigation at the hearing was whether the death of Mr Saccu was an accident or suicide, there was no further examination of witnesses on this point. I am satisfied that this issue was adequately investigated and there is sufficient evidence before me to make the required findings.

In relation to the risk of absconding and suicide, there were three areas of opportunity for intervention and risk reduction ('risk controls'). These might also be described as preventative or protective measures.

The first risk control I consider is the diagnosis and treatment of Mr Saccu, in particular, how that influenced the decision to transfer him from the PICU to the LDU. The second risk control considered is the manner of identification and effectiveness of periodic observations. Then I turn to management of patient's ability to the leave the unit for outside.

Risk Control - Diagnosis and Treatment

Dr Rigo Van Meer, a Consultant Psychiatrist since 1983 and with Cairns and Hinterland Mental Health Service since 2007, reviewed Mr Saccu on admission to the MHU on 18 January. He was familiar with Mr Saccu since an earlier admission in July 2008. Dr Van Meer had frequent contact with Ms Saccu over the following months as an inpatient and in the community.

Dr Van Meer reported:

> My treatment of Mr. Saccu has always been with the long view in mind. Mr. Saccu suffered from a severe form of paranoid schizophrenia. He would have needed treatment for the rest of his life. There would be strong swings in his mental state, involuntary admissions and involuntary injections. To try to build and keep a workable relationship through all these vicissitudes requires a level of trust. I have always endeavoured to be honest and open with Jonathan, also when this was difficult or painful. I had at times to tell him that he was ill when he believed there was nothing wrong with him, to tell him that I would admit him against his will and to tell him that he would be given injections against his will. When he was admitted on his last admission to the hospital I saw this at the time as one step in his illness and treatment, to be followed by many more steps through the coming years. Being honest and trustworthy was an important ingredient.

Dr Van Meer expanded on the reasoning underlying his management plan for Mr Saccu:

> I reviewed Mr. Saccu on 18 January 2010 and formulated the plan, to get him well, to keep Mr. Saccu admitted and assure him that he can stay in hospital. He was to be transferred to the open ward (LDU), with no leave, placed on observation category C and an increase in his anti psychotic medication (depot increased from 40mg Flupentixol [long acting injections] every fortnight to 100mg Flupentixol every fortnight; to start with a single extra dose of 40mg) and for Mr. Saccu to keep contact with his mother.
>
> My rationale of this plan was that Mr. Saccu was happy to stay in hospital and felt safe here. He had attended of his own volition. To lock him up would be a breach of his confidence and would not serve any goal.

> Mr. Saccu required long term treatment and my goal was all the time to build a relationship with support, trust and mutual respect. Mr. Saccu was afraid to be locked up and such course would have been anti-therapeutic. He had tried to commit suicide in the last weeks, but he chose to come to the MHU to seek help.
>
> Mr. Saccu wanted a long stay in hospital; he wanted to be admitted for a long term in a facility. This was in my opinion a very reasonable request. But to my knowledge this type of facility is not available in Queensland.
>
> Mr. Saccu was therefore to be admitted to the LDU, with an increase in his anti -psychotic medication.

Dr Van Meer was asked whether it was appropriate for Mr Saccu to remain in the LDU after returning from absconding on 18 January. He responded that Mr Saccu returned of his own volition after he had been assured that he would not be locked up.

It is evident that Dr Van Meer saw the circumstances of his return as the opportunity for the service to build on a therapeutic relationship with Mr Saccu. In evidence, Dr Van Meer re-iterated that Ms Saccu was only admitted to the PICU as it had the only bed available, not due to any assessment for the need to secure him. He also re-iterated the fact that Mr Saccu's initial presentation to the service was voluntary.

Dr Bayley, Director of Mental Health, also commented on the treatment plan and decision to transfer Mr Saccu to the LDU:

> The rationale of this plan was to keep Jonathan happy as he wanted to stay in the hospital and he felt safe in the hospital due to his concerns about his plans to commit suicide.
>
> Further, Mr Saccu had voluntarily come to hospital seeking assistance for his current mental state and advised that he was happy to stay and wished to be admitted long term to the MHU. Given his clinical presentation and in accord with the practice of restraint with the least restrictive measures, transfer to the LOU with Cat C obs was appropriate.
>
> In the long term, Jonathon wanted a long term psychiatric admission to a mental health facility. While this request is not unreasonable, it is a very difficult to fulfil in the public health system in Queensland as this type of resource is virtually unavailable throughout the State.
>
> It was noted that the logical step for treating Mr Saccu's schizophrenia was with oral Clozapine, however; this was not a feasible option due to his known non compliance with oral medications.

> While Mr Saccu was an inpatient he could be strictly monitored for compliance with his medication therapy, once discharged, this would be unmonitored and would in all likelihood lead to another mental health crisis.

Dr Bayley later reported:

> At 1830 hrs Mr Saccu contacted the MHU by telephone and told the staff that he would voluntarily return to the MHU. He told staff that he left as he was afraid of being locked up. Mr Saccu agreed to return to the ward. On his return to the MHU, he denied any thoughts of self harm or homicidal ideation and agreed not to leave the MHU. The QPS were faxed that he had returned.
>
> Mr Saccu's mood was noted on return to be brighter and reactive and based on his clinical indicators; there was no clinical indication to alter his visual category of observation from Cat C obs.

Dr Bayley reported Mr Saccu presented challenges to the mental health service. He had paranoid schizophrenia and suffered from severe psychotic episodes. He was known to be non compliant with his anti-psychotic medications. Mr Saccu had a dislike for medication and she reported an occasion when he fled Queensland to avoid his medical drug treatment. Dr Bayley reported this made the clinical and medical treatment on the one hand, and the building and maintaining of a therapeutic alliance on the other, a difficult balancing act. Mr Saccu sometimes saw the treatment team as people who tried to help him, but during times of paranoia, the treatment team were seen as his torturers.

The court engaged the services of Dr McVie, Consultant Psychiatrist, to review the clinical management of Mr Saccu on the occasion of his last admission and to write an independent expert report of her findings.

Dr McVie concluded the risk assessments, medication, clinical decision making and care plan; were appropriate. She also reported that there was sufficient nursing staff to ensure the treatment plan was followed and observations made notwithstanding issues with absconding and medication absent from the Unit.

Dr McVie expanded on her reasoning about allowing Mr Saccu to remain in the LDU after his return to the unit after absconding on 18 January:

> In retrospect, a simple view might be that Mr Saccu should have been managed on closer observations or in a locked unit. Having regard to the totality of his history, his recent presentation in 2009 and the history relating to the admission on 1711/10 and the circumstances of his leaving on 18/1110 and of his subsequent return, I would concur with the decision made at the time to let him remain on the open ward area.

Dr McVie was cross examined about her opinion in this topic. It was put to her that transferring Mr Saccu to the Low Dependency Unit was inappropriate unless it could be made secure:

> Mr Feeley: And I'm suggesting to you that putting him into the low dependency unit, unless it could be made secure, was inappropriate. That's the basic proposition I'm putting to you?
>
> Dr McVie: Well, it was clearly inappropriate, in retrospect. It's difficult to know what the justification would've been for keeping him in the locked area of the ward at the time that that decision was made to shift him to the open area of the ward.
>
> Mr Feely: Right. Well, one justification might've been that there was no lock on the front door of the low dependency unit and that there was no-one apparently there keeping guard on him or others who might simply leave. That would be a justification for keeping him safe in a locked or secure area, would it not?
>
> Dr McVie: It would be, yes.

However, earlier in response to questions about the appropriateness of placement in the Low Dependency Unit on initial admission, Dr McVie said:

> It would have depended on the assessment of the consultant psychiatrist at the time. If a consultant psychiatrist who knew him very well and was well aware of his history, how he responded to being in hospital and how he responded to medication and what the other risk factors were at the time, had assessed him, perhaps there may have been a rationale for putting him in the low dependency unit initially. But generally when people come in, particularly when they're severely psychotic they are admitted to a locked area for - for closer observation for the first 24 hours of their admission.

Mr Saccu was well known to Dr Van Meer who was his treating clinician for two years. Dr Van Meer demonstrated a full appreciation of all risk factors and has offered a rationale for transferring Mr Saccu to the LDU. Presumably the same factors identified by Dr McVie as relevant at admission apply equally to the decision to transfer Mr Saccu from PICU to LDU. In short, the treating clinician was in a better position with personal knowledge of the past history and presenting condition to make the final assessment in comparison with a clinician reviewing the medical records with the benefit of hindsight.

The challenge to clinicians managing Mr Saccu and patients like him was put into context in the following exchange with Dr McVie:

> …
> Well, if you look at his long-term case, this is a man who was diagnosed with an extremely serious mental illness; he was diagnosed at a very early age. He had a severe psychotic illness, he had a long history of taking off by himself, a lot of history of self-harming

behaviour. He's really got an illness that's got an extremely poor prognosis.

Yes?-- And if you look at schizophrenia overall, just having the diagnosis of schizophrenia gives you a 10 per cent risk of suicide.

Right?-- So, if you add that to this man with his particularly poor prognosis, he's got a fairly high risk of self-harming behaviour.

Are you suggesting that-----?-- You can manage that by locking people away, but in 2010 we don't do that; people have their rights, they want to be out in the community. I mean, part of his problem was he was very ambivalent, one minute he says he wants to be locked up and the next minute he says he's afraid of being locked up, and that's a classic symptom of schizophrenia.

Mr Feeley: Yes. Well, Dr McVie, the priority, can I suggest to you, the most urgent priority for this gentleman, or anyone in his situation, was his actual personal safety. Correct?

Dr McVie: Yes, at the time of admission, yes. And at some later point, if the risk was high that he would simply leave, if he could leave - and did leave - wherever he happened to be and go away from the safe environment of the hospital where he was at risk of doing, ultimately, what he did to himself - correct?

What ultimately caused the death of Mr Saccu was the condition from which he suffered, a condition that carried with it, for him, a lifelong and very poor prognosis with a high risk of self harm. Admissions to hospital during acute episodes to stabilise and moderate those aspects of the behaviour that might result in self harm in preparation for release back to the community. Admission to the PICU for the duration, if resources permitted, would reduce the risk of self harm to near zero. However, the risk of release into the community would be very high. The treatment plan must be based on a risk assessment that balances risk of absconding and self harm against treatment options including transition in the community.

In this context, the transfer of Mr Saccu into LDU was reasonable and appropriate.

Risk Controls – Nursing Observations

I now consider how RN Maran and RN De Vere conducted the observations and how the absence of Mr Saccu went unnoticed until 9.30pm.

RN Maran was scheduled to conduct observations between 5 and 7pm. In her statement to the court, she reported that on her first sighting of who she believed was Mr Saccu, he was wearing headphones. Rather then disturb his listening to music; she got the assistance of another person (whom she could not identify) to identify him. Thereafter, RN Maran reported seeing Mr Saccu in various locations during observations.

In her statement, by way of explanation, RN Maran reported:

> I am aware that I have recorded the deceased as being present within the LDU during the period 6:30 pm to 7:00 pm. I have since been informed that the deceased left the ward at approximately 6:08 pm. Notwithstanding that information, at the time of my last observations round, after 6:30 pm, I was 100 per cent certain that I saw the deceased within the LDU. I cannot recall where the deceased was located when I made the observations for the period 6.30 pm to 7:00 pm and I cannot recall the last occasion upon which I sighted the deceased.
>
> Due to lack of time, in between my last two observation rounds, I started, as well, to write entries in my patients' notes and to complete all relevant paperwork (the nursing plan for the day, observation sheets and one risk assessment). I continued my entries until around 7:40 pm when Eloise Johnson and I started to dispense medications for the entire ward. In addition to my other duties, I was the second nurse assigned to medications (with Eloise Johnson) for the 8:00 pm round. I recall that this round commenced early (at around 7:40 pm). The medications were dispensed from behind the nurse's station counter. I am not sure whether I remained in attendance until the end of the medications round, or whether I left early to write up patient notes ahead of the end of my shift.

Her evidence during the hearing was consistent with her statement. She was not able to elaborate on who assisted with the identification or provide any more about the description of the person she believed was Mr Saccu.

RN De Vere also provided a statement to the court. He worked on a casual basis, working a few shifts a fortnight. He reported that Mr Saccu was not known to him but recalled asking a group of nurses if anyone had seen Mr Saccu. It was Mr De Vere's first shift since admission of Mr Saccu on 17 January. One member reported a recent sighting and that was the basis for recording his presence at 7.30pm. During the observations for 8pm, Mr De Vere reported asking another person in the courtyard which person was Mr Saccu. That person indicated another seated in the courtyard and RN De Vere acted on that information in recording Mr Saccu as present. Mr De Vere was unable to say who the informant was or whether that person was a patient or nurse. Mr De Vere asserts that the two further observations were conducted of Mr Saccu at 8.30pm and 9pm. In hindsight, Mr De Vere accepts that the person he identified as Mr Saccu must have been another patient, a patient on leave from the PICU or a visitor.

By way of explanation, Mr De Vere reported:

> During the time period that I was allocated to undertake the visual observations for the Unit, there were three patients who were noted to be AWOP. This creates a significant amount of stress when conducting

> the visual observations. This is on the basis that as well as doing visual observations for the remainder of the Unit, attempts must be made to ascertain the whereabouts of the patient, speaking with the nurse who has responsibility for the patient, notifying the team leader, checking that for example the patient is not outside having a cigarette or in the bathroom. Essentially once a patient goes AWOP, there is a lot of tension within the staff at the Unit.

There were a number of troubling aspects to the evidence of Mr De Vere.

Firstly, in his statement, Mr De Vere reported he was in the practice of asking the nurse responsible for a patient about that patient's status and to act on that information for the purpose of conducting and recording visual observations. He also reported acting on the information of others about identification including information from the patient approached, a person visiting the patient or another patient. This contrasted markedly with the evidence as to the practice of other nurses.

Secondly, Mr Sweeney, then Acting Nurse Unit Manager, reported a conversation with Mr De Vere on 22 January about continuing to record Mr Saccu as present when he had absconded. Mr Sweeney reported that he reinforced with Mr De Vere the importance of visual observations and how to perform them. He explained that to identify each patient correctly, the nurse must ask the patient their name, and if unsure of their identity, have another staff member identify them. On 28 January, Mr Sweeney saw Mr De Vere in the Unit and he was not performing visual observations in the manner directed. He was performing 'radar observations', ticking and flicking the observation sheet without using the identification method he earlier directed. Soon afterwards, Mr De Vere was not offered any more shifts.

In his evidence, Mr De Vere strenuously denied any suggestion that he minimised the importance of visual observations. However, there was clearly an issue with the quality and manner in which he conducted the observations. This is evident from what happened with Mr Saccu and the later observations of Mr Sweeney.

How were nurses expected to conduct visual observations and how was this reflected in documented guidelines?

Acting Nurse Unit Manager Anthony Sweeney provided a report to the court outlining the workings of the Unit and in particular, how observations were conducted.

> 28. Properly conducting the observation necessarily requires that the staff member identify the consumer the subject of the observation. Most consumers are photographed upon admission and a copy of the photograph is contained in the patient file. If a staff member is unsure about the identity of any consumer then that staff member can refer to the photograph for confirmation. Occasionally, a consumer will refuse to be photographed. In that event, the staff member conducting

observations would be required to inspect the consumer's admission bracelet to confirm his or her identity.

29. The conduct of observations is not intended to be a passive undertaking. Staff are encouraged to have interaction with the consumers when performing the observations. Typically, that interaction could take the form of an exchange as follows:

Hello, my name is Anthony, *and* you *are ... ?*

With a maximum of 30 consumers, it is not usually difficult for staff members to get to know each patient's name.

During examination, Mr Sweeney was taken to guidelines current at the time of this incident and was unable to indicate any section which prescribed the manner of identification in the way he now outlined. However, Mr Sweeney told the court that observations were a basic nursing duty and he didn't think it was necessary to document for experienced nurses how to perform such a basic function.

It is conceivable that RN De Vere was influenced by the practices of other nurses and misunderstood how to conduct visual observations. For example, when other nurses did visual observations, they may have asked Mr De Vere if he'd recently seen a particular patient. He may have thought from this interaction that recent observation by another was adequate. Unbeknown to him, that nurse followed-up on his information, located the patient and independently validated the patient's status.

How effective are observations as a risk control measure in any event? Observations have a limited role in mitigating the risk of absconding. Regular observations might deter patients from attempting to abscond. Further, it is an important tool for monitoring mental wellbeing. Although it might only be a brief encounter, Mr Sweeney reported that an experienced nurse can pick up important information about patients wellbeing, particularly in terms of mood and affect. This information will inform clinical decision making resulting in better management and reduced risk of absconding. Finally, observations played a larger role in mitigating the risk of suicide through early recognition that a patient is absent and initiation of the process for their return.

Although Mr Sweeney considered visual observations a basic nursing duty that was performed the same way throughout Australia, he reviewed the procedures for visual observations in March 2010, identified opportunities for improvement and has implemented numerous changes; including the issuing of a Work Instruction requiring the photographing of patients on admission, inclusion of the photograph on the clinical file and the fitting of identification bracelets. This will facilitate nurse's familiarisation with patients and positive identification, reducing the risk of reliance of lesser forms of identification. There is also now a requirement that the Clinical Nurse or Team Leader complete an End of Shift Report documenting a number of reportable events or incidents as well as matters relevant to visual observations. Allocations of nursing staff to visual observations must be recorded and completed

observations sheets must be attached. Another Work Instruction was issued detailing how intermittent visual observations were to be conducted.

All of the witnesses to the events of that night, as well as those that reviewed those events (Mr Sweeney, Dr Bayley and Dr McVie) agreed that it was an usually chaotic and hectic night due to a number of factors including the attempted overdose on the footpath at the front of the Unit during a nursing handover at the start of shift, the chasing up of medication due from the hospital pharmacy that hadn't arrived, and unsettled patients with 3 others leaving during the evening. It was a full ward and the nurses were struggling in overwhelming circumstances to play catch up with regular duties including observations.

On reviewing the video footage of the entrance for the period leading up to Mr Saccu's departure, it is apparent from his behaviour that he was skulking about near the entrance waiting for the opportunity to leave unnoticed.

Dr McVie reported that no single person was responsible for the tragic outcome. In her opinion, the system broke down. I agree with that assessment. The practices and layout of the entrance to the building at the time of the Mr Saccu's departure left little margin for error. I am satisfied that the mistakes of RN Maran and RN De Were happened in the context of a very chaotic shift. The opportunity to reduce the risk of absconding returns to the question of physical controls. To the extent that human controls have a role to play, I am satisfied on the evidence of Mr Sweeney, all reasonable steps are now in place. However, there will always remain a risk.

Risk Controls – Monitoring of Entrance

The question of monitoring the entrance to the MHU is not without its difficulties.

There is a degree of sensitivity amongst mental health clinicians and advocates when dealing with restrictions on patients. Dr Bayley told the court:

> … we're trying to create a therapeutic environment, not a prison, and that's something that we often struggle with, but to - it is a state-wide Queensland Health policy which I've had expressed to me by the Director of Mental Health in Queensland - Aaron Groves is in the substantive position but currently on leave - that his opinion and ethos is that we try and have open units where possible to promote recovery and treatment in the least restrictive alternative in a hospital - you know, rehabilitative setting rather than a locked away setting…

Although the issue returned to monitoring the entrance as opposed to locking it, Dr Bayley emphasised that the senior clinicians and nursing staff had discussed this issue for a very long time and whether it was locked or closely monitored, there was an overriding concern about how that might impact therapeutically on patients like Mr Saccu who suffered acute episodes of fear and anxiety about being locked up, patients who ultimately had to be transitioned back to the free environment within the community.

Dr Bayley earlier stated:

> It's difficult because this is a hospital. We're trying to create a therapeutic environment for people. It's not a prison. And, you know, we try and help people take personal responsibility for themselves as much as we can, try to keep them safe and well within a pleasant environment, in the least restrictive ways. It - it's - it's a difficult balancing act.

As an example of a necessary but therapeutically unsatisfactory arrangement, Dr Bayley referred to the occasional presence of security officers.

> … when we've had a number of people that we are worried about but we don't have room in PICU, we've put a security guard on the door, and that's just awful to have security guards standing at the door. It's just such an awful thing to - awful message. You know, the security guard can be as friendly as you like but having a security guard standing at the door is - changes the whole tone of the place.

During discussion in evidence, Dr Bayley raised a number of considerations relevant to the question of monitoring. She reported that there was no universal position about the wisdom of monitoring amongst academics, clinicians, consumers, carers or various advocacy groups. Although there are construction standards for mental health facilities, the issue of monitoring is not addressed. She thought psychiatrists were divided, some thinking it was a great idea while others considered it dreadful. The issue had a polarising effect. Dr Bayley thought that when you drilled down through layers of attitudes and perceptions, it's not as clear cut as she first thought.

Dr Bayley reported that due to architectural changes necessary to increase the bed capacity by 2, it was necessary to relocate and create a new entry and entrance. It was more suited to closer monitoring.

From 2012, access to the Unit was monitored through a reception facility Monday to Sunday from 7am to 9pm. The Unit is not accessible (entry or exit) for patients or visitors outside of these hours. The access doors have a camera phone on the exterior to allow communications with the Unit. The interior also has a camera phone so staff may view the area inside the door before it is opened. Staff will activate the door to permit entry or exit on request of the patient or visitor. All patients are signed in or out of the facility in compliance with their inpatient status.

Three administrative positions were created and this has assisted in ensuring that the new entrance is monitored. Dr Bayley noted that this architectural change was a matter of necessity for other reasons and co-incidentally facilitated better monitoring of the entrance. However, the desirability of monitoring remained a vexed issue. She also expressed concerns about

whether the persons monitoring the exit should be administrative or nursing staff. Nursing staff through their training and interaction with patients on the ward are likely to have better relationships with patients, particularly those at most risk of absconding. However, it seems to me that an administrative officer at a reception like facility near the entrance will have immediate access to nursing staff if required.

When redeveloped in 2014 the MHU will expand from 38 to 50 beds. Access to the current Low Dependency Unit is planned from the Esplanade. Patient and visitor access in and out will be staff monitored at the entrance.

Further, Dr Bayley reported a discussion with a colleague working in psychiatric facility that moved to a closed doors approach. It did not result in a reduction in the number of persons absconding. They just found other ways of absconding.

Dr Bayley was not aware of academic studies or literature reviews that considered whether therapeutic aspects of an otherwise open mental health unit were compromised or adversely impacted by monitoring of the entrance.

There is a need for consistent policy of statewide application about the desirability for managing and monitoring the risk of absconding through the physical layout of mental health facilities. Although the appropriate treatment of patients and intermittent visual observations may mitigate the risk of absconding and suicide, the physical layout and monitoring of the entrance presents a further opportunity to mitigate that risk. It should not be left to the managers of each facility to decide what is appropriate. There needs to be a carefully considered and researched best practice that is implemented statewide.

Required Findings (s.45 Coroners Act 2003)

Who died: Jonathon Saccu

When he died: 20 January 2010

Where he died: On the railway line adjacent to a point on the Bruce Highway between Anderson Road and Charlotte Close, Woree.

What caused his death: Multiple injuries due to due to contact with a train

How he died:

1. At about 9.16pm on 20 January 2010 Mr Saccu was lying on the railway line when a freight train struck and killed him. Although the drivers detected his presence lying on the track and immediately sounded the horn and applied the emergency brakes, it was impossible to stop the train in time to avoid striking him.

2. The manner in which he was lying on the track, the failure to respond to the sound and horn of the approaching train and his likely state of mind at the time; make it likely that Mr Saccu's laid down on the track with the intention of causing his own death. Therefore, his death was due to suicide.

3. At about 6 pm that evening, Mr Saccu absconded from the Mental Health Unit at Cairns where he was a patient on an involuntary treatment order. He was admitted on 18 January 2010 after deterioration in his mental health against a background of Schizophrenia. His departure through the main entrance was recorded on CCTV but went undetected during period observations until about 9.30pm.

4. Two different nurses responsible for periodic observations of Mr Saccu between the time of his departure from the Unit and his death had purported to identify him as present. The mistakes were made in the context of a chaotic afternoon and evening on the ward with a number of unforeseeable events occurring. There was some reliance on information from others that contributed to the mistaken identity of other persons as Mr Saccu.

5. The diagnosis and treatment of Mr Saccu including his placement on Category C (30 minute observations) in the Low Dependency Unit was reasonable and appropriate having regard to risk of absconding and therapeutic benefits of less restrictive measures.

6. Mr Saccu was able to depart through the main entrance without being detected due to the combination a layout that does not co-locate a nursing station or reception like facility adjacent to the main entrance and absence of a permanent presence at a nursing station nearest the main entrance.

7. The Mental Health Unit has identified and implemented substantial improvements to the manner of conducting identification during periodic observations, and changed the physical layout to co-locate a reception and nurse's station at the main entrance to ensure, amongst other things, only involuntary patients with permission can leave the Unit.

8. Although the long term prognosis for Mr Saccu was poor and there existed a chronic risk of suicide, there remains an expectation that whilst an inpatient in a Mental Health Unit all reasonable efforts will be taken to reduce the risk of absconding and suicide to as low as reasonably possible. Nonetheless, the risk will always exist.

Comments/Recommendations

I recommend that Qld 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.

Coroner Kevin Priestly
Cairns
2 July 2013