FINAL REPORT

Health Service Investigation

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ABSTRACT

This report outlines the context, process and findings of a Health Service Investigation undertaken in late 2016 and early 2017 for Queensland Health into the provision of mental health treatment and care to Mr A. O'Donohue at Queensland public sector health services.

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Forward

The Health Service Investigation (HSI) was set up to review the care received by Mr O'Donohue from Queensland mental health services in the context of the terrible incident that led to the death of Mr Manmeet Sharma. The HSI panel (the investigators) acknowledges the tragic nature of this event and acknowledges the loss of Mr Sharma to his family and community.

The story of Mr O'Donohue's treatment and management should not simply be read backwards with the concluding tragedy providing the prism through which previous events are endowed with significance. In drawing conclusions about actions which were, or were not, taken it should be kept in mind that those responsible for the decisions could only operate on the basis of what was knowable to them at the time. They did not have the benefit of knowing what was to happen. This does not absolve the investigators from the duty to critically evaluate the care delivered to Mr O'Donohue but it does constrain the investigators from too readily apportioning blame, if blame there be, without taking full account of what was knowable at the time. Occasional failures of communications and infelicities in management are likely to emerge through any careful review of the care and management of someone who has been a mental health care consumer over many years. Their identification may offer the opportunity to improve future procedures and practice. Caution is, however, advisable when attributing a role to such failings in any unwanted events which may later occur.

The investigators have identified areas where systems, procedures and practice could be improved. We often place these factors in the context of potentially improving the management and the assessment of the risk of future violent behaviours. This does not amount to identifying any such factors as having contributed to the fatal attack. To reiterate, identifying weaknesses in the system exposed by our enquiry does not of itself propose, let alone establish, a causal link to the killing of Mr Sharma.

Clinical decisions are not made in isolation from the influences of the expectations of the prevailing culture and service leadership, the clinical evidence base for treatment, the legal framework, and above all the resources available to accomplish any given management plan. Health services operate within some degree of constraint created by the availability of resources. In most health services these constraints include, in addition to human resources, the availability of technologies, facilities, and the capacity to provide procedures and medications. Mental health differs somewhat in that technologies, procedures, and even the availability of the latest and best medications rarely restrict the capacity to provide services to consumers. The limiting factors are to some extent facilities, in the form of beds, clinics, hostels, and rehabilitation centres, but the most important constraint is funding and sustaining a sufficiently numerous skilled, capable and effective mental health workforce.

The investigators appreciated the cooperation we received during the investigation from all of those involved.

1. Executive Summary

The Health Service Investigation (HSI) was requested following the killing of Mr Manmeet Sharma allegedly by Mr O'Donohue who had previously been a patient of Queensland's mental health services. The investigators examined the quality of the care Mr O'Donohue had received over the years 2010 - 2016 to consider processes and review effectiveness and ascertain whether this might have influenced the occurrence of the terrible events of 28th October 2016. Equally important, the question was addressed as to what can be learned from this case which will reduce the chances of a similar tragedy occurring in the future. The report is about a single dreadful event but this must first be considered in a wider context.

Severe psychotic illnesses are found in between 8% and 12% of homicide offenders, which is some 10 times higher than would be expected by chance. Homicide rightly attracts considerable public concern, although it is fortunately a rare offence in Australia, occurring at a rate of less than 2 per 100,000 per annum. The consequences of homicide are, however, so severe for the victims, their friends, their family, and the whole community, that reducing the frequency of such killings must command a high priority.

There is no way that the one individual in every 5,000 people with severe mental illness who will go on to kill can be reliably identified in advance. What is possible is to identify factors such as; substance abuse, a disturbed social environment, certain types of delusions, and particular personality traits, which are associated with increased rates of violent behaviours of all types including, on rare occasions, the murderous. These risk factors can all, potentially, be managed in a manner which will reduce the chances of future violence, through good clinical care and active rehabilitation, rather than by coercion and incarceration. Research has shown that the rates of violence among the seriously mentally ill has not increased from the days when sufferers were locked up in the tens of thousands in mental asylums.

Mr O'Donohue suffers from a delusional disorder characterised by beliefs that he was being persecuted by the trade unions and public servants. He had been reasonably successful professionally, but by the time Mr O'Donohue came to the notice of the mental health services his delusional beliefs had so dominated his thinking that he had been rendered unemployed, destitute, and homeless. Mr O'Donohue was first admitted in 2010 following a suicide attempt. He was re-admitted a year later when he told police he was afraid he would attack those he believed were persecuting him. Following his discharge on this occasion Mr O'Donohue was treated in the community, first in the Metro North Hospital and Health Service (HHS) region of Brisbane, and later in the Metro South Hospital and Health Service region of Brisbane. In August 2016 he was discharged with a plan for him to receive the care of a General Practitioner (GP)

Delusional disorders are uncommon. They occur in less than 2% of those with psychotic illnesses. Those with these conditions are difficult to manage as, unlike the more common schizophrenias, they only respond partially, at best, to medication and often actively resist attempts at treatment and rehabilitation. Managing the risk of violence in those with delusional disorders is particularly difficult.

In 2012 the Community Forensic Outreach Service (CFOS) provided a well formulated guide to managing Mr O'Donohue's risk of violence. The responsibility for carrying through these recommendations fell to the community mental health services, who the investigators considered probably lacked all the resources, and the necessary depth of

experience, to put these recommendations fully into practice. With the benefit of hindsight it would have been preferable if Mr O'Donohue had been managed with ongoing input from experienced forensic mental health clinicians. The situation was not assisted by the recommendations from the CFOS psychiatrist inadvertently not being handed over when Mr O'Donohue was transferred from Metro North HHS to the Metro South HHS. This occurred in part because of privacy concerns over forensic assessments. The investigators consider that this information ought to have been handed over, but note that this has now been addressed to prevent any recurrence. The investigators are unable to determine whether this would have made any difference to the outcome if the information had been handed over, but given the time period between the hand over between services and the events of 2016 it probably did not make a material difference. Perhaps the most important thing to remember was that whatever the limitations may have been in the services Mr O'Donohue was managed over these years in a manner, which kept him functioning in the community without harming himself or anyone else.

Currently Queensland does not have a state wide forensic mental health service able to offer ongoing care and treatment for consumers who present a significant risk of serious offending in the future. Even if such a service had existed, Mr O'Donohue, who did not have a history of offending, nor of overt violence, may not have been seen as a suitable. Forensic services in other States do, however, often take on consumers with delusional disorders.

The attempts to manage Mr O'Donohue's psychosis and the risks of both suicidal and violent behaviour were repeatedly frustrated by his uncooperative behaviour. He refused to allow any contact with family, friends, or personal contacts, who might have been able to provide the all-important background information. He also refused to see a forensic psychiatrist for assessment; he refused almost all attempts to provide social support and rehabilitation services; he refused referral to a private Medicare funded psychiatrist; and he refused to allow any communications between the community mental health service and the GP who was to undertake his care after he was discharged in 2016; the last probably being the most unfortunate. This recalcitrant behaviour and attempts to control the mental health professionals treating them is characteristic of those with delusional disorders.

Mr O'Donohue frustrated through his uncooperative behaviour, both his assessment and treatment which created a difficult dilemma. Mr O'Donohue for much of the time was an involuntary consumer, but to use these powers to enforce compliance in a consumer with anything other than medication is difficult and often not in accordance with the relevant legislation. It is a problem knowing how to strike a balance between the rights of the consumer and the need to protect those with serious mental illness from harming themselves or others. The best solution is not greater coercive powers but having mental health professionals with the time and skills to persuade, or at least wear down the consumer's resistance, to what is in their own, and the community's, best interests.

Mr O'Donohue's Involuntary Treatment Order (ITO) was removed in 2014 on the grounds that he was complying with treatment at least up to the point where he was attending regularly and seemed to be taking his medication. There did not appear to be sound reasons to continue an ITO, and, in fact, Mr O'Donohue continued to cooperate, to the extent he ever cooperated, after the ITO ceased.

After careful consideration, the investigators consider that based upon the information available before the treating team, the actions taken were reasonable with respect to decisions made relating to involuntary and voluntary treatment.

The decision to discharge Mr O'Donohue in August 2016 is certainly unfortunate given what was to occur so soon after, however the investigators were careful to base their consideration upon the information available at the time and not rely on hindsight. The situation the community team was faced with was a man who had seemed to be reasonably stable, who had not shown much change over the previous year, who was denying he would harm himself or others, and for whom they felt they had nothing further to offer. In these circumstances to move towards discharge was clinically defensible. Mr O'Donohue did not wish to stop attending the clinic and expressed, and demonstrated, considerable anxiety about separation. The transfer of his care to a GP did not progress well because the clinic continued to acquiesce in Mr O'Donohue's refusal to allow any communication between the clinic and a GP Mr O'Donohue later attempted to return to treatment at the community clinic. This attempt on his part to gain help failed.

While the investigators considered that the decision for discharge was reasonable they considered that Mr O'Donohue's discharge would have been better managed by making full communication with the GP service, to which he was to be transferred, a condition of discharge. The attempt by Mr O'Donohue to return to the community service should have been handled in a manner which at least explored why he was seeking help. These two failures conspired to leave Mr O'Donohue in the community untreated and unsupported.

In the light of the deficiencies in the procedures covering Mr O'Donohue's discharge and failed attempt to return to care, changes have been made in the guidelines governing both the process of discharge to GP care, and how to respond to consumers seeking to return to care soon after discharge. The investigators support these changes.

In cases like this hindsight always allows the identification of moments when had different decisions been made the eventual tragedy might have been avoided. Those making the decisions at the time do not have the benefit of knowing what will happen and have no alternative but to act on the information available to them at the time. The decision to terminate Mr O'Donohue's ITO is entirely defensible, and in any event the investigators consider this had little obvious effect on his subsequent management. The decision to discharge Mr O'Donohue is understandable, but the transfer of care should have been better managed, as should his attempt to re-engage with the service. The assessment and management of risk in Mr O'Donohue is in accord with current practice but was disrupted by his lack of cooperation and, in the view of the investigators, by the absence of a dedicated community forensic service.

This is a tragedy that could not have been predicted. Inevitably, had different decisions been made at certain times then the killing might not have occurred. However, the investigators were unable to conclude that any issues identified with respect to handover of information between services, management of risk, management of the discharge from the service in 2016 and handling of the attempt by Mr O'Donohue to re-engage with the service would necessarily have changed the outcome. That said, there are certainly lessons to be learned and some of these have already led to changes. The changes made are commended and endorsed. There are also larger and more complex questions raised about how to manage and assess those mental health consumers who may present a risk of harming others, particularly with regard to how to organise the State's forensic mental health services. There is no silver lining to the tragedy, but it may act as a spur to changes that will reduce the chances of a recurrence.

2 Context for the Review

2.1 Background

According to background briefings provided to the investigators, a bus arrived at Ipswich Road, Moorooka bus stop at approximately 9.00 am, Friday, 28 October 2016. Mr Anthony O'Donohue entered the front of the bus and allegedly released and ignited a flammable liquid which resulted in a fire on the bus. This action resulted in an on-board explosion. Passengers on board had to be evacuated. A 29 year old bus driver, Mr Manmeet Sharma was declared deceased at the scene.

Health Minister Cameron Dick released the following statement in relation to the incident on 31st October, 2016, announcing the HSI.

"*Like all Queenslanders, I was shocked to learn of the terrible incident which unfolded in Moorooka on Friday. On behalf of all Queenslanders, I extend my sympathy to the family, friends and colleagues of Mr Sharma, and my thanks to the Queensland Ambulance Service and Queensland Health staff for their swift and effective response to the incident.*

I am advised by my Department that the accused had previously received public mental health services through the Metro South Hospital and Health Service.
Metro South Hospital and Health Service will conduct an internal review of treatment and services provided to the accused. This is a mandatory process in cases such as this.

However, given the very serious nature of this incident I believe it is appropriate that there be an independent external investigation into the treatment provided within the health system to the accused. Accordingly, I have requested the Director-General of Queensland Health to commission an independent investigation under the Hospital and Health Boards Act 2011 regarding treatment provided to the accused.

I am advised Professor Paul Mullen has agreed to conduct this independent health service investigation. Professor Mullen is one of Australia's leading forensic psychiatrists. It is expected that this investigation will be completed within 8 weeks.
To the extent possible, any findings and recommendations of this investigation will be released publicly.

Queensland Health will also assist with any investigation or inquiry conducted by the Queensland Police Service and State Coroner in relation to this incident.
As this incident is subject to an ongoing police investigation and is the subject of criminal proceedings before the courts, it would be inappropriate to comment further."

2.2 Terms of Reference

The Terms Of Reference (TOR) for the HSI are provided at Appendix 1 and they detail the scope of the investigation, the manner with which it was to be conducted and the nature of the findings to be reported. The scope of the HSI was as follows:

1. The Health Service Investigators are to investigate matters relating to the management, administration and delivery of public mental health services as provided to Anthony O'Donohue by the Department of Health and the Hospital and Health Services particularly Metro South Hospital and Health Services and Metro North Hospital and Health Services. Specifically the Health Service Investigators are to:
    a. review the patient records for Anthony O'Donohue and any documents, including reports, file notes, and telephone records, whether held on Anthony O'Donohue's patient record or not, created or received by staff in relation to Anthony O'Donohue;
    b. review decisions and actions taken by staff in relation to the treatment and care of Anthony O'Donohue, particularly including:
        i. The decision to close his status as an open patient of the Princess Alexandra Hospital Authorised Mental Health Service in August 2016; and,
        ii. The decision to treat him other than on an involuntary treatment order under the *Mental Health Act, 2000* (Qld).
    c. develop a sequence of key events and clinical decision-making points relevant to the clinical management of Anthony O'Donohue's mental illness;
    d. review the admission, examination, assessment, diagnosis, treatment, discharge, post-discharge follow-up and overall management of Anthony O'Donohue;
    e. review the effectiveness of liaison between relevant Hospital and Health Services regarding the assessment, treatment and care for Anthony O'Donohue including any post-discharge care and follow up arrangements;
    f. if relevant, review the effectiveness of communication and liaison between Queensland Health and other government agencies or other relevant organisations in respect of Anthony O'Donohue;
    g. review the compliance or non-compliance with relevant policies and procedures (including statewide and local) applying in relation to the treatment and care of Anthony O'Donohue, and
    h. consider whether the content and level of compliance with existing legislation, policies and/or procedures had any impact on the standard and quality of care provided to Anthony O'Donohue
2. While the treatment and care of Anthony O'Donohue is the focus of the Health Service Investigation, the Health Service Investigators are also to consider identification of systemic or system-wide issues in relation to the matters outlined in section 1 above.
3. The Health Service Investigators must make findings in respect of the matters outlines at 1 and 2 above, in a report under section 199 of the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) regarding,
    a. the ways in which the management, administration or delivery of the public sector health services, can be maintained and improved; and
    b. any other relevant matter identified during the course of the investigation.

2.3 Conduct of the Investigation

The HSI panel was appointed in November, 2016 pursuant to Section 190 of the HHB Act and brief biographies of the members can be found at Appendix 2. The investigators took a considered and focused approach to the matters specified in the Terms of Reference (TOR), complying with the requirements outlined and delivering findings as articulated. Data informing the findings included background documentation relating to the patient care provided, organisational context and structure, governance and service delivery policies. It also included data generated through in-depth face-to-face interviews with clinicians and leaders of HHSs and through on-site observation undertaken over a five-day period in November, 2016. A level of engagement and candor from Queensland Health officers as well as broad commitment to quality service delivery was observed through the interview process. All interviewees were formally requested to meet with the investigators, provided with the TOR, invited to bring support with them and advised that there was no guarantee of confidentiality related to this investigation. All interviews were voice recorded.

Additional documents and audits from the CIMHA system were requested during the HSI and were provided to the investigators. A list of relevant documents informing the report and their source can be found at Appendix 6. Following the interview phase of the investigation, the investigators worked together to provide the present report with findings and concluding remarks. The findings reflect a synthesis of common themes that emerged in this context and across the various data domains. This report represents a synthesis of opinions of the three Health Service Investigators, which have converged and aligned to present the final agreed report. Sections of the report and findings that directly relate to each HHS and its teams have been provided in writing to the HHSs for comment and feedback prior to finalising the report. The investigators noted the timely, thorough and comprehensive responses provided by HHSs through this feedback process, which have been carefully considered in preparing this report.

It is important to note that although Mr O'Donohue only became directly engaged with forensic mental health services following the event on 28 October 2016, the structure, role and opportunities presented by the CFOS were critically important in the review of the care provided. The findings therefore include comment on opportunities for improvements in this critical service delivery arm of Queensland Health. The TOR specifically designated that no recommendations should be made as a result of the HSI, but rather that findings be made. An extensive review of the available literature was neither in scope nor undertaken.

Furthermore, the investigation of care provided to Mr O'Donohue was made in context of the existing legislation at the time that care was provided, that is the *Mental Health Act 2000* (Qld) and policies and procedures in place at the time including the existing statewide standardised suite of clinical documentation. It is acknowledged that new mental health legislation commences in 2017 *(Mental Health Act 2016* (Qld*)),* which will impact on involuntary treatment regimes for patients going forward, and that changes are underway to improve the clinical documentation suite. The investigators were advised that implementation of a statewide Standardised Suite of Clinical Documentation was a key recommendation of the *"Achieving Balance: Report of the Queensland review of fatal sentinel events: A review of systemic issues within Queensland Mental Health Services 2002-2003*". The report was published in 2005. The development of statewide clinical documents was a key recommendation of this report. In early 2016, an Expert Panel of senior mental health clinicians reviewed the core suite of clinical documents and made 25 broad recommendations for changes to the forms, based on feedback from clinicians,

targeted literature reviews, and information about clinical documentation used in other jurisdictions in Australia. The revised forms will be implemented on 5 March 2017.

2.4 Report Outline

Section 1 of the report is an Executive Summary of the content of the findings subsequently detailed. The main body of the report has been structured to provide a background framework for the review with local and broader policy context seen as an important foundation for the findings that follow in Section 2. In Section 3 the findings have been synthesised and summarised from written documentation provided, data available, observations and the interviews undertaken. In Section 4 some concluding remarks are recorded, and in section 5 a set of related documents form the Appendices to the report. Given the nature of findings made, feedback in this report has not been attributed to individuals and to the greatest extent possible has avoided being personally identifying except in relation to the identified patient.

2.5 Public Mental Health Service Delivery

2.5.1 Public Mental Health Service Delivery in Australia

State and territory governments fund and deliver public sector mental health services that provide specialist care for people with severe mental illness. These include specialised mental health care delivered in public acute and psychiatric hospital settings, state and territory specialised community mental health care services, and state and territory specialised residential mental health care services. In addition, states and territories provide other mental health-specific services in community settings such as supported accommodation and social housing programs.

Mental health related services are provided in Queensland in a variety of ways, including: admitted patient care in hospital and other residential care; hospital based outpatient services; community mental health care services; and consultations with both specialists and GPs. Access to treatment from psychiatrists, psychologists and other allied health providers may, dependent on eligibility, be provided through Medicare and also subsidised through state initiatives to support clients to live well in the community (National Mental Health Commission, 2014).

The key contemporary policy setting in which public mental health services are provided in Queensland is through a recovery framework defined as follows: “Recovery-focused services aim to support individuals to come to terms with their illness, learning how to accept and move beyond it. Recovery-oriented services focus on the potential for growth within the individual and acknowledge that individuals are active participants on the recovery process” (*Connecting Care to Recovery, 2016-2021* Dept Health, 2014).

2.5.2 The Policy and Service Delivery Framework in Queensland

In Queensland, the policy and performance settings are led by the Department of Health and sit within a devolved governance structure with HHS. Clinical mental health services, delivered through HHS as a program within the acute health care system, are provided for people with severe and acute mental illness within standardised processes of assessment including for risk, and for the provision of treatment. Services are provided on a catchment basis and people can refer themselves or be referred by family or another

service provider for assessment and treatment in the most appropriate setting (inpatient or outpatient or home based settings) depending on the needs assessment. The newly released Plan for Queensland's State-funded mental health alcohol and other drug services, *Connecting Care to Recovery 2016* sets a future orientation for service improvement and investment.

The *Mental Health Act 2000* (Qld) regulates service provision and is soon to be replaced by new mental health legislation (*Mental Health Act 2016*) due for implementation in 2017. The *Mental Health Act 2016* seeks to empower people with mental illness to take charge of their own recovery journey, regulates and limits compulsory assessment, detention and treatment, and may impact on the proportion of people living in the community unrestricted by involuntary treatment orders. The tension these two phenomena create is evident. On the one hand, clinicians are being encouraged, through legislative limitations, to support decision-making by a person even if that decision may imply a degree of risk. At the same time, community tolerance and anxiety are high with rare but horrific violence amplifying the anxiety and creating a surge of fear and concern.

Queensland's current forensic mental health service is made up of a number of autonomous components. There are prison based services, inpatient units, court liaison services, joint police mental health programs, and community based services. The community based services are further divided into FLOs who are attached to general mental health clinics and employed, and largely managed, by these services, together with the CFOS which have their own independent management structure. The CFOS is a service that assists public mental health services to enhance their capacity to provide effective and safe community management of patients with forensic issues. Patients referred to CFOS must be existing HHS mental health service patients. CFOS clinicians provide a range of specialist risk assessment, consultation, advice and training. The CFOS service is governed as an 'arm' of the Metro North HHS.

The context in which Queensland's forensic mental health services function is unlike that of any other Australian state or territory. This is because of the manner in which the state's Mental Health Court functions and the resultant very large number of consumers being managed on forensic orders. Those on forensic community orders are usually managed by FLOs not by any dedicated community forensic mental health service. The range of offenders currently being placed on forensic community treatment orders is very wide, both in terms of the nature of their previous criminal activities and their mental health needs.

The investigators were informed that the FLO works collaboratively with community and inpatient mental health services, Statewide services, other government and non-government organisations to provide oversight, monitoring and coordination of the treatment and care of Forensic Order (FO) (Mental Health or Disability), and other consumers at a high risk of violence as per the requirements of the *Mental Health Act 2000* and were provided with the Forensic Patient Management Policy and Procedures issued by the Director of Mental Health and other relevant Statewide policies and the FLO network standards. The FLO actively contributes to the Statewide FLO Network and works closely with the Program Coordinator, Statewide Forensic Liaison Network, Queensland Forensic Mental Health Service. The FLO assists the HHS mental health service to develop capacity to confidently work with those on FOs, ITOs, and with complex high risk consumers. In the case of Mr O'Donohue the only evidence of the involvement of the FLO in each HHS where he was receiving treatment was in their authoring of the referral to CFOS. In both recorded instances of referral to CFOS there was no further follow up from the FLO being involved in

the treatment planning, implementation or review. This will be discussed further at Section 3.4.4.

Clinical assessment and treatment in mental health services relies heavily on the skill base of the clinicians providing care and treatment. Clinical mental health services in Australia, including in Queensland are provided by multidisciplinary teams usually including consultant psychiatrists, clinical psychologists, nurses, social workers, and occupational therapists. In terms of the workforce metrics that contribute to high quality care, having a 'competency' focus implies that in areas where people are not competent they will be educated and supported to achieve in those areas. Professional Development Plans for each staff member should clarify what is expected and how they will be trained and supported to deliver this. The HHSs are accountable for workforce development and capacity building across their services.

2.5.3 Policies and Procedures – Queensland Health

Relevant documentation in relation to policies and procedures in place during the period where services were provided to Mr O'Donohue was made available to the investigators. The list of documentation is at Appendix 6. Of particular relevance was;

- the Statewide Standardised Suite of Clinical Documentation especially the Risk Screening Tool
- the Community Care Team Model of Service
- the HHOT Model of Service
- resource guides related to the *Mental Health Act 2000*

The Model of Service Guides (Guides) detail expectations for clinical services in their delivery of care including intake, assessment, planning, treatment options, review and discharge processes. The requirements for documentation, collaborative partnerships with other agencies and team clinical governance are detailed. The Guides have also guided the investigators in reviewing Mr O'Donohue's care against the explicit expectations defined by Queensland Health for HHS staff.

2.5.4 Building on recent developments

In September, 2016 Queensland Health publically released *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services* (the Review Report) and a Sentinel Events Response (the Response). That Review Report is of great relevance to the present investigation providing a comprehensive background for mental health service providers on the complexity of the challenges in providing care. It articulates concerns in relation to the assessment of risk of violence and the provision of appropriate treatment options for such people with mental illness calling for more action to improve outcomes including:

- improvements in risk assessment and management
- engaging with and supporting families
- enhancing information sharing practices between the mental health service and others
- building on the competencies, capacity and support of clinicians working with this very complex consumer cohort (the Response, 2016)

The Review Report outlined a comprehensive approach taken by that Committee in examining reports of 29 incidents of homicide, attempted homicide or death as a result of

police use of force intervention, widely consulting with providers, peak bodies and consumers and their families and comprehensively reviewing the relevant literature and research. The investigators acknowledge this important contribution and notes that this present investigation and findings in relation to the care provided to Mr O'Donohue builds on and aligns with the themes identified through that work.

2.6 Diagnostic Complexity in Mental Health

Health care has two basic elements – firstly the diagnostic formulation (that is, describing and classifying the patient's disorder) and secondly providing treatment (that is, management, therapy and care for a patient). These two activities are linked in that treatment is targeted to relieve symptoms associated with a particular diagnosis. What follows is a brief examination of the diagnostic challenges presented within psychiatry in particular related to psychotic illnesses, delusional disorders and violence.

The chances of violent and suicidal behaviours in most of the psychotic conditions is influenced by clinical factors such as substance abuse, antisocial attitudes, poor self-control, failure to comprehend the long-term consequences of words and actions, and emotional deficits and instabilities. The risk of violence is associated, in schizophrenic disorders, with histories including childhood deprivation and abuse, educational failure, conduct disorder, juvenile delinquency, and prior criminal convictions. Finally the social conditions in which those who suffer from psychotic illnesses live can increase the risk, as when they live in disorganised unsupported situations, alongside those predisposed to substance abuse and offending. Conversely, the risk is far lower when there is available supportive living environments, social networks made up of ordinary people rather than just the drifting and dispossessed, and where there exist valued relationships, including those with health professionals and non government partners and primary health care providers.

The presence of active psychotic symptoms in the schizophrenias, such as delusions and hallucinations only have a minor role in the identification of those at higher risk of attacking others. This may seem surprising from the perspective of common sense, or the clinical perspective of most mental health professionals, but it is nevertheless the case. For many years the empirical evidence relevant to risk assessment was considered to rule out psychotic symptomatology in schizophrenia as any kind of a risk factor for violence. This was an error, but so is the overemphasis on delusions, hallucinations and 'threat control override' symptoms as harbingers of violence in the schizophrenias.

Delusional disorders are different. Central to the chances of criminal behaviours such as attacks, stalking, threatening, and making false accusations, are the delusions themselves. The risk of future violence in someone with a delusional disorder can be increased by substance abuse and current social pressures, but most of the factors critical to managing and assessing the risk of violent behaviour in other psychotic disorders are largely irrelevant. Histories of criminal acts motivated by the delusional beliefs in this group should alert a clinician to the very real chances of a repetition. The absence of such histories is less reassuring than in most other clinical situations. In delusional disorders characterised by, for example, a delusion of a partner's infidelity, over 50% of sufferers if untreated will go on to act violently toward their partners.

There is no reliable data on the rates of violent and criminal behaviours in most of the types of delusional disorders. Erotomaniacs almost always stalk the object of their delusional love, but rarely attack. The delusional querulant complains, litigates, threatens, and sometimes attacks. What proportion of querulants attack is still uncertain. Those like Mr

O'Donohue with predominately persecutory delusional systems can engage in a range of criminal behaviours that they believe are justified to protect, or avenge, themselves. Again, the frequency of actual violence is uncertain. This uncertainty reflects both the rarity of the conditions and the fact that people with delusional disorders almost never come voluntarily to mental professionals for help. The usual route into a mental health service is via a suicidal or criminal act.

Increasing social isolation and destitution can occur in those with delusional disorders as a result of their lives being totally taken over by their morbid preoccupations. The delusions, and the activities these motivate, can make continuing employment impossible, and will often alienate friends and family (even when they have not been incorporated into the delusion). Some with delusional disorders, however, somehow manage to work and care for themselves in the community, without breaking any laws, and only coming to attention, if they come to attention at all, when some accident or physical illness brings them into contact with a sufficiently observant mental health professional.

To summarise, violence in delusional disorders is closely linked to the patient's morbid beliefs. The risks of acting on their delusions increases as the levels of distress and anger associated with the ideas increases. Social supports, valued relationships, and having things in life they value are protective, with their absence increasing the risk.

3. Findings

3.1 Statewide service delivery

The investigators found that there were a number of services accessed by Mr O'Donohue from March 2010 to the present day as depicted in the table below. A more detailed chronology of care provided can be found at Appendix 5.

Dates	Time Period	Phase of Care	MH Act Status	HHS Provider
March 2010 – April 2010	4 weeks	Inpatient Admission	Voluntary	Metro South HHS – Yugaipa, Redland Hospital
April 2010 – May 2010	4 weeks	Community Treatment	Voluntary	Metro South HHS - Redland
May 2010 - Sept 2010	3 months	Discharged. No PMH* service		
Sept 2010 – Nov 2010	2.5 months	Community Treatment	Voluntary	Metro North HHS
Nov 2010 - Oct 2011	11 months	Discharged. No PMH* service		
Oct 2011 – Nov 2011	4 weeks	Inpatient Admission	Involuntary	Metro North HHS RBWH
Nov 2011 – Dec 2012	13 months	Community Treatment	Involuntary	Metro North HHS Homeless Health Outreach Team (HHOT)
Jan 2013 – Dec 2014	22 months	Community Treatment	Involuntary	Metro South HHS – Burke Street Team (BST)
Dec 2014 - August 2016	19 months	Community Treatment	Voluntary	Metro South HHS - BST
Aug 2016 - October 2016	2 months	Discharged. No PMH* service		
October 2016 - Present	5 weeks +	Inpatient Admission	Involuntary	The Park High Security Program AMHS

*PMH – Public Mental Health

It should be noted that on no occasion was a CFOS face to face assessment undertaken, despite referrals being formally made on two occasions and discussed within team meetings on at least four occasions (14 January, 2013; 27 May, 2013; 16 December, 2013; 7 January, 2014; 25 July, 2014) over more than two years. The investigators found that this apparent inaction appeared to be related to the determination of Mr O'Donohue to decline being subject to such assessments. Despite the lack of engagement with specialist forensic services, it is likely that such an assessment may have provided additional support for the treating teams decision making and understanding of both the suicide and violent behavior risks posed by Mr O'Donohue's illness. This matter is discussed further at Section 3.4.4.

3.2 The pivotal role of risk assessment.

The identification, in advance, of an individual who will commit serious, let alone homicidal, violence is simply not possible. What is possible is to recognise the risk factors, which in particular groups of consumers are associated with higher rates of violence in general. The nature, and to some extent the number, of risk factors in the context of the consumers current clinical and social state does allow assigning the individual to a group who are at high, low, or medium risk of some form of violence in the future. We cannot know which members of any group will actually be violent. What we can know is that successfully managing the risk factors in an individual will reduce the probability of future violence. A good risk assessment helps us assign the priority to be given to intervening in an individual case, and, most importantly, directs the therapeutic endeavors to the relevant factors elevating risk. It should never be forgotten that the management of many of the factors increasing the chances of violence, such as substance abuse, social isolation, unemployment, certain delusions, and personality traits conducive to impulsive and irresponsible behavior, is part of the good clinical management of anyone with a serious mental disorder whatever their assessed level of risk.

The investigators found among most of the clinicians interviewed an understanding that the primary role of a risk assessment is to guide the development of risk management strategies. There was an awareness that attempting to ascribe levels of risk, be it high, low, or medium, could only at best function as an indicator of the priority to be ascribed to any actions that might decrease the chances of future violence either to self or others. This approach is in line with current best practice in the area of risk management and assessment.

The investigators found a low level of confidence and satisfaction with the current mental health risk screening tool which is incorporated into the Consumer Assessment as well as with the risk evaluations set out in the involuntary treatment order review documentation. One of the more robust critiques of the current approach identified a disconnect between risk assessment and risk management. Noting that by failing to privilege the proper longitudinal approach that should inform a clinical evaluation the current risk assessment documentation format encouraged a hollow exercise of ticking boxes, void of critical thinking and compounded by the routine practice of cutting and pasting within the electronic medical record. Many of the mental health professionals interviewed found these documents had insufficient value in the proper assessment and management of risk.

The current risk screening tool broadly used and evident in the clinical record has a focus on assigning consumers to low, medium, and high risk categories across the domains of suicide, self-harm, aggression, vulnerability, and absconding. The simultaneous assessment of risk and risk management around violence directed both at the self and others is present in the current risk assessment forms.

The Review Report indicated that “though there was widespread use of risk screening, there was little evidence of more comprehensive risk assessments being conducted, even when the consumer had a history of violence” (Dept Health, 2016 p.7). The report suggested the adoption of a three-stage approach. Stage one was a screen conducted on all consumers on entering the service, followed by a second stage assessment in those where the risk of violence might be elevated conducted by a senior clinician. The final stage was a referral of those still considered at high risk for assessment

by a forensic mental health professional experienced in assessing and managing risk. The report does not spell out how the first and second stage assessments should be conducted. The report, in its overall approach, gives primacy to the issue of risk management, but this is perhaps not sufficiently emphasised in describing the basics of the approach to be adopted, particularly at stage two.

This is not the place to develop a new approach for the clinical management and assessment of risk in general mental health services. A few points are worth mentioning as they bear on how consumers like Mr O'Donohue might be better evaluated and managed in the future.

The assessment, except in rare circumstances, which include some delusional disorders, is an assessment of the chances of violence recurring. Not occurring in someone with no history of violence, but recurring in someone with such a history. The first step is to enquire about past episodes of violent or threatening behaviour. Questions in this area are usually productive when you move from the history of victimisation to the history of perpetration [Has anyone punched or kicked you? Have you ever been so upset you punched or kicked someone?]. People tend to be remarkably honest about such matters. Studies have shown that the great majority of incidents revealed by criminal record searches, questioning relatives and other informants, as well as reviewing case files, can be revealed by simply asking the person concerned in the right way. Honest, that is, if they accept you have the right to ask the question and that the response is to be used in their care and will be kept reasonably confidential.

The next stage is to obtain some information about the previous episodes of violence. The important aspects include the context in which it occurred, the provocation, the motivation, the consumer's state of mind at the time, the role of intoxication, and finally what was their social situation and level of social support at the time.

The third stage is to cover, however briefly, those areas known to be associated with violent behaviours, such as substance abuse, conduct disorder, prior offending in general, and a history of physical and sexual abuse in childhood. The penultimate stage is to put this together to at least identify the factors active in previous violent episodes whose recurrence will increase risk, together with any factors likely to predispose to violent behaviour in any context. Ultimately, and by far the most important, is to consider what can be done to reduce the probability of the violence recurring. If clinicians are able to identify some of the predisposing risk factors, and protective factors when they exist, then they can adequately design management strategies to reduce the risk.

The assessments of suicide risk and violence risk are not only similar but share many factors in common. Good clinical management will often cover most of the needs of good management of violence risk, with a few changes of emphasis and a few specifically targeted areas of vulnerability, All that needs to be added is appropriate training to increase awareness and reinforce relevant skills, plus ideally a way of documenting such assessments that encourage good practice and facilitate communication with those who will follow.

One point that requires close monitoring is the use of risk ratings. If they are to be recorded at all they must reflect the clinical realities in the population of consumers being cared for by the service. In clinics like that at Metro South HHS BST, serving populations from areas with elevated levels of substance abuse, crime in general, and domestic violence in particular, one would expect somewhere in the region of 10% of the consumers to fall into

the high risk group, at least in the early stages of their care. The level of risk recorded in Mr O'Donohue's notes almost certainly reflects an unwillingness to rate any but the most immediately threatening consumers as high risk. There is limited utility in using a three point scale if the top rating is not used in a case such as that of Mr O'Donohue's, at least on some occasions. High risk means no more, and no less, than the need for thinking carefully about risk management strategies and implementing them as and when practicable. It does not mean the patient should routinely be managed as an inpatient let alone in a secure unit. Those decisions depend on how severe is the apprehended violence likely to be, and how likely it is to occur in the near future.

A balance has always needed to be maintained in mental health services between, on the one hand, controls intended to reduce the risks of consumers harming themselves or other people, and on the other hand managing the consumer within the context of the least restrictive practice. The Recovery Model has not changed this basic dialectic, but has more clearly articulated the importance of encouraging the relevant levels of consumer autonomy, self-reliance, and personal responsibility. Engaging with people during purposeful observation contributes to clinical staff fulfilling their duty of care. The Recovery Model also recognises that people who experience mental illness have significant capacity to influence their health outcomes and therefore should have the opportunity to be involved in decisions regarding their mental health care and treatment. The model should also encourage accurate assessment through therapeutic engagement. The investigators found that engagement with Mr O'Donohue appeared from the clinical notes to be, at times, less than optimal, which would have impacted on the adequacy of the risk management. Medical notes may, of course, tell us less about practice and more about the clinician's enthusiasm for keeping full records of interactions.

3.3 Formulation and treatment planning

Risk assessment, formulation and planning occurs through direct contact with consumers, including sitting and listening to them, asking questions and developing an understanding of the most important issues/concerns at that time. The consumer's strengths and personal resilience must be considered. The diagnostic formulation is critical in both the overall management and the assessment of risk. While there is evidence of widespread use of risk screening within the medical record there is little evidence of more comprehensive risk assessment and evaluation of related management or effectiveness of current treatment.

Consistent with the findings related to risk assessment and management plans whilst at Metro South HHS BST there is limited evidence in the clinical notes of a consideration of Mr O'Donohue's previous care and treatment afforded by the Metro North HHS HHOT, or previous history of violence, or the complexity of managing the delusional disorder. There was also a limited pursuit of a comprehensive forensic assessment or critical evaluation of treatment planning formulated by longitudinal assessment, treatment evaluation and consumer or General Practitioner collaboration. The Metro South HHS BST did not seem to focus adequately at times on Mr O'Donohue's delusional ideas which is a central part of managing a consumer with a disorder of this type. There is little to suggest that the team regarded Mr O'Donohue's mental disorder as something unusual and outside of the experience of any of the clinicians involved in his care. This despite some of those interviewed acknowledging unfamiliarity with the specifics of his condition. The need to be concerned about consumers with delusion disorders was highlighted in the CFOS letter in May 2012 but this never found its way to the Metro South HHS BST. In the case of Mr O'Donohue the only evidence of the involvement of the FLO in each HHS where he was

receiving treatment was in their authoring of the referral to CFOS. In both recorded instances of referral to CFOS there was no further follow up from the FLO being involved in the treatment planning, implementation or review.

3.4 The care journey for Mr O'Donohue

This section examines the key aspects of the consumer journey for Mr O'Donohue and in line with the TOR of the HSI and makes findings in relation to the care provided.

3.4.1 Summary (Refer to table on page 16)

Mr O'Donohue first made contact with the mental health services (Metro South HHS) in March 2010 following a suicide attempt. He was assessed at that time as of being medium to high risk of making a further suicide attempt. He was admitted as a voluntary patient. His delusional ideas about being persecuted by the unions and public servants was noted. The diagnosis of a delusional disorder had become the favoured formulation by the end of his four-week admission. The focus of the admission was quite properly on managing the risk of self-harm. On discharge and transfer to the home-based acute team he was regarded as being a low risk both for suicide and for aggression. In April 2010 he was transferred to the care of a GP Mr O'Donohue re-presented in June 2010 and was accepted back into the Metro South HHS for another period of community care which ended in November 2010 when he was again separated and returned to GP care. At the time of this discharge he was rated a low risk for both suicide and aggression.

In October 2011 the events at Peel Street police station occurred. In essence, Mr O'Donohue was making threats to kill public servants and had progressed some way along a plan of action before handing himself, and his constructed weapon, over to the police. Following this he was admitted as an involuntary patient. On admission he was assessed as being at high risk of violence. Mr O'Donohue remained an inpatient for some four weeks and was discharged on an ITO. At this point he was still rated as a medium risk of both suicide and aggression and it was decided he needed long term follow up and medication. He was discharged to homelessness as he refused help for services but then later persuaded to accept Ozcare and transitional housing team support alongside the Metro North HHS HHOT.

When Mr O'Donohue was discharged into the care of the Metro North HHS HHOT, based at the Valley Clinic, he was rated as a medium level of risk of suicide. This evaluation was based on his ongoing statements that he would eventually kill himself at some time in the future. At this point he was rated as a medium high risk of aggression based on his ongoing delusional preoccupations with a conspiracy against him orchestrated by the unions and public servants, and his thoughts of revenge. The investigators found that the outpatient service from the Metro North HHS HHOT appeared thorough with sound multidisciplinary team interactions and case review. This included a focus on the delusions and linked with them Mr O'Donohue's history yielding a strong view that he presented high chronic risk to others. Throughout the time he was treated by this team they are clear in recognising risk and seriousness, they kept him on an ITO and were consistent as a team with their treatment and care to support the plan and recovery.

A transfer of care from Metro North HHS HHOT to Metro South HHS BST was precipitated by a change of address for Mr O'Donohue. The transition will be commented on further at section 3.4 but in summary the investigators noted that in the case of Mr

O'Donohue appropriate care was taken to ensure successful transition including face-to-face handover between case managers with him present, and written handover. A further 3 years of outpatient care was provided to Mr O'Donohue during which he was made a voluntary patient and provided with a graduated discharge, occurring in August 2016. He attempted to re-engage with the service later that month without success and the index event occurred some 2 months later. He is currently receiving involuntary treatment at The Park High Security Program, West Moreton HHS

3.4.2 Diagnosis

The diagnostic formulation is critical in both the overall management and to the management of risk. Mr O'Donohue was recognised soon after his first admission in 2010 to be suffering from a delusional disorder, persecutory type. The approach to managing Mr O'Donohue, particularly as regards the use of antipsychotic medication, was informed by that diagnostic formulation. Such cases are often initially confused with paranoid schizophrenia, and not surprisingly this diagnostic formulation was raised on several occasions by psychiatrists when they first examined Mr O'Donohue. Prior to the attack in October 2016, all the psychiatrists who had ongoing contact with Mr O'Donohue, and most who only had brief contact, were of the opinion that this was a delusional disorder. The history and observations of Mr O'Donohue recorded in the case files covering 2010 to July 2016 all tend to strongly support this formulation. The investigators found no good evidence to doubt the diagnosis of delusional disorder made by those managing Mr O'Donohue over the many years prior to the tragedy and would caution against moving away from such a diagnosis.

3.4.3 Risk Assessments of Mr O'Donohue

The risk of violence can be viewed as having three elements, probability, proximity, and potential severity. Risk in the case of Mr O'Donohue can be described in this manner. He fell into a group with a medium probability of some kind of future violence for much of his time in care. The likely proximity of such behavior did not seem close and could have reasonably been regarded as likely to occur, if occur it did, in the distant future. The severity of any apprehended violence, despite the lack of a history of assault or criminality, should probably have been regarded as potentially severe given the nature of the delusions, the associated intentions to seek retribution, the fantasies, and the behavior in October 2011. It is perhaps this last element of potential severity than was not given sufficient weight. Put differently Mr O'Donohue may have been regarded as having a low probability of acting violently at some times, and that violence may well have been judged as only a distant possibility, but the apprehended violence, should it occur, was always likely to be severe.

The investigators found indications in Mr O'Donohue's clinical notes over the five years that followed his initial admission that he continued to express very much the same intentions with regard to suicide and continued to harbor the same delusional conviction about persecution by public servants. The extent to which Mr O'Donohue seemed to be distressed and angry about the supposed persecution does seem to have varied, though this aspect is not regularly addressed in the clinical record available to us. The other element which seems to have continued through these years is that he reported having fantasies on an almost daily basis of taking revenge against his persecutors. In short the clinical indicators used to assign a medium to high risk of aggression and a medium risk of suicide remained essentially unchanged throughout his period of care, first at the Metro North HHS HHOT and secondly at the Metro South HHS BST. What did change were the recorded levels of risk in Mr O'Donohue, of both his suicide potential and his potential for aggression

to others. There are a number of reasons why this might have occurred as the risks for example of aggression are going to be different if either the social context or the consumer's state of mind changes. The understanding of risk in terms of probability, proximity, and potential severity is not part yet of normal clinical practice. The failure to analyze risk in this manner can be noted but not form a basis for any adverse finding.

The extent to which Mr O'Donohue spoke spontaneously about the suicidal and homicidal ideas varied from time to time, as did the apparent emotional involvement in these preoccupations. The investigators found from the notes indications that whenever Mr O'Donohue was directly questioned about either the suicidal or aggression related delusions he continued to essentially express the same beliefs. The fantasies of revenge that are noted quite frequently over the years were sometimes identified simply as fantasies, sometimes referred to as obsessional ruminations, and occasionally related to some kind of sleep phenomena. The fantasies of revenge never seem to have attracted the label of threats which might have been considered given that they were in the context of delusions of persecution and expressed intentions to act self destructively or destructively to others on the basis of those beliefs.

The investigators found that the level of risk ascribed to Mr O'Donohue's potential suicidal and aggressive behaviours tended to decrease with the passage of time, which in itself occasions no surprise as this is to be expected as in the vast majority of cases as the consumer's condition improves. As already noted in October 2011 Mr O'Donohue was considered to have a medium to high risk of aggression. A month later the aggression risk was downgraded to medium and there it stayed until December 2012. Following Mr O'Donohue's transfer to the Metro South HHS BST his risk of aggression was initially recorded as medium. Through 2014, 2015, right up until 14 June 2016 Mr O'Donohue was recorded as having a low risk for aggression. On 28 October 2016 immediately after the tragic death of Mr Sharma and the apprehension of Mr O'Donohue the risk assessment of aggression was entered by the examining psychiatrist as being 'medium'. The investigators noted this is an example of a risk assessment which preference the clinician's personal impression at the time over a longitudinal analysis which, in this case, included the very recent homicidal attack.

With the benefit of hindsight the manner in which Mr O'Donohue's risk of aggression was rated and recorded across the period of care in the Consumer Assessments appears unfortunate. The more important question is how, given what was known at the time about Mr O'Donohue's history and current mental state, it was possible to repeatedly ascribe to him a low risk of aggression.

The current approaches to risk assessment often fail in practice to take a longitudinal perspective. The impression created by the clinical notes, not just the formal recording of risk assessments, was that emphasis was placed on Mr O'Donohue's current cross sectional functioning and present state of mind to the virtual exclusion of his history of the episode of suicidal behaviour and the other incident of behaviour suggestive of homicidal intent. Assessing and managing risk in delusional disorders is difficult even for those experienced in the area. In Mr O'Donohue's case, however, an excellent guide on how to assess and manage the violence risk was provided by CFOS in May 2012 (see below). The failure to provide handover of this letter and consequent failure to apply the principles articulated there is an unfortunate aspect of this case. Had Mr O'Donohue continued to be managed in the light of these recommendations, it is just possible that the tragedy could have been averted on the basis that they provided an evidence based clinical practice framework for managing someone with the issues presented by Mr O'Donohue. The investigators view the inability

in the present service model for CFOS to take on any ongoing role in Mr O'Donohue's long-term management as a lost opportunity however ultimately the investigators were unable to conclude that this would necessarily have changed the outcome.

Mr O'Donohue attempted suicide in March 2010. This was in the context of his despair and anger at a rejecting and persecuting world based on his delusional beliefs and their consequences, combined with social isolation and multiple recent losses. In October 2011 Mr O'Donohue set out on the road to homicide also in the context of the same delusional system combined with social isolation and homelessness. This suggests the chances of the re-emergence of either suicidal or homicidal behaviour will likely be related to the presence of the delusions in combination with social isolation and possible losses.

3.4.4 The role of CFOS

Prior to October 2016 Mr O'Donohue had two documented episodes where there was involvement with the forensic mental health services. The first was in May 2012, and the second in September 2014.

The Metro North HHS HHOT made a referral to the CFOS on 24 April 2012. The history in the referral form notes Mr O'Donohue had "a seven-year history of psychotic illness characterised by delusions of persecution that the union movement had conspired to ruin his life." Also noted was his thinking about getting back by shooting officials. The referral requested an opinion on the "risk of homicidality" and recommendations on risk management.

Mr O'Donohue refused face to face interviews with the CFOS team. Mr O'Donohue was at this time on an ITO, but his wishes were respected following consideration around engagement, therapeutic alliance and longitudinal treatment and collaborative discussions between Consultant Psychiatrists and teams. It might be questioned whether it is wise to ever let a consumer on an ITO refuse to cooperate with a specialist forensic assessment, initiated because of concerns over their potential to attack others. In the event, the resulting CFOS assessment was based entirely on a case review and discussions with the treating team. On the basis of this, the CFOS assessment team, consisting of a Forensic Consultant Psychiatrist and a CFOS Allied Health staff member, provided an opinion to the Metro North HHS HHOT dated 22 May 2012.

The opinion notes both Mr O'Donohue's "delusional beliefs and his drive to right the wrong… has become an important part of his identity." Positive features were noted, including his engagement with the service, cooperation with treatment, and decreased levels of preoccupation with the ideas. The report states that "Anthony has no history of violence to our knowledge." There was, however, an allusion to the incident at Peel Street Police Station where he presented a home-made weapon, stating he had been planning to kill a police officer to obtain their gun as a step on the road to avenging himself against unions and public servants. The report suggested that in managing the risk that "continued engagement is a key factor," and that clinical interactions should include strategies to manage his delusions "appeal to his self-interest by aiding him to see the costs to him of pursuing his ideas." Also indicated is the need to try and assist Mr O'Donohue to find a "face saving exit" from the delusional ideas "which have dominated his life for the last years." There is an emphasis on taking all threats seriously and on the need to look "for signs of an increase in risk as displayed [in] last resort thinking, suicidal ideation or more specific homicidal intent or plans."

Management of his delusions was regarded as a key factor, but sensibly this was placed in the context not of focusing exclusively on removing the delusional system entirely, but in terms of decreasing the degree of preoccupation and emotional involvement. Management of Mr O'Donohue, it is emphasised, must be long term and consistent, which the CFOS writers consider is likely to require his remaining on an ITO.

This report, despite being prepared under the disadvantage of not having directly assessed Mr O'Donohue, provides a clear risk assessment and an outline of best practice in managing a delusional disorder associated with the risk of becoming violent towards others. The investigators viewed this opinion as having significant clinical value offering specialist expertise and guidance to the team and subsequently informed team discussions and care planning. The opinion specifies the need to regularly address the current state of Mr O'Donohue's delusional beliefs. This is implicit in the recommendations to gradually move him towards a greater recognition of the damage to himself, both by wasting his days caught up in the delusional ruminations, and the consequences should he act on his fantasies of vengeance. The only additional element that might have been usefully mentioned, in the view of the investigators was maintaining Mr O'Donohue in as stable and supported a social situation as possible.

The comments made by some of those interviewed about the unrealistic nature of CFOS recommendations suggests the need to assess the implications for a general mental health community clinic of the May 2012 letter. To follow the recommendations would have required:

- maintaining Mr O'Donohue in long term, and potentially indefinite care and supervision
- having a clinician with the time and expertise to provide what amounts to the psychotherapeutic management of a delusional disorder
- having a clinician with the time and experience to assess and manage the risk in someone who is both making reassuring noises about not acting violently and recounting fantasies of bloody revenge
- the investigators would add having someone with the time and persistence to eventually re-engage Mr O'Donohue with social activities able to give his life some meaning and which he did not wish to sacrifice by harming himself or others.

These four requirements would be a tall order, though not an impossible ask, for a well-resourced community forensic mental health service, even if such had existed. But it was beyond the resources of the Metro South HHS BST as constituted. It might have come closer to being realised had the clinic FLOs been involved or a suitably experienced psychiatrist been engaged using the Medicare provisions.

The investigators found that during the subsequent ten months whilst Mr O'Donohue remained in the care of the Metro North HHS HHOT, that there were entries in the record indicative of the treating team acting on the management advice contained in the CFOS letter. What was not triggered was any ongoing involvement of the FLO. The approaches that reflected the advice from CFOS do not seem to have survived the transfer of Mr O'Donohue to the care of the Metro South HHS BST. This is in no small part because the report prepared by CFOS did not make the transition from one HHS to the next when Mr O'Donohue made that move in his treating team as a result of moving house. This issue is discussed in Section 3.5 on communication between health HHSs.

With the benefit of hindsight it is tempting to regard the failure of the CFOS report to be communicated from May 2012 to have had a greater influence on Mr O'Donohue's long term care once it was taken over by the Metro South HHS BST as a lost opportunity. It cannot be known whether this influenced the eventual tragic outcome. Not only did the May 2012 report fail to inform Mr O'Donohue's long term management after 2012, it did not influence the outcome of a subsequent CFOS referral from the Metro South HHS BST in September 2014. This was because the original hard copy report was not located in the CFOS records and not available on the CIMHA system. This matter is discussed further in Section 3.6 on information systems.

The second referral to CFOS appears to have been initiated in May 2014, though there was a four or five-month gap until the actual assessment took place. On this occasion, based on the information supplied to CFOS, it was decided that Mr O'Donohue "does not warrant formal review, and would probably rate as a low moderate risk at present" (CIMHA 30 September, 2014). As stated earlier, CFOS acted in ignorance of Mr O'Donohue's previous assessment by CFOS. The actual referral from the FLO at the Metro South HSS BST does not appear in the records, but its content is summarised in the note of the treating psychiatrist on 30 September 2014. If this note is correct, Mr O'Donohue was described as having schizophrenia rather than delusional disorder, to be taking his medication, "participating in interventions with psychologist", to have an improving mental state, to maintain "good rapport with the treating team", to have "no history of violence", and "no current homicidal ideation." It is assumed that this impression is based on the information provided to CFOS via the local FLO. Given that information base, and the lack of any other information, it is hardly surprising that CFOS made a decision that there was "no indication for a risk assessment." Furthermore if this view of risk was the broadly held view of the Metro South HHS BST, it is unclear why a referral to CFOS was initiated in the first instance.

The response to the second misplaced CFOS referral (in 2014) was found to have been less than ideal. Quite apart from the CFOS letter from 2012 not being made available to the treating team, the nature of the information which appears to have been conveyed by the FLO failed to articulate any concerns that those directly treating Mr O'Donohue may have had about the risk of aggression. If they had no such concerns, why would they have made the referral in the first place? This raises the possibility of a less than adequate level of information sharing between the members of the Metro South HHS BST and the FLO who is understood to be part of the team.

The investigators found that the length of time that elapsed between referral and assessment, or as it turned out, declining to accept for assessment, was far too long. CFOS assessments should only be made when there are real anxieties about a consumer's current level of threat. Whether the anxieties are well founded or misplaced, adequate management requires the concerns be addressed in a timely manner.

The investigators also found that despite there being a FLO embedded within both clinics that managed Mr O'Donohue, the role played no identified part in management. The FLO role appeared to have a gatekeeper function mediating between the treating team and CFOS with no discernable contribution to patient care, practice development or capacity building. The investigators were advised that FLOs rarely play any active role as case managers of patients unless they are on a forensic order. In examining the reasons for this further the key issue of prioritising service demands emerged.

The Metro South HHS BST reportedly manages more than 170 consumers on forensic orders. The investigators note Queensland's approach to the sentencing of mentally

ill offenders results in relatively large numbers of offenders being placed on forensic community orders. The effect of having large numbers of minor offenders on forensic orders is that the resources of the community forensic professionals can be taken up managing consumers who present no significant risk of acting violently, whilst many patients in the general mental health services who present far greater challenges in managing their risk of violence are left entirely to those general mental health services. This is not an ideal use of resources.

As discussed earlier, in April 2016, Associate Professor Peter Burnett and Professor James Ogloff presented their report (Review Report). In this report they described the current forensic mental health service system as "decentralised and fragmented" with aspects of the service located administratively in no less than six separate hospitals and health services. They recommended that there be established an integrated state wide forensic mental health service with a governance structure independent of the existing hospital and health services.

The investigators found that the lack of integration between the existing CFOS and the clinic based FLO impeded what might have been the more effective management of Mr O'Donohue. The problem in his case was the inability of the first CFOS report to trigger the ongoing involvement of experienced forensic mental health professionals at either the level of FLO or CFOS.

CFOS, for the most part, is not a community forensic mental health service but an advice and support service, which liaises with the general mental health services actually carrying the responsibility for managing consumers. This, judging by the comments of several interviewed, is a source of considerable mutual aggravation. Clinicians in the general mental health services indicated to the investigators that many of the recommendations handed down were impractical and at times failed to appreciate the realities of the resources available to general services. On the other side, some forensic mental health clinicians were highly critical of general services' priorities and lack of urgency in responding to what they perceived as high risk situations. The investigators note that in their experience, services that advise without being involved in the day to day management of the type of consumers on whom they offer opinions are at risk of providing advice which is impractical. The investigators consider the situation would be improved by the recommendations recently made in the Review Report for an integrated state wide service including a genuine community forensic mental health service involved in ongoing management of consumers, both independently and in partnership with HHSs.

Furthermore, and also consistent with the findings of the Review Report the structure of existing forensic mental health services appears to be fragmented and contributive to multiple service tensions, different sets of clinical governance processes, responsibilities and lines of communication.

3.4.5 Risk Management and the use of Involuntary Treatment

Management plans are to be informed by issues raised in consumer wellness plans and should include referrals to relevant non-government organisation (NGO) agencies that can provide services that are outside the scope or service capacity of the mental health service (Queensland Health Community Care Team Model of Service Guide). The investigators found that for much of the time Mr O'Donohue was receiving care there was some focus on his delusional beliefs but only inconsistent attempts to enhance his social functioning and networks. The overt acknowledgement that this was central to the risk

management was absent particularly once he was receiving community treatment at Metro South HHS BST. There seems to have been a less vigorous approach to management and the effectiveness of the treatment plan was not critically evaluated with little or no collateral information evidenced in the medical record. There was variable evidence amongst the Metro South HHS BST clinicians of active engagement with Mr O'Donohue to support recovery, comprehensive planning for transitions of care or application of the recovery model. The investigators observed a passive monitoring and reporting of medication compliance and a lack of active consultation with the GP and utilisation of available services to support services was evident. The quality of engagement between Mr O'Donohue with some members of his treating team appeared to be sound, but some interactions and their descriptions were less impressive. The investigators formed a view that this team had work to do in improving clinical engagement competencies.

The investigators found, among the individuals interviewed, a few who seemed to indict the Recovery Model for a potentially problematic conflict between the pressures to remove consumers from involuntary status and what they regarded as maintaining a reasonable level of caution about future compliance with effective risk management. This perception, though it may reflect the realities in individual cases, is not supported by the reported community mental health team activity data. The investigators were informed that of the 1300 odd consumers whose cases are open, there were just over 400 on an ITO. Added to this would presumably be the 170 consumers currently on various forensic orders imposed by the mental health court. The investigators were advised that around a third of consumers are being cared for in the community on an ITO. This speaks, if anything, to an overuse of ITOs. The population served by Metro South HHS BST, have high rates of disadvantage, social disorganisation, and co-existing substance abuse, which may go some way to explaining the frequency of the use of legal compulsion. There is nothing, in our view, in these statistics to support the notion of any general or systemic reluctance to employ an ITO. The investigators note that Metro South HHS clinicians have made important contributions to the scholarly literature in the area of conflict between involuntary treatment and the maintenance of effective therapeutic engagement with consumers free of coercive practices.

One of the factors determining the rate at which compulsion is employed is the level of service which can be provided to consumers. Regular contact with health professionals with the knowledge and skills to build and maintain therapeutic relationships experienced by the consumer as helpful is a critical variable in avoiding the necessity to employ compulsion. In the case of Mr O'Donohue it is notable that he continued his engagement with the clinic after the ITO was revoked. This speaks to the value he placed on the support provided by the mental health professionals at the clinic which mitigates the criticisms inherent in some of our earlier comments.

Further, the investigators noted that the number of forensic patients being managed in HSSs may have the effect of attenuating the focus and attention to active risk management. It is possible that there is a diminution or a sense of complacency with regard to forensic patients evidenced by no follow up on requests, referrals that permit case reviews without examining the patient, and the absence of direct engagement of CFOS to partner and build capacity in case management teams.

3.4.6 The clinical decision to not continue the ITO.

The Metro South HHS BST revoked the ITO on Mr O'Donohue in December 2014. The risk levels for aggression had all been, with a solitary exception, rated as low through 2014. Case Management progress notes, had been indicating repeatedly "a low risk to others." Mr O'Donohue had begun receiving regular psychology sessions from a psychologist on the treating team. The focus of these sessions was not primarily on Mr O'Donohue's persecutory delusions, but these are mentioned in the record of the sessions, together with material pertinent to the risk of future aggression. On 27/8/14, for example, clinical notes indicate that Mr O'Donohue "expressed details about past homicidal ideation but denies current intent and recognises consequences for acting on plan." Similar comments reappear in the notes from sessions held on 5/09/14, 24/09/14, and 24/10/14. On 21/11/14 the psychologist noted "no current homicidal ideation reported, and reports he is feeling less angry about the events that happened." The events referred to are presumably his delusional elaboration of the conflicts at work nearly a decade earlier. The psychology entries in the case file are among the more informative entries about Mr O'Donohue's state at this time.

Mr O'Donohue had been attending nearly all appointments, for example he was to attend for 23 out of 24 appointments with the psychologist. Mr O'Donohue had been moved to oral paliperidone in March 2014, and it was believed he was fully compliant. We now know this may not have been the case. There had been no incidents related to acts of aggression. He was not considered to be uttering threats. This was despite his continuing to occasionally report fantasies of violent revenge. His persecutory delusions were still present but there were notes to the effect that he was considered to be less preoccupied and emotionally involved in the ideas. If Mr O'Donohue was asked to estimate how often, or for how long, he thought about the delusions each day, this was not reported in the notes. Similarly, no details of the content of the violent fantasies at this time appear in the notes.

It appears the clinicians directly involved with Mr O'Donohue had to decide whether it was justified to continue Mr O'Donohue on an ITO. The burden on the clinician is to justify continuing to legally coerce cooperation with treatment. Mr O'Donohue was attending appointments, cooperating with the case manager, and in their view at the time was taking his medication. The only possible justification for continuing the order would have been a reasonable belief that without compulsion Mr O'Donohue would not continue to cooperate with the clinicians and would not continue on the medication. The issue of the risk of suicidal or violent behaviour is important but secondary to the need to compel a consumer to cooperate with management. The first question is whether an ITO is required to ensure the consumer complies with treatment. The second question is, if they cease to comply will their condition deteriorate to a point where they will potentially be at a significant risk of harming themselves or someone else.

In Mr O'Donohue's first period of inpatient and community treatment he was considered for some time at a significant risk of suicide, but because he cooperated fully with treatment an ITO was quite correctly not invoked. The treating team, when the decision was made not to continue the ITO were of the view, based on their own assessment of risk, and the assessment they received from the CFOS, that Mr O'Donohue was at a low risk of acting aggressively. If they had considered Mr O'Donohue at even a moderate risk of violence at this time they would probably have requested the ITO be continued. Strictly one could argue that whatever the level of assessed risk, given the treatment team's view that Mr O'Donohue was cooperating with all aspects of his management and appeared to them to have an improving clinical state, that in such circumstances the justification to continue

the ITO would have been questionable, both legally and clinically. It is worth noting, however, that Mr O'Donohue's cooperation was only partial.

Mr O'Donohue, for example,

- refused to cooperate with a CFOS evaluation
- refused referral to an external Medicare psychiatrist
- refused to allow any communications with his GP
- refused consent to contact relatives or friends for collateral information.

In addition:

- Mr O'Donohue declined attempts to involve himself in rehabilitation and support services in the community.

This is typical of those with delusional disorders who insist on controlling and limiting access by mental health professionals to independent information and attempt to prevent information sharing or the involvement of other agencies. It appears the treating team became so used to working within the boundaries set by Mr O'Donohue that they ended up seeing this as his being compliant and cooperative.

With the benefit of hindsight, it is clear the revocation of the ITO was an important step on the road to the events of 28 October, 2016. Those making the decision made it based on what they believed to be the case at the time. It is possible if the report prepared by CFOS in May 2012 had been available to the treating team, their assessment and management of the risk of aggression would have been better informed. This is particularly in terms of the differences between delusional disorders and the schizophrenias, both as to how to manage the morbid beliefs and on the likelihood of acting on a delusion. In our view, even if this report had been in the notes, where it should have been, the patient's cooperative behavior over the intervening 30 months would probably have weighed more heavily in favour of the decision to discontinue the ITO than would a two-year-old forensic assessment. Had the treating team known, or even suspected, that Mr O'Donohue was not taking the prescribed medication, it is also likely that the ITO would not have been revoked.

In summary and in relation to the TOR Item 3(b) the investigators were required to review decisions and actions taken by staff in relation to the treatment and care of Mr O'Donohue, particularly including the decision to treat him other than on an ITO under the *Mental Health Act 2000.* The investigators found that removing Mr O'Donohue from the ITO was based upon incomplete information. The Metro South HHS BST did not have access to the early advisory letter written by the CFOS team (see above). It is the unanimous view of the investigators that this letter would have provided a strong basis of caution for the treating team on the basis that the recommendations therein provided an evidence based clinical practice framework for managing someone with the issues presented by Mr O'Donohue. This included recommendations to pursue the collection of further collateral information to better understand pre-morbid history particularly that related to violence and his delusional system; build therapeutic engagement focusing on face saving strategies and weighing costs and benefits of pursuing his ideas; take seriously any threats and watch closely for signs of increasing risk, last-resort thinking, suicidal ideation and homicidal intent; treat the psychosis, keep him on an involuntary treatment order and increase medication.

The fact remains, however, that Mr O'Donohue, by the team's standards appeared to be fully compliant, or, more strictly, continued his partial compliance at the time the ITO was revoked. Following revocation, he continued to be equally compliant and his eventual discharge appears to have been against his wishes. Revoking the ITO did not of itself adversely affect the management of Mr O'Donohue. The only question is whether in the

minds of the service being a voluntary consumer might have been confused with not requiring long term care and supervision from the service. In the view of the investigators it may not have been wise to have been quite so willing to accept the boundaries placed by Mr O'Donohue on what information could be accessed, what assessments made, and above all, what management approaches he would or would not accept. Admittedly it is no easy matter to persuade those with delusional disorders to allow effective information gathering and optimal management and rehabilitation. But that is exactly what needs to be struggled with if those with this condition are to be effectively managed and cared for.

3.4.7 Treatment - the use of medication

At the time when the decision to revoke the ITO was taken, risk assessments were indicating that Mr O'Donohue posed a low risk and the team took the (likely incorrect) view that Mr O'Donohue was reliably taking his medication. A factor related to supporting patient choice is the question of depot versus oral antipsychotic medications. There are consumers who prefer the convenience of depot and value the contact it brings with nursing staff, which however brief can be, for some, one of their only social interactions on that day. Other consumers object strongly to the intrusive nature of depot administration and what they regard as the lack of trust implicit in injections as opposed to self-administered oral medication. Some simply object to the medication irrespective of the method of administration. There is, in the Recovery Model, an emphasis on autonomy and responsible choice, which would support a patient's right to select oral rather than depot if that is their preference. The figures supplied to the investigators suggest somewhat over half of current consumers attending the Metro South HHS BST are on depot antipsychotics. Again, this does not suggest any marked reluctance to rely on the use of depot. It was not possible to obtain the figures on the correlation between being on an ITO and receiving medication via depot injection. It is possible, in fact probable, that there is a strong correlation and that the psychiatrist's determination to continue depot against consumer's expressed wishes is a major reason for continuing an ITO.

3.4.8 The clinical decision to use oral rather than depot antipsychotics

In March 2014, the Metro South HSS BST made the decision to discontinue the use of depot medication and transfer Mr O'Donohue to oral paliperidone. This decision was made in the context of pressure from the consumer for this change. Contributing to the decision to accede to Mr O'Donohue's request may well have been that he had already had a period of some two months off depot and on oral paliperidone. This was because Mr O'Donohue had taken a six-week holiday in Thailand in January 2014 and had been provided with oral paliperidone for this period as arranging a depot injection was not feasible. On return from holiday Mr O'Donohue continued the oral medication which, according to the clinical notes, he was taking as prescribed. On this basis the oral administration, for which Mr O'Donohue was responsible, became henceforth the method of medication administration. Mr O'Donohue is noted to have been saying he was fully compliant with the oral medication throughout the subsequent period up until his discharge in July 2016.

The investigators were advised that the case manager checked the medication blister packs on home visits to ensure the number of missing tablets reflected what Mr O'Donohue should have taken. Nowhere in the case file is this practice alluded to or documented. Most psychiatrists would probably also have simply accepted Mr O'Donohue's claims to be taking his medication regularly, particularly as his clinical state was not deteriorating, and by some measures was even improving. The investigators found that, based on the history provided by Mr O'Donohue after the events of 28 October, 2016, that he only took the oral medication

for a relatively brief period. He may not have been taking any medication for much of 2014, 2015, and 2016 up until the tragedy.

The decision to shift patients with psychotic disorders from depot to oral medication is never simple. The advantage of such a shift is that it acknowledges the consumer's right to control and take responsibility for their own illness. The transfer to oral can be an act of trust which strengthens the therapeutic alliance. Voluntary patients have a right to insist on moving to oral medication. There can even be benefits in a more consistent level of therapeutically effective compounds in the blood, which can occasionally even lower the overall dosages required when using oral medication as opposed to depot.

This all supports a transfer to oral from depot antipsychotics when the consumer is pushing for such a change. On the other hand, a number of studies over the years have indicated problems of compliance when using oral medication. Most patients on oral antipsychotics are at best compliant to some extent, but not fully, and a significant proportion cease taking their medication completely after a few months. It is interesting that those who have always turned up for their depot injections do not necessarily take the substituted oral medication with the same regularity, and may cease completely. This suggests that such consumers may have a genuine intention to take the medications as prescribed, but other contingencies intervene.

Transferring a patient from a depot antipsychotic to an oral equivalent should always take place in the knowledge that for a substantial number of consumers this amounts to cutting or stopping the drug treatment. What is relevant is that not all patients with illnesses of a schizophrenic type relapse when they stop their medications, and even among those who do there may be long periods of function unburdened by drug side-effects. In Mr O'Donohue's case the main contribution of the paliperidone was probably to reduce the levels of the insistence and emotional engagement with the delusional ideas rather than directly affect the delusional beliefs themselves.

On balance the investigators took the view that the move to oral paliperidone, even though it may have resulted in Mr O'Donohue discontinuing the medication, was a defensible decision in the circumstances. Mr O'Donohue's history suggests that his predisposition to suicidal or violent acts was kept in check whilst he was receiving support and treatment at the Metro South HHS BST despite the fact that he may not have been taking any antipsychotics for at least a year prior to his discharge. What was holding Mr O'Donohue, and keeping him and others safe, does not appear to have been the antipsychotic medication but the ongoing contact and support provided by the clinic.

3.4.9 Psychosocial rehabilitation

The Model of Service documents for the Homeless Health Outreach Team and the Community Care Team promoted by Queensland Health to guide delivery of care to patients such as Mr O'Donohue underline the importance of 'consumer choice, building resilience and enhancing opportunities for social inclusion' with the aim of 'working towards transitioning from the service … to function independently in their own community' (p3, Community Care Team, 2012). These documents emphasise for clinicians the critical role they take in working across services with other providers, in partnership with the consumers and their families to deliver a range of assessment and treatment options, recovery based

psychosocial interventions and transition to discharge processes. They are supported by a set of guidelines called *Queensland Mind Essentials* focused on best practice with particular diagnostic groups or presentations such as those with delusions and those with risk of violence or aggression.

The investigators found that again due to Mr O'Donohue's resistance to engaging in social inclusion and employment related activities over time that these were rarely included in treatment planning even during the final phase of care at Metro South HHS BST. This is characterised in the notes as his 'resistance to engaging in rehabilitation focused treatment' (12 October 2015) and is linked directly to the decision to discharge him in the same note.

Other instances where this resistance impacted on his treatment includes where he declined access for the treating team to his family for collateral history and to build supportive connections and manage risk, where he declined to participate in CFOS assessments, where he declined invitation to attend social group and employment support activities, where he declined to accept seeing a psychiatrist using the Medicare system, and where he declined contact between the treating team and his GP. There is evidence on the other hand that where engaged and encouraged, and where interaction between himself and the service provider is individualised and relationship-based he has allowed himself a connection that was containing and generative. This is particularly observable in his interactions with the psychologists in the two treating teams.

It should also be noted that there is mention of alcohol use in the notes but on the basis of the case record it is not clear if Mr O'Donohue was drinking to excess. Substance abuse does not appear to have been a factor in the incident in 2010, nor to our knowledge in the tragic incident on October 2016.

The recovery model was suggested, by one of those interviewed, to tend to increase the pressure to discharge patients back to the care of a GP prematurely. The investigators found no evidence to support this opinion. The investigators conversely found evidence of bi-directional clinical handover between the GP and the HHS and attempts to effectively transfer professional responsibility and accountability for some or all aspects of care for Mr O'Donohue only occurred in 2010 but not subsequently. In this case the transfer of care to the GP during 2016 by the Metro South HHS BST was in some ways problematic.

In summary, treatment planning, and the psychosocial components of this in particular, in Mr O'Donohue may have led to missed opportunities. Some of the problems were created by the understandable, but unfortunate, willingness on the part of the Metro South HHS BST to allow Mr O'Donohue to dictate the limits on the assessment and management of his disorder, discharge planning and transfer of care arrangements.

3.4.10 Discharge Planning and Closure

Mr O'Donohue received treatment and support from the public mental health community services from December 2011 until June 2016. This, by current Australian standards, would in all probability be a longer period of service provision than the current norm. The important point is simply that public community mental health services are now organised around time limited engagements with consumers, not open ended commitments. In the current context, four and a half years is a long episode of care.

Mr O'Donohue was recognised at an early stage as someone who would benefit from ongoing contact with a private psychiatrist which was not time limited, with more frequency

than could be provided by the public services. There are psychiatrists in the Brisbane area who could potentially have provided ongoing private care within the Medicare system. Mr O'Donohue's repeated refusal to cooperate with such a referral to a private psychiatrist is one of the elements which contributed to his being left without treatment and support in the weeks prior to the events of 28 October 2016. Why Mr O'Donohue so consistently opposed referral to a private psychiatrist is not fully clarified in the records. Subsequent events might have been very different if Mr. O'Donohue had established a therapeutic relationship with a psychiatrist willing and able to take on the long term commitment of supporting and keeping safe someone with a delusional disorder.

In early 2016 Mr O'Donohue was engaged with his treating team and there is nothing in the notes to indicate he was pushing to be discharged. He was a voluntary patient and could have discontinued contact with the service, should he have chosen, at any time. The move towards closing his case and transferring his ongoing treatment to a GP we can only assume was based on the assessment of the clinical situation and appropriate next move. Team members did not report to the investigators that they experienced any direct pressure in this case, or any other, from management to expedite discharge. Whether a role was played by the more subtle influences of the recovery model, and an awareness of the pressure of new referrals, is not knowable.

A careful study of Mr O'Donohue's case file reveals that following his admission in March 2010 he had a brief period of community follow up before being discharged in May of that year. The GP referred him back in July 2010 and he received another four months community care before again returning to GP care. The next time Mr O'Donohue comes into contact with services is in October 2011 when he presents at the Peel Street Police Station and is admitted as an inpatient as an involuntary patient. A pattern of discharge and relapse months or years later is typical of the community care of consumers with psychotic illness. The only reason Mr O'Donohue's history of discharge and relapse might have created clinical anxiety was the manner in which he presented in October 2011.

The records suggest that the Metro South HHS BST had a preference for transferring the care of Mr O'Donohue to a private psychiatrist alongside the GP involvement. Mr O'Donohue prevented this occurring. They were then faced with a patient whose clinical condition was not changing, whom they believed was taking his medication, who denied suicidal or homicidal intentions, and who had already had a very long period at the clinic. This would all tend to encourage a decision to move towards discharge. Mr O'Donohue was also a man who refused to accept that he was mentally ill, and continued to express delusions of persecution and fantasies of revenge. He had also been able to frustrate the treating team's attempts to involve outside agencies in his treatment and rehabilitation. These factors might have tended to encourage keeping Mr O'Donohue in the current care arrangements, as whatever else they were doing they were providing support and holding in check whatever suicidal or violent impulses that might be occurring. The critical point is that the treating team was reassured by Mr O'Donohue's repeated assurances he was not going to act on his suicidal or violent ideas. One of the more experienced psychiatrists who spoke to us was scathing about his fellow mental health professionals taking any notice of a consumer's assurances they are safe and would not harm themselves or others. The fact of the matter is, however, that most mental health professionals do give weight to just such reassurances. In accepting Mr O'Donohue's repeated assurances he was safe, those caring for him were unfortunately acting as would most of their colleagues.

In relation to the TOR Item 3(b) the investigators were required to review decisions and actions taken by staff in relation to the treatment and care of Mr O'Donohue, particularly

including the decision to close his status as an open patient of the Princess Alexandra Hospital Authorised Mental Health Service in August 2016. In summary the reasons to move towards closure are easy to understand. His status appeared to be relatively stable. He had been provided with a relatively long term period of care. Whilst he talked about suicide and homicidal thoughts there is nothing in his actions that triggered team concerns. He was able keep appointments. The investigators found that clinical judgment emphasised the current presentation and underplayed the collateral information, and history. The investigators found that given the clinical situation as perceived at the time by the treating team, the decision to move Mr O'Donohue toward discharge was in line with current practice. How the transfer of care occurred in the absence of comprehensive transition planning and without adequate communication with the GP who was to assume professional responsibility is a different matter and remains concerning. The investigators would have expected the service, having made the decision to discharge Mr O'Donohue to have engaged him in transition planning as he had experienced previously when transferred between services and then made every effort to connect him reliably to follow up services including to provide clinical advice and information, a face-to-face handover and advice on how to re-refer him to the service should that become necessary.

While the investigators considered that the decision for discharge was reasonable they considered that Mr O'Donohue's discharge would have been better managed by making full communication with the GP service, to which he was to be transferred, a condition of discharge. The attempt by Mr. O'Donohue to return to the community service should have been handled in a manner which at least explored why he was seeking help. These two failures conspired to leave Mr O'Donohue in the community untreated and unsupported.

3.4.11 Re-entry to services

The pattern of re-entry to services over the 6 years that Mr O'Donohue was in receipt of care was for the most part via someone else (friend in 2010, GP in 2011, Police in 2012) facilitating access and entry following an escalation of risk and concern. Mr O'Donohue only personally approached the service for help to re-engage with the service on one occasion, that being in August 2016 following his discharge from the Metro South HHS BST.

The investigators were provided with documentation that indicated a mutually agreed discharge plan over the six months preceding July 2016. However, it is the view of the investigators that Mr O'Donohue was anxious about discharge and conveyed his ambivalence in several ways.

1. The clinical notes from December 2015 indicate that Mr O'Donohue 'became enraged when discussion about discharge and future treatment options were raised' and when discussed further with him in February he is noted to be 'clearly anxious about discharge' (15 February 2016).
2. In May the Princess Alexandra Hospital record indicates that he was transported by ambulance following chest pain and after some tests was advised to agree to an admission for further cardiac monitoring. The records indicate an impression that this chest pain was due to a 'panic attack' (2 May 2016). He declined an admission and returned home. There was no evidence of further follow up and the case manager who visited the following day did not record a discussion about this event presumably because Mr O'Donohue did not raise it, and the hospital information was not readily accessible for the mental health team. This was a missed opportunity to examine the links between the Mr O'Donohue's increasing anxiety about discharge and his physical health.

3. Mr O'Donohue attended the clinic unannounced requesting to see the psychologist on 3 June 2016
4. Mr O'Donohue failed to present on 14 June 2016 for his medical review and this was understood to be 'likely to be experiencing difficulties with discharge – impending loss of support has triggered anxiety and anger in the context of feelings of abandonment'. The response was to offer a further session but proceed with discharge. He did not attend the follow-up session either and was therefore discharged with a 'nil follow up plan as he did not give consent to correspondence with the GP' (1 August 2016)

The investigators took the view that whilst Mr O'Donohue was apparently agreeing to discharge, his actions over those months were indicating very real anxiety about losing supports that he had relied on for three years in the context of a very limited social network and no other services involved. Despite evidently understanding this anxiety as indicated in the notes, the team proceeded towards discharge. The investigators regard this as an oversight. Even without hindsight discharging a long term patient without ensuring any viable transfer of care, ongoing support and treatment cannot be regarded as best practice. Against this backdrop of anxiety and conveyed ambivalence in relation to the discharge that Mr O'Donohue then called the service for help on 31 August, 2016. He had by this time been provided with letters advising him that he had been discharged from the service and could re-contact if needed via the MHCALL (centralised triage line). However, he chose to ring the Metro South HHS BST directly to request help. Probably having attended this clinic for some years he would be very familiar with reception staff and assumed they would assist him.

The records on CIMHA do not concur with what the investigators were told about this event at interview. The CIMHA records and audit trail indicate that only one person accessed the records on that day (case manager). It was recorded in the notes that Mr O'Donohue had called requesting help and had been advised by the Duty Officer that he was 'closed to the service'. According to the Metro South HSS BST file internal review following the events of October 28, 2016 the Duty Officer had no recollection of receiving this call and 'it is possible that the call may have been answered by an Administrative Officer and referred directly to the consumer's previous case manager'. It is recorded on CIMHA that Mr O'Donohue 'was advised he was a closed consumer to the service. Anthony did not accept this and was advised that the previous case manager would call him back'. It is unclear what 'closed consumer' means and the investigators were advised that this meant his case was closed. The case manager then attempted to contact him. The phone was not answered, no messages were left and there was no further contact initiated apparently on the basis that Mr O'Donohue had been provided previously in writing with the relevant contact details for the MHCALL system to re-open his case.

The investigators had two particular concerns in relation to this matter. Firstly, that Mr O'Donohue's anxiety in relation to the discharge, whilst apparently understood by the treating team does not seem to have been the focus of planning, intervention and team review. Secondly, that his attempt to reconnect with the service very soon after discharge was met with a cursory but superficially justifiable response in the sense that information had already been provided for re-entry and Mr O'Donohue was evidently not using the 'right' one. Nonetheless, the internal review from Metro South HSS that was provided to the investigators included a hand written annotation that indicated that 'the service has had a long standing process that enables people to be referred directly to the previous treating [team] if discharged/transitions from the service for <6 [months]'. This apparent breach of process was noted by the investigators which found that the lack of active follow up of Mr O'Donohue's request for help constituted further evidence that the team may not have fully

understood the importance of their engagement with Mr O'Donohue in containing him and managing his risk.

3.5 The effectiveness of liaison between Hospitals and Health Services

Three HHSs have been involved with Mr O'Donohue's mental health care – originally with Metro South HHS in 2010 with Metro North HHS also involved briefly that year and then again from 2011 – 2013. This period included involvement with inpatient, outpatient and CFOS teams. Metro North HHS HHOT transitioned care to Metro South HHS BST in January 2013, who remained involved for more than three years. West Moreton HHS became involved after the tragic events of 28 October, 2016 and currently has Mr. O'Donohue in care. General medical care was also provided by these health services via emergency department presentations prior to each psychiatric admission (2010 and 2011) and assessment and treatment in 2016 following ambulance transport for chest pain, and following the tragic events of 28 October, 2016.

Liaison between HHSs references active transition planning and facilitation during a consumer's episode of care. This only occurred once – that is, in December 2012 between Metro North HHS HHOT and Metro South HHS BST. Such a transition is likely to routinely include referral, face-to-face handover including the consumer themselves, the family and the two treating teams and written documentation to support transition. The Community Care Team Model of Service Guide (in Mr O'Donohue's case applying to the receiving service) and also the one for HHOT (in Mr O'Donohue's case the relinquishing service) define the expectations on HHS in managing transitions between different internal service components (such as from inpatient to outpatient care). They also indicate that there is an expectation on the relinquishing team to ensure a written handover and verbal handover are both provided. The investigators noted that in the case of Mr O'Donohue appropriate care was taken to ensure successful transition including face-to-face handover between case managers with him present and written handover. However as has been noted elsewhere in the report, the key CFOS report was not transferred at the time, nor included or referenced in the CIMHA and therefore did not later inform the receiving Metro South HHS BST treating team. The investigators found that despite this important document not being available to the new team, information about Mr O'Donohue's risk for suicide and interpersonal violence was conveyed both in handover documents and also comprehensively stated in clinical notes made over two years during the time he was being treated by the Metro North HHS HHOT.

Of note, the relevant guides indicate that where a consumer is being transitioned between services they should "receive an equivalent level of care" in the new district (Queensland Health, CCT pg. 25). This would have been complicated to comply with given that the relinquishing service (Metro North HHS HHOT) was specifically required to ensure a level of assertive outreach for clients of increased complexity, a role not necessarily required from the Metro South HSS BST. Nonetheless, the investigators found that transition was sensitively handled although could have been strengthened by a face-to-face handover discussion without the patient present between the two treating consultant psychiatrists and case managers.

As noted above on 1 May 2016 Mr O'Donohue was taken by ambulance to the emergency department with chest pains and following a series of tests was diagnosed as having suffered a panic attack. There was no referral made to mental health services, no

follow up from mental health in relation to this incident and apparently no awareness of that incident by the Metro South HHS BST. Whilst this is not strictly a matter of 'liaison between Hospitals and Health Services' it provides evidence that despite a comprehensive written communication protocol and the supportive technology provided by CIMHA, service continuity across care domains requires people involved to actively alert one another of their involvement. The investigators found that this oversight, especially in the case of a consumer who is unlikely to volunteer such information could have assisted the treating mental health team in understanding the underlying impact of the proposed discharge on Mr O'Donohue.

3.6 Effectiveness of communication between Queensland Health people and other agencies

The investigators found that there were two areas of concern in relation to communication with other agencies. The first related to the initiation of engagement with other agencies, and the second related to the communication effectiveness once others were involved. These two matters seem to have become enmeshed in the case of Mr O'Donohue.

As has been discussed elsewhere, Mr O'Donohue was resistant to the involvement of others in his engagement with mental health services. This can be seen in his routinely declining permission for the treating teams to contact his family and his GP. His ambivalence in engaging with housing service providers early in treatment led effectively to his discharge into homelessness. His ambivalence in relation to accepting a disability support pension meant he initially declined any engagement between the social worker assisting him with Centrelink during his second admission in October 2011. Furthermore, he declined an assessment with CFOS, and routinely declined invitations to meet with employment providers and take up social opportunities offered. This type of behavior is not uncommon in those with delusional disorders. In this case rather than actively pursuing these issues he treating team at Metro South HHS BST chose to acquiesce in Mr O'Donohue's obstructiveness. Mr O'Donohue also sought to reassure the Metro South HHS BST treating team in particular that he had connections with a GP and would follow up with the GP as needed, but he did not provide permission for communication between the service and the GP. The dilemma this position placed the team in was evident. In respecting Mr O'Donohue's right to privacy the team's capacity to identify family history and collateral information, to generate a network of community and social supports, to manage risk and to ensure ongoing treatment and care was effectively compromised. The investigators were of the view that in someone with a psychotic illness like Mr O'Donohue there are clinical imperatives of greater moment than his notions of privacy.

The guideline on *Information Sharing* between mental health workers, consumers, carers, family and significant others was provided to the investigators (Queensland Health, 2016) and provides 'information on the legislative framework within which consumer information can and should be shared, and how it can be applied in clinical practice' (p1). There is a comprehensive description of when information can be shared without consent as would have been the case with Mr O'Donohue – whether he was being treated on an ITO or as a voluntary patient.

According to the guideline, where information was required or permitted to be disclosed by law it can be shared without consent. This did not occur in Mr O'Donohue's case but was referred to in the CFOS report in relation to the requirement to disclose to the

Queensland Police Service under the *Weapons Act 1990* where a consumer is unsuitable to own a weapon. As far as the investigators can ascertain, this did not occur in Mr O'Donohue's case although he is recorded to have discussed 'pricing a gun' in April 2012. The guideline also supports sharing information without consent where it is 'necessary for the consumer's treatment and care' (p3). The example given in the guideline relates to GPs or other service providers. In reviewing the case following the tragic events of October 28, 2016 the Metro South HSS identified redistributing this guideline to all staff as an action to address the concern articulated that 'the treating team made no contact with the GP during the episode or on discharge' and that 'there is no documented evidence that the team considered contacting the GP to share information that was necessary to the treatment and care without the consumer's consent…' The investigators found that this lack of contact with a GP whilst at the same time relying heavily on a GP for follow up care was not acceptable and as has been discussed previously would helpfully have involved more assertive engagement of Mr O'Donohue in transition planning and formal handover of care.

As indicated, the second matter of note for the investigators in relation to effective communication was an examination of communication where other agencies were involved. The investigators found that in the period from entering care in 2010 to transition to Metro South HHS BST in December 2012 there was comprehensive engagement with relevant services where it was required based on appropriate to care treatment and recovery plans and that communication was appropriate and consistent with policies as indicated.

3.7 Compliance with policies

3.7.1 Compliance with Clinical and Service Delivery Policies

The investigators found that access, assessment, treatment and discharge were compliant with the *Mental Health Act 2000* including proper clinical review prior to extension of any ITO. When Mr O'Donohue took an overseas holiday whilst on an ITO, the relevant action was taken in relation to locating him. In terms of service delivery policies, compliance was sound in general terms and this by extension means that compliance with the National Standards for Mental Health Services was sound given that the Queensland policies are based on the National Standards.

There was, however less consideration given to recovery planning, active rehabilitation and the practices in relation to engaging Mr O'Donohue in recovery-oriented care. As an example on 8 December 2011 his Recovery and Relapse Prevention Plan was completed but not signed by Mr O'Donohue. The investigators found little evidence of what was expected to be, during an outpatient episode of care, a quarterly review of recovery plans. The investigators also had no sense that Mr O'Donohue's care focused on retaining hope, understanding his abilities with purposeful engagement to pursue a social identity, meaning and a positive sense of himself. Compliance with recovery planning appeared from the documentation, as with the Risk Assessments, to be a routine endeavor with an element of 'cutting and pasting' of material from previous reports without evidence of review or influence of past information on current planning.

3.7.2 Information Recording Policies

The review of Mr O'Donohue's care underlined the challenge service provider's face in accessing information and identifying the salient components where there is a complicated mass of information available. The investigators found that documentation was not always easy find and concluded that whilst this might have been a function of the lack

of familiarity with the CIMHA system, it may also indicate a general challenge for clinicians navigating the case file material effectively. The case files were printed and bound for the investigators to review in hard copy, but were therefore not in strict chronological order requiring time for organising and sorting information. This was confounded by poor attention to the detail of properly dating entries (eg Pharmacy discharge medication 9.4.10; HoNOS Report 3 May 2010; Discharge Summary 14 May 2010; Request for assessment MHA Section 16(a) 28 October 2011; Referral to CFOS 27 April 2012).

In terms of detailed feedback on the documentation itself, the investigators found that there was inconsistency in clinicians reliably signing documents (e.g. Physical examination 23 March, 2010; Recovery Plan 10 April, 2010; File Note 7 May, 2010; Admission assessment 28 October, 2011; 31 October 2011 and 3 November, 2011 cannot read treating doctors name; 9 April, 2012 File Note). There were occasions where the handwritten notes were unable to be read (e.g., 29 October, 2011 Handwritten updates squeezed into the margins on continuation sheets and initialed only; 30 October, 2011 illegible handwritten notes). There was a "Patient Alerts" page completed 2 April, 2012 which identified an alert for aggression but date was crossed out and 'error' is written against it. Date reviewed was noted as 2 April, 2012 but the ambiguity of this communication was noted to be particularly concerning given the risk of interpersonal violence of Mr O'Donohue. There is a record that medication (depot) was administered both on 13 June, 2012 and 14 June, 2012 with different nurses. There is a note in the file on 26 December, 2012 that explicitly names other clients/co-patients which is not acceptable practice. Involuntary status was ambiguous on every report provided after the involuntary status was revoked (that is, for 18 months until discharge) indicating that Mr O'Donohue was both a voluntary and involuntary patient at the same time. This was never attended to or amended. The above matters, whilst of concern are not seen to be material to the outcome of care provided. What they identify is the broader risk inherent in the electronic medical record era. There is clearly a requirement for strong corporate governance processes at an immediate team leader level to ensure records are reliable and accurate in line with policy requirements.

The main matters of information sharing compliance have been discussed elsewhere and findings have included the role of the CFOS letter of May, 2012 and the recording of risk assessments and management plans. Queensland Health advised the investigators that the implementation of a statewide Standardised Suite of Clinical Documentation was currently underway. In early 2016, an Expert Panel of senior mental health clinicians reviewed the core suite of clinical documents and made 25 broad recommendations for changes to the forms, based on feedback from clinicians, targeted literature reviews, and information about clinical documentation used in other jurisdictions in Australia. The revised forms will be implemented on 5 March 2017.

3.8 Impact of compliance on care provided

The TOR of the HSI required the investigators to consider whether the content and level of compliance with existing legislation, policies and/or procedures had any impact on the standard and quality of care provided to Mr O'Donohue. As indicated the investigators found that access, assessment, treatment and discharge were delivered compliant with the *Mental Health Act 2000*. This Act is the most relevant statutory framework in reference to this case.

Further, as indicated in other sections of this report there are instances where compliance with routine assessment and review documentation appears to have been counter-productive preventing the treating team from focusing on a longitudinal view of Mr

O'Donohue's presentation. There was a sense that particularly during his treatment at Metro South HHS BST a level of routine compliance drove a passive team approach, including a sense that some components of reports were repeatedly copied and pasted without apparently being reviewed. The challenge for service leaders in a context such as this is to provide frameworks and guides for service delivery (which in this case are clear and comprehensive) and then attend to workforce variability and ensure a competent and supported staff team who understand and can work reliably within this policy framework. The investigators found that this tension was most evident in the compliant and routine nature of recording clinical care, and the management of risk in the case of Mr O'Donohue.

The CFOS team was asked to provide the investigators with details about how their expert advice was routinely provided to the referring mental health care team. The investigators understood that there had been a history of ensuring that these forensic assessment reports were only provided to the treating team and not routinely added to CIMHA to ensure comprehensive access to what can be highly sensitive reports. The investigators found that compliance of CFOS in relation to leaving the assessment reports out of CIMHA (not loading them onto the system) and therefore only forming part of the hard copy file may have contributed to the oversight in not handing the CFOS report on Mr O'Donohue from the Metro North HHS HHOT to the Metro South HHS BST at the time his care was transitioned. The CFOS team has advised that they have reviewed this policy and currently make such reports more reliably available.

Team compliance with what was understood to be the agreed discharge and re-referral protocol was an example where adherence appeared to disadvantage Mr O'Donohue when he sought to re-engage with the service. That is, for re-engagement with the service after discharge Mr O'Donohue was required to call MHCALL – the centralised intake service. The investigators found that this incident was an example of where rigid compliance with protocols and policies prioritised over understanding the consumer and leveraging the therapeutic engagement can mean clinicians miss individual patient variation.

3.9 Summary of Findings

The HSI panel was appointed in November, 2016 pursuant to Section 190 of the HHB Act 2011 and took a considered and focused approach to investigating matters relating to the management, administration and delivery of public mental health services as provided to Anthony O'Donohue by Hospital and Health Services (HHS) of Queensland Health. Data informing the findings included background documentation relating to the patient care provided, organisational context and structure, governance and service delivery policies, in-depth face-to-face interviews with clinicians and leaders of HHSs and on-site observation undertaken over a five-day period in November, 2016.

As a result of the investigation the investigators made no findings against individual clinicians or other officers of Queensland Health. Care was found to have been broadly compliant with legislation and the broad parameters articulated for service delivery in inpatient and outpatient settings. In making these findings, the investigators are strongly of the view that where deficiencies have been identified, they are attributable to the prevailing culture, practices and protocols within the service, and therefore the investigators do not attribute any deficiencies to an identified individual involved in the management of Mr O'Donohue.

The TOR require the Health Service Investigators to make findings in a report under section 199 of the HHB Act regarding, the ways in which the management, administration or delivery of the public sector health services, can be maintained and improved, and any other relevant matter identified during the course of the investigation. Throughout the text of the report findings are made in relation to specific matters. These are gathered and articulated below. In making these findings, the investigators are strongly of the view that where deficiencies have been identified, they are attributable to the prevailing culture, practices and protocols within the service, and therefore the investigators do not attribute any deficiencies to an identified individual involved in the management of Mr O'Donohue.

1. **Risk assessment and risk management** - The investigators found among most of the clinicians interviewed an understanding that the primary role of a risk assessment is to guide the development of risk management strategies. The investigators found that in relation to Mr O'Donohue's management at Metro South HHS BST, clinical judgment tended to emphasise a one-dimensional view of the current presentation and underplayed the collateral information and history, which may have impacted on decisions made about the management of Mr O'Donohue.

2. **Diagnosis -** The investigators found no good evidence to doubt the diagnosis of Delusional Disorder made by those managing Mr O'Donohue over the many years prior to the tragedy and would caution against moving away from such a diagnosis.

3. **Engagement and therapeutic relationship** - The investigators found that engagement with Mr O'Donohue at Metro South HHS BST was impaired by Mr O'Donohue's refusal to provide access to, or the sharing of information, and his resistance to engaging in any rehabilitation efforts. The investigators consider this behavior to be a reflection of his delusional disorder. Metro South HHS BST, and on one occasion CFOS, tended to acquiesce in the limits he set rather than actively challenge and manage this impediment to good clinical care. In prioritising Mr O'Donohue's right to privacy and self-determination the team's capacity to identify family history and collateral information, to generate a network of community and

social supports, to manage risk and to ensure ongoing treatment and care was effectively compromised.

4. **Treatment Planning and Review –** The investigators found that the outpatient service from the Metro North HHS Homeless Health Outreach Team (HHOT) appeared thorough with sound multidisciplinary team interactions and case review. The investigators found that for much of the time Mr O'Donohue was receiving care from the Metro North HHS HHOT an appropriate focus on his delusional beliefs and on maintaining and enhancing his social functioning and networks was apparent, despite Mr O'Donohue's resistance to involvement in these activities.

5. **Medication compliance -** The investigators found, based on the history provided by Mr O'Donohue after the tragic events of 28 October 2016 that he probably only took oral medication for a relatively brief period. He was probably not taking any medication for much of 2014, 2015, and 2016 up until the tragedy.

6. **Transition between Hospital and Health Services -** The investigators found that the critical transition between Metro HHS HHOT and Metro South HHS BST community teams was sensitively handled and met the policy and practice expectations.

7. **Revoking the Involuntary Treatment Order (ITO)** - The investigators found that removing Mr O'Donohue from the ITO at Metro South HHS BST was based upon incomplete information. The investigators, however, recognise there is a legal and clinical imperative to revoke an ITO when the consumer has demonstrated a willingness to comply with management on a voluntary basis, which appeared to be the situation in this case.

8. **Decision to discharge in 2016** - The investigators found that given the clinical situation as perceived at the time by the treating team, the decision by Metro South HHS BST to move Mr O'Donohue toward discharge was in line with current practice and the investigators consider it was clinically defensible. However, the investigators found that the lack of contact with an identified General Practitioner (GP) in order to transition care whilst at the same time relying entirely on a GP for follow up care was not acceptable and should have been better managed through full communication with the GP service to which he was to be transferred, as a condition of discharge.

9. **Re-entry to the service** – The investigators found that Mr O'Donohue's attempt to reconnect with the service very soon after the discharge in 2016 was met by Metro South HHS BST with a cursory but superficially justifiable response in the sense that pathways had been provided for re-entry and Mr O'Donohue was evidently not using the 'right' one. The investigators consider that this should have been better managed through active follow up.

10. The investigators found, among the individuals interviewed, a few who seemed to indict the **Recovery Model** for a potentially problematic conflict between the pressures to remove consumers from involuntary status and what they regarded as maintaining a reasonable level of caution about future compliance with effective risk management. The investigators were not convinced of any such relationship.

11. **Communication between Queensland Health officers and other agencies.** The investigators found that in the period from entering care in 2010 to transition to Metro South HHS BST in December 2012 there was comprehensive engagement with relevant services where it was required based on appropriate to care treatment and recovery plans and that communication was appropriate and consistent with policies as indicated.

12. **Compliance with policies.** The investigators found that access, assessment, treatment and discharge were broadly compliant with the *Mental Health Act 2000* (Qld) including proper clinical review prior to extension of any ITO, and also broadly consistent with policy and practice guidelines. The investigators found that the incident of August 31, 2016 when Mr O'Donohue called the Metro South HHS BST seeking help and was not provided with help was unfortunate. The investigators noted that Metro South HHS has made an assurance that procedures and practices have since been amended to prevent a recurrence.

13. **Information sharing -** The investigators found that documentation was not always easy to find and concluded that whilst this might have been a function of the lack of familiarity with the Consumer Integrated Mental Health Application (CIMHA) system, it may also indicate a general challenge for clinicians navigating the case file material effectively. However, the investigators also found that compliance of Community Forensic Outreach Service (CFOS) in relation to leaving the assessment reports out of CIMHA (not loading them onto the system) and therefore only forming part of the hard copy file may have contributed to the oversight in not handing the CFOS report on Mr O'Donohue from the Metro North HHS HHOT team to the Metro South HHS BST at the time his care was transitioned.

14. **Role of Community Forensic Outreach Service (CFOS)** – The investigators consider the current fragmented structure of Queensland's forensic mental health services does not make optimal use of the resources in that service and in CFOS in particular.

15. **Role of Forensic Liaison Officers** (FLO) - The investigators found that despite there being a FLO embedded within both clinics who managed Mr O'Donohue, they played no identified part in his clinical management. The investigators found that the lack of integration between the existing CFOS and the clinic based FLO impeded what might have been the more effective clinical outcomes for Mr O'Donohue.

4. Concluding Remarks

The investigators was appreciative of the warm welcome and willingness of staff to give time to orientate the investigators, share their insights and experience of their respective services, and respond to the queries made by the investigators. It would have been a significant intrusion into the busy professional lives of all those we met, and there is inevitably a level of anxiety for any clinician or manager participating in such a review after critical incidents, and the positive, transparent, and collaborative attitude on display made the task of the investigators much easier and is reflective of a positive culture and genuine interest in continuing service improvement.

APPENDIX 1

DEPARTMENT OF HEALTH

HEALTH SERVICE INVESTIGATION

ANTHONY O'DONOHUE – MENTAL HEALTH TREATMENT AND CARE AT PUBLIC SECTOR HEALTH SERVICES

TERMS OF REFERENCE

1. Purpose

The purpose of this health service investigation is to investigate and report on matters relating to the management, administration and delivery of Queensland public sector mental health services provided to Anthony O'Donohue (DOB: 22 February 1968) (**Investigation**).

2. Appointment

2.1. Under section 190(1) of the *Hospital and Health Boards Act 2011* (Qld) (**HHBA**), following my assessment that they are qualified for the appointment because they have the necessary expertise or experience, I have appointed Professor Paul Mullen, Angela Karooz and Leanne Beagley as Health Service Investigators to conduct this Investigation.

2.2. The Health Service Investigators must investigate the matters outlined under '*3. Scope of the Investigation*' below and prepare a Health Service Investigation report to me in accordance with section 199 of the HHBA.

2.3. The terms and conditions of the indemnity provided to the Health Service Investigators are detailed in **Attachment 1 - Instrument of Indemnity**.

3. Scope of the Investigation

3.1. The Health Service Investigators are to investigate matters relating to the management, administration and delivery of public sector mental health services as provided to Anthony O'Donohue by the Department of Health and the Hospital and Health Services, particularly Metro South Hospital and Health Service and Metro North Hospital and Health Service. Specifically, the Health Service Investigators are to:

a) review the patient records for Anthony O'Donohue and any documents, including reports, file notes and telephone records, whether held on Anthony O'Donohue's patient record or not, created or received by staff in relation to Anthony O'Donohue;

b) review the decisions and actions taken by staff in relation to the treatment and care of Anthony O'Donohue, particularly including:

i. the decision to close his status as an open patient of the Princess Alexandra Hospital Authorised Mental Health Service in August 2016; and

ii. the decision to treat him other than on an involuntary treatment order under the *Mental Health Act 2000* (Qld);

c) develop a sequence of key events and significant clinical decision-making points relevant to the clinical management of Anthony O'Donohue's mental illness;

d) review the admission, examination, assessment, diagnosis, treatment, discharge, post-discharge follow-up and overall management of Anthony O'Donohue;

e) review the effectiveness of liaison between relevant Hospital and Health Services regarding the assessment, treatment and care for Anthony O'Donohue, including any post-discharge care and follow-up arrangements;

f) if relevant, review the effectiveness of communication and liaison between Queensland Health and other government agencies or other relevant organisations in respect of Anthony O'Donohue;

g) review the compliance or non-compliance with relevant policies and procedures (including state-wide and local) applying in relation to the treatment and care of Anthony O'Donohue; and

h) consider whether the content and level of compliance with existing legislation, policies and/or procedures had any impact on the standard and quality of care provided to Anthony O'Donohue.

3.2. While the treatment and care of Anthony O'Donohue is a focus of the Health Service Investigation, the Health Service Investigators are to also consider identification of any systemic or system-wide issues in relation to the matters outlined in section 3.1 above.

3.3. The Health Service Investigators must make findings in respect of the matters outlined in 3.1 and 3.2 above, in a report under section 199 of the HHBA, regarding:

(a) the ways in which the management, administration or delivery of the public sector health services, can be maintained and improved; and

(b) any other relevant matter identified during the course of the Investigation.

4. Powers of the Health Service Investigator

4.1. The Health Service Investigators have all of the powers given under section 194 of the HHBA including to enter a public sector health service facility when it is open and to access, copy or take extracts from any document (including documents that contain confidential information) that is relevant to the Health Service Investigators' functions and is in the possession or control of an employee of the Department of Health or a Hospital and Health Service.

4.2. The Health Service Investigators must make every reasonable effort to also obtain any other information or documentation that is relevant to the Investigation.

5. Conduct of the Investigation

5.1. The Health Service Investigators are to notify any person who provides information for the Investigation that they have been appointed as independent Health Service Investigators, having no conflict or perceived conflict of interest regarding the matters under Investigation.

5.2. The Health Service Investigators are to be aware of and comply at all times with the provisions of Part 9 of the HHBA which govern the undertaking of this Investigation, including (but not limited to) the duty of confidentiality.

5.3. With the prior notification to, and facilitation by me, or the relevant Hospital and Health Service Chief Executive (as appropriate), the Health Service Investigators will:

(a) interview those persons who the Health Service Investigators believe may be able to provide information relevant to the Investigation, which may include persons who are not employees of the Department or a Hospital and Health Service (noting the limitations of the Health Service Investigators' powers to compel information from non-employees); and

(b) request a Hospital and Health Service and/or the Department of Health (as applicable) to give any lawful and reasonable directions to its employees which may be required during the Investigation. For example, to provide a lawful direction and reasonable direction to an employee to maintain confidentiality, to attend an interview, or to provide copies of documents in their possession or control. The Health Service Investigators must inform me of any failure to comply with a direction.

5.4. The Health Service Investigators may co-opt specialist clinical, clinical governance, or human resource management expertise or opinion, or administrative, information technology or other assistance, where necessary in accordance with section 197(3)(a) of the HHBA. The Health Service Investigators must obtain my, or my representative's written approval before incurring any expenses in this regard.

5.5. Where the Health Service Investigators propose to make a comment or finding that is adverse to a person, the Health Service Investigators must first afford that person an opportunity to respond to the substance of any allegations against them or any potential adverse comment or finding about them.

5.6. The Investigation report prepared in accordance with section 199 of the HHBA must specifically address the matters outlined in section 3 above. The Health Service Investigators are to provide in the body of the report, their assessment of the evidence and reasons for their findings.

5.7. A summary of evidence relied upon by the Health Service Investigators to make a finding is to be included in the Investigation report.

5.8. The names of persons providing information to the Health Service Investigators, and any patient, staff or other names, must be kept confidential and referred to in a de-identified form in the body of the Investigation report (with a legend confirming the identity of those persons to be provided by way of attachment), unless it is agreed by the Health Service Investigators and me that the

identification of a person is essential to ensure that natural justice is afforded to any particular person.

5.9. Legal advice may be obtained by the Health Service Investigators at the arrangement and cost of the Department of Health where necessary in accordance with section 197(3)(a) of the HHBA. The Health Service Investigators must obtain written approval from me or my representative before incurring any expenses in this regard.

5.10. The Health Service Investigators are to provide to me within 7 days (or as otherwise agreed) of receiving the appointment and these Terms of Reference:

(a) an Investigation plan;

(b) an estimate of hours of work required to complete the Investigation; and

(c) confirmation in writing of an ability to meet the timeframes for the conduct of the Investigation, including the due date for the Investigation report.

5.11. The Health Service Investigators are to notify me about the progress of the Investigation at regular intervals, as will be agreed following the submission of the Investigation plan.

5.12. Any request for an extension of the due dates for the Investigation reports is to be made in writing to me at least 7 days before the due date, with supporting reasons.

5.13. The Health Service Investigators are to submit:

(a) within five (5) weeks after commencing the Investigation, a draft report (that may be released publicly), identifying key issues and significant findings to date to me;

(b) within seven (7) weeks after commencing the investigation, a final report (that may be released publicly) identifying key issues and findings as per section 3 'Scope of Investigation' above to me.

5.14. After delivery of the draft report and final report, the Department or Minister for Health and Ambulance Services (**Minister**) may deem it appropriate to make a public statement regarding the matter, the subject of the Investigation, including comments regarding the conduct and findings of the Investigation. The Health Service Investigators will work collaboratively with departmental and ministerial staff to prepare an appropriate statement, taking into account matters of confidentiality and subjudice.

5.15. Terms and conditions relating to the health service investigators' professional rates, out-of-pocket expenses, travel arrangements and other relevant matters are contained in the associated consultancy agreement for provision of the health service investigators' services.

5.16. If necessary, the Health Service Investigators should report back to me (or other person nominated by me) for further instructions during the course of the Investigation.

Appendix 2 – Health Service Investigators Panel

Biographical Statements

Chair: Professor Paul Mullen
MB BS DSc FRANZCP FRCPsych

Prof. Emeritus Monash University.
Previously Medical Director Victoria's Forensic Mental Health Services 1991-2011, Prof Psychological Medicine Otago University 1981-1992, Consultant and Senior Lecturer Maudsley and Bethlem Hospitals, Institute of Psychiatry London 1978-1982.

Author of over 200 papers in refereed journals and over 50 chapters in psychiatric texts. Co-author of 3 books, Jealousy: Theory and Clinical Practice, Child Sexual Abuse An Evidence Based Approach, Stalkers and Their Victims.

Ms Angela Karooz

Bachelor Health Science (Nursing); Graduate Diploma Project Management, Graduate Diploma of Government; Masters of Clinical Practice.

The consultant has over 30 years working in, around and with public health services in New South Wales and provided a prospective on operational management, service delivery, enterprise wide risk management and professional leadership within Mental Health Services.

Ms Leanne Beagley
Consultant.
B.App Sci (OT); Grad Dip Fam Ther; Master Business Leadership

The consultant has 30 years experience working in, around and with public mental health services in Victoria from a range of perspectives including direct care, operational management and government policy roles. She also brought complementary post-graduate academic training in organizational systems and culture, leadership and management.

Appendix 3 – References and Bibliography

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APPENDIX 4

Queensland Government

PRIVATE AND CONFIDENTIAL

To be opened by addressee only

TITLE FIRST NAME SURNAME
ADDRESS
ADDRESS

Email:

Dear NAME,

Health Service Investigation – Anthony O'Donohue – Mental Health Treatment and Care at Public Sector Health Services

We have been appointed by Michael Walsh, Director-General Queensland Health pursuant to Part 9 of the *Hospital and Health Boards Act 2011* (Qld) as health service investigators.

We have been appointed as independent health service investigators having no conflict or perceived conflict of interest regarding the matters under investigation.

The functions of a health service investigator are to investigate and report on matters relating to the management, administration or delivery of public sector health services. The scope and purpose of this investigation is outlined in the attached Terms of Reference.

We invite you to attend an interview about the matters we have been appointed to investigate and report on.

We propose to undertake the interview in person at LOCATION at TIME on the DATE. The interview should take no longer than 60 minutes. The interview will be electronically recorded. We may also take handwritten notes during the interview.

You are welcome to have a support person attend during the interview. However, the support person will not be permitted to advocate for you during the interview, suggest responses or otherwise speak while the interview is in progress. You may also have a legal representative accompany you during the interview.

We request that in the interests of ensuring procedural fairness to all, that the nature and scope of the investigation, and all correspondence, is kept confidential. This of course does not preclude you from discussing the matter with your advisors.

Thank you for your assistance with this matter. If you require any further information, please contact Professor Paul Mullen on telephone 0408 292 733. Alternatively if you wish to discuss matters outside of the investigation please contact Ms Jan Rodwell, Manager, Policy, Systems and Compliance on telephone (07) 3328 9581.

Yours faithfully

Professor Paul Mullen
Lead Investigator
DATE
On behalf of investigators Professor Paul Mullen, Ms Leanne Beagley and Ms Angela Karooz

Terms of Reference 3.1 (c) SEQUENCE OF KEY EVENTS

*** Note that what has been provided here are key events or commentary as recorded in the patient file and judged to be useful in understanding the patient journey. It does not include every recorded interaction with the patient particularly during admissions and in intensive treatment phases where he received daily home visits and phone calls.

Date	Source	Event
18.3.10	South Vol 1	Suicide attempt "allowed car registration to lapse. Drove to [redacted] to a national park where he consumed a bottle of whisky, took an overdose of Oxazepam with the intent to die. He vomited after consuming the tablets then drove intoxicated, causing a motor vehicle accident."
20.3.10	South Vol 3	Consumer Intake (Bayside). CN. [redacted] phoned. Concerned [redacted] has untreated mental illness; reports last night ETOH intoxication and overdose that he vomited; drove car erratically and had MVA; collateral from friend; [redacted] thinks actions were suicide attempt. Information provided. Plan: Contact QPS if imminent risk to self or others; JEO process explained. Not entered onto CIMHA as insufficient information.
21.3.10	South Vol 3	Friend [redacted] called. Spoke to ACT. [redacted] had picked AOD up from hospital after MVA and he is staying there. AOD was agreeing to come to hospital today
22.3.10	South Vol 3	Brought to hospital by friend Assessed. Handwritten Progress notes History taken. Risk identified as medium to high for suicide. Voluntary admission arranged.
22.3.10	South Vol 1	AMHS Consumer Assessment: ACT Team. Presented with suicide attempt 18.3. Brought in by friend [redacted]. Denies perceptual disturbance. Uses alcohol. Thought content non-bizarre delusional. Risk Screen: no history of violence; assessed as a medium risk for suicide and low risk for aggression. Admitted to Yugaipa: Voluntary.
22.3.10	South Vol 3	Recovery Plan: Assess, monitor; medications; observation
23.3.10	South Vol 3	Progress notes on ward. Medical review. Nursing notes: prefers staying in quiet areas. Mood reactive cooperative. Does not want contact with [redacted] who has rung the unit. Medical Review. Indicates the suicide attempt in context of distress due to professional and social stagnation.
23.3.10	South Vol 3	Physical exam: [redacted] heard arrhythmia; bump on head from car accident; chronic sinus infection.

Date	Source	Event
24.3.10	South Vol 3	CT Head Scan; ECGMedical Review: No past psych history; pressure of speech; single delusional theme. Nursing notes: keeping to himself, watching TV, no psychotic content, risks low
7.4.10	South Vol 3	Medical Review: Life is being ruined by the unions. Speech is less pressured; denies perceptual abnormalities. Maintain medication; discharge by Friday. HBACT follow up. Nursing: Low for aggression or self harm
9.4.10	South Vol 1	Discharged from Yugaipa. Discharged on medication. No MHA status. F/U Home Based Acute Team. Discharge Drugs; Risperidone 3 mg 2 tabs x nocte Diazepam 5mg 1 nocte
10.4.10	South Vol 3	Recovery Plan (individual Care Treatment Plan) Redland HBACT Summary : monitor mental state and risk and return to work.
22.4.10	South Vol 1	Medical Review Appointment outpatients Some side effects of medication. Ax low risk of suicide. Living in shared accom not stable. Complex non-bizarre delusions. Agrees with treatment plan including home visit in 2-3 weeks. Reduced medication to support compliance.
27.4.10	South Vol 3	Team Clinical Review. Confirmed current plan.
3.5.10	South Vol 1	"Consumer Care Review Summary" with Case Manager at clinic not home. Noted to be difficult to engage and has not responded to phone messages.
10.5.10	South Vol 1	Medical review (Psych Reg) on site at clinic. Protective factors are summarized as his willingness to seek help and engage, and improving future orientation. Risk current low. He has moved out of the area and it is therefore anticipated that he will be discharged. Recommending engagement with GP and supportive psychotherapy counseling.
11.5.10	South Vol 3	Team Review: Plan to close the case once provided with local contact details for GPs and psychologists.
13.5.10	South Vol 3	Email with contact details for private psychologists, GPs and the Royal Brisbane Mental Health Service in his area
14.5.10	South Vol 1	Discharge Summary written
28.6.10	South Vol 3	Email from AOD requesting medical cert for Centrelink and help with legal support as he has received a police summons (driving under influence of alcohol in suicide attempt)

Date	Source	Event
30.6.10	South Vol 3	Email to AOD advising that Doctor will do a Centrelink Cert as requested. Legal advice centre contacts provided. Suggest he gets in touch with local mental health service for his area (no contact details provided)
12.7.10	South Vol 3	Signed information release request for medical information for GP
15.7.10	North Vol 1	Consumer Intake call. Call from GP – new client. Reports AOD is low in mood, tearful, possible persecutory ideation. AOD aware of referral. Written referral following Received 24.8.10
16.7.10	North Vol 1	P/C to AOD. Declined service
19.7.10	North Vol 1	Review of referral and outcome by Intake team. No further action. Close.
31.8.10	South Vol 1	Phone Triage contacted by friend of AOD who is worried that AOD is not taking medications, not sleeping, paranoid. Caller requests MHS to do a report for AOD for court re 'drink driving'. Outcome: Service declined to do court report. Access information if ongoing concerns.
3.9.10	North Vol 1	Intake call from GP following written referral. Note by Intake clinician. AOD difficult to engage on phone. GP indicates that he is not presenting with psychotic symptoms but that presentation is more consistent with a narcissistic personality disorder. An assessment has been arranged for 7.9.
7.9.10	South Vol 3	Assessment provided at clinic. Being managed by his GP. Reports ceasing medication due to side effects saying medication made no difference. Pressure speech, delusional system about the unions, nil evidence of active psychosis. Plan to provide mental health management. To be seen by the psychiatric registrar. Documentation includes a Consumer Family Developmental and Social Assessment.
8.9.10	North Vol 1	Medical Appointment. AOD attended and was assessed as having a delusional disorder with low mood, suicidal thoughts, persecutory ideas. Plan: engagement, psycho-education, follow up review next week.
9.9.10	North Vol 1	Team discussion followed by call with referring friend who indicated he thought AOD had deteriorated recently and was not taking medication, sleeping and talking ++ about persecutory ideas.
20.9.10	North Vol 1	Reviewed by Dr. MSE. Plan to consider ITO, Case Management and medication if he is still refusing medication. Advised to contact ACT as needed.
5.10.10	North Vol 1	Reviewed scheduled but AOD cancelled by phone.
18.10.10	North Vol 1	Reviewed with team. Plan to await attendance at appointment.
19.10.10	North Vol 1	Medical Review. Feeling trapped and helpless but no suicidal or homicidal plans. Seen as low risk for suicide and homicide. Engagement and psychoeducation. Review in 1 month.

Date	Source	Event
27.10.10	North Vol 1	Medical Review. AOD advised he has not commenced medication. Agreed to start. Same plan
3.11.10	North Vol 1	Medical Review. Risk and MSE no change. Plan to increase medication. Ongoing psycho education
10.11.10	North Vol 1	Medical Review. Some improvement noted in ongoing issues of compliance and insight
19.11.10	North Vol 1	Team Review: Dr reports he plans to close at next review. 'Not suitable for case management'.
24.11.10	North Vol 1	Medical Review AOD expressed resentment and was critical about the Centrelink certificate provided by the service as he disagrees with diagnosis. Low risk of suicide and aggression but likely to increase if symptoms exacerbated by stress, non-compliance or substance use. Agreed to transfer treatment to GP.
25.11.10	North Vol 1	Dr discussed transfer of care with GP. Letter to be sent. Free to contact and re-refer as needed. Discharge Letter sent
27.11.10	North Vol 1	Clinical Team Review. Close case.
28.10.11	North Vol 2	Emergency examination order Sections 35&41 QPS request for assessment "Person has a mental illness as he stated to police that he wants to walk outside and kill someone or hit a cop in the back of the head and take his gun and shoot people himself. Police located a tyre lever, hammer and box cutter. AOD stated the tyre lever was to hurt someone"
28.10.11	North Vol 2	Request for assessment MHA Section 16(a)
28.10.11	North Vol 2	Recommendation for assessment 16(b) & 49(a) 'Due to high risk of aggression and harm to others needs immediate assessment.
28.10.11	South Vol 3	PEC Assessment. Plan to hit a police officer in back of head with plan to steal gun, shoot them & then himself. Has been contemplating accessing a gun 'somehow' and getting 'as many union officers out there as I can … as publically as I can'. Angry, cognition supporting violence, recent threats to harm others has plan to do so Assessed as high risk for violence to others and medium risk for suicide. Has been homeless for two weeks.
28.10.11	North Vol 2	Extensive admission assessment. Plan to commence medication and sedation; monitor; CFOS assessment.
29.10.11	North Vol 2	ITO – Inpatient. Admitted to HDU. Completed "Recovery Plan". Issues: Substance use, paranoid delusional ideation; aggressive behavior; deterioration in mental state re non-compliance; homelessness
31.10.11	North Vol 2	Nursing notes: ongoing paranoia; mod appears low; no aggression observed Psych Reg: assessment. 'Initially refused to discuss then went into long monologue re unions' Stated that he

Date	Source	Event
		has three options: 1. Stay in hosp; 2. Go to jail for murder; 3 kill self. Unclear precipitant/trigger for admission
2.11.11	North Vol 2	Medical Review: Continue current regime, short periods out of HDU
3.11.11	North Vol 2	Medical Review: Consistent picture – delusional unshifting. Risks medium for self harm and med/high for aggression. Didn't want DSP due to stigma. Plan: engage and then assist with accom and DSP
4.11.11	North Vol 2	Multidisciplinary team review: Reduce medication due to drowsiness
8.11.11	North Vol 2	Multidisciplinary team review: Feeling better. Introduce escorted leave.
9.11.11	North Vol 2	Progressing applications for DSP and Transitional Housing Program with SW
11.11.11	North Vol 2	Medical Review: 'Medications may be helping'. More hopeful about future. Continue treatment plan, reduce meds
15.11.11	North Vol 2	Multidisciplinary team review: Change medication; increase unescorted leave
17.11.11	North Vol 2	SW Progressing plans for accom. Referral Form to HHOT for post discharge follow up
21.11.11	North Vol 1	HHOT Intake Meeting. Being discharged from 'Ground Floor' effectively to backpackers/homelessness. Has an appointment for HHOT follow up. Given appointment card. Says he is undecided if he will attend.
22.11.11	North Vol 1	Discharge Summary: Well-systematized delusion about unions and public sector involving also family and friends from school. As a result socially isolated. No other psychotic symptoms or mood disturbance. Poor insight and judgment. Admitted for containment and further assessment. ITO on discharge.
23.11.11	North Vol 1	Discharge summary: faxed to GP. Consumer Intake HHOT Team: Medium risk for aggression, suicide, absconding. Indicates a 'need for service other than MHS'. Plan to administer Depot, complete assessment, medical review.
24.11.11	North Vol 1	Medical Review: Due depot 25.11. "monitor closely, history of procuring firearm to kill co-workers"
25.11.11	North Vol 1	Depot 'test dose' given. No issues. Settled.
29.11.11	North Vol 1	DNA Medical Appt. "Close followup: Firearm history"
7.12.11	North Vol 1	Attended Medical Review. Plan: Due to poor insight needs ITO to ensure compliance with medication (depot). Monitoring risk; homeless health outreach team; assistance with housing
8.12.11	South Vol 1	Alerts placed on CIMHA for aggressive intent– CIMHA quoted in ISP 30.6.12
20.12.11	North Vol 2	Copy of MHRT Letter to AOD advising change of IT0 to Community

Date	Source	Event
21.12.11	North Vol 1	P/C with AOD: No current concerns but ambivalent about ongoing stressors saying ' no change … neither here nor there…" No other stressors identified. Agreed to attend for depot
23.12.11	North Vol 1	Attended clinic for depot.
4.1.12	South Vol 3	Clinical report for ITO Review. Description of situation leading to admission. Review of mental state. Request to continue ITO on community basis due to poor insight and high risk to self and others. Likely to be non-compliant with medication otherwise.
10.1.12	North Vol 1	P/C to team from AOD requesting assistance for housing and accommodation. Provided. Agreed to attend for next depot dose.
23.1.12	North Vol 1	Medical Review : Same plan as 7.12
4.1.12	North Vol 1	Clinical Report ITO Review for MHRT. Recommend continuing with ITO due to risk of non-compliance
27.1.12	North Vol 1	Presented for appointment to see "OSP" as requested. Focus on accommodation options and assistance. MHRT Report given.
30.1.12	North Vol 1	Presented for appointment to see "PSP" as requested. Described as anxious with pressured speech.
31.1.12	North Vol 1	Seen by chance at [redacted] by Case Manager. He has secured a bed there. Presented as significantly more settled. Attended medical review where MHRT review discussed – AOD raised concerns about some content of the application. Changes made and he agreed to the final version. Plans to attend hearing on 2.2.12
2.2.12	North Vol 1	AMHS Risk Screen completed by Case Manager. Assessed as low risk on all accounts.
8.2.12	South Vol 3	1. MHS Recovery Plan 2. MHS Relapse Prevention Plan Not signed by AOD
14.2.12	South Vol 1	Progress Note; Transitional Housing Team. Noted a history of aggression 'medium risk of physical aggression when unwell. History of aggression towards public servants.'
16.2.12	South Vol 1	'STORI' checklist. Notable that he is happy with whom he is, angry and hopeless about his current situation and indicating he has no agency do control or do anything about it.
29.2.12	North Vol 1	Presented for scheduled appointment. Reports ongoing low mood in the context of stressors (homelessness, unemployment, debt). Insight nil. Declined recent offer of THT housing. Plan: continue to assist with housing, letter from Dr. in relation to debt.

Date	Source	Event
15.3.12	North Vol 1	Medical Review: Seems more hopeful. Mental state unchanged. Plan unchanged.
30.3.12	North Vol 1	Psychol Session: Reporting some improvements. Reconsidering resistance to THT housing and wants to reconnect. Denied suicidal and homicidal ideation.
2.4.12	South Vol 3	Consumer Care Review Summary. Repeats history and confirms medication.
4.4.12	South Vol 3	AMHS Risk Screen. Determined to be low risk for self harm, aggression, vulnerability and absconding and medium for suicide.
5.4.12	North Vol 1	Team Discussion: chronic risk of harm to others given fixed delusions. Given limited access to firearms, a moderate chronic risk overall. Plan to continue monitoring mental state, contact police immediately if homicidal thoughts increase, reinforce negative consequences of homicidal actions, support sourcing accom, discuss at team meeting.
16.4.12	North Vol 3	Note by Psychol. AOD advises that he has talked with people at [redacted] and has priced a gun at $2000 but this is a protective measure because he hasn't got the money. MSE consistent."Has entrenched beliefs that are almost impossible to address that influence his worsening existential concerns. Due to this he presents a high chronic risk of harm to others as it is likely as some point in the future that he will exact revenge on the people he believes have engineered the his circumstances if his life continues to be without meaning. While his plan of procuring a firearm from QPS is not feasible the likelihood that he will eventually be able to either purchase or steal a firearm in the long-term is quite high".
19.4.12	South Vol 3	Review by Dr. Ongoing medication, monitoring and ITO needed. CFO opinion for ongoing homicidal ideas.
23.4.12	North Vol 1	Psychology Session. Review by CFOS was offered and declined 'didn't want to make it official'.
27.4.12	North Vol 1	Referral to CFOS for help in assessing AOD and his risk to others now that he was in the community.
29.4.12	North Vol 1	Patient Alerts and Allergies page completed identifying risk of use of weapons and previous suicide attempt
13.5.12	South Vol 3	Referral for transitional housing program [redacted]
15.5.12	South Vol 3	Internal Referral to PAH Mental Health
17.5.12	South Vol 3	Review by Dr. Has violent fantasies of hurting public servants. Plan: ongoing treatment.
22.5.12	North Vol 1	Letter to treating doctor from Psychiatrist Community Forensic Outreach Service following case conference with team - Need more collateral information to understand pre-morbid history particularly violence and history

Date	Source	Event
		of the issues related to his delusional system - Engagement is a key factor to attempting to manage patients with these features - Strategies that may help are to appeal to his self-interest by aiding him to see the costs and benefits to him pursuing his ideas. - He may need a face saving exit from the issues - It is unlikely to be helpful to attempt to develop any victim empathy with AOD - All threats should be taken seriously and he should be made aware of this - Watch for signs for increasing risk such as displaying last resort thinking, suicidal ideation or more specific homicidal intent of plans - Weapons Licensing Branch should be notified. - Treatment of the psychosis is a key factor for safety - Increase medication - Keep him on an ITO
28.5.12	North Vol 1	Psychologist, Unable to define why he is feeling better but accepts that it may be linked to the antidepressants. Continues to deny clear intentions to act out thoughts of harming others
10.6.12	North Vol 1	Client has moved to transitional housing unit, home visit from support team to new unit, no concerns
12.6.12	North Vol 1	Letter by treating team "To Whom it May Concern" identifying AOD, his illness and needs for long term accommodation.
14.6.12	North Vol 1	Note: Depot given. Remains insight less but is compliant under ITO
15.6.12	North Vol 1	Note: H/V, focused on program and activities
28.6.12	North Vol 1	Consumer Care Review Summary, Diagnosis, paranoid schizophrenia. Notes significant improvement in mental state, engaging well in THT program
30.6.12	South Vol 1	Client Signed "Individual Support Plan" with Transitional Housing Team. Indicates he is on an ITO. Indicates he was facing homelessness.
11.7.12	North Vol 1	Clinical review report for MHRT. Risk issues to self and to others are of concern Recommendation, continue with involuntary treatment to ensure compliance and monitor risk
11.7.12	North Vol 1	Medical review: Plan, as previous except discontinue antidepressant
17.7.12	North Vol 1	MHRT outcome= ITO confirmed

Date	Source	Event
8.8.12	North Vol 1	Medical review. More settled than earlier presentation, continue depot medication, risk assessment and outreach from HHOT. Discussed employment options: AOD reticent
17.8.12	South Vol 1	THT home visit - employment focus. Progress halted. Sense of hopelessness. Escalated to clinical team for follow up.
3.9.12	South Vol 1	THT home visit and 1 to 1 outing. Long description of amotivation and hinting at past relational problems.
6.9.12	South Vol 1	THT home visit - unremarkable but noting a pattern of resisting social contact and options for employment support
6.9.12	North Vol 1	Medical Review: mental state stable with chronic delusions, continue with plan
22.9.12	North Vol 1	Consumer Care Review Summary and Plan (date actually states 26.9). Risk assessed as medium aggression and suicide, low on others. Plan, attempt to modify risk levels by improving hope for future by developing social networks, increasing activity levels and integrating into employment
23.9.12	North Vol 1	Client meeting with Case Manager re: case review, plan to increase supports on recovery program and employment providers. He has little interest in most activities and ambivalent about work, became angry when family discussed and says they were involved in his decline
3.10.12	South Vol 1	THT home visit - negative and amotivated. Initiated a call later and requested help with accommodation
4.10.12	South Vol 1	THT assisted transport to review a boarding house accommodation option. He later initiated phone contact requesting further assistance.
4.10.12	North Vol 1	Presented for depot, advises recovery plan, is of little assistance to him. Plan, includes 'consider reattempting forensic review'
16.10.12	South Vol 1	THT home visit and assisted in moving house
19.10.12	North Vol 1	H/V to new address. Reports it's going well. Improved mood, planning a holiday in [redacted] Some irritability when discussing logistics in relation to holiday and ITO and depot every 4 weeks. Continues to defer referral to recovery program.
1.11.12	North Vol 1	Depot administered, mood up and down. Denies current intent, awaiting date for withdrawal of superannuation for holiday. Plan, referral to local mental health service following his return and he is moved to a new area

Date	Source	Event
20.11.12	North Vol 1	Team discussion agree to refer to PAH . Discuss transfer to PAH, AOD Agreed. Wants to reduce depot dose
28.11.12	South Vol 3	Medical Review. Transfer of care to Princess Alexandra Health Services Decrease depot injection at the request of AOD
3.12.12	South Vol 2	Clinical report ITO review. Diagnosis schizophrenia. Being treated in the community but requires ITO to facilitate depot medication and due to homicide and suicide risks
4.12.12	South Vol 1	THT Exit Summary. Reports good progress. Offered follow-up support from an NGO but this was declined.
14.12.12	South Vol 3	Referral from HHOT to PA metal health triage
14.12.12	South Vol 3	Risk Screening Tool identifies medium risk for suicide, self harm, aggression and absconding.
15.12.12	South Vol 1	Consumer Intake (ACT). Referral for assertive case management. Indicates he has a diagnosis of schizophrenia. Detailed referral information provided.
17.12.12	South Vol 2	Act Triage multidisciplinary team review. Query need for CFOS assessment
21.12.12	North Vol 1	PAH, referral accepted but no appointment until new year. HHOT to provide depot on 27.12
9.1.13	South Vol 1	Home visit by new case manager. Appointments made for medical review and depot.
14.1.13	South Vol 1	H/V. Mental state recorded. Clinical note focused on engagement and clinical impressions.
14.1.13	South Vol 1	Medical Review: Synthesizes past history. Notes anger about 'public sector unions and thoughts of being violent to them' and that family had also turned against him. Insight is poor and this is linked to the need for an ITO. Introduces the diagnosis of major Depressive Episode. Develops of plan for monitoring risk, modifying medication – weekly case management, fortnightly MO, 4-6 weekly Consultant review. Suggests a Community Forensic Outreach Service (CFOS) risk assessment
22.1.13	South Vol 1	MHRT = ITO Confirmed. AOD did not attend as previously advised
23.1.13	South Vol 1	H/V for monitoring and depot. AOD apparently not home. Not contactable by phone.
30.1.13	South Vol 1	As above. Team confirm he is overseas and will not return until March
15.2.13	South Vol 2	Authority to return patient was issued
15.2.13	South Vol 2	Change of category of ITO to inpatient
15.2.13	North Vol 1	Transfer Order MHRT to new treating doctor
5.3.13	South Vol 1	T/C to AOD who is now home from trip. Has not taken medication. Denies mental heath issues whilst OS.
5.3.13	South Vol 2	Cancellation of the authority to return the patient

Date	Source	Event
14.3.13	South Vol 1	Medical ReviewL Risk: intention to kill union officials in 2011 in response to paranoid delusions. Overdose 2010 with suicidal intent. Psychotic at the time. Ongoing high suicide risk. Dr is 'quite concerned about future treatment'.
15.3.13	South Vol 2	ITO changed from inpatient to community
25.3.13	South Vol 2	Review with Dr. Blood screen reviewed. Responds well to therapeutic alliance, would greatly benefit from a long term private psychiatrist
5.4.13	South Vol 1	H/V. Depot administered. AOD assessed as low risk to self. Fortnight visit planned.
15.4.13	South Vol 1	"Consumer Care Review Summary and Plan" completed by Case Manager Indicates it is a "Standard Review". Indicates, using risk screening tool medium level risk of suicide, self-harm, aggression, vulnerability and absconding.
24.4.13	South Vol 1	Medical Review. Detailed description of history of delusions emanating from work situation and impact on family and romantic relationships, which have all ended. Cease antidepressants.
9.5.13	WPH	Clinical Report involuntary treatment order review MHRT. Astute assessment of risk – seen as a high risk individual. Behaviorally settled but presents ongoing high risk of acting on delusional thoughts as has means and motivation. Needs longitudinal views. Previous homicide plan with aborted attempt.
27.5.13	South Vol 2	Review with Consultant. 'Don't want to be here' ' No meaning in my life' Disagrees that he has an illness, says he would not attend if he was a voluntary patient, social supports limited, not pervasively depressed, thoughts of killing unionists he finds calming. Insights nil, some family history described, declines having a CFOS review.
3.6.13	South Vol 1	Clinical Report ITO Review. Risk issues described: "Previous high lethality suicide attempt; Current suicide plan via overdose with no date or time set; Risk of further mental deterioration precipitated by social isolation. Previous homicide risk with aborted attempt"
4.7.13	South Vol 1	Dr Review - "mental state effectively unchanged for 6 months" Plan: in view of the risks and the motivation problems, it is too high risk to reduce the reduce the medication dose currently. The goal would be to reduce over time and see if AOD remains behaviorally stable. Wait and watch. When AOD expresses readiness, bulk-billing private psychiatrist would be extremely helpful. Currently does not want this. R/V with psychiatrist.
15.7.13	South Vol 2	AOD called Dr, wanted to correct various points in the report for the tribunal. Advised that this current

Date	Source	Event
		report stands
17.7.13	South Vol 2	ITO confirmed by the tribunal
9.9.13	South Vol 2	Review by Dr. Mental state stable, appears more spontaneous. Very rigid and pedantic about the wording and specific details in the tribunal report. Report corrected and kept for next hearing. Insight remains poor
1.10.13	South Vol 1	T/C initiated to CM to alert housing need. CM unaware that the accom was time limited. Team is requested by AOD to assist with documentation to push him up the list for housing.
18.11.13	South Vol 2	Review by Dr. Chronic fixed delusions. 'Lack of justice' fanaticizes about shooting union reps. States that killing someone is wrong and believes his own sense of ethics and values would stop him from committing such an act. Needs a letter or report for department of housing
16.12.13	WPH	Clinical Review ITO MHRT – Dr. Fixed systematized persecutory delusions. Recurrent fantasies of revenge most likely constitute ruminations, which he has no plans or intent to act upon. Poor insight into his illness – refutes this entirely. Referral to CFOS opinion regarding risk and risk management. AOD dies not wish to participate.
17.12.13	South Vol 1	AOD self presented to clinic for IMI Depot and script for overseas trip.
6.1.14	South Vol 1	H/V from CCW service. RN, [redacted]. Provided with a letter to take overseas about his medication. Had filled oral script and demonstrated that he would take the medication. Confirmed he understood he would miss the hearing with the MHRT indicating he did not see there was any point in being there.
7.1.14	South Vol 1	Clinical Report ITO Review. Indicates lack of change, insight. Introduces plan for referral to CFOS opinion. Indicates AOD is not wishing to participate.
14.1.14	South Vol 2	ITO confirmed by tribunal
20.1.14	South Vol 1	"Consumer Care Review Summary and Plan". Risk summary has moved all but suicide risk to low from medium. Planed focus on lack of motivation and work on decreasing suicidal thoughts.
7.3.14	South Vol 1	T/C and H/V Was expecting AOD back from [redacted] on 5.3.14
28.3.14	South Vol 1	T/C and H/V. AOD reports good trip that he extended by 2 weeks and that he was compliant with medication regime.
31.3.14	South Vol 2	Review by Dr states compliance with oral meds, remains rigid about vocational rehab and extending social networks. Accepts discussion re 'black and white thinking'. Refer to psychologist for exploration of grief and

Date	Source	Event
		loss
5.5.14	South Vol 1	T/C and H/V RN, [redacted]. AOD thinks he is not depressed. 'He fantasises about what he would do to make the unions pay for what they did to his life but stated that it is only a fantasy and everyone has fantasies'. Agrees to see psychologist on team.
13.5.14	South Vol 1	"Consumer Care Review Summary and Plan". Refuses to do a recovery plan. Goals to increase motivation and decrease suicidal thoughts.
27.5.14	South Vol 1	T/C from CM to remind him to attend medical review. Says he is compliant with medication despite thinking it is useless, because if he becomes worse without it doesn't want Dr to say non-compliance is the reason. Has a ritual of imagining shooting union reps and this is 'relaxing' before going to bed. 'CFOS referral pending'
27.5.14	South Vol 1	Psychiatrist Review. Nil homicidal thoughts, daily delusional ruminations, mostly at night but less intense. Rigid thinking: would not be satisfied to settle for work and relationships that are less than they were. Happy when away (although amotivated), more down since his return. Discussed grief and loss and suggest psychologist assessment for counseling. Remains anxious about accommodation (CM to assist). Review of meds – reduce if continues to be stable or consider alternative
27.6.14	South Vol 1	Psychol assessment. Engagement focus. Agreed to 6 one hour sessions. Insight fair, judgment poor. Talks about feeling ashamed at where his life is. Chronic, suicidal ideation with plan.
11.7.14	South Vol 1	Psychol Session.
21.7.14	South Vol 1	Clinical Report ITO Review. "He ruminates on his ideas of seeking revenge , however there is no evidence that he intends to act on these ruminations at present".
25.7.14	South Vol 1	Psychol Session Fixation on view that suicide is his only option.
4.8.14	South Vol 1	MHRT hearing = IT0 Confirmed.
8.8.14	South Vol 1	"Consumer Care Review Summary and Plan". Assessed as medium risk for suicide and low for all others including aggression. Goal – increase motivation
22.8.14	South Vol 1	CM file entry – meeting with accom provider and AOD. He wants to stay and can only do so if he moves to the high priority for housing list with DoH. AOD to action.
22.8.14	South Vol 1	Psychol Session. Presented tearful and stressed from housing meeting. Responded well when underlying

Date	Source	Event
		emotions were reflected back. Spontaneously linked homicidal ideation, plans and intent triggered by current feelings of anger at feeling unfairly treated with regards to housing. Committed to 6 further sessions.
1.9.14	South Vol 1	Psychiatrist Review. Consistent themes. Notes accommodation stress. Continue current treatment. And: "Await response from CFOS".
2.9.14	South Vol 3	Letter from Dr Department of Housing, Identified that AOD requires very high priority status
5.9.14	South Vol 1	Psychol Session. Discussing desires for travel, money, partner and ambivalence thinking his only ultimate option will be suicide. No change in MSE.
15.9.14	South Vol 1	P/C recorded by treating doctor from CFO dotor re referral for risk assessment received 28.8.14. Case discussed. No indication for risk assessment. Consultant from CFO wrote *"…is on an ITO Dx schizophrenia, now taking po medication after period of time on depot, participating in interventions with the psychologist. There has been an improvement in his mental state in last year – less irritable, not angry and wound up. Has no insight into his illness. Has developed a good rapport with the treatment team. NO history of violence, does not abuse substances, intelligent, work as an accountant. No current homicidal ideation. There is no indication for a risk assessment currently'.*
12.11.14	South Vol 1	H/V. The idea of revoking ITO was raised by CM. AOD did not think much would change except he would feel less restricted.
21.11.14	South Vol 1	Psychol Session Finding sessions useful. Sessions to continue.
2.12.14	South Vol 1	"Consumer Care Review Summary and Plan" Note that no risk factors are identified for violence. All risks now rated as low. Plan – decrease suicidal thoughts (psychologist) and increase motivation
8.12.14	South Vol 1	Psychiatrist Review. Consistent themes. Psychological interventions seen as positive and progressing his capacity to identify emotional states. Plan to reduce medication to deal with side-effects and to revoke ITO
16.12.14	South Vol 2	Letter to AOD from administrator Metro South. Notice that ITO has been revoked by [redacted]
19.12.14	South Vol 1	Psychol Session Angered by a comment from last session and thought the Psychologist had been cynical. Expressed worries about confidentiality in the public system. It was suggested he could use the private system.
19.12 14	South Vol 1	Psychological formulation. All or nothing thinking. Uses coping strategies such as avoidance, withdrawal, rumination and alcohol abuse. Therapy aims to develop insight

Date	Source	Event
9.1.15	South Vol 1	Psychol Session Themes of loss, disconnection, hopelessness.
23.1.15	South Vol 1	Psychol Session Tendency to misinterpret intentions of others.
3.3.15	South Vol 1	"Consumer Care Review Summary and Plan" MHA status is ambiguously recorded. Risk assessed as low on all measures. Introduces in the plan for social outings
9.3.15	South Vol 1	Psychiatrist Review. Consistent themes. Gets himself to sleep with repetitive fantasies of revenge (murder by shooting) upon union members at his former workplace whom he holds responsible for his professional demise and subsequent social losses. Reduce (halving?) medication to reduce side effects and due to improvements
16.4.15	South Vol 1	H/V Case Manager advises extending time between sessions and looking to discharge from case management. AOD agrees
1.5.15	South Vol 1	Psychol Session. AOD thinks therapist is wrong about fear of failure or being set up to fail. Wants to change the relationship to being two sided and having a chat. Therapist is his 'life-line' but then requests monthly sessions
29.5.15	South Vol 1	Psychol Session. Discussed family and past work issues for first time. Noted changed demeanor as he discussed feeling persecuted. He then rang and cancelled all future psych sessions. Team discussion initiated.
1.6.15	South Vol 1	T/C by Psychol. He is frustrated by the limits of the therapeutic relationship, by trust issues, by focusing on the irrelevant issues. She will contact closer to next scheduled time
15.6.15	South Vol 1	Psychiatrist Review. Consistent themes – chronic suicide risk. Recently got info about Nembutal online. No changes to the plan.
2.7.15	South Vol 1	Psychol Session. Session focused on future of therapy – this work, longer term public/private and AOD's capacity to use the sessions to make changes. For further descision by AOD
10.8.15	South Vol 1	Summary Entry for Psychol Sessions. AOD declined further sessions after a 'therapeutic rupture'.
25.8.15	South Vol 1	"Consumer Care Review Summary and Plan" The MHA status is ambivalent and inaccurate. Risks are all described as low despite recent disclosures (This does not record disclosed material about buying and hoarding benzos and reviewing access to Nembutal) Plans targeting suicidal thoughts and motivation and relying on psychology input which has now ceased.

Date	Source	Event
4.9.15	South Vol 1	T/C from AOD requesting H/V. Positive engagement. Planning another trip. Otherwise unremarkable. Setting time frame for suicide (in the next year) as he has in psychol and medical sessions.
12.10.15	South Vol 1	Clinic appointment with Dr. Became 'enraged' when discussion about future treatment raised in relation to discharge and private options. When given a timeframe of 6-12 months said he would suicide in 12 months. Stated he would not see a private psychiatrist. Derogatory about mental health clinicians (not helping, having nothing to offer, making errors of fact in his history, saying he has a mental illness). Took script = ambivalent. Discussed at team meeting. Planned discharge given 'resistance to engaging in rehabilitation focused treatment'.
24.11.15	South Vol 1	"Consumer Care Review Summary and Plan" Risks are all described as low. Plans are as per previous. There is no mention of discharge.
17.12.15	South Vol 1	H/V CM. Asked about suicidal and homicidal thoughts. He doesn't think about the union issue often but when he does it makes him very angry. Wanting to get all his money, go overseas and never come back.
25.1.16	South Vol 1	H/V CM. Risk changed to 'medium' in the notes but unclear why.
10.2.16	South Vol 1	H/V CM raises the issues of work/employment. When asked about trying a different career path, A. states that what they want him to do and he will kill someone before he does that and he stated that he has told the psychologist this. Plan to discuss "discharge from case management soon"
15.2.16	South Vol 1	Psychiatrist Review. Refuses to give permission for discussion with GP. Dr [redacted] indicates diagnosis is Delusional disorder with narcissistic traits and chronic suicidal ideation. Quickly becomes critical with thinly veiled anger when diagnosis/symptoms/discharge discussed. Clearly anxious re discharge but uses denigration and criticism of Dr and Psychol for perceived faults in care and errors in documentation of his history. Proceeding with plan to discharge after two more medical reviews and reduction of CM frequency and duration of visits.
16.2.16	South Vol 1	"Consumer Care Review Summary and Plan". Risks are all described as low. Plans are as per previous. There is no mention of ITO or discharge/transition planning.
3.3.16	South Vol 1	H/V CM. Discussed discharge plans "he appeared to be ok with this this"
18.4.16	South Vol 1	Psychiatrist Review. Remains stable. Limited social outlets. On discussing discharge plans states ' nothing has changed. Medication has made no difference'. Accom and DSP have helped more. Has not sense of a meaningful future due to inability to adapt to the consequences of his illness, which he has no insight into.

Date	Source	Event
		Orders a metabolic screen 'with copy to GP'
1.5.16	South Vol 2	Ambulance report form, taken to hospital from home. Chest pain, final assessment: Ischemic Chest pain- Admitted to short stay unit.
2.5.16	South Vol 2	ED admission Princess Alexandra Hospital, Referring doctor. Redlands hospital
2.5.16	South Vol 2	Records of Neurological and Vascular functioning, pain and vital signs, X-ray (admission to Princess Alexandra Hospital). Progress notes reveal knowledge of mental health problems. Impression- panic attack Plan- monitor blood pressure, advise patient to see GP. MAPU card admission proposed but patient declined and went home. Reg requested nursing staff to make the patient sign a 'discharge against medical advice' form
3.5.16	South Vol 1	H/V CM No suicidal thoughts today because: "someone he thought was the opposition is not the opposition". Repeated this twice. Did not elaborate. Talked about the unions and that they are going to get what's coming to them but denies homicidal ideation. Blew superannuation money at [redacted] two months ago. Medical review session and then discharge planned.
3.6.16	South Vol 1	Attended clinic for unscheduled psychol session. Was seen. Says he now has his 'head out of the sand' and was feeling more unsettled as a result. Recent issues alluded to but he was unwilling to elaborate. Declined offer of referral to private psychologist
9.6.16	South Vol 1	H/V CM Discharge discussed. AOD says nothing will change once he is discharged. Does not want info communicated to GP. Explained that he can recontact service and will put this in a letter to him.
14.6.16	South Vol 1	"Consumer Care Review Summary and Plan" Risks are all described as low. Plans are as per previous. Discharge transition to GP
14.6.16	South Vol 1	Scheduled Psychiatrist Review and final prior to discharge: AOD failed to present. Impression: likely to be experiencing difficulties with discharge – impending loss of support has triggered anxiety and anger in the context of feelings of abandonment. Send letter with re-contact details and offer of a further session. If he does not attend then discharge. Has a script for 4-5 months supply of medication
14.6.16	South Vol 1	Letter sent. Signed by Case Manager. Discharged with access advice to call mental health MHCALL if needed. Letter also sent from Dr. New appointment offered for 26/7
26.7.16	South Vol 1	Did not attend final appointment
1.8.16	South Vol 1	Discharge summary by CM. Nil follow up plan as he did not give consent to correspondence to GP

Date	Source	Event
31.8.16	South Vol 1	Clinic Reception received a call from AOD requesting appointment with Dr but was advised his case was closed, "did not accept this and was advised that Case Manager would call him back. No answer on contact. No further entries.
28.10.16 9am	South Vol 2	Ambulance called
28.10.16 11am	South Vol 1	Phone call from QPS at the vulnerable persons unit at Holland park requesting information re AOD at 11am. Incident had occurred
28.10.16 12:35pm	South Vol 2	Admission Paperwork for Princess Alexandra Hospital and admitted by law enforcement
28.10.16 2pm	South Vol 1	CMental Health Services Consumer Assessment CFOS Psychiatrist and PAH EDMH Psychiatrist conduct assessment post incident. Will be transferred to high security forensic mental health setting next week
31.10.16	WPH	[redacted]
31.10.16	WPH	Admission paper work. The Park CMHRTE Medical Review – note that he says he stopped taking oral meds 3 mths after commencing but lied to Dr repeatedly that he was still taking them. About the incident "I don't feel good about it at all, but don't feel as bad as I should, there had to be a consequence to this" ITO (MHA Section 108 & 112); Involuntary patient charged with an offence MHA Section 237(1) – Murderx1; Attempted Murder x11; Arson Notification of Classified Patient Status MHA Section 70 Custodians Assessment Authority MHA Section 65(1) & 70 Recommendation for Assessment MHA Section 16(b) & 49(a) Agreement for assessment administrator, authorized mental health service Director of Mental Health Section 54 & 55 Request for Police Assistance Section 25, 30, 117, 119, 163, 168, 507, 54

APPENDIX 6 - DOCUMENTS PROVIDED TO THE HEALTH SERVICE INVESTIGATION PANEL

DOCUMENT TITLE	Provided by:
Models of Service (MOS) • Community Care Team MOS • Consultation Liaison Psychiatry MOS • Homeless Health Outreach MOS • Mobile Intensive Rehabilitation Team MOS	Mental Health Branch - QH
Sentinel Event Review Report and Queensland Government Response The findings and recommendations of the confidential review report; *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services* 2016 and the Queensland Health response can be accessed at: https://publications.qld.gov.au/dataset/mental-health-sentinel-events-review-2016	Mental Health Branch - QH
The newly released Plan for Queensland's State-funded mental health alcohol and other drug services, Connecting Care to Recovery 2016 https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/documents/connecting-care.pdf	Mental Health Branch - QH
National Standards for Mental Health Services 2010 http://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf	Mental Health Branch - QH

APPENDIX 6 - DOCUMENTS PROVIDED TO THE HEALTH SERVICE INVESTIGATION PANEL

DOCUMENT TITLE	Provided by:
Mental Health Act, 2000	Mental Health Branch - QH
Mental Health Statement of Rights and Responsibilities 2012 https://www.health.gov.au/internet/main/publishing.nsf/Content/E39137B3C170F93ECA257CBC007CFC8C/$File/rights2.pdf	Mental Health Branch - QH
Dual Diagnosis Clinical Practice Guidelines	Mental Health Branch - QH
Guideline for the use of standardised suite of clinical documentation	Mental Health Branch - QH
Documents from the statewide suite of clinical documentation • Consumer intake • Consumer care review summary and plan • Consumer end of care discharge summary • Clinical Report involuntary treatment order review	Mental Health Branch - QH
Compiled Clinical File for Mr O'D in 5 volumes	Mental Health Branch - QH
Risk Screening Tool	Mental Health Branch - QH
Certain chapters from *the Mental Health Act 2000* Resource Guide The *Mental Health Act 2000* Resource Guide is issued by the Director of Mental Health under sections 309A and 493A of the Act. It provides explanatory information about the Act and related legislation, and sets out the Director of Mental Health policies and guidelines.	Mental Health Branch - QH

APPENDIX 6 - DOCUMENTS PROVIDED TO THE HEALTH SERVICE INVESTIGATION PANEL

DOCUMENT TITLE	Provided by:
Chapter 2 – Authorised mental health services, statutory officers and statutory bodies Chapter 3 – Involuntary assessment, justices examination orders and emergency examination orders Chapter 4 – Involuntary treatment orders Chapter 5 – Classified Patients Chapter 6 – Persons charged with an odffence Chapter 11 – Patient rights	
The Resource Guide in entirety is at: Ihttps://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/act-2000/default.asp	Mental Health Branch - QH
Overview of the *Mental Health Act 2016*	Mental Health Branch - QH
More information about the new legislation to commence on 5 March 2017 is at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/2016/default.asp	Mental Health Branch - QH
Budgeted FTE Spreadsheet	Metro North HHS
"Information Sharing between mental health workers, consumers, carers, family and significant others" - guidelines	Mental Health Branch - QH
Data on service provision – Forensic Consumers in a Specified Period	Mental Health Branch - QH
Employee Induction Checklist – MSAMHS Psychosis ACU	Metro South HHS

APPENDIX 6 - DOCUMENTS PROVIDED TO THE HEALTH SERVICE INVESTIGATION PANEL

DOCUMENT TITLE	Provided by:
Copy of CIMHA Audit Trail – 31.8.16	Mental Health Branch - QH
MSAMHS Strategic Plan	Metro South HHS
Data demonstrating breakdown of case managed consumers for Burke Street	Metro South HHS
Team Review Attendees – Mr O'D Case Reviews Metro South HHS	Metro South HHS
Clinical Documentation Audit – Psychosis ACU Quarterly Report Jul 2016 – Sept 2016	Metro South HHS
Clinical Documentation Audit – Psychosis ACU Quarterly Report Apr 2016 – June 2016	Metro South HHS
Clinical Documentation Audit – Psychosis ACU Quarterly Report Jan 2016 – March 2016	Metro South HHS
Clinical Documentation Audit – Psychosis ACU Quarterly Report Oct 2016 – Dec 2016	Metro South HHS
Psychosis ACU – Clinical Improvement Action Plan Q2 2016	Metro South HHS
MSAMHS Community Documentation Audit Tool 2015	Metro South HHS
Acute Management Plans and related documents • Guidelines • AMP Template • Police and Ambulance Intervention Plan	Metro North HHS

APPENDIX 6 - DOCUMENTS PROVIDED TO THE HEALTH SERVICE INVESTIGATION PANEL

DOCUMENT TITLE	Provided by:
Memorandum of Understanding between Queensland Health and the Queensland Police Service for Mental Health Collaboration 2016	Metro North HHS
RBWH – Acute Inpatient Discharges – Average Length of Stay	Metro North HHS
Intake Criteria for Community Forensic Outpatient Service – Updated 4/11/14	Metro North HHS
CFOS Intake Meeting Agenda and annotations 2/9/14	Metro North HHS
Signed Chart Review O'Donohue	Metro South HHS
Metro South Addiction and Mental Health Services – Psychosis Academic Clinical Unit (ACU) Patient Needs Framework. Strategic Plan Focus Area 1	Metro South HHS
Divisional Budgeted FTE	Metro North HHS
Metro North Mental Health – RBWH Activity Data – Acute Inpatient Discharge and Average Length of Stay Data FY 09/10 to FY 15/16	Metro North HHS
Police and Ambulance Intervention Plans - Mental Health Intervention Project Information	Metro North HHS
RBWH Complex Case Committee Terms of Reference	Metro North HHS
MNMH RBWH Risk Management Committee Terms of Reference	Metro North HHS
RBWH Mental Health Critical Incident Committee	Metro North HHS
Annual reports for all three HSS for FY 14/15 and 15/16	