Release Notes RTI 5221
Patient Safety and Quality Improvement Service

Right To Information – 5221 - Data relating to Critical Incident notifications for Mental Health Services as required under the Mental Health Act 2016.

Purpose of report

Provide applicant of RTI 5221 details of clinical incidents reported in RiskMan meeting criteria as *Critical Incidents* as defined in "Chief Psychiatrist Practice Guidelines - Notifications to Chief Psychiatrist of Critical Incidents and Non-compliance with the Mental Health Act 2016".

Data source

- The data presented in this report is extracted from RiskMan and is self-reported by HHS staff;
- RISKMAN is the Clinical Incident information system. It is designed to enable reporting, investigation and management of clinical incidents reported by HHS staff;
- The data was current in RISKMAN as of 21/06/2019 and is subject to change.

Search Methodology

- RiskMan data was extracted based on search criteria and checked by Systems team, Patient Safety and Quality Improvement Service (PSQIS). This was then qualified by the Clinical Governance Team Mental Health Alcohol and Other Drugs Branch to include only those incidents that met the requirements for services to notify the Chief Psychiatrist include notification of:
    - Deaths (equivalent to SAC1 under Health Service Directive (HSD))
        - open clients
        - within 30 days of receipt of care
    - Significant physical or mental harm occurring to an inpatient (equivalent SAC2 under HSD)
    - Allegations of sexual assault or sexual safety incidents occurring to an inpatient (equivalent SAC1 or SAC2 or SAC3 under HSD)
    - Serious adverse clinical incident, such as the incorrect administration of medication, that could have resulted in harm (equivalent SAC1, SAC2 or SAC3 under HSD)
    - Any incident affecting the health, safety or well-being of a patient or another person which could attract public attention or adversely impact upon the reputation of the AMHS (does not meet criteria for clinical incident reporting in RISKMAN and constitutes a new reporting item).
- Notification of critical incidents for private mental health services directly to the Office of the Chief Psychiatrist.

Search Results

- A total of 314 Public Hospital Critical Incidents that meet the criteria are included.
- A total of 12 Private Hospital Critical Incident Notifications were received.

Interpretation notes

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culture that ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

Interpreting numbers of clinical incidents, comparing the number of clinical incidents between HHSs, or using the number of clinical incidents as indicators of performance is not advised due to:

- a degree of clinical subjectivity in deciding whether an adverse outcome is a clinical incident i.e. what is reasonably expected is different from one clinician to the next, as well as what is expected by the patient/family. For example, a death may not have been reasonably expected and therefore met the definition of a SAC1 incident, but is later determined to have been the result of an underlying condition. Consistent with best practice across the world, it is important to us to have a reporting system that captures a broad scope of adverse patient outcomes that *could* be potentially preventable so that we can continue to learn and improve.
- Classification of a clinical incident does not describe 'negligence' or 'fault' on behalf of our staff or systems.
- Not all clinical incidents are preventable.
- Higher incident reporting rates are generally accepted as an indicator of a positive and transparent safety culture, rather than a marker of less safety care.
- SAC 2, SAC 2 and SAC 4 clinical incidents are not mandatorily required to be reported.

Severity Assessment Code (SAC) Definitions

SAC 1 - Death or permanent harm which is not reasonably expected as an outcome of healthcare

SAC 2 - Temporary harm which is not reasonably expected as an outcome of healthcare

SAC 3 - Minimal harm which is not reasonably expected as an outcome of healthcare

SAC 4 - Near miss which is not reasonably expected as an outcome of healthcare

PRIME ID	Incident ID	Incident date	HHS	Under MH team?	Primary incident type	Type of behaviour	Details	Confirmed level of harm
(None Entered)		2018	MACKAY	Yes	Behaviour	Risk taking Self harm and suicide	Patient in bathroom sat on the floor with around neck. Refusing to take it off, trying to tighten the knot when asked to cooperate.Verbal de-escalation utilised with no effect. When staff tried to remove the stated that wanted to 'end this' and when PRN PO was offered has refused. Informing staff that nothing is working and that wants to 'numb the pain'.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Instructions not followed	Pt was on approved escorted leave with . Staff received phone call from Police communications at that was driving car & had an accident at the in Police on the scene & Pt had sustained injury to . Pt was transferred to Hospital by QAS for further care. Pt was attended to in Hospital ED & was plastered. Pt was mobilising later that day.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Medication		Patient had dosed increase on /18 to mg (dose given that night). On 18 at order was ceased with the reason "wrong encounter" written. Patient did not get dosed then on /18. /18 as documented by nursing staff CL Psyc Reg was notified in the (approx) to review the order. Unfortunately no review was made till /18 which means now >48hrs has passed post last dose and retitration must occur. (If it was reviewed on /18 no retitration would have been needed and patient would have theoretically been able to discharge as planned on as hoped) Psyc Reg contacted myself for review on /18 and we discussed patient needing new bloods and titration doses of	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Falls	Risk taking Self harm and suicide	Client attempted to strangle self by putting a around neck, while in the toilet. was found later unresponsive, having seizures. MET call was activated and was transferred to ED for further cares.	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Self harm and suicide	At patient activated nurse call button in room.Writer and security member attended.Patient was found lying in bed with a noose over neck made of t.Both arms and legs has jerking movement at that time. eyes were closed.Writer and security member removed the .	Harm - temporary (moderate)
		2018	METRO NORTH	Yes	Behaviour	Aggression Patient/Resident unable to be located	Pt was banging head on door and shouting through door to NUM office where ACT clinician was working on MHCALL. Pt unable to be placated by clinician through door. Clinician opened door to speak with pt. Pt tried to take clinicians glasses from face then grabbed lanyard with swipe access and ID from clinicians neck and ran out of the area. ACT clinician unable to call out to pt to stop them as pt not known to ACT clinician. ACT clinician not able to call out to staff as unable to identify on floor. Act clinician unable to access safe staff area to call security without swipe access. Pt found in QAS bay by staff member and security and required physical restraint by security x 4 to escort back to and be placed in seclusion. Pt required sedation. Nearest Duress buzzer to ACT clinician stuck in corridor without back-up was the Medical emergency button.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression	Consumer began banging on windows and doors and making verbal threats to harm nursing staff. All efforts to verbally de-escalate were unsuccessful and consumer's behaviour escalated, placing self, co-consumers and nursing staff at immediate risk of injurious harm. Nursing staff called Health Security and medical Officer and attempted to place consumer in seclusion. Health Security Officers X 2 placed consumer in wrist locks and walked into the seclusion room. Consumer was then asked to lay on mattress and followed this direction however just before making contact with the mattress consumer began to attempt to kick, contorting body and limbs into an unnatural position. When consumer made contact with the mattress an audible sound was heard, followed by consumer screaming loudly, appearing to be experiencing a significant level of physical pain. Writer immediately contacted MET team who attended. Consumer was later transferred by QAS to ED. Following medical imaging consumer was found to have a fractured right humerous.	Harm - temporary (moderate)
		2018		Yes	Behaviour	Self harm and suicide	was referred to as a potential presentation, had not been seen face to face by and was not currently an open consumer <br/ was seen jumping in front of train and was subsequently hit by the train at 40kms an hour on /18. Currently in ICU, with minimal neurological recovery to date	Harm - permanent

		2018	Metro North	Yes	Behaviour	Patient/Resident unable to be located Risk taking Self harm and suicide	Mental health patient on a recommendation order absconded from the department. Miscommunication at time of handover team leaders aware of patient but security not informed. Patient initially very flattenned of affect and resting on a chair, did not appear elevated in any way or at iminent risk of walking out. Long wait for psyc reg and patient suddenly became distressed and bolted from the department. I followed , whilst calling security to let them know where we were and what had happened and found hanging from a tree by a length of rope over a steep bank. Patient had only been hanging briefly and the noose had not yet tightened I was able to reach around the tree and support the patients weight and use my arm beneath the rope to make space between the patient's neck and the rope. Whilst, continuing to lean around the tree and support the patient's weight I was able to keep the noose from tightening around the patient's neck. Security then joined us and were able to help support the patient's weight whilst slipping the noose around the patient's head. The patient was on the edge of a sloping bank and I slipped a number of times during the process of getting the patient down. Increasing neck and bilateral shoulder pain now developing and the experience was very stressful.	Harm - temporary (moderate)
(None Entered)		2018	WEST MORETON	Yes	Behaviour	Self harm and suicide	Patient inserted a couple of unspecified objects into around the 2018. However did not inform staff as per the treating team request for to let staff know. Patient disclosed the incident to support worker who subsequently informed nursing staff on /2018.	Harm - temporary (moderate)
		2018	Metro North	Yes	Behaviour	Self harm and suicide	Pt admitted voluntarily for wound which had cut with a double edged razor blade. note: from earlier today. Pt was searched by myself for razor blades on entry to ward as there is a risk assessment from mental health in file - none found. Pt then told ACT CN had a blade on person Security and medics alerted, team assembled and pt started cutting self as we approached Immediate action(s) taken Pt told to stop and disarm self. Did so by putting blade into sharps container. 2x security held arms as doctors applied pressure to wound. Wound cleaned and dressed with security attending. Pt searched again, another blade found in bag. Unsure where was hiding both blades, . pt states they were - however I checked there earlier. cubicle cleared of all equipment, pt body searched (privately with curtains closed, by myself, with metal detector and security in cubicle) Mental health order in place and security special watching pt with pts hands above the sheets at all times Result of immediate action(s) Pt did not manage to puncture . approx. 2.5cm deep wound approx. 15cm wide deepened/widened by actions on the unit. unsure of specific diameters. All razor blades cleared from person/belongings/bed space. All potential weaponry removed. What stopped the patient from being seriously harmed? Suggestions to prevent reoccurrence	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Instructions not followed Risk taking	Patient absconded from the unit and found on top of the container at hospital ground by security.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	was reportedly doing well today until after lunch when other residents of the Level supported accommodation reported was trying to throw self off the verandah. Management assisted and gave prn medication of mg, then a further mg 30 mins later when didn't settle. Management are very experienced in assisting when becomes acutely psychotic. On settling into room to allow the medication to take effect, Management then heard loud screams and on rushing to room, found that had set self alight using lighter. Management immediately pulled into the shower and applied cold water to the burnt area) and contacted QAS.	Harm - permanent
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	When attending room with treating team at , nursing staff found knot of at top of closed bathroom door. Nursing staff opened the door, , fell face first onto floor unconscious with around neck. was turned onto back and CPR started.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Self harm and suicide	Patient admitted to @ hrs young well groomed and neat polite on approach, appeared flat affect good eye contact offered dinner but declined asked of had dinner at ED said no. Items considered as high risk for the patient and for COPTS were collected from the patient on admission were leather black belt wearing on pans and 2 shoe lases removed from black shoes was wearing on admission. 2 mobiles black and white collected and small black torch, pt. compliant with admission procedures. patient has no prn's on time of admission the Nurse in charge aware allocated nurse oriented patient to the Ward took obs then took to room to settle offered a cup of tea bt declined. The Nurse came back after few minutes to take the patient to storage room to get a comfortable cloths for the night as stated has no support person for , the Nurse found the door locked then she opened the door with the key found the patient hang on the with a blanket face turned dark blue and legs off the ground and , the Nurse called loud for help then tried to left the patient up to relief neck from tied blanket so can breath then other Nurses came and help to untie the blanket from the patient's neck then patient was lifted measly to the ground patient was not breathing the allocated Nurse started CPR then the patient start breathing making noise CPR stopped patient on comfortable position until the CODE Doctors arrived. all obs stable patient responded to the Nurses before th Doctors arrived.	Harm - temporary (moderate)

(None Entered)		2018	METRO SOUTH	Yes	Medication		when coming to give mane meds for pt @ hr found 1x large of vomit (chocolate color) on the floor and bed. pt was alert and orientated at the time but appeared to be drowsy and and sedative but verbally responding and adhere to n/s instruction, physical obs was obtained which showed BP 110/76, P 120. spo2 94%, R 19 pt stated that needed to go to the toilet and mobilizing to the toilet with nil assist, spend almost 30 mins on the toilet, required n/s' supervision while on the toilet due to pt's safety and unsteadiness on feet. pt was able to take self back to bed but asked for breakfast and orange juice at the time. advised pt it might not be a good idea to eat just yet as just vomited. pt was then went back to sleep, went and checked on pt second time @ approx hr with RMO Dr found lots of saliva on mouth, after cleaning it up, it still kept coming out, pt was still breathing and able to hear it loudly. physical obs was rechecked which showed BP 82/52, P120 and spo2 65%. o2 was then put on for pt 6L/min and then it went up to 92%. MET was contacted and pt was then transferred to ED for further intervention. all mane meds was withheld due to sedation and worried pt might vomit again.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	Pt was moved to mental health pod after being medically cleared. Observations were attended at the pod, all within normal limits, pt appeared distressed and teary. Pt searched by staff compliant to all requests, car keys removed from pt. 15 minute visual observations initiated because of past MH history. Pt initially settled but staff noticed increasing agitation. (EPS) review pt when pt notifies that they had taken 40 , swallowed and self-inflicted a wound into before being moved to mental health pod. .. CNC informed and pt then moved to resus bed. Pt able to mobilise self, GCS =15, nil visible signs of self harm except small patch of blood on shirt.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Medication		Claims to have ingested pt brought into hospital and had secreted in personal care products. Same products confiscated and processed as per illicit substance due to unknown nature of substance. Sample taken by RMO and sent for analysis. Mirt called # bags of fluid given and closely monitored overnight.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Falls	Patient/Resident unable to be located Risk taking	Patient seen by staff member hiding/laying in shrubbery across the road from MH unit. Unable to weight bare, returned to unit in wheelchair, administered pain relief and reviewed by RMO. Taken for X Ray, nil breakage found, mobility aid being explored.	Harm - temporary (moderate)
(None Entered)		2018	DARLING DOWNS	Yes	Behaviour	Risk taking Self harm and suicide	Pt was nursed in HDU on constant obs- pt searched when constant nurse became suspicious pt was attempting to self harm. Pt was search. nothing found. Pt then removed and re-opened wound on . Wound was covered and dressed. Obs done - NAD. ward call paiged. Pt requested a shower. when had finished nursing staff noted that wound was still bleeding heavily. nursing staff reviewed wound and noted that vein had been cut. Ward call phoned and requested to attend ward asap. Psych reg phoned and requested to attend ward. Physical obs done again at hrs - pulse 156. Code blue called. Wound reviewed, patient was still refusing any interventions. After much encouragement and involvement from psych consultant, medical staff, ICU staff and surgical staff, has allowed staff to apply a compression dressing and wound has stopped bleeding. IV fluids put through. 2hrly physical obs. Currently awaiting blood results. constant to continue. CNO informed. NUM informed and NOK informed. Razor has been removed. No staff injury was sustained.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Instructions not followed Risk taking Self harm and suicide	- returned from leave at approximately . - appeared flat in mood but gave no obvious indication that situation had deteriorated since taking leave. - returned belongings to the locker and retired to room. - At co-patient alerted staff that was calling for staff from bathroom. - Staff responded to find droplets of blood leading to bathroom. The door was closed. - was found slouched in the corner of the shower. The floor was covered in blood. Lacerations to both forearms - Code Blue activated immediately. - Staff responded with gloves and towels. Applied pressure to both forearms. - was conscious throughout, but appeared sedated. - MET team responded promptly (within 5 minutes). - Handover was given. Transferred to ED for medical treatment.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	S: Code blue post overdose of . B:Took around tablets (in total) of over the last 3 days since , admitted to buying these on leave. Took tablets at . A: hrs Patient notified writer, writer notified TL. QADDs of 1 as HR 101. TL called code blue at hrs. RMO notified, psych registrar notified, NUM notified. ECG completed. Code blue team attended ward at hrs and taken to Emergency at hrs. R: Await outcome of ED presentation	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Aggression Instructions not followed Self harm and suicide	Patient pushed fingers into self inflicted wound causing bleeding including arterial spurting. Pressure applied by staff, but patient repeatedly trying to pull wound open to encourage bleeding, stated wouldn't be worth being seen by surgeons if not actively bleeding. Patient then became combative against staff ++.	Harm - temporary (moderate)

(None Entered)		2018	MACKAY	Yes	Medication		extensive delay in parental consent for administration for NAC with lengthy discussion with who was not happy with the administration of NAC after previous advice from another hospital last year. delay in getting order NAC and was not commenced when ordered. further query around this not being attended due to workload? as per documented in paed review	Harm - temporary (moderate)
(None Entered)		2018	NORTH WEST	Yes	Medication		As a very brief background, subsequent to input from Mental Health team to treat mental health condition, was prescribed one daily orally (and im as a different dose) commenced 18. im dose is being given here at Hospital. When represented today .18 for a scheduled review, it transpired that of the x tablets dispensed .18, there were possibly or so tablets not accounted for. As a result, this required the pharmacy RN to request an overnight supply of oral .	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Aggression Instructions not followed Substance misuse	Pt admitted to Resus 2 at hrs initially drowsy BAL 0.24 but quickly became agitated and aggressive towards staff.Settled but by required security to return to bed and further Droperidol to be administered. Continued to be verbally aggressive throughout the evening. Attempting to leave, attempting to punch security.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression Instructions not followed	Unprovoked outburst from patient, pushed self into the nurses office, was directed out. Began screaming. Staff went into medication room to get PRN for patient, patient pushed self into the medication room and began attempting to damage property in medication room including pyxis machine. Patient had locked the door behind . Staff began restraint of patient, managed to restrain to the floor. Staff unlocked medication room door. Patient remained on ground- continued to scream and fight against staff- would not comply with instructions. Security attended and assisted with restraint, was given, patient transferred to .	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Self harm and suicide	Verbally abusive and intrusive with staff Taken out on escorted leave with male staff member. has been demanding to know if could get unescorted leave back today. Quite demanding and banging on doors when did not get the response wanted. Around was seen by other staff (students) with a noose around neck. Noose was created by . They reported that was beckoning them to come see as walked to room. Staff ran after to room and had attached the noose to the door and attempting to hang. was put down and the noose was cut off. He sat on the floor for a bit, vitals done and they were within normal range. Co-patient UR kept yelling about how “you are doing this to , frustrated due to the incident. Dr attended; had some redness around neck and mild pain. has been put on 1:1 special as of hrs until further notice. Risks: high on all domains. Leave suspended.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Self harm and suicide	Pt returned from and it was noted that had a burn approx. 15cm long and 4cm wide. Unsure of exact time and date burnt self at with a lighter. Notes from indicate they found a burnt on the /03. Rang and they reported that pt had not told them of the burn.	Harm - temporary (moderate)
(None Entered)		2018	SOUTH WEST	Yes	Medication		Patient admitted for intentional overdose on the /18 and ceased during this admission. Discharge summary clearly stated that the patient was admitted for an intentional overdose however despite this the patient was provided with a further prescription for tablets with 1 repeat) on the /18. Patient presented with a repeat overdose on the /18	Harm - temporary (moderate)
(None Entered)		2018	SUNSHINE COAST	Yes	Behaviour	Self harm and suicide	Patient was annoyed that lost razor blade earlier this morning, and now had found these objects could use to self harm with.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression Instructions not followed Self harm and suicide	made a phone call to a family member which terminated after a short time. went into bedroom and a short time later was heard to be banging the walls. On staffs arrival was found to have kicked a hole in the bedroom wall (bed 2). sat on the bed and refused to talk to staff although when asked stated that the voices weren't there at the moment. declined to engage further ordering staff to "go away". Staff advised of probability of QPS attendance, stated "I know how the game works" behaviour escalated quickly, set off the fire alarms and came out of room and destroyed property +++, throwing all computers, laptops, obs machine and printers to the floor, banging on door to staff office attempting to gain entry, throwing CDs and DVD player and all remote controls at staff with obvious attempt to cause harm. DSH lacerations to both wrists, screaming and shouting at staff. All attempts by staff to de escalate situation met by projectiles thrown and further self harm. QPS and QAS called and attended.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	RN observed protruding from upper door frame, called for support to which author responded. Forced entry to bathroom attended. slumped on floor with tied around neck. removed, non responsive to verbal command, nil respirations or pulse. Code blue activated. CPR commenced and maintained until Medical Emergency Team arrived.	Harm - permanent
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression Risk taking	Consumers looking for cigarettes from each other - no cigarettes available. states that was punched in the L) side of the face in an unprovoked attack.	Harm - temporary (moderate)

(None Entered)		2018	CAIRNS AND HINTERLAND	Yes	Behaviour	Self harm and suicide	Patient was put on a category B observation level as a step down from 1:1 category a observation as per consultant treating plan. Patient asked to go for a shower and risk was discussed with by the Team Leader. Patient gave assurances would be safe and was using the shower as a means to self soothe. Despite not being on category A observations as per treating plan, decision made by Team Leader to post a nurse outside the bathroom door in order to reduce risk. Patient went in to shower at as per ieMR notes and at MET call was being made due to patient being found on floor in shower having opened wounds with a razor. Staff unsure where razor had come from as patient was refused the use of razor's whilst on the unit. Patient had been granted unescorted leave by treating team off of the inpatient unit.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	S: Client URN: ingested on unit, requiring transfer to for endoscopy. B: Hx of suicide attempts via OD and swallowing objects. Since /18 , has swallowed or attempted to swallow and . Has voiced thoughts to run to train station and suicide by train. Hx of self-harm by cutting. Reports command auditory hallucinations to harm self and others. Assaulted staff /18 by lunging at neck during dysregulated period (possibly attempting to grab staff member's ID lanyard) and subsequently charged toward staff aggressively. A: During handover at commencement of afternoon shift, staff were informed that had several potentially harmful items in possession, which staff had been attempting to convince to relinquish without success. On emergence from handover room hrs, staff attempted to verbally convince client to relinquish potentially harmful items including , (on which was chewing), and a immediately became behaviourally agitated upon verbal request, yelling "No I don't want to! Leave me alone! I'm going to swallow them"! Staff made attempts at verbal deescalation, which proved unsuccessful. hrs client walked to bedroom and closed door on , supported by and . hrs Staff applied force to open door of bedroom. Verbal contact kept entire time door was closed. kept visual contact with client through bedroom window from outside , during which client was observed to be stabbing door with . Door was opened enough to allow passage to room. NUM entered room and encourage to exit the bedroom, which did. NUM engaged in verbal de-escalation. Joined by (Psychologist) both actively attempted to engage in de-escalation/co-regulation. hrs offered and accepted PRN mg PO by . Continued attempts were made to engage in distress tolerance and self soothing, active instructions to assist with breathing, challenging negative cognitions, attempts to gain cooperation with handing over items. were relinquished to NUM. continued to speak with and NUM, allowing some physical touch to shoulder to assist with co-regulation, some verbal communication expressing negative cognitions, not wanting to go home, not wanting to remain in hospital. following firm directions to remove item from mouth, to place head down or to open eyes, but still not able to relinquish . expressed concern that if wasn't able to follow direction to hand over PSO may be required to intervene, continuing to encourage to take control of situation. voiced that wasn't able to take control and intended to swallow at that point tilted head back and swallowed at approx hrs NUM called Codes blue, nursing staff called black called simultaneously hrs. NUM instructed client to walk to rocking chair, providing assistance to reduce falls risk. Requested nursing staff immediately obtain equipment to monitor vital observations.	Harm - temporary (moderate)
							did not appear to be experiencing any difficulty with breathing. NUM offered reassurance, expressing concern about being a burden to family, NUM assured that team would work hard to upskill family to enable support in community. Client walked to chair and sat down calmly following ingestion of able to converse with staff. , code blue physician and code blue nurse assessed client medically. Reported 3/10 pain in lower oesophageal area. Physical obs taken hrs with SpO2 remaining above 98%, NAD. Taken again hrs, SpO2 99%, NAD. NUM informed CTC of flight risk - disclosed that intent to swallow item was part of plan to abscond during transit. Advised if possible to have X-ray on CTC organised for mobile x-ray of chest. Conducted hrs. CTC analysed same - outcome for client to be transferred to ED for further investigation. Client visited by family on extra-care side of unit hrs. Remained settled in behaviour with reactive affect, laughing and joking with family throughout visit. Client transferred to via ambulance on stretcher with 1:1 special hrs. PSO escort conducted to ambulance. ATOR client at receiving endoscopy. will phone unit when client is ready for transfer back to via Ambulance.	

(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Aggression Instructions not followed	Patient was in the process of being transferred to for admission under the Psychiatry team. Prior to transfer patient was settled and compliant and no medication was given as per Psychiatry Registrar instructions. Patient is under the Mental Health Act on a Treatment Authority and due to procedures of the hospital, a nurse and security were in attendance for the transfer from ED MH to . During transfer outside the department in the main hospital corridor, patient attempted to abscond and security attempted to verbally de-escalate patient. However, patient became highly agitated and screamed delusional thoughts. ED nursing staff witnessed patient kicking and scratching one male security officer while waiting for further security officers to assist. Irrational behaviour unable to be managed which endangered self, health care staff, other patients and other members of the public. Security required the assistance of operational service staff, nursing staff and members of the public to contain patients erratic and violent behaviour. On arrival of more security staff patient was placed on a trolley and restrained on the trolley. Patient continued to resist, remained highly agitated which required patient to be moved to ED for ongoing management. After 20 minutes patient continued to be agitated, requiring chemical restraint in On arrival to patient was cyanosed and oxygen applied, vital signs monitored and ECG performed. Patient required 45 minutes of physical restraint before patient settled from chemical restraint. Following an hour of observation, patient was settled and ED doctors were happy for transfer to . On movement, nursing staff noticed swelling and bruising to patients right elbow. Pt also localised to pain in right elbow. ED doctors informed and reviewed patient. X-ray of right arm attended to which revealed a fracture. Cast applied, CT attempted, Ortho advised, Psych Reg advised. Neurovascular obs of right arm- pink, warm, CR < 2 seconds, sensation intact, moderate swelling, good movement. Depending on Ortho input, Psych Reg happy for patient to be cared for on . ED Consultant notified patients .	Harm - temporary (moderate)
(None Entered)		2018	WEST MORETON	Yes	Behaviour	Self harm and suicide	Patient expecting to return to this . Not responding to nurse's oral prompts to rise and vacate room. Similar presentation to past when highly anxious and avoidant of unfavourable outcomes. Shaking head when nurses offered to assist out of bed at hrs. Continuous attempts by various staff to get response. Doctor paged re. patient refusal to cooperate. Physical obs performed and found to be compromised. Oxygen retrieved from clinic and bedhead elevated. Doctor phoned and informed of obs., doctor attended unit. Two doctors attended unit, vital signs becoming increasingly compromised so emergency response begun at hrs. team attend and IV line up and bloods taken. QAS attend and handed over to at hrs.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumer called at approximately stating was going to hang self. The friend contacted QPS who attended the scene and discovered the consumer suspended. Consumer transferred to DEM where lengthy resus occured. Consumer later transferred to with poor prognosis.	Harm - permanent

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	active in common area at commencement of shift hrs. Under supervision of 1:1 special RN , conversing appropriately. 1:1 special taken over by RN hrs so that RN could attend group supervision. RN given handover re: client's risks, presentation and traffic light safety plan system. Client subsequently conversing appropriately with 1:1 special nurse RN in lounge area. hrs client took from while under direct supervision of 1:1 special nurse, but did not proceed to , instead grasping in hand and standing in area. CN approached at this time and inquired into client's mental state as per traffic light plan. Client stated "red". Client asked to hand over by CN - refused stating "I'm going to swallow it". Client encouraged to move to closed side of unit, which did without issue at staff direction. Encouraged again to hand over upon reaching closed side of unit - refused and reiterated intention to swallow Offered and accepted PRN hrs. CN and RN attempted de-escalation of client between hrs and hrs. Traffic light plan for "red zone" walked through with client, with which partially engaged at times though at others simply stated "I want to die. I'm going to swallow it. You can't stop me". Offered use of sensory items - chose to use sensory putty with limited effectiveness. Offered mindfulness techniques including deep breathing, with which partially engaged before reiterating plan to swallow Offered use of rocking chair, which used to minimal effect. Offered reminders of support network, reasons to live, focusing on staying present with staff through five senses with occasional effect noted, but client would subsequently disengage from staff. hrs client bundled self up in corner where walls meet, refused to turn and face staff despite repeated attempts to encourage same. Further attempts to encourage handing over of made without success despite client engaging verbally with staff throughout. hrs client began lifting to mouth in corner facing back to staff - unresponsive to repeated strong redirection. held firmly by client who was also using body position and walls to block access of staff to . hrs client inserted down oesophagus . At no point during entire incident was in any position to be physically taken by staff. Codes blue and black called simultaneously hrs. Following insertion of ; client settled, sat on bed and allowed staff to perform physical obs hrs. CEWT score 0. Code blue team arrived hrs.	
								Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Alerted to people shouting/calling out in the corridor near the noted at this time that another staff member had called a code Black on entering the pt's room- pt was standing in the far corner facing the corner into the wardrobe. nurse special and RN were trying to stop the patient from swallowing an object. as I entered the room I tried to verbally talk the patient down however by the time I reached I noted that the patient had a in mouth (only 1/3 of the visible) At this time I tried to prevent the pt from passing the further into mouth at which point I was not successful and the pt pushed hand into mouth dropped the down her throat NB the pt did not choke or gag when this occurred At MET called immediately. pt returned to bed to attend obs. within moments of sitting in bed the pt loss consciousness, and began shaking- appeared to be seizing At this time the MET team had not yet arrived. CN supported airway- requesting naso pharyngeal airway could not be passed, jaw thrust and Air viva at which MET team arrived and pt began maintaining her own airway. see as per MET Call Medical record for additional information please note there was a significant delay in the arrival of Security. The code Black was called a number of minutes before the Code Blue was called (as the patient had not yet swallowed the) and yet the Met team arrived before security.	Harm - temporary (moderate)

(None Entered)		2018	METRO NORTH	Yes	Behaviour	Instructions not followed Risk taking	The first patient dropped onto the bush and fell to the ground. The patient stayed down for a short amount of time, and called for help. The second person dropped from the roof and fell over missing the bush. . The second person stopped after I told to stop. After my arrival from 10-15 meters away ran away through the walk way between the buildings.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient open to Psychosis team was found post attempted suicide by jumping . Currently in ICU at .	Harm - permanent
(None Entered)		2018	WEST MORETON	Yes	Behaviour	Risk taking Self harm and suicide Sexual behaviours	Nursing: Pt alert and oriented. Mental state/behaviourally settled with nil overt evidence of psychotic phenomena, agitation or aggression. Compliant with meds. Ate breakfast and lunch. When initially asked this morning how was feeling, pt stated "yeah good thanks". Pt has been having visitor in the yard who is a support worker from . At visitor asked to speak to staff. Reported that has reported to that has inserted an entire into when had and that has tried to get it out but is unable to. Stated that reports feeling very embarrassed and ashamed and asked the support worker to inform us rather than informing us self. has been signed out since yesterday @ 0700 , reportedly yesterday evening when staff requested to be signed back in informed staff that couldn't remember what had done with and was unable to find it, bedroom was searched by staff and it was unable to be located.	Harm - temporary (moderate)
(None Entered)		2018	CAIRNS AND HINTERLAND	Yes	Behaviour	Risk taking	Client in ED with injuries after MVA	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Self harm and suicide	Pt was a voluntary pt in overcensus, discharged from MH but did not want to leave. Expressed intent to overdose on own medications a number of occasions, escalated to CNC + MH. MH director aware and advised pt for discharge. Escorted out of department. Pt than witnessed by other ED patients taking full packet of panadol off hospital grounds.came back into department with CNC and security. Pt placed in bed in acute. Had a respiratory arrest and was moved to resus for further management and placed onto infusion.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Pt on involuntary treatment order for previous suicidal attempt. on leave from MH unit and jumped in a suicidal attempt.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Aggression Instructions not followed Risk taking Self harm and suicide	At on /2018 Pt UR requesting to access the Unit Yard. Pt UR# informed of policy of not being given access to the Unit Yard when it is dark. Pt UR# again requested to the Constant Observations Nurse to access the Unit Yard with Pt UR# becoming agitated and reporting that was being punished for no reason. The Constant Observations Nurse informed Pt UR# that was not being punished. Pt UR# became verbally abusive and told the Constant Observations Nurse to "Get Fucked" Pt UR# then Refused Regular Nocte Medications and PRN Medications. Pt UR# then demanded for Bedroom lights to be turned off. The Constant Observations Nurse requested for books, crayons and pens be handed back. Pt UR# reported that would not be handing anything back and that it was a two-way street, when can go to the Unit Yard would give them back. Pt UR then swallowed a and reported you won't get that one back. Pt UR# then stood up and presented at Bedroom door and began screaming, self-harming by banging r head on Bedroom door window with enough force to bleed. At on /2018 CN contacted the Duty Doctor, CSO, 000 QAS and QPS by phone to report that Pt swallowed a and is currently self-harming by head-banging. At on /2018 the Duty Doctor attended t Bedroom to Review/ assess Pt UR# On Review Pt UR# was bleeding from forehead wound, crying and saying wants to return to . Pt UR reported that the reason for self-harming was the voices asked to do that and could not control self. Pt UR# reported that swallowed the was using to write because feels that will make feel better. Pt UR# reported that feels pain in chest but denies feeling choked or shortness of breath. Pt UR was engaged to describe feelings and experiences and says is frustrated at hearing voices that seem so real. Pt UR# reported everyone is talking about feels people are ganging up against and feels very unsafe. Pt UR# reported that acted on the voices telling to hurt self. The Duty Doctor reassured Pt UR# that these are symptoms of Mental Health Disorder and encouraged to take Medications for agitation, which consented to. Pt UR# given and accepted PRN at on 2018 for agitation/ auditory hallucinations with good effect with Pt UR following the Treating Team instructions, verbally de-escalated and resting on bed. Pt UR# was informed that will need to be taken to a General Hospital for Investigations and to intervene in bringing out the	
(None Entered)		2018		Yes	Behaviour	Self harm and suicide		

							Pt UR# reported that will like to have the removed. The Duty Doctor completed the Authority to Transfer Patient and Police Assistance Forms. The Duty Doctor informed the Consultant on call. Pt UR# co-operated with 6 x Nursing Team Members in full PPE Kit, 2 x QAS, 2 x QPS and 1 x Security Team Member. Pt UR# through Bedroom door hatch by 2 x QPS with assistance of 3 x Nursing Team Members in full PPE Kit and placed onto the QAS stretcher. Pt UR# Released from at on /2018 and escorted to with 1 x Female Nursing Team Member, 2 x QAS and 2 x QPS. Ongoing high risk of aggression to self and others at in the context of personality dysfunction and deterioration in Mental State in custody in the context of non-engagement with Treatment.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Aggression Risk taking	Physical aggression in response to verbal aggression from co-pt - punched co-pt x3 left side of the head resulting in break? to hand	Harm - temporary (moderate)
(None Entered)		2018	DARLING DOWNS	Yes	Behaviour	Self harm and suicide	Patient rang the bell from bed; on entering darkened room and asking how I could help I did not get an answer. On inspection of the patient when I got close to the bed, I saw that had tied around neck tightly and the other end was tied tightly to the overhead "monkey bar". was leaning back on the bed so the was tight. eyes were rolled back in head and was barely breathing. Patient was gurgling. I pulled the patient forward to release the tension on the and removed the from around neck. The patient then took a deep breath and began to cry.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Aggression Instructions not followed	While briefing the EPS team security and a colleague RN monitored client.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Risk taking	At hours approached staff distressed, loud and agitated. blood evident, dishevelled and unsteady gait. Left hand middle finger deeply cut; after being shut in pt's bathroom door. Sat in dining areas engaging in conversations with staff, appears confused and unable to clearly state events leading up to event. Denied pain in finger.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	presented settled behaviourally on the AM shift. Awake at the start of the shift using phone in bed. reported that was in the green zone (meaning, was feeling mentally stable. Appropriate interactions with the 1:1 nurse special (making eye contact, talking and laughing). Compliant with prescribed medications. Visited by around hrs, brought in food for Appropriate interaction observed between them. was informed and would be visiting later on in the afternoon. asked to attend to ADL's (shower & brush teeth) around hrs after left the ward. Unsupervised access to the bathroom was granted whilst the nurse remained outside the door. came onto the ward to visit at this time (roughly hrs). After shower whilst sitting in bed osed to that had been dishonest with the nurses about mental state. added that the voices had return when was in the shower. reported that the voices told to swallow the and not to tell any nursing staff. Nurse in charge was notified about the situation and a code (Blue) was called immediately. (CNC) was notified and informed Dr. , and	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Self harm and suicide	Pt walked beside writer up the corridor and writer noticed cut on L) thumb, asked pt what happened, stated "Nothing, it's just a little cut ok?" and rubbed the blood off continuously, then stated "Look I just fucking tried hanging myself then I fell, ok?" Writer spoke with in room and was agitated then picked up that looked pre-twisted and started twisting it tighter and threw it on the bed. Said to writer "They're all coming to get me aren't they? Let's face it, I won't be here in the morning will I?, tell me seriously, you know they're coming after me don't you?" Pt refused wound care.	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Self harm and suicide	Client was given 2 hours LCT break from the ward with ran into reception to inform staff that e had bought back and was refusing to come into the the ward. Staff attended to the driveway near the bike racks to assist. Client was heavily distressed and refusing to return to the ward. Security were called, initially told to call duress if needed assistance, they arrived some time later 1 x male security and 1 x female security. Staff spent time talking to client to encourage to come back into the ward, it took over 1 hour for to come back into the unit. During this time the NUM had called QPS as we were concerned that was going to run away, subsequently during this time started moving back towards the ward and sat down a few more times. Least restrictive practice was utilised, verbal de-escalation, allowed to finish smoke as this was settling . Encouraged multiple times to come back into the ward, stopped a few more times to light up another cigarette, was also looking at cars driving past and staff had to wave down cars to drive slowly as worried that would jump in front of cars, driving past. eventually with alot of encouragement came back into the ward and was escorted through to	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Risk taking Self harm and suicide	patient found on hrs visual observation in toilet space with self harm wounds to arms and a tied around neck. Self harm instrument was a disposable blade that the client had brought in from home.	Harm - temporary (moderate)

(None Entered)		2018	METRO NORTH	Yes	Behaviour	Risk taking Self harm and suicide	Initially cooperative with NS and was a low profile on the ward. Reported low mood, congruent affect. Reported subjective extreme anxiety and agitation post T/T/family review. Given as charted which initially had a settling effect. Denied a plan to hurt rself or others. Good food and fluid intake. MEWS=0 @ 1610. Compliant with medication. Spent significant portion of the shift with called the ward @ approx reporting that had been sending distressing farewell messages. n was then reviewed again by NS @ approx disclosed that had taken a poly-pharmacy OD @ reported that had been hiding it and stockpiling meds. reports that the OD included grams of grams of of and gram of Placed on 15min physical obs, MEWS=3, due to tachycardia and respiration rate between 20-23, last MEWS=2 HR 126 @ , GCS=15. ECG taken and reviewed by RMO and bloods were taken. Bed gradient raised to decrease aspiration risk. Family contacted and given update. The plan is to transfer to a medical ward. After hours Nurse Manager, Team leader, Family, After hours psych reg in and RMO informed of the situation. Remaining medications confiscated. The remaining medications are in a clip sealed bag.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Self harm and suicide	Pt called out to nursing staff when in the bathroom having a shower at approx hrs, was found with fresh lacerations to right wrist, mostly superficial one cut deeper than the others (around 3cm). Pt stated that didn't want to do it but felt that nursing were not meeting needs, and that didn't know could ask for PRN, was advised that can always approach staff when feeling the need to self harm. Moderate amount of blood on floor, 2 x razor blades (see picture attached), later found a strip of disposable razor heads in room	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient swallowed in the context of behavioural de-compensation. Pt approached RN to advise that had swallowed the .	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Self harm and suicide	Client was found during sparodic visual observations attempting to hang self with and t behind the bathroom door.	Harm - temporary (moderate)
(None Entered)		2018	CENTRAL QUEENSLAND	Yes	Behaviour	Aggression	Between heard a loud noise/screaming from area and observed consumer 6 and physically fighting each other on the floor and consumer sitting on the floor next to r Just outside treatment room. Code black activated. Myself and other Staff physically separated the two from further fight and managed to deescalate the situation with nil further incident. Code black present just after de-escalation. Both consumer sustained injury- superficial laceration near left eye. Swelling/laceration below left eye and nasal bleeding.Fractured nasal septum confirm by CT/xray Upon discussion with parties involved/other consumers witnessed the incident it was identified that consumer said something inappropriate to and in response punched in face . This incident triggered and ended up in full physical fight with .	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Risk taking Self harm and suicide	hrs: 1st presentation with SI & SH superficial lacerations bilateral medial forearms. Also had ligature marks. Under EEA. hrs: RV by Psych Registrar, Pt for Vol Admission to MH hrs: requesting DC, reports reduced risk, agreeable to follow up from 5hrs: Re-presenting under EEA following Polypharm hrs: Psych Reg RV, discharged home with apt with CM in place	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Patient/Resident unable to be located	Was given unescorted leave by another RN at hrs on /2018 and due back at .Failed to return on time.Tried to contact - no answer,message left.Family is also hasnt got any communication from Police emergency 000 contacted and ATAP done and emailed to relevant addresses.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Aggression Instructions not followed Patient/Resident unable to be located Risk taking Self harm and suicide	took a chair and jumped over the back fence	Harm - temporary (moderate)

(None Entered)		2018	METRO SOUTH	Yes	Clinical process	Aggression	Patient arrived at on a EEO suicidal ideation and trying to tie a rope around neck. prior to this was chasing with a hrs medically cleared at hrs patient not engaging with with MH, waiting collateral from DABIT R/V 0hrs Collateral from obtained. DW Psych SMO Dr placed on Recommendation and waiting Psych Reg R/V hrs MH contacted - re patient escalating and trying to leave the building. 1 hrs Mg given s patient becoming verbally aggressive to staff. SMO requested for the patient to be taken to the de escalation room. I received a call from the shift manager stating the patient was being taken to the de escalation room by security. Patient had previous absconded from the ED while was waiting to see the Psych reg. The patient had been in the department for over 13 hours. I followed security and the patient into the de escalation room. I verbally tried to de escalation the patient and asked if would bend knees so we could sit down the floor. The patient was yelling and lashing out. was taken down by security and restrained in the prone position during the take down the patient to bite one of the security guards. Whist on the floor the patient started banging head against the floor. I double tapped on vocera and emergency button was pressed. A member of the resus team brought mg which was given. Approx 30 secs after the was given the patient became stiff, was hyperventilating and ? seizure activity. The patient was moved to resus mg was drawn up but not given. Patient was complaining of a painful wrist, mobile xray confirmed a fractured . For POP. CT Head NAD. Security have completed a formal report. 1:1 security guard has been requested for the night shift and the paper work has been completed. Mental health team aware of the circumstances	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Instructions not followed	presenting as labile in mood this shift. 1 previous episode of dysregulated behaviour in morning shift, however, quickly de-escalated with 1:1 staff time and sensory modulation, remained settled afterwards. Feigning following co-consumer out main doors, redirected by staff, limits put in place. observed smiling and giggling in response to same. lingering around nurse's station attempting to engage n/s in conversation about previous AWA attempts. Non-compliant with re-direction. Making numerous requests for leave, escorted and unescorted. Explained unable to facilitate due to staffing levels. Continued to make demands for leave, threatening to run away from staff if they take out. Offered time in courtyard, but refused same. At hrs, as visitors were re-entering the ward with student nurse, squeezed past, pushing nursing student out of the way. Reported to Admin Officer was "going for a walk" as left building.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Aggression	Security were called to assist in removing plastic from the patient who was witnessed on camera hiding an object under mattress, after plastic was removed & explanation of why patient was unable to go outside for a cigarette until after the Psych/Reg had reviewed nurse & security went back into office area & witnessed patient catching r finger in the door as attempted to shut the door. Nurse & security went back into patient & noted tip of finger on the floor, picked it up wrapped finger & organised patient to go straight around to Minor injuries. CNC notified & CCTV coverage saved.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Self harm and suicide	Patient presented voluntary for MH input. Mh were aware of this patient. was provided with medication. Security were present outside the interview room near .At security alerted me to the patient who was covered in blood with a razor blade to neck.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression Instructions not followed Risk taking Self harm and suicide	Client was noted with a abrasion toe and complaining of pain with morning duty. Reported by client that time, it may happened while was running through the chairs in the courtyard and later on in the afternoon shift reported to 2x staff that it happened in the morning while security restrained one of the was standing on feet with boots on. Not witnessed/ reported by staff.	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Aggression Risk taking Self harm and suicide	saw the doctor this morning and then allowed to go on leave for 3 hours. Said before e left that would not harm self. On return to unit had cut with a blade said bought at shopping centre. Came back to the hospital and cut elf a nd then diusposed of the blade in the toilet near Doctor sutured the wound and then ate lunch and tried to eat more, then jumped the counter into the kitchen. Seciroty called amnd followed to room where purged. Taken to with Securityh and purged again.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Risk taking Self harm and suicide	Patient was witnessed jumping injuries are extensive and has been transferred to for further management	Harm - permanent
(None Entered)		2018	METRO SOUTH	Yes	Medication		MWC, Reg, AHNUM, MHExec notified	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour		Admitted to the under joint care of paediatric and mental health teams for mental health optimisation - unable to maintain weight at home. On the /18 patient attempted to abscond and security presence was requested. Two female security guards attended and patient was restrained for approximately 3 hours.	Harm - temporary (moderate)

(None Entered)		2018	GOLD COAST	Yes	Behaviour	Aggression Instructions not followed Risk taking	CODE BLACK CALLED BY STAFF MEMBER whom was providing 1:1 care to pt due to an incident that had occurred where the pt had attempted to strangle elf earlier on. Nursing staff entered the room whom the code black was called on and pt was observed to be standing over in a headlock.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Self harm and suicide	Writer went into room to wake up at around 8hrs, on approach was laying on right side and observed to be breathing. Writer attempted to wake up by calling out to did not respond despite this. Writer removed blanket which was placed slightly covering face, was observed to have ligature around neck approximately four times which was tied really tight. Writer proceeded to untie, loosen and remove the strap. Duress was pressed. was breathing however observed to be going blue in the face. Nursing staff attended, MET call initiated. e was observed to have stopped breathing, nursing staff moved to the floor and commenced CPR for around 20 seconds before ceasing as there was a return of carotid pulse and consciousness. was observed to be trembling and eyes had rolled to the back of head. MET team arrived, vital assessed at hr as BP - 118/ 68, SP02 - 99%, HR - 67, T - 36.5 and RR - 10. was provided with reassurance, support and re-orientation to T Vital signs assessed again at hr as BP - 117/ 69, SP02 - 95%, HR - 106. was over to the Emergency Department at around hrs.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression	was antagonising co-clients. Continuous verbal aggression towards co-clients during the whole day. Unresponsive to staff intervention. Co-client punched in the face	Harm - temporary (moderate)
(None Entered)		2018	SUNSHINE COAST	Yes	Behaviour	Self harm and suicide	Was advised of planned discharge today, agreed with plan, stated would contact to come and collect	Harm - temporary (moderate)
(None Entered)		2018	DARLING DOWNS	Yes	Behaviour	Patient/Resident unable to be located	Patient found not to be in ward. Phone call from Police to state patient had had a car accident and was being bought into ED	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Patient/Resident unable to be located Risk taking Self harm and suicide	Pt went to bathroom unassissted by nursing staff. No nurse aware that patient in bathroom. Urgent assistance broadcasted from SSU TL via vocerra to help in bathroom. Pt found to have around neck. Pt had hit the staff assist button while in bathroom. No LOC. Pt had been medically cleared at 5hrs on the 2018, however awaited psych review since. Pt only reviewed post incident.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Self harm and suicide	Pt on 15 min visuals at hrs pt was laying in bed. Went to pt's room at hrs could not see pt, called out name many times as it was lunch time, No response. Walked up the hall way to the lounge room to see if was there, could not see I then went back to room called out again with no response. Noticed that bathroom door was closed, knocked on the door and called out again, still No response. Went into the pt's bathroom and found @ 5hrs in the bathroom laying on the floor with head back against the wall (slumped) near the toilet with) tightly wrapped around neck approx 4 times with several knots in it. This material which was around the pt's neck was tied to the metal rail which had a small gap on the right side edge curved part of the rail close to the right side wall (enough to slip this type of material through). Called out to nursing staff, duress alarm activated , CN called Code Blue. Myself and RN attended to Pt and CN retrieved emergency trolley. It was during that time other department staff attended ward and assisted with incident. This was prior to Code Blue team taking over. Treating team informed of incident and recommended transferring of Pt. to once medically cleared. Photo's of the material used and place of incident were taken and sent to & all NUMS.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Aggression Instructions not followed Risk taking Self harm and suicide	Patient on meal plan. Requiring monitoring during and after meals. Patient refusing step 1 of plan and nursing staff suggested step 2 for the next option as non-adherent with step 1. Patient became extremely angry and threw plate of food on the floor and the ceramic plate smashed into pieces. Patient removed and placed in room then processed and cut herself on both arms with the broken piece of ceramic. Nursing Staff attended to cuts and ward call paged and attended. Affected areas cleaned, X-ray and sutured. Given firmed limit setting and counselled. Re enforced appropriate behaviour. Offered and given prn medications. Other patients counselled and reassured. PRN administered. RMO reviewed as was already on ward	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Patient/Resident unable to be located Risk taking	Absconded from ward.	Harm - temporary (moderate)

(None Entered)		2018	METRO NORTH	Yes	Behaviour	Patient/Resident unable to be located Self harm and suicide	Pt presented to ED with suicidal thoughts with plan and intent. Had documentation with from r doctor outlining plan. private GP had contacted ACT and advised of the situation and request for admission to Mental Health. The client presented to ED around , e had with a letter from treating Dr outlining presentation and was advised to take a seat in the waiting room. MHC had returned to office at and was advised that pt was at ED. MHC drove from to ED. MHC attended the B ED around 0 to review the pt. Advised by ED nurse in charge pt was in ED waiting room. MHC unable to locate pt in waiting room. Advised the nursing team leader I was unable to locate the pt. Went outside the hospital building to contact pt. Pt advised that was at home, states left as was becoming more agitated. Advised pt to return to hospital but stated would be fine. MHC called team leader to advise pt had left ED. PT had called back 5 minutes later to advise MHC that it was all too late, stated that had taken mg s I and also had other medication with MHC stayed on the phone to pt and returned inside to ED to seek assistance for nursing staff required someone to call 000. A male nurse was at the front desk and 2 other nurses. Advised the male nurse my name and position advised of pts name and presentation to ED, advised male nurse had left ED and had returned home and has just overdosed on mg of . I advised that I have on the phone and asked if could please call 000 for an ambulance. I observed the male nurse to look up details on EDIS, proceeded to slide me the dect phone got up from the desk and left the area. I also watched 2 other nurses walk away with There were no staff left at the front counter I could seek assistance from. I was unable to unlock the dect phone. I advised the pt that I needed to hang up and call OOO. Fortunately I had been carrying the pts sealed chart with address details. Contacted 000 and advised them of the pt situation. The 000 responder advised that will be calling the patient following our conversation. MHC then contacted my TL to inform of contact with pt and overdose and advise QAS was on route. MHC also contacted her GP Dr to advise of pts overdose. QAS was sent to the pt home and transported to ED and admitted to ICU.	Harm - temporary (moderate)
(None Entered)		2018	WIDE BAY	Yes	Medication		patient became disruptive,unsteady on feet, slurred speech,restless ,incoherant	Harm - temporary (moderate)
(None Entered)		2018	WIDE BAY	Yes	Medication		Insulin dose not given at breakfast and lunch by medication nurse SMN. (separate riskman) BSL at hrs "HI" RMO consulted and ordered 32units be given. Same given by SMN and checked by LP. Order not written on medication chart. Pt then taken to DEM however BSL was then 15.5. No further action taken by DEM	Harm - temporary (moderate)
(None Entered)		2018	CENTRAL QUEENSLAND	Yes	Clinical process	Aggression	QPS brought a very agitated MH patient to . patient has long history of psychosis and hypomania and was very difficult to medicate and manage in only ED room so police stayed (no security, restraint or seclusion facilities available at Staff assessed patient and tried to manage until Dr could get a reliable history (from GP in and treatment instructions were obtained from Mental Health Team (MHT). Keeping patient in the hospital and preventing harm to staff was very difficult as is positive and was very aggressive and combative, threatening staff and trying to abscond. QPS officer remained to assist CNC as the 2 ward staff were dealing with 2 other acute admissions and other patients in the facility. Dr spoke to on-call psychiatrist at Hospital) who gave instructions for medication and to call back for video conference when patient settled enough to be assessed. Same attended with difficulty. Required 1x IM injection and he violently refused further IM medication so required a further 4x IV injections to settle initially. EEA completed and faxed to MHT - Dr phoned MH Nurse re EEA and to initiate video conference with psychiatrist to assess patient but psychiatrist not available, instructed to phone back in 30 minutes. Local QAS Officer notified of imminent transport, she notified QAS Communications (QAS). - Dr filled out Request for Police Assistance (Public Health Act) and was faxed to Brisbane. - Patient aggressive again and required 2 more IV injections. PC from QPS- would not accept Request for Police Assistance (Public Health Act) wanted Request for Police Assistance (Mental Health Act). Same filled out and faxed to Brisbane . Dr Phoned MHT to talk to psychiatrist but spoke to registrar who needed to consult with new psychiatrist as initial psychiatrist was no longer on-call. Dr phoned registrar for an update was informed psychiatrist had accepted patient and a Request for Assessment form was needed before patient could be transferred. Same attended and faxed to MHT Dr Phoned SMO Emergency Department who accepted transfer and gave instructions for further medication if required. Inter Hospital Transfer Form Completed. PC from QPS they now want Request for Police Assistance (MH Act) form faxed to same attended. PC from QAS supervisor they require a Transport Request Form. Same completed and faxed by CNC Patient aggressive required 1 more IV injections. - PC from QAS- they have not received Transport Request Form, re-faxed by RN. Repeat PC from QAS- they have not received Transport Request Form, re-faxed by QAS officer using different fax machine. QAS officer called QAS Comms to enquire about fax as it had been over 1hr since 1st form faxed and was informed that there was a fault with their fax machine Dr called QAS put in verbal request and official complaint about the >1hr delay in transporting pt. Patient aggressive again and required 2 more IV injections. Patient finally transferred to Ambulance with QPS and CNC escort and transfer to appropriate level/type of care commenced.	Harm - temporary (moderate)

(None Entered)		2018	METRO NORTH	Yes	Behaviour	Self harm and suicide	PT found at approx with tightly around neck attached to R) side of bed rail on ward bed which was in the up position. Emergency buzzer and HELP called out loudly by myself, I was first to found pt. PT was red in the face with drool/froth noted on pt's bottom lip. Oxygen applied straight away by NRM mask which was already in pt's cubicle from earlier seizure like activity. was cut from around pt's neck by passing male QAS officer. Nil change in pt's oxygenation or cardiac rhythm noted on cardiac monitor. Redness and ligature mark noted around pt's neck. Pt had brief period > 1min of being unresponsive and when came to stated "let me die, I want to die" or words to that effect. Security in attendance x 3 and pt moved across from resus to resus When pt moved across to area pt then grabbed and wrapped it tightly around neck stating "just let me die, I want to join my and or words to that effect. removed quickly by security who were standing next to pt's bed. Due to continually suicidal behaviour Dr ordered IV 10mgs with effect. Pt was then closely monitored by 2 x security officers + resus nurse who stayed at pt's bedside. Shift coordinator aware of escalating suicidal behaviour and CPO paperwork attended.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Instructions not followed Patient/Resident unable to be located Risk taking	(NB: Riskman was completed the following day by a staff member who was not present at the incident. Therefore times especially should be considered approximate). had gone AWOP on , paperwork filed at . On returned to and attempted to gain entry back into by climbing the fence. not sure what happened but states fell and felt shoulder likely dislocate. has suffered dislocations in the past. then presented to ED where was seen by Dr ED Reg who confirmed dislocation and relocated same. was then brought down to MHU and placed in	Harm - temporary (moderate)
(None Entered)		2018	SOUTH WEST	Yes	Behaviour	Self harm and suicide	Cardiac monitor alarming for apnoea. Noted that Heart rate was 190bpm. Went into patient's room and saw that was awake and bleeding. Called for help and 2 other RNs arrived. Assessed where bleeding was coming from and found patient had 3 cuts on Pressure applied on wound site. Asked patient how wounds were inflicted to which stated had "stabbed elf with ". found in bedside drawer and covered in blood. Emergency buzzer pressed and medical team arrived. As patient had only been been admitted earlier in the day, had not yet been accessed by the Mental Health team. had been referred to Mental Health for assessment but had not been awake enough for assessment in hours. Patient in then and . De-fibrillated, adrenaline and amiodarone commenced. Ultrasound done and blood found in the space. Surgeon called, theatre arranged, blood commenced and patient taken to theatre. Staff not aware that had the in possession.	Harm - temporary (moderate)
(None Entered)		2018	DARLING DOWNS	Yes	Behaviour	Risk taking Self harm and suicide Substance misuse	went on unescorted off ground leave to @ hrs and on return to ward @ hrs disclosed to staff, while smiling, had "done something stupid". Reluctant at first to disclose what e had done, with encouragement stated had taken "50 tablets" between and a " with a bottle of milk. Stated the reason was because staff were busy and "didn't know what else to do". Nil anxiety, restlessness or agitation noted before going on leave.	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Self harm and suicide	Attempts to commit suicide and self harm overnight required restraint and medical review.	Harm - temporary (moderate)
(None Entered)		2018		No	Behaviour	Self harm and suicide	Situation: attempted suicide by hanging using . was found at 5 by). r and a commenced CPR. called QAS who arrived, intubated, ventilated and transported to was transferred to the ICU at Immediate family are with and treating team report a guarded prognosis. Background: is a year old who is currently under the care of for treatment of depression, chronic suicidal ideation and self harm. had a recent admission /18 to /18 for containment of risk in response to a planning to complete suicide on the 2018. was managed on the Suicide Prevention Pathway; was last reviewed by case manager on 18 and last presented at the multi-disciplinary team case review on the /18. Current treatment includes and mgs), individual sessions and parent sessions to manage risk, and undertake safety planning. has previously attempted suicide including hanging, jumping . current service episode began on /18/ Has previously been involved with since 2011.	Harm - permanent
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient had been noted to be in the verandah area from approximately hrs, except briefly in the toilet @ hrs. had been sighted by the nursing staff completing visual observations at hrs to be in the verandah area. Nursing staff were alerted by cleaning staff of code blue at approximately hrs, when they found patient with t around neck and to tied bed end rail of the bed, patient was suspended by the sheet, in what appeared to be a sitting type position. staff immediately lifted the patient to take the weight, the patient made a sigh sound. Code blue was activated at this time also. Patient initially not responding however, responding to staff requests shortly after, (no cardiac arrest), verbally responding to staff, stating "I'm alright, I don't need it" - this was referencing an attempt to take physical observations & request for an ECG. Patient was noted to have blood coming from nose. Ward nurses and medical staff also in attendance, code blue response team arrived and decision made to transfer patient to Department of emergency Medicine for further investigation and treatment of medical emergency.	Harm - permanent

(None Entered)		2018	METRO NORTH	Yes	Behaviour	Self harm and suicide	patient admitted to at 0hrs /18 with poly pharmacy OD and self inflicted wounds to wrist and legs. Patient had CPO in attendance on and during admission. CPO was relieved by RN for break. Patient asked to go to the toilet and was assisted to toilet RN stayed outside toilet door waiting for patient to finish. CPO returned from break and RN told patient was in the toilet. CPO knocked on door to check if patient was ok patient replied was ok just constipated. Another approximately 2 minutes patient pressed buzzer in toilet. CPO opened door to find patient on the floor in a large pool of blood MET called.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Instructions not followed Risk taking Self harm and suicide	Escorted to bedroom in order to conduct a search of person as authorised by duty Dr due to recent alleged swallowing of . x2 female nursing staff and female Duty Dr present throughout this time. No distress was evident during this time though Pt reluctant to follow staff direction. No found during search. Later as Pt was laying on bed fully covered by blankets, Pt displayed suspicious behaviour (appeared was trying to hide something under the doona). Writer and fellow staff member entered Pt room and asked what she had on person. Pt became defensive and said had nothing under the doona, though later handed nursing staff the of the reluctantly and stating that had broken the and swallowed it. Item removed from Pt, CN/Duty Dr notified of events, nil compromise of airways evident, Pt able to talk and breathe without incident.	Harm - temporary (moderate)
(None Entered)		2018		No	Behaviour	Self harm and suicide	A clinician in the team received a phone call at approximately from private psychiatrist, informing her that had completed suicide via hanging. A follow up call to the private psychiatrist by a medical officer from our team revealed that was on life support and not in fact dead was referred to our service by an internal process ( ) on the /2018. Feedback was given to private psychiatrist who maintained ongoing regular contact and we continued providing consultation to that practitioner until the /2018. No further direct contact between our service and the occurred after the /2018.	Harm - permanent
(None Entered)		2018	WEST MORETON	Yes	Behaviour	Aggression	Pt was already secluded and on Continuous Observations. Due to recent violence and incidents of very low respirations recorded. Was treated in recently to find the cause of "falls". Pt fell/slipped on some water spilt. banged head and remained on the floor, appeared unable to help self up, so four Staff entered the room. was helped up and physical observations were taken. Staff from the adjoining ward [ ] were asked to attend [due to having a Hx of unpredictable violent behaviour. Pt asked CN [author] to take home just as the staff arrived. Pt then stood up and started throwing punches. was able to punch the Clinic nurse] with great force on the left side of jaw immediately prior to staff restraining .	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Aggression Patient/Resident unable to be located	Patient was doing well on Graduated leave for two days.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Clinical communication	Instructions not followed Risk taking Self harm and suicide	Despite clearly being laid out in the form, was allowed to go off site to dinner with did not exercise due care and caution and dropped back to the front entrance of Mental Health and did not escort back on to the ward (which is the usual procedure). was feeling vulnerable, and was four days off being admitted to rehab facility for and management. states felt rejected by and was upset about this. As was coming back onto the ward, saw that the kitchen in had a bottle of hand sanitiser sitting in plain view and the room was not locked. took the opportunity to imbibe three quarters of this bottle of 70%v/v alcoholic hand sanitiser. became highly intoxicated, required seclusion and multiple medical reviews including toxicology input. on a breath test blew 0.9 at highest reading however a previous reading was so high it would not register. could very well have put self into liver failure and is lucky that this did not occur.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Risk taking Sexual behaviours Substance misuse	co-pt found intoxicated, breath smelling of alcohol, singing, and slurring, hand sanitiser found in r bedroom under bed, all consumed. RMO called and 15/60 visual obs commenced.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	Attempted suicide at contacted Service to advise consumer attempted suicide with a in the bathroom.	Harm - temporary (moderate)

(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	•Staff member observed holding a in between hands at which time proceeded to hit head against the •Code Black initiated •All staff and consumers in immediate area evacuated due to involvement • stood up with in hands – From a distance was asked to drop the which did after two loud instructions • laid on the ground in foetal position and began to cry •Code Blue initiated due to injuries sustained to •Treating Consultant attempted to engage consumer – became aggressive, loud voice, using profanities, demanding to be allowed leave for a cigarette – Paranoid themes evident during conversation asking Psychiatrist why 'people had emptied' bank account and that medication given to was poisoned •Medical Response Team requested consumer be transfer to ED for further examination of injuries. •Consumer transported to ED for assessment and management.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Skin integrity	Instructions not followed Risk taking Self harm and suicide	patient found by writer during 15/60 visuals. patient locked self in bathroom with note saying don't come in. patient refusing to come out of bathroom. writer opened door , patient was hiding behind door. writer found patient with a very large laceration to left wrist with attempt to suicide. writer seen razor on floor and lots blood. writer shouted out to other nurse in corridor to call a MET straight away. writer applied pressure till Met team arrive. surgical team contacted but un- available. wound cleaned and dress by MET team. patient placed into for close observation until surgical come and review patient	Harm - temporary (moderate)
(None Entered)		2018	WIDE BAY	Yes	Behaviour	Risk taking Self harm and suicide	Pt admitted to the Ward with a Mental Health special due to self harming. We were told by day shift nurses that the pt required strict 1:1 specialling due to significant self inflicted wounds, and that a razor blade had been found hidden in clothing (and disposed of). MHU night shift special commenced at h and confiscated pts phone as per MHU protocol. Pts behaviour escalated throughout the night. At approx h MHU nurse pressed pt buzzer for assistance, as pt had gone into the bathroom by self and caused a large, deep cut on leg (I found out later that the pt had hidden another razor blade on self & used this). At this point the MHU nurse tried to stop the pt from injuring self further, resulting in an escalation in pts behaviour. Pt attempted to abscond from the Ward. Pt was running up & down the hallways, shouting, screaming and banging on doors attempting to get out. At this point I called for security, who responded quickly & restrained pt appropriately. Pts behaviour continued to escalate, therefore the MHU reg on-call was phoned and a MET call was made. Pt continued to attempt to escape and was shouting, swearing etc. (At this point also it's important to note that all the on the ward and their were awake & terrified- we did our best to try to comfort the other patients). Pt was given oral & IM sedatives, and was eventually transferred over to the MHU.	Harm - temporary (moderate)
(None Entered)		2018	DARLING DOWNS	Yes	Behaviour	Self harm and suicide	patient had been readmitted to ward at after having 'cut up' on leave - required extensive stapling in Ed - initially jovial on the ward - accepted food and drink - went to the bathroom - patient was heard screaming loudly in bathroom - had cut both leg and arm again with a blade(possibly a surgical blade secreted from Ed) - due to the anaesthetic and adrenalin in system could not feel the pain and was able to cut quite deep - there was also no bleeding (due to the adrenalin)	Harm - temporary (moderate)
(None Entered)		2018	WEST MORETON	Yes	Behaviour	Aggression	Approached co-patient regarding the noise on the unit, verbal altercation ensued followed by the 2 throwing punches at each other, CN the 2 fighting and nursing staff intervened and separated the pair. Patient UR sustained a laceration to the top of left eyebrow, escorted to seclusion, compliant with nurse direction.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Medication		Patient admitted to ED on 18 - acute deterioration in mental state, delusional. Background of psychosis managed by Wellbeing team. Patient treated on in communit . Dose not charted in ED on /18. Patient transferred to ward in the on 1 /18. Dose charted for 1 /18 by ED registrar but does not given on ward. Nursing administration task for at was 'Not Given: Order requires clarification'. dose not given on therefore not given for 48 hours while in hospital. Mental health ward pharmacist reviewed patient on /18 and notified treating team about dose not given for >48 hours. On advise from senior mental health pharmacist and treating team, decision was made to re-titrate dose as per protocol as dose withheld >48 hours (stat dose of mg given + initiation of rapid dose titration). Unsure why nursing staff did not give dose on /18. Order was clear and stock could have been borrowed (or ED pharmacist or on-call pharmacist could have been contacted to organise supply of medication). No access to stock should not have been the reason not given. Administration note stated that order required clarification. As this is a high-risk medication and abrupt withdrawal >48 hrs leads to re-titration, nursing staff should have contacted ward call or pharmacist for advice about administration after hours so that dose was not missed and patient did not have to undergo re-titration of in hospital.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Clinical process		Consumer presented under an EEA on /2018 consequent to expressing intent to harm others and reporting auditory hallucinations with graphic details to murder people and harm animals. Review by 2 Psychiatry Registrars on /2018. Appeared to be at baseline with no new psychotic phenomena or evidence of pervasive disorder. On /2018 the consumer allegedly attacked a person with a	Harm - permanent

(None Entered)		2018	GOLD COAST	Yes	Clinical process	Instructions not followed Patient/Resident unable to be located	After a deterioration in mental state it was decided by the treating team that required a more contained/acute environment so that could be observed and assessed more closely. A handover was provided by nursing staff to nursing staff at hrs after the consultant from had handed over to the psych reg from staff were awaiting a phone call back from to notify them that they were ready to accept the transfer, while waiting for this to occur absconded from at approximately hrs. A phone call was received at hrs by nursing staff on from a clinician in Emergency Department alerting them that had been detained by Police at as was agitated and refused to co-operate with them. The clinician from the Emergency Department notified staff that the Police had requested Authority to Return Absent Patient (ATAP) paperwork be completed so that they could transport back to the hospital. The ATAP paperwork was completed by staff on but was not sent off as had been transported to Emergency Department by Queensland Ambulance Service, escorted by police before this paperwork could be sent off. On assessment in the Emergency Department it was determined that had sustained a fracture of the while being detained by Queensland Police Service.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Instructions not followed Risk taking	pt was utilising leave with the allocated nurse attempted to run away from staff member, pt ended up falling over and hurting left knee	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Aggression Instructions not followed Risk taking Self harm and suicide Substance misuse	Patient post Colonoscopy At HRS reported took 15 tablets and want to go to go Emergency and wish to go to ward and want to play	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Risk taking Sexual behaviours	Client called writer into room and told writer that has a tear on . Writer asked client on how obtained the injury and client said that had sexual intercourse with co-client, then noticed afterwards that was bleeding. Client said had a shower straight after the incident.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	• hrs went on leave in company of friend • Risk assessment completed prior, had already been on successful leave this shift and previous day. Mood somewhat flat, reported felt going for a walk would be beneficial to mental state, stated felt safe to do so. • hrs p/c from n/s at Respiratory ward, stating Friend (who is currently inpatient at ward) had returned distressed and had stated had walked off and sent a text message stating "I'm sorry", reportedly at . • hrs N/s attempted to phone phone went straight to voicemail, message left to contact ward. • P/c made to already aware, stated was on the phone to and that was "lying on the grass", stating had taken 150 tablets, was on the way and to call ambulance and police. N/s informed was at . • NUM informed, Psych reg informed, psych reg contacted consultant on call. • hrs 000 phone call made to police as per consultant – Provided with information around potential whereabouts, risks, and physical description. • P/c received from respiratory ward staff, stating they had called ambulance • hrs subsequent 000 call to ambulance to confirm job had been logged and provide updates on whereabouts – Address of provided – 000 dispatcher advised it appeared an ambulance was just arriving at the scene. • hrs p/c made to to notify was in emergency department. P/c made to respiratory ward to inform	Harm - temporary (moderate)
(None Entered)		2018	WIDE BAY	Yes	Behaviour	Aggression Instructions not followed Risk taking Self harm and suicide	Patient was for planned surgery in morning for self inflicted gaping wound on , however became highly agitated and declined surgery, requesting discharge. Patient not amenable to reason and continued to express suicidal ideation and thoughts of self harm. Given prn mg at hrs with nil effect, began self sabotaging wound by collecting debri and soil and placing on wound despite being informed of risk of infection. Reviewed by treatment team and advised of being placed under a treatment authority due to impaired judgement, poor decision making and risk of further self harm and need for wound to be reviewed by medical team Seclusion authorised, entered seclusion with security presence, however required physical restraint with ABM techniques in order to lie patient down on mattress for administration of . Patient then began banging arm on seclusion wall causing wound to bleed profusely. MET call initiated at hrs. MET team reviewed client and treated wound. Plan was to transfer patient to surgical to attend to wound, however patient withdrew consent so monitored in on constant observations	Harm - temporary (moderate)

(None Entered)		2018	WIDE BAY	Yes	Behaviour	Instructions not followed Risk taking Self harm and suicide	Client being nursed under 1:1 nursing care. Staff prevented Pt from being out of view in the toilets by ensuring toilet door was left open with nurse presence, this was due to the imminent risk of self harm. Pt began yelling, screaming, threatening physical violence toward staff and slamming the door. Pt removed the dressing to and began to interfere with the wound. was asked to enter seclusion with security present which did, but commenced bashing arm against the wall. was placed in a seclusion gown but begged to keep . . Within moments of being alone in seclusion was attempting to cut into wound with ID hospital name band. Staff entered seclusion and removed the ID name band, underwear and leaving the client in only seclusion gown. On doing so, numerous razor blades were found . A further packet of 10 blades was later discovered on the floor after the pt had turned back to the seclusion window out of direct view from the nurse doing the constant obs. . A search of belongings revealed more blades. A total of 27 blades were found. Pt did not have the opportunity to use the blades on the ward although one that was found had been previously used and had dry blood on it.	Harm - temporary (moderate)
(None Entered)		2018	WEST MORETON	Yes	Behaviour	Self harm and suicide	1525: Nurse on visual observation rounds saw patient hanging at side corridor fire door, nurse pulled duress alarm. Nursing staff responded and from neck, put patient into recovery position, met call alerted.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Patient/Resident unable to be located Risk taking Self harm and suicide Substance misuse	on leave on hospital grounds to with nursing staff at commencement of shift Family meeting with Reviewed by Psych Reg - see medical note linked below Mood euthymic, reactive affect Observed laughing and giggling with co clients in community area Mental Health Safety Plan reviewed and updated prior to leave Risk screen completed Went on day leave in the care of on hospital grounds at hrs Phone call at hrs from reporting had absconded from hospital grounds Notified Emergency Phone numbers as per - AWA protocol including: PSO (instructed to perform search of grounds with client description) 000 - QAS and QPS NUM e Treating Psychiatric Registrer Dr. (Dr. subsequently informed Medical Director Dr.). 0hrs - Telephone call from reporting had phoned) at 9hrs advising she had tablets with which to overdose hrs - Telephone call from reporting took the to and has taken an overdose of and is at the there informed would drive to Telephone call to notify Police of same hrs - Telephone call from reporting had phoned reporting to had taken 30 X / tablets and was at the also advised that had phoned for an ambulance 5hrs - Telephone call to Ambulance to advise of same 17.35hrs - Police confirmed is at hrs - Telephone call from advising is in an ambulance and on way to Emergency hrs - Staff phone call received reporting had absconded from QAS upon return to and was currently in hospital food court with PSO in attendance. RN dispatched to hospital food court with aim of facilitating least restrictive transfer of client to ED for medical clearance post-overdose. CN phoned RN via deck phone hrs, who stated client was in ED awaiting assessment. SBAR email sent as per protocol Riskman completed.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	Pt took overdose while on day leave from t MH unit	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	Noted to have been seen multiple times by the mental health service in the lead up to this incident	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression Instructions not followed Substance misuse	Pt emptied the contents if bum bag onto the bed and HSOs and observed a bundle of tablets. quickly picked the tablets up and placed them back into bag. HSOs informed EN the tablets and EN approached the bed to speak with refused to hand the bag over to clinical staff to search then pulled mobile phone out and began to record HSOs and clinical staff. was told to put the phone away and to not record. hrs: PT escalates and HSO and HSO are forced apply Occupation Violence Prevention (OVP) soft hand technique and restrain the PT.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Self harm and suicide	Patient contacted a co-consumer whom found in the bathroom post self-harming. had made a large wound approximately 20cm length and 3cm width on her upper arm. had done this with a razor blade which was then disposed of.	Harm - temporary (moderate)
(None Entered)		2018	MACKAY	Yes	Behaviour	Risk taking Self harm and suicide	Patient has been seen walking out of bedroom @, with a bleeding left forearm and pt has been applying pressure to the wounds with a towel. Pt observed to have made several cuts to left forearm with a tiny blade (blade from ?), pt reported that did it in toilet, noticed. Pt had heavy bleeding from the cuts. Pt wouldn't disclose where got the blade from. MET team and On-call doctor been contact sooner. Wound had been dressed appropriately.	Harm - temporary (moderate)

(None Entered)		2018	CENTRAL QUEENSLAND	Yes	Medication		patient in ed following overdose of had been assessed by medical team and mental health team. Was continuingly drowsy and awaiting finalisation of admission process. climbed over bed rails and took 25 x mg tablets. Pt told staff who removed meds from vicinity, informed medical team and continued on cardiac monitoring.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Aggression	was placed in seclusion at hrs after barricading self in bedroom. Prior to seclusion stated that was in an alternate reality and can not cooperate because will go to hell for eternity. Intense fixed eye contact on interaction. Reported would retaliate if was forced to have medication. You are all part of 'the Construct'. Security was phoned to assist with medication was agitated and refusing medication. Nurses present CN CN writer RN 2 security officers. Treating REG Dr and RMO also present in corridor. Door opened by security. was standing with chair against the door. Refusing to cooperate. Raised arm towards staff in aggressive manner. became highly agitated and aggressive throwing body around quickly on attempt to escort to bed, was taken to the floor. Assisted to stand and physically escorted to seclusion. Given . Dr was present at time of seclusion and has authorized seclusion.	Harm - temporary (moderate)
(None Entered)		2018	CENTRAL QUEENSLAND	Yes	Medication		Patient admitted to mental health unit from the night before. Missed the night time dose and morning dose of anti-epileptic medications (they were not charted from previous night) on admission. Patient had several tonic-clonic seizures on ward in the morning and was sent to ED.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	on leave at commencement of shift. Phone call received from client's . Stated client had taken overdose of Unsure of specific medication or quantity. Stated had already called QAS on 000, who were on their way. Scribe ascertained that client was "sitting up, eyes open" and encouraged to monitor client's level of consciousness and place into recovery position if become unconscious. unable to identify any trigger for client's behaviour. Stated had presented as behaviourally settled and of reactive affect throughout leave. terminated phone call at this point hrs) in order to visually monitor client without dividing attention. awaiting QAS at time of phone call.	Harm - temporary (moderate)
(None Entered)		2018	DARLING DOWNS	Yes	Behaviour	Aggression	Both pnts walking together in when co- pnt struck Staff intervened. Seperated both pnts. taken to treatment room for rV my psych reg.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Self harm and suicide	was referred by in patient to for follow up post discharge from hospital Dis date 0/18, did not attend s follow up appointment post discharge on /18 contacted on /18 stated had run away and had not seen since /10, did not attend for depot medication which was due on /18, who hold treatment authority issued an ATAP. has been attempting to contact and via phone On /18 was advised that has sustained an injury from self mutilation, checked the information with . had cut off and had been admitted to	Harm - permanent
(None Entered)		2018	METRO SOUTH	Yes	Behaviour	Self harm and suicide	Pt found with bandage around arm, when taken off pt had clean deep cut to L) forearm, patient dismissive about how did it. Admitted later that it was done with a razor blade from Confiscated razor and checked pt room for anymore razors .	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	A: Ward received phone call from G ED hrs /18) informing unit that had been BIB QAS following intentional OD of 0mg and 0mg tablets. Reportedly required code black in ED due to aggression. Handover included administration of IM Droperidol 10mg. As per EMR notes pt transferred to ICU for close observation. R: Client remains in ICU ATOR (/18).	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Aggression Instructions not followed Risk taking Self harm and suicide	PT brought to ED by QPS on EEA after being found in car not responding to anyone. PT moved to MH post being medically cleared. PT multiple code blacks due to trying to abscond. PT was taken down in over flow after escalation and attempt to run away. PT created an unsafe environment with 10 plus ambulances in the same area. PT then given dropiridol IM and moved to MH again. PT then ran at door leading to courtyard and broke door and hinges and arci tray and absconded climbing tree in court yard. Another take down and another HNC contacted engineering and door temporary fix completed. PT then in ED with multiple escalations to executive as MH Reg not happy to put PT on TA for PICU admission as this is the only bed available. PT has # hand post breaking down door.	Harm - temporary (moderate)
(None Entered)		2018	CAIRNS AND HINTERLAND	Yes	Behaviour	Sexual behaviours	Upon regular observation rounds @ hrs, noted both clients engaged in intercourse in bedroom .	Harm - temporary (moderate)

(None Entered)		2018	CAIRNS AND HINTERLAND	Yes	Behaviour	Sexual behaviours	Upon regular observation rounds @ hrs, noted both clients engaged in intercourse in bedroom .	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Self harm and suicide	On arrival to , pt disclosed ingesting 4 x tablets & 2 x tablets. Reports had concealed this on person and took same during transfer with QAS	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	At approximately scribe entered the room to find lying on the floor on the far side of the bed with a tied around neck, with a inserted into the ligature and twisted to tighten it. face was a light purple colour, and was taking very short gasping breaths. Scribe immediately called other N/S member for help and to retrieve a ligature cutter. N/S returned within 45 seconds with the ligature cutter and the ligature was cut and removed from neck, at this point face was a deep purple colour and breathing had stopped. CN was notified and a code blue was immediately called. CPR was commenced for approximately 30 seconds when began to spontaneously take breaths again and a strong pulse was evident. Physical observations at this moment were BP - 167/87 O2 sats - 97% Pulse - 105 BSL - 9.0 mmol GCS 11. was unresponsive to spoken words, however responsive to painful stimuli and pupils were responsive to light. Code blue team was in attendance several minutes after calling the code. GCS 14 at . A soft collar was applied to neck and was rolled onto a back slab and transported to ED resus bay for medical attention.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Self harm and suicide	On observation check undersigned found with ligature around neck lying on the floor.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Clinical process	Instructions not followed Risk taking Self harm and suicide	Patient currently under Mental health Act as a voluntary patient. Multiple endoscopies and laparotomies for foreign body ingestion.Patient being specialled by Enrolled Nurse special. EN nurse special went to complete Patient observations, instead of using a tympanic thermometer used oral thermometer with probe cover under the patients tongue. Patient proceeded to swallow thermometer cover and then escalate in agitation from that point forward- pulling at abdominal wound. 3x nursing staff removed fingers from wound in presence of Security officer.	Harm - temporary (moderate)
(None Entered)		2018	TOWNSVILLE	Yes	Behaviour	Aggression	Waiting for lunch time meal. Accused fellow patient of taking place at the and told in a aggressive manner to move, voice raised which alerted staff. Would not respond to requests to leave the area. then hit fellow patient with fists to the upper body and face.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Instructions not followed Patient/Resident unable to be located	Reported to have absconded from ward during OT session on hospital grounds.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Instructions not followed	Social worker called nurses station approximately hrs notifying that e thinks was hit by a car near the on . The driver of the vehicle had already called the police and another member of public had called the 000. was conscious but appeared to be in shock at this time. Taken to ED by ambulance with one nursing staff for further assessment. Co patient (URN:) was with and witnessed the scene - stated the patient was in rush to return to from leave (This was also supported by other witness statements) and was struck by a motor vehicle when attempted to cross the road. PEC) of notified that is at casualty notified staff approximately hrs that there was no major issues with the patient and will be monitored for 4 hours, however, later notified that would be staying overnight and have tertiary examination tomorrow morning. Doctor also informed staff that had a but they were not going to do anything about that. CN then liaison with PEC and short stay to inform of recent mental state and risks after discussion with psychiatrist on call. Other relevant staff have been informed (Ward consultant, CAC, NUM, Director of nursing of mental health and work consultant emailed chief psychiatrist. A copy of medication chart has been faxed via and ED coordinator confirmed that med charts have been received. Patient's has been informed the above.	Harm - temporary (moderate)
(None Entered)		2018	GOLD COAST	Yes	Behaviour	Aggression	active in main unit area shortly after observed conducting a hostile belligerent interaction with another patient, escalated rapidly to violent assault on patient , punching them multiple times around the head region, withdrew self after staff requested to cease the action, appeared to be a targeted attack and without immediate provocation, supported by another patient, had been reported at handover some earlier provocation had been occurring and during the previous 2 shifts conflict between the two had been rising to critical levels, CODE BLACK INITIATED,	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Nurse Call buzzer activated and when staff attended f was sitting on the side of the bed with feet in a tub of water and holding an active power board threatening to drop it in the water and electrocute self.	Harm - temporary (moderate)

(None Entered)		2018	GOLD COAST	Yes	Behaviour	Self harm and suicide	Patient self harmed by placing under boiling water using hot water urn in kitchen at hrs.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Risk taking Self harm and suicide	Patient placed a large plastic bucket in room. Filled it with water and placed feet in the bucket. The pt connected a power board to a wall socket next to the pts bed. The pt then pressed the nurse call button in room to draw attention. Clinical staff attended and requested security to attend as the pt had only recently come out of the low stimulus area in seclusion. Clinical staff observed what was set up and requested the treating Dr attend. Duress was activated. I requested a long wooden item like a broom handle to hit / move the power board out of the bucket as quickly as possible if the pt dropped it in. Clinical staff went to organise engineering to attend asap to switch off the power to the pts room. Clinical staff returned with 2 metal poles. I advised they could not be metal. Engineering staff attended and walked past the room. The pt was assumed to have seen them. Whilst the Dr was continuing to speak to the pt made demands to not be given medication any more. The pt then counted down 5, 4, 3, 2, 1, and then proceeded to drop the power board in the bucket of water. This was directly observed by numerous staff. The Dr was the closest person to the bucket and wall socket. The Dr flicked the switch on the wall socket and removed the power board from the bucket. I was finally given a long wooden pole so I double checked and used the pole to ensure the power was switched off and cancelled the nurse call as it was still activated. The pt was moved back onto bed and clinical staff proceeded to do obs and called a MET Call and QAS. Security took notes and video and secured the area. I remained inside videoing the details of the pt who was now being	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Risk taking Self harm and suicide	Loud scream heard from area of bathroom. No reply from to knock on door and staff calling out. Staff entered bathroom within 60 seconds of initial scream. found on floor, clothed with tied around neck. Face blue, rest of body perfused. Ligature removed and patient slid away from door. Non responsive including to pain. RMO onsite did initial assessment and then called. Non-responsiveness persisted for approximately 30 minutes. This despite blood being drawn and vitals being performed on multiple occasions. Transferred to trolley via backstrap and 6 person lift. Eventually responsive to verbal stimuli, able to look with intent. Able to feel feet and hands but not move same. Transferred to ICU by team.	Harm - temporary (moderate)
(None Entered)		2018		Yes	Behaviour	Risk taking Self harm and suicide	Consumer's contacted community mental health on /18 to advise that the consumer had attempted suicide on /18. At the consumer reportedly jumped . The consumer sustained multiple significant injuries. Ambulance attended the scene and the consumer was resuscitated, ventilated and transported to ICU. .	Harm - permanent
(None Entered)		2018	DARLING DOWNS	Yes	Behaviour	Self harm and suicide	Patient was admitted to Unit as Voluntary Patient on at admitted for suicidal ideation on the background of problematic substance use and multiple social stressors with a possible underlying depressive disorder. Today at patient was found hanging from the door at the entrance to bathroom, by nursing staff. Patient had made a hanging device (noose) out of a , patient had tied t around the door handle and hung it over the top of the door, than placed it around neck. Prior to the patient being found the patient had been in the courtyard of Unit at the on the routine half hourly check. Patient had been noticed by nursing staff to be watching tv, approximately 5-10 minutes prior to being found in r room. The patient had been found hanging from the door when nursing staff had gone to advise the patient that dinner had arrived. The nursing staff member immediately notified other nursing staff present on the ward, nursing staff immediately attended and lifted the patient form the door where was hanging unconscious and placed onto the ground. Patient was objectively cyanotic, patient was not breathing and a pulse could not be found. Staff immediately instigated a Code Blue and commenced CPR. After approximately 1 minute of CPR patient began shallow breathing and a pulse could be found, other staff present brought emergency resuscitation equipment to the immediate area, oxygen therapy was commenced and the patient was placed in the recovery position whilst awaiting the Code Blue Team's arrival. Once the Code Blue Team arrived they took over the patients care. Once stabilised the patient was taken to the Emergency Department prior to being transferred to the Intensive Care Unit. CNO were notified of the incident, as well as the on-call psychiatric registrar, subsequently the Nursing Director, Executive Director MHS & AODS and on call Consultant were informed of the incident. Nominated next of kin - was notified of the incident, than notified the patients who called the ward and the call was transferred to ICU. Attending staff were informally debriefed.	Harm - temporary (moderate)
(None Entered)		2018	WIDE BAY	Yes	Behaviour	Self harm and suicide	Pt was happy and smiling at start of shift but became upset when could not get the allocated nurse of choice. tends to try to pick nurse and this cannot always be accommodated. escalated in a short space of time and opened a wound that had on leg from recent self harm. The wound still had stitches insitu. On RTW she remained demanding, continued to try to control who nurse was when PN was on break. Ipad was removed from possession in presence of security, and at one point was banging head repeatedly on the wall because Ipad was removed. Oncall Dr notified before removal to DEM and again on RTW when head banging commenced.	Harm - temporary (moderate)

(None Entered)		2018	MACKAY	Yes	Behaviour	Self harm and suicide	Writer was completing hour visual observations and found in room at approximately hours sitting upright with legs out in the corner of room. When writer approached , writer could see a ligature without a fixed point, made from around neck. was stretched out and wrapped around neck tightly several times. Duress activated and writer untied was pink in colour and able to answer questions asked by writer. Staff attended to needs. Writer continued with visual observations to ensure all other patients were safe on the ward.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Behaviour	Risk taking	Pt had returned from esc leave and then inserted paper clip into	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Medication		Patient had dosed increase on 18 to 600mg (dose given that night). On /18 at 1 order was ceased with the reason "wrong encounter" written. Patient did not get dosed then on 18. 1/18 as documented by nursing staff CL Psyc Reg was notified in the afternoon (approx 1pm) to review the order. Unfortunately no review was made till /18 which means now >48hrs has passed post last dose and retitration must occur. (If it was reviewed on /18 no retitration would have been needed and patient would have theoretically been able to discharge as planned on as hoped) Psyc Reg contacted myself for review on /18 and we discussed patient needing new bloods and titration doses of	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Medication		when coming to give mane meds for pt @ hr found 1x large of vomit (chocolate color) on the floor and bed. pt was alert and orientated at the time but appeared to be drowsy and and sedative but verbally responding and adhere to n/s instruction, physical obs was obtained which showed BP 110/76, P 120. spo2 94%, R 19 pt stated that needed to go to the toilet and mobilizing to the toilet with nil assist, spend almost 30 mins on the toilet, required n/s' supervision while on the toilet due to pt's safety and unsteadiness on feet. pt was able to take self back to bed but asked for breakfast and orange juice at the time. advised pt it might not be a good idea to eat just yet as just vomited. pt was then went back to sleep, went and checked on pt second time @ approx hr with RMO Dr found lots of saliva on mouth, after cleaning it up, it still kept coming out, pt was still breathing and able to hear it loudly. physical obs was rechecked which showed BP 82/52, P120 and spo2 65%. o2 was then put on for pt 6L/min and then it went up to 92%. MET was contacted and pt was then transferred to ED for further intervention. all mane meds was withheld due to sedation and worried pt might vomit again.	Harm - temporary (moderate)
(None Entered)		2018	METRO NORTH	Yes	Medication		Claims to have ingested pt brought into hospital and had secreted in personal care products. Same products confiscated and processed as per illicit substance due to unknown nature of substance. Sample taken by RMO and sent for analysis. Mirt called # bags of fluid given and closely monitored overnight.	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Medication		MWC, Reg, AHNUM, MHExec notified	Harm - temporary (moderate)
(None Entered)		2018	WIDE BAY	Yes	Medication		patient became disruptive,unsteady on feet, slurred speech,restless ,incoherant	Harm - temporary (moderate)
(None Entered)		2018	WIDE BAY	Yes	Medication		Insulin dose not given at breakfast and lunch by medication nurse SMN. (separate riskman) BSL at hrs "HI" RMO consulted and ordered 32units be given. Same given by SMN and checked by LP. Order not written on medication chart. Pt then taken to DEM however BSL was then 15.5. No further action taken by DEM	Harm - temporary (moderate)
(None Entered)		2018	METRO SOUTH	Yes	Medication		Patient admitted to ED on /18 - acute deterioration in mental state, delusional. Background of psychosis managed by Wellbeing team. Patient treated on in community mg nocte). Dose not charted in ED on /18. Patient transferred to ward in the on /18. Dose charted for /18 by ED registrar but does not given on ward. Nursing administration task for at was 'Not Given: Order requires clarification'. dose not given on therefore not given for 48 hours while in hospital. Mental health ward pharmacist reviewed patient on /18 and notified treating team about dose not given for >48 hours. On advise from senior mental health pharmacist and treating team, decision was made to re-titrate dose as per protocol as dose withheld >48 hours (stat dose of mg given + initiation of rapid dose titration). Unsure why nursing staff did not give dose on /18. Order was clear and stock could have been borrowed (or ED pharmacist or on-call pharmacist could have been contacted to organise supply of medication). No access to stock should not have been the reason not given. Administration note stated that order required clarification. As this is a high-risk medication and abrupt withdrawal >48 hrs leads to re-titration, nursing staff should have contacted ward call or pharmacist for advice about administration after hours so that dose was not missed and patient did not have to undergo re-titration of his in hospital.	Harm - temporary (moderate)
(None Entered)		2018	CENTRAL QUEENSLAND	Yes	Medication		Patient admitted to mental health unit from the before. Missed the night time dose and morning dose of anti-epileptic medications (they were not charted from previous night) on admission. Patient had several tonic-clonic seizures on ward in the morning and was sent to ED.	Harm - temporary (moderate)

PRIME ID	Incident ID	Incident date	HHS	Under MH?	Primary incident type	Type of behaviour	Details	Confirmed level of harm
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Above patient was admitted to ICU following an overdose on 17. was stepped down to Short Stay Unit on 17 and seen by an MO with the plan for discharge to family's care that evening and ACT follow up. On 17 at approximately hrs the above patient was readmitted to ICU via ED following cardiac arrest. Patient's condition was confirmed by ICU staff to be subsequent to a further overdose following discharge. (confirmed via comparison of level at point of discharge and post re-admission). Informed by ICU staff that on .2018 at hours the above patient was declared deceased as a result of a suspected suicide from overdose of	Death
		2018		Yes	Behaviour	Self harm and suicide	MHS informed by of patient's suicide by hanging.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	It was reported by that patient previously known to Mental Health had completed suicide on 2018 by overdose at . patient had been previous inpatient of in 2017 for days	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	CIMHA clinical notes indicate died by hanging	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	contacted MH CALL to advised that was found deceased at home at , on the 2017. staed it appeared had completed suicide by ovedose and left a letter	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Client was discharged from hospita 17 for community follow up, had appointment at hrs 2018 to be reviewed by MO, DNA, MO advised via phone call from Police at that client was found deceased.	Death
(None Entered)		2018		Yes	Deterioration		Author advised by patient safety of the suspected suicide of on the 2018 by . Consumer was closed to the Acute Care Team 18	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Pts contacted the treating team on the morning of 18, via text message to inform us that the pt was deceased. Further information provided by QPS confirmed Pt was found deceased, hanged, .	Death
		2018		Yes	Behaviour	Self harm and suicide	Consumer under the care of a community mental health team discovered suspended in home after a request was made to QPS to provide a welfare check.	Death

(None Entered)		2018		Yes	Clinical communication		Patient was brought over to Emergency from MH by an AIN due to deterioration. AIN has lined up in Triage line. I was CIN nurse at time and recognised the AIN and I have said hello to the AIN who was second in line. Quickly spoke to the AIN and established has brought a patient over from MH and advised we will be with them shortly. By this I meant the triage nurse would triage the patient next. I have stepped out the back to finish care on a patient in the . The AIN has then sat down in the waiting room taking the patient out of the triage line, expecting me specifically to know the reason for the patients presentation and expecting the patient to be seen too immediately. When I have returned to the front of triage a few minutes after first speaking to the AIN, I saw them sitting in the waiting room. I assumed the patient had been triaged by . I did not know the extent of the patients medical condition or the seriousness of the presentation. has seen the patient in the WR and asked if they were ok at a later point which they have said yes, not knowing the patient has not been put onto the system and been triaged. Approximately a hour after the patient first presented to emergency, the AIN has come up to me as I was at the front of Triage, asking, how much longer the wait would be. I have tried to find patient on EDIS and couldn't. I have then established through questioning the patient was never triaged. I have immediately triaged the patient, then advised the triage TL and Resus TL of the situation and taken the patient into a bed in Resus, when the patient was immediately seen by consultant . The CNC and CTC have also been notified of situation.	Death
		2018		Yes	Behaviour	Self harm and suicide	Notification received by Police Communications that the patient had been found deceased by a at on the . The patient had reportedly gained access to and had been using .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Family advised that had jumped from a height and that he was subsequently deceased	Death
		2018		Yes	Behaviour	Self harm and suicide	patient found after harming self in bathroom. Pt unconscious and non responsive. Had ligature around neck which required cut down sissors. Alarm activated and initially 2 staff commenced CPR. Code Blue activated when other staff arrived. Code Blue team arrived. Unable to resuscitate pt and ICU consultant called time of death.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Open consumer of Community MH deceased of likely suicide	Death
		2018		No	Behaviour	Self harm and suicide	Believed to be suicide. Coroner's form 1 received. Suicide note viewed and other collateral that indicate death was planned. will be conducted by staff with assistance of Pt Safety Unit. GP has been invited.	Death
		2018		No	Behaviour	Self harm and suicide	Suspected community suicide	Death

		2018		No	Behaviour	Self harm and suicide	informed at on 2018 by police that has been found deceased suspected but not confirmed suicide informed at on 2018 by police that has been found deceased suspected but not confirmed suicide informed at on 2018 by police that has been found deceased suspected but not confirmed suicide	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Consumer had disclosed finding hanging on 2018 - during open disclosure process surname of discovered via Police. CIMHA review ascertained that had been known to Mental Health - most recent contact in 2018	Death
		2018		Yes	Behaviour	Self harm and suicide	Mental Health Services notified via QPS of alleged suicide by consumer of service. Found by	Death
(None Entered)		2018		Yes	Behaviour	Risk taking Self harm and suicide	Police reported the event occurred at and initial reports indicated possible suicide by jumping	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient referred to ACT- community on 2018 following attendance at -ED on 2018 on EEA, expressing thoughts re harm to self. Community contact attempted via phone to both patient and NOK. On 2018 Phone call received from Rehab based OT who advised patient had not attended booked appointment. P/C made to patient, NOK- , and Decision made to call QPS for welfare check - advised at time of call QPS already attending address. Further to the above QPS attended to advise patient found deceased. Later information - currently deemed suspected suicide.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient was recently assessed by the on the th 2018. The patient then had a psychiatric review by a medical officer on the th 2018. Emailed then received from Information Support Officer with evidence suggesting the patient was found deceased at home.	Death
		2018		Yes	Clinical process		Consumer found deceased in with a syringe in hand, a spoon with with white residue, burnt paper and a lighter. left a phone message advising of consumer's death on writer's mobile phone on 2018	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Pt seen in ED due to intoxication and aggression. Placed under MHA and transferred to ED for MH Assessment. Pt Assessed by both Clinician and Psychiatric Registrar. Discharged home following and referred to ACT. ACT called day of discharge to monitor risk and offer f2f. F2f booked for . Pt declined interim calls/contact from ACT and according to CIMHA notes denied any SI/Plan/Intent at time of call.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	police notified psychiatric registrar based at that the patient who had contacts) with CL psychiatry in has completed suicide shortly after contact with the service. was found on 18. registrar then emailed CL consultant on 2018 at hrs. At this stage no further details known	Death

		2018		Yes	Clinical process		Client took overdose of	Death
		2018		No	Behaviour	Self harm and suicide	Patient was on approved home leave from th with plan in place for return to ward nd for review , discussion re medications and discharge planning. was contacted by phone by RMO on st and all reports were favorable at that time. approx. the palliative consultant was contacted by the police to inform that the patient was found deceased at home by - The medical officer reported being informed that it was death by hanging -	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	On 18 at about hrs ACT received a call from the of advising had a communication and conversation with which became abusive. There were no threats to harm self or others at this time. . called ACT for support and advice as to how to manage behaviour. Previous interactions with QPS had reviewed in ED. was provided information and options which accepted. ACT confirmed arrangements for contact and review with .18. Consultant on call Dr contacted by QPS Comms Brisbane about hrs same date and advised of the call to QPS by advising of the threat received by to hang self. That the QPS attended the residence and confirmed that was located in a deceased state. Dr contacted the and provided advise of the incident reported as per protocol.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	QPS called CYMHS to advise that consumer had been located deceased.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	The consumer was found by Queensland Police Service hanging .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Suspected suicide of consumer days following d/c from . Further details unknown. Service became aware of incident through liaison with police over years after the consumer's suspected suicide.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Reported (from of) that had gone to with , had locked self in the house. gained entry and found hanging. MHAS informed 2018.	Death

		2018		Yes	Behaviour	Self harm and suicide	hrs – Patient seen in . Presented as pleasant during brief interaction, appropriate eye contact. Affect reactive, smiling appropriately during interaction, settled in behavior, nil evidence of agitation or distress. When asked how was stated was good. Speech- normal rate, tone and volume. Patient request as usual everyday. Patient appeared authentic in request to attend to personal hygiene needs. hrs – Patient approached the nursing station holding a towel which gave the impression that was intent on attending to personal hygiene needs, given toothbrush and toothpaste. He reminded nurse that he wanted a razor and some shaving foam, same given and patient stated he would return items when he finished. Thought form- nil evidence of formal thought disorder – logical and sequential. Perceptual disturbances – No observed responding. Speech – normal rate, tone and volume. Mood – described as "good" Affect – reactive, appropriate, congruent with mood and content. Behavior – settled, appropriate, nil evidence of agitation or distress. Appropriate eye contact during interaction. Appeared authentic in his requests. Content – Nil suicidal or thoughts of self harm expressed. 0727 Author observed patient walk past the TV carrying a towel, unaware he was carrying items under the towel, however, this would not have raised alarm as had been assessed as appropriate and given said items by his nurse. 0728 Author preparing for the 0730hr observation checks of the ward. I was standing in the dining room area looking toward the TV area. I noted the patient walk past me, down the hall with his towel and proceed toward his room. I did not note anything else in his hand. Minutes latter I was perusing the area, noting people waking and coming towards the communal areas for breakfast. I noted from the hallway that there was a towel over the door at the end of the hallway. This being the patient's room. This raised my concern as it is unusual. I proceeded toward this room at the end of the Swing corridor to commence my observation rounds and check why the towel was there. I raised the left hand corner of the towel to look into the room. I saw the patient bent over and staggering from the bathroom. He was holding his neck. There was blood all over his clothes, door and wall. I immediately pulled my alarm and called for help. At the same time I unlocked the door and swung it open. Staff attended within seconds. and were the first in attendance. I alerted staff be was bleeding from the neck. Staff from other areas began to arrive in moments. MET call initiated . Crash trolley and towels bought to area. Patient had fallen to the floor and staff applying pressure to stop blood flow. Patient resisting relocation to the bed and making difficult to stem blood flow. Initial obs taken. Met team and AHNM x2 arrive. Care taken over by the same. At this time very hostile and agitated and	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	; of deceased contacted ACT on 18 to advise that is deceased reportedly via suicide	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Clinician received phone call from employer of consumers advising that had been found deceased. Phone call from QPS to Clinician @ hours confirming body had been found .	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	The had been seen by the whilst in . . It was reported that the patient took a large quantity of prescription medication prior to retiring to bed. The next morning went to wake but without success. The circumstances of the death were unclear. However a note entered in CIMHA 2018 and later saved on 2018 by noted a phone call had been received from the patient's , who advised that "had completed suicide" and this was "by overdose".	Death
		2018		Yes	Behaviour	Self harm and suicide	of client contact contacted and spoke to CN informing her that client would not be attending appointment as they had died by hanging on the 2018. of client contact contacted and spoke to CN informing her that client would not be attending appointment as they had died by hanging on the 2018.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	2018 - referred from Mental Health to Mental Health Service, for follow up and treatment after an admission to /2018 - /2018 - for ongoing use, depressed mood and suicidal ideation. Booked for Psychiatric Registrar review - /2018 /2018 - Seen by Psychiatric Registrar - impression documented - MDE- severe having resulted in unemployment, complicated by use. Risk identified as moderate - however indicated was willing to engage with Mental Health Services and community supports, with the support of . Financial instability was seen as a risk factor at this time. Medications reviewed at this time. 2018 - Follow up phone call provided to - Psychiatric Registrar appointment booked for 2018 2018 - attended appointment at Mental Health Unit, although was not seen by Psychiatric Registrar. 2018 - Call to to re-book Psychiatric Registrar for /2018 /2018 - Seen by Psychiatric Registrar - impression noted - MDE - symptoms improving. Plan to continue with medications and community supports. New appointment re-booked for 2018 /2018 - contacted QPS stating that has hung self at home address. QPS attended and confirmed is deceased.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Staff notified by community pharmacist on 18 that last picked up medication ( ) on 18 and picked up 3 take away doses. Pharmacist advised that had been found deceased . reported missing on 18 and police found on 18 deceased. Cause of death unknown client last reviewed at on 18. Nil illicit substance use. Prescribed decreasing fortnightly. Follow-up appointment booked for 18. Mood was happy	Death

(None Entered)		2018		Yes	Deterioration		staff checked client and at hours found client slumped across bed; cyanosed lower limbs; face & neck discoloured; pulse not detected; nil breathing detected;CNO notified Emergency operator notified then QAS contacted; Duty MO contacted to attend & declared life extinct at hours. NOK notified at hours QPS attended at hours	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumer under care of the Mental Health Service's Continuing Care Team post discharge from the In-Patient Unit 18 to 18) for manic episode of .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumers family notified the service that has committed suicide by hanging. QPS have confirmed that consumer was found deceased on 2018. Consumer was an outpatient at time and was found at home.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	alerted QPS and QAS who transported patient to	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	(NOK) woke up at on 18 and could not locate the deceased. NOK has exited where has observed the deceased hanging from a . NOK has attempted to hold the deceased up to attempt to save and has started screaming for help. The successfully cut the and the NOK commenced CPR before QAS arrived at . QAS continued to work on the deceased until they pronounced dead at .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Return call from stated that had "taken own life last night"	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Thank you for the conversation just now. I am just confirming that the Coroner has advised the HHS that the consumer was found deceased at home in on . Thank you for speaking with / supporting the clinicians from your team who were involved in this person's care. I will phone now if you can contact . Please also escalate this to , and as per the unexpected death process, in anticipation that we will meet and discuss in the next 24-48 hours to discuss arrangements including contact with family. Yours sincerely,	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumer had an intentional overdose and attempted poisoning. The consumer was transferred to and was intubated and transferred to ICU. The consumer was diagnosed with . Despite maximum medical therapy in the ICU, the consumer continued to deteriorate, requiring massive amounts of and support. After discussion with the family, and in light of the consumers failure to improve it was decided to change to a palliative approach. The consumer was extubated on 18 and died shortly after. Case referred to the Coroner.	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	On 2018 family observed to be sleeping at when hadn't awoken by approx. the family attempted to rouse , calling ambulance at . was transported to where was treated at the emergency department then transferred to ICU. was diagnosed with in the context of overdose.	Death
(None Entered)		2018		Yes	Clinical communication		phone call was received from QPS enquiring about the time when the patient was discharged and stated that the patient has passed away on suspected illicit drugs overdose.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	QPS contacted the MHS and notified of completed suicide of MH consumer by hanging at private residence in	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Received a phone call from QPS to inform the A/NUM the client was found this morning hanging at residence. It was considered a suspected suicide.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide Substance misuse	On arrival to the patients apartment QPS entered and found client deceased	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient found in car on - deceased	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	QPS informed Health service of completed suicide of a recently closed Mental Health client of the MHS. had been closed to the Mental Health Service on the 18 after being lost to follow-up after disengaged from the MHS post the initial contact in 2018. QPS advise they were called to a private residence (address unknown) in , to an alleged hanging. A nylon rope had been secured to a wooden ceiling beam. There were no signs of life when QPS attended.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Notification from QPS consumer found deceased at home	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Contacted QPS Sgt who advised that the client had been located "at residence deceased by hanging"	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	patient on TA for medication had been attending appointments, notified of death from hanging by QPS	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Information received from on 18 stating consumer found hanging on 18, QAS in attendance - to and admitted to ICU at this time. Information provided to for ongoing supports, as of /18 consumer remained in ICU. On review of clinical notes audit, information obtained off Viewer - consumer registered as deceased on /18.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	informed by QPS of completed suspected suicide of and then Informed by of and that patient completed suicide by hanging, reportedly in context of dispute with family and excessive alcohol use	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Notified by Support of who had taken own life, details at the time of notification was unknown, . Approximately days later, re-notified and name of was provided. CYMHS identified that had recently attended a appointment in at one of the community sites, referred by GP. and was seen. was engaged with private psychologist, who they were seeing in three days, and a private psychiatrist at the end of the month. After thorough assessment, elected to stay with private psychologist and and were given emergency support service numbers and advised to reconnect if there was a deterioration in mental health.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Clinical Nurse attended responding to Code Blue called by at . On attending Officers asked to cease CPR, she declared life extinct at hrs post assessment finding no signs of life.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Pt was found yesterday by QPS (I'm unsure how they were made aware) inside unit where had apparenlty taken a large quantity of prescribed medication as well as lit 2 BBQ pits inside unit. apparently left a detailed suicide note and had packed up belongings for ease of removal.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumer registered as missing person by on 18, advised by QPS consumer currently subject of missing persons report, has been found deceased. Death is suspected suicide.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Clinical Nurse and student social worker attended consumer's home to administer depot medication. Contact with consumer had been attempted on the 2018 and then again in of 2018. When able to contact, team decision made to attend premises anyway. Upon arriving at the consumer's home, they could see lying on the couch. They knocked. They could see that the consumer looked a blue colour. The staff found door unlocked and entered the unit to check that the consumer could not be revived. The consumer was blue, cold and in a state of decompositions. The staff left the unit and contacted the team leader of and the police and proceeded to await police and ambulance arrival.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide		Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	I was informed this morning by hospital clinical staff that was BIB QAS at approx hrs after found hanging in the community. I was advised that police had attempted CPR but without success. I have listed as an 'Outpatient" above in the 'Patient Affected Type' box as there was no correct option to choose from, eg: member of community. is not a current client of MHS. NB: was not a current case managed client of however last engagement with MHS was between the 2018. was referred to .	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	We were advised by QPS that patient contacted them advising was going to self. On arrival was found to have completed suicide .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	MET called to . Consumer suspected suicide. Transferred to DEM where deceased.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Pt found deceased (2018) at approx. hrs at residence. Cause of death is currently unknown and is still being investigated by QPS. It appears there are approx. 17 x tablets and 20 x tablets unaccounted for. At this stage no suicide note has been located. QPS believe Pt took an overdose due to the amount of medication unaccounted. Further investigation is required to rule out a medical condition.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Received news that client has been found deceased at home of residence	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Client on the 18, informed by QPS suspected suicide on the 18	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	QPS attended, was at the property, had been asked to attend by the to check on . attended the property prior to hrs. was locatedl in the lounge room slumped against the wall with . . QPS advise that . Documentation was located on the kitchen table which described was experiencing financial hardship.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Email referral received by on . presented to Emergency Department on with suicidal ideation and a plan. A psychiatric review was completed and sent home with , provided advice to return if further concerns and after-hours acute care phone support was organised. Phone contact made with in the on the 18, was at . Phone call was made in the . no contact made.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	reportedly deceased secondary to what appears to be suicide. Community mental health patient.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	After review by emergency department medical officers, ACT clinician and ACT registrar . was discharged home with CYMHS and ART follow up . ART was contacted by ACT the following day to ensure the referral had been received.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	The person was seen by the ACT on 2018 and 2018 for assessment of mental health and risk assessment. The person was discharge home into the care of the community Palliative Care team and others. The person died on /2018 from suspected suicide.	Death

(None Entered)		2018		No	Behaviour	Self harm and suicide Substance misuse	presented as a walk in to the at today, seen by Doctor and nurse. Expressing suicidal ideation and plan referred to past attempted hanging. Talked to doctor about reasons why wouldn't kill himself, stating protective factors. Agreed to MH assessment, requesting to speak to who had driven to the and was waiting in a car in the car park. spoke to , then absconded. QPS called. rang who was at home and stated told the what had happened. QPS & QAS responded, informed by QPS that was found hanging in home and unable to be revived. reported to the doctor "I am off my head". reported to the doctor had taken , , , and	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	MHS clinician advised on 18 by , that consumer had completed suicide in area on /18.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Client was on Treatment Authority under Qld Mental health Act, active client of local service,living by self in new accommodation in near to . Phone call to Service at hours 2018 from informing them that QPS had notified MH & AOD Service that client was deceased	Death
(None Entered)		2018		Yes	Behaviour	Aggression	At : the patient continued to appear agitated, refusing to take medication and was sitting in chair prior to staff attempting to give Inj . The writer explained to that we planned to give some and tried to get the patient to take the oral medication. At this time refused and started to become agitated, security x3 and 2 Male staff were also in attendance as writer attempted to negotiate with the patient.The patient continue to refuse and escalated and got up out of the chair and stood up and went to place patient in a hold to prevent patient from harming others. The patient to fight with nursing staff and . Due to risk of harm and to ensure safety for the patient and others, the team utilised Occupational Violence Prevention (OVP) approved technique for physical restraint to administer injection. mg Inj as per phone order was given. During the restraint the patient fell to the ground on top of one of the security guards. was restrained in prone position intially due to the level of resistance and fighting this was less than 2 mins. Writer was communicating with patient we released holds after was administered. The patient tried to get up and continued to be aggressive and was further restrained but suddenly face changed colour and it appeared that the patient had collapsed and was unresponsive. A staff member checked and found that had no pulse and no breathing noted, CPR was commenced immediately at hrs and hrs med call was facilitated. MET team arrived and they took charge of the situation. The MET team were documenting the outcome of the MET call on IMER	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	contacted mental health team today to notify that found the consumer hanging. QPS have confirmed.	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Phone contact received from the consumers advising QPS had contacted to advise that was deceased by suicide. Confirmation received from QPS.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	was in a depressive phase of illness. At medical review on , Consultant psychiatrist ( ) had changed medications and recommended access psychology sessions through a mental health care plan with GP. had attend ed GP to obtained referral to private psychologist and made 2 appointments, the first of which was scheduled for . was also receiving ongoing psychoeducation and support from case manager. had attended home on the on the for scheduled home visit however there was no answer when knocked or attempted to contact by telephone or text. had spoken to who had said would leave work early to check on	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Contact with State Coroner who advised date of death is between , 2018	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	A -year-old patient presented to ED accompanied by and on the /18 with chief complaint was 3/7 days of confusion, decreased oral intake. Patient not making eye contact. Fidgeting with toy at triage. Denies . Has been wondering around at home Triaged as Category 3 Observations and bloods completed by Triage Nurse. Approximately 3 hours after waiting in ED waiting room, the patients approached the counted and stated it was taking too long and the patient wanted to go home and they all walked out. hospital then received notification on the /18 that the patient had committed suicide on /18. Patient was taken to but did not have recoverable head injuries.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	QPS contacted by the manager (?) who advised that had been contacted by of advising that he has grave concerns for welfare. Informant has gone to the door of the and there is a suicide note on the door indicating	Death
(None Entered)		2018		Yes	Clinical communication		It is alleged that the patient went to a person's home with the intent to cause a fracas. The patient allegedly grabbed one of the residents of the home with a view to causing harm. Other persons intervened to stop this and they restrained the patient on the ground. The patient expired during the struggle.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	The consumer (DOB) was found deceased by emergency services on 2018. was an open voluntary client of , with referral occurring in 2018. The Hospital stated that was informed by emergency personnel that the consumer had been found deceased in home of “suspected overdose”. Further information has been obtained from the QPS that the consumer's had requested a "welfare check" hence QPS attendance. There was reportedly a note (contents unknown at this time) and "suspected overdose" was noted due to the presence of open medication packets in the home. Date of death unknown at this time.	Death

(None Entered)		2018		No	Behaviour	Self harm and suicide	It was reported that were away and had CTT access and noticed the back door was open and dogs were running in and out . Reportedly they contacted their who attended home and discovered . Reportedly QAS declared client dead at scene	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	is an year old referred to ACT post ED presentation /2018 in the context of deliberate self harm. History of suicide attempt/DSH in . Previous client - discharged in 2018. Diagnosis - and Referral request for ACT contact post ED until reviewed by PP and Psychologist. Apts in place Psychologist apt and service apt on /2018. Phone contact made with consumer - and further contact planned for - phone contact with consumer - noted to have engaged in further self harm behaviour and family report they were organise apt with GP to review. Further phone contact as per .	Death
(None Entered)		2018		No	Behaviour	Patient/Resident unable to be located	The information regarding the patient absconded on /2018, during my shift. The patient was an in-patient since 2018, admitted for iv antibiotic for . During our shift on /2018 around Patient requested for few hours leave to go home and have a shower and bring clean clothes in. Informed MO about patient's request. Based on MO's assessment of the patient earlier that day, MO was happy to discharge the patient. The initial plan was to give the dose of antibiotic and discharge patient on oral antibiotic ( ). MO gave a phone order for mg tab for days, POAB to start next day in the morning . Oral antibiotic was taken out of the drug cupboard. The other nurse had given the last dose of iv antibiotic and checked the OBS. The ADDS score was 5, due to temperature and pulse rate. While I was writing the dispensing instructions on the antibiotic box, the other nurse notified me the ADDS score of the patient. The oral antibiotic box was handed over to that staff without completing the dispensing instructions. MO notified about the QADDS score of 5 and discharge plan was cancelled. Medications given for temperature, after half an hour the QADDS score came to 3. As per MO, Patient needs to stay in hospital for next 24 hours. MO advised that will come and review the patient in an hour. Informed the patient that needs to stay in the hospital for next 24 hours for observation. After I got back from , the other staff member informed me that the patient absconded, and that has notified regarding Doctor's request for patient stay at the hospital for observation. advised that was out of town at that time and assured the staff that will contact and ensure to bring back to the hospital. We were expecting the patient back, so kept the bed open for , and handed over to the staff.	Death

(None Entered)		2018		Yes	Deterioration		This patient had presented to the GP surgery on with " " and other symptoms including . Noted and . Represented following day following teleconsult with dermatologist where prescriptions were provided. Represented days later at hospital with extensive to shoulder and chest as well as . Nursing staff identified confusion, restlessness and impulsivity. On call MO ws contacted advised mg and admission with review following . The patient's observations included a temperature of 35.8C and BP of 98/51 QADDS score of 3. No cannula or bloods were attended at this time. Patient had 2 falls with extreme agitation ?delerium. GP on call informed and declined further intervention at that time. Progress notes identify patient experiencing auditory hallucinations. Seen by GP at approximately of / - oxygen, bloods, nurse special implemented. CXR showed , bloods - . IV and OABs instigated. transfer arranged for transfer to Hospital for treatment of Acute delerium due to secondary to sided and . There are very limited progress notes from to on /18, although regular observations have been completed.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Time line of events: /18 Medical Review with psych reg completed: was seen without . Was early for appointment today. States that was doing alright. Is awaiting call from . Later, received call and was informed that will be seen at office after this clinic review. was looking forward for the meeting with . /18 - Consumer pulled over by QPS at with . QPS contacted QAS due to concerns regarding the appearance of physical health. heart rate was elevated and QAS requested attend hospital but declined. . 18 - Concerns raised to via consumers that consumer had not been responding to messages. then contacted QPS to conduct a welfare check. At this time QPS informed of their contact with consumer on 18. At approximately hrs, received a phone call from QAS requesting meet them at consumers premises however, upon advising them that resided in they withdrew request and conducted the welfare without company. /18 - Approximately . contacted QPS for an update to which they had informed that consumer was deceased.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Partner informed . Suspected overdose.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	QPS attended scene, pt located deceased by hanging. QPS were awaiting post mortem results to confirm cause of death as death was suspicious. QPS have now confirmed death as suicide. Pts was at the residence at the time of death.	Death

(None Entered)		2018		Yes	Behaviour	Risk taking Self harm and suicide	Staff found the patient with tied around neck attached to and the patient . Staff immediately called for assistance, duress activated. removed using a cut down knife, and patient removed . Patient unresponsive, BLS commenced. Met call and code blue initiated, emergency response team attended the incident. Patient was resuscitated and transferred to ICU for further cares. Relevant stakeholders notified.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	had phoned in to tell planned to jump . Ambulance and Police arrived at the scene just after had jumped.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Client has been working hard while having . Client's had come from and was helping but returned to home. Separation from and . CIMHA note from 2018. "QPS contacted by who advised that can see hanging from a rope - Informant advised that the is grey in the face and believes that is deceased. Informant was hesitant to check on the .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide Substance misuse	was abusing alcohol and ? other substances. Was referred to ACT after calling MHCall. had recently been evicted from house as the now had asked to leave as the alcohol and ? substances were having a detrimental effect on the . call QPS and stated that had jumped . QPS declared deceased at the scene.	Death
(None Entered)		2018		Yes	Behaviour	Risk taking	CURRENTLY UNDER INVESTIGATION BY QPS	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	MHS attempted to contact the pt via phone calls as pt did not attend scheduled appointment. When Case manager was unable to reach the pt, phone call out to pt's was contacted. Pt's notified of pt's suspected suicide on at a private residence in	Death
(None Entered)		2018		Yes	Behaviour	Instructions not followed	Presented on EEA by QAS Medical review by consultant at hrs Impression - in partial remission Plan Plan: 1-Agreed to voluntary admission to hospital / Acute Mental Health Unit. 2-Prescribed mg (agreed to it) 3-Prescribed prn for agitation/ anxiety/ elevated mood. 4-Lowest level of observation at the inpatient unit and is to have short unescorted leaves like 15-30 minutes up to 5 times/day on hospital grounds. 5-Team review mane	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	communication	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	was a -year-old with no apparent previous contact with mental health services. self-presented to Mental Health on the of 2018, initially saying that wanted to get "head sorted". On elaboration, explained that needed a script for usual dose of) mg daily. usually lived in and obtained scripts there on twice-weekly pickup . It was explained to that would need to link in with a regular GP to prescribe this on an ongoing basis. As intended on travelling to l, we facilitated making an appointment with a GP in . At that time, was not suicidal, psychotic, manic, or severely depressed. There was evidence of future planning. subsequently travelled to . saw the GP as planned on the afternoon of /2018. obtained tablets of mg, which was a reasonable choice given history. death was communicated to us by Police on /2018, having occurred on /2018. Preliminary reports indicate an overdose of . The had been prescribed over a long period of time for persistent pain associated with end-stage , and it was intended for therapeutic use. It was last prescribed by treating GP in . There were used syringes and a quantity of medication missing from the packet when was found by Police, hence the presumption that death was due to a overdose. We are not aware of a suicide note or other clear indication or communication that the intention of the overdose was suicide. . had also been historical contact with ATODS in . Given all of this, we are uncertain as to whether the intention of this overdose was suicide, or if it was misadventure due to misjudgement of level of tolerance in the setting of recreational use.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumers contacted and informed treating team reportedly found by QPS - alleged hanging. Diagnosis of delusional disorder, on a Treatment Authority in the community. Medications include and Open to since 18. History of intermittent contact with since - History of admissions to hospital this year. History noted suicidal ideation intermittently reported since age . . On 18 bought a rope, went to and contemplated hanging.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Advised by at approximately hrs during shift observation rounds patient was found hanging .	Death

(None Entered)		2018		No	Behaviour	Self harm and suicide	In my role as MH Police CoResponder it was reported to me by QPS that was found deceased from suspected suicide (hanging) as was found hanging in . Important to note this incident report is being filed as second hand information as I was not directly involved in anyway.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient was recently discharged from Inpatient unit on the 18 with a diagnosis of depressive disorder with psychotic symptoms. Contact made by allocated of on the /18 to offer appointment for followup on the /18. Patient attended followup appointment with and further appointment made for the /18. was informed by a member that patient had died by suicide. TL of contacted vulnerable persons unit who confirmed that patient had died by hanging at on the 18. This information was then handed onto the treating team by the Team Leader of .	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	MHCALL contacted by QPS to advise consumer had been found deceased in home (who lives with), hanging and blue in the face. could not be revived. advised in the morning.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient had been seen at ED on EEA. following discussion with family patient was discharged to their care. Next contacted MHCALL concerned re whereabouts of patient who had left family home on previous . Patient was found in and reported to police at that was deceased by hanging.	Death
(None Entered)		2018		Yes	Behaviour		Patient found deceased by member of the public. Method by hanging, no suicide note left. Police contacted. No suspicious circumstances. Information confirmed by Officer .	Death
(None Entered)		2018		Yes	Behaviour	Instructions not followed	found deceased by on /18, police where call and they advised the ACT who in turn advise	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	staff from Mental health informed that client was deceased and suicide was suspected	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Referred to by from (QLD Health) on the /2018. Presenting problems indicate "feeling like shit", , not eating, difficulty sleeping, vomiting, Difficulties with current living arrangements and financial stressors, ongoing suicidal ideation. Risk Assessment completed on the day of intake. Supports put in place by , , On the /2018 contacted C/M informing that was making innuendoes that is suicidal. P/C made to message left requesting urgent responce. P/C made to message left requesting urgent responce. P/C to Police Link requesting Welfare Checks be done by Police. P/C directly to Police Station and they most likely responded. Unknown if the Police located at this time. ACT informed of possible presentation and concern for risk. C/M contacted by informing has not been attending school. C/M made P/C's attempting to locate for further assessment arranged face to face with CM at on the 2018 but did not attend Lost to follow up at this time as unable to locate Recommended referral to 0n /2018 Co-responder Team noted a suicide on QPrime and identified a completed suicide Informed Acting Access Manager of ACT Riskman completed as per protocol	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient was found to have hanged self at home address on /2018	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Visited GP yesterday and referred to ACT to review medication and for psychiatric assessment. Entered on CIMHA. QPS contact MHS asking for any information and informed he had written a suicide note and had reported as a missing person. Informed by QPS they had located body hanging . Nil further information or detail.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Telephone call from GP ( ) today ( ) reported that police had contacted today to inform of probable suicide discovered today. Last contact from was a telephone call on /18 requesting extra take-away dose for on /18. Usually gets / of . Team provided swapped for / and / , so client last seen at pharmacy on /18. Clinic repeatedly tried to contact client & GP without success from /18 onwards. Long-term client of on mg, mg, mg. Ongoing anxiety problems and cardiovascular concerns. Last saw GP on /18 for referral to for withdrawal from alcohol and ; neither disclosed to at last visit on /18.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Referred by to ACT on the 18 as was seen in hospital and not under any current mental health team. Nil acute concerns or risks but had been informed by Dr. to think about the outcome for chronic airway/end of life management. self referred on /18 stating was feeling suicidal. Visited by ACT the same day. Plan in place to support but did not answer any calls after this time. Planed home visit cancelled after hearing Police radio confirming death	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	QAS was called by consumer. This was following ingestion of tablets.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Seen by EDMH after being seen at home by PACER/QPS, threatening suicide. Discharged as per acute management plan, for re-referral to community mental health team. days later QPS contacted by support worker regarding suicidal threat. Consumer found deceased.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Contacted this morning unable to make contact on mobile. Called mobile, spoke with who advised that passed away this morning. advised that was found hanging . Advised that went to the and found and called out for . advised that there was no indication anything was wrong with . states that their family spent the day and playing a game followed by lunch yesterday.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	The client had been living with and family since discharge from hospital. was at home with the family during the day of the incident. When the family went out the client stayed behind and used to hang self . The family returned to find client not breathing. Attempts to resuscitate were unsuccessful. Ambulance and police were called and attended, and the body was taken away for autopsy.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumer was seen by ACT Mental Health clinician in Emergency Dept on /18 following a suicide attempt earlier that morning. Assessed - consumer presented with no current suicidal ideation, plan or intent, able to identify protective factors and agreeing to plan of further follow up /18.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	The clinical governance team received notification this morning, that (DOB) who was discharged from on 18, died by suspected suicide 2018.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Advised by medical director today, who had been notified by that client had died by suspected suicide.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	was a community based consumer of ACT at the time of death	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Phone call this afternoon from Shift Supervisor from Police Station in regards to patient. Prior to calling QAS and QPS crews were in attendance at patient's residence, where patient was found deceased. The reports from first responders are that patient was found hanging in home from an apparent suicide. Police and QAS were still on scene but was able to confirm that patient unfortunately was deceased. No other details available at this time. Important to note that this riskman is being completed in relation to information received from QPS	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Confirmed consumer deceased via Patient safety.	Death

(None Entered)		2018		Yes	Deterioration		Consumer cleared for weekend leave from the , to return , 2018 at hrs. Consumer had numbers of Hospital and Community numbers to call incase he needed help. Consumer did not return on time, attempted to contact consumer. called to try and get a contact to consumer, did not return phone calls, went to check in on at , Door was locked and no one was there to contact for . Contacted real estate who said they would try to contact consumer. At some point consumer found unresponsive, emergency services on scene. Consumer taken to Hospital Emergency Department, intubated and sent to ICU. Life support turned off /2018. Consumer deceased.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	had two presentation to ED in 2018 with suicidal ideation in context of stressors. Followed up by both and ACT - transfer of care to GP on 2018. Request for information from coroner on 2018. Contact with VPU ascertained that Police attended residence on 2018 at hrs. Advised that had sent a message to saying that had taken . Police attended residence at and was not in the home. The Police noted that the door to the shed in the back yard open, and found to be in the shed hanging from a beam. Police attempted CPR without success. Police indicted that whist they were still on the premises that arrived.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumer discharged from ward on 18 and referred to for follow up in the community. An appointment was made for 18 for seven day follow up at . Consumer did not attend appointment on /18. have left text messages and voice mail messages encouraging contact. On /18 QPS contacted admin officer requesting NOK details as consumer found deceased at from suspected overdose.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient found deceased at home by . Suspected suicide by hanging.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	We received a phone call in the of 2018 from Dr and have been informed that (DOB;) had committed suicide by hanging. The tragic incident occurred sometime during the on the 2018 at family home. t who is a , had been engaged with for alcohol detox from /2108 to /2018. Dr saw around on /2018 for the completion and we had discharged on that same day. During the engagement with , there was no indication of a suicide risk.	Death
(None Entered)		2018		No	Behaviour	Aggression	Consumer is not deceased, the victim of the homicide is.	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Advised that the patient had jumped and was in an Induced Coma in	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Staff member attempted contact with consumer to follow-up initial assessment with service. Consumers ( ) reported that consumer was found deceased, initial report indicated consumer deceased 18. indicated believed death to be intentional. Further review of iemr records indicates that time of death is likely between and .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient known to service and had attended within the last 30 days	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	I believe learned of death through QPS information systems. asked me to check if was a known client of the mental health service. I checked CIMHA which indicated that was a current client of the Mental health Service.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Phone call received from police station services on the /2018 around . The police office was requesting information about the patient whom the police office stated they completed suicide after had been discharged from the ward the previous day. The officer was advised to ring later as the reporter had no information about the patient.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	clinician had been called by consumers this morning regards concerns about consumer and was advised to contact QPS for a welfare check. Consumer is currently on-going consultation to since /2018.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Consumer required admission to ICU. Is not expected to survive.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Phone call was made to QPS by client's after found in the shed on the back of property in having . Client had been a client of the ACT in with deterioration in mental state subsequent to of months earlier.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide Substance misuse	Heard that a body was discovered somewhere near . When Police were able to get access to the body they found on person a key card with name on it. Heard over the radio futher details including date of birth. Located on CIMHA and discharged from ACT on /2018. Had been transfered to ACT after D/C from directly to as was living with . History of psychois and substance abuse	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	called service to advise that had suicided a few days ago. advised that had hung self. requested that ATODS send a representative to funeral as had thought highly of the service.	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Queensland Police Service notification tha a year old consumer who had been assessed on the and 2018 in the Emergency Department had been found deceased after texting that "cannot do this anymore"	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Referred to community team by the Acute Care team /2018 for management of depression and PTSD. Patient was seen by treating registrar /18, /18, by treating psychiatrist /18, and 10 times by case manager (last /18). At most recent doctors appointment /18 was increased from mg to mg and was on mg. On the /18 the treating psychiatrist noted that the patient was depressed and restricted however that the patients mood had started to improve. The doctor also noted that the patient continued to self harm on a regular basis but that intensity was decreasing. Plan was for ongoing trauma informed therapy by case manager and medical review in 6 weeks. Case manager last reviewed patient on the /18 and noted that patient was and restricted but was continuing to work and had enjoyed attending a recent concert with . Plan was for a follow-up case manager appointment in one week. Patient did not present for scheduled case manager appointment on the /2018 so case manager tried to contact patient without success. Patient did not present for scheduled medical appointment /2018. Case manager contacted patients who advised case manager that patient had been deceased since 2018). Treating team currently not aware of cause or circumstances of death.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	advised by via email that the consumer is deceased.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient was reviewed in ED on 2018. Patient was referred to Acute Care Team and discharged home with . It was reported that patient had jumped by Social Worker at .	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Pateint recently referred to team, but admitted to Hosptial prior to first appointment and then discharged for follow-up with HHS, reported to have commited suicide days post discharge from hospital.	Death
(None Entered)		2018		No	Behaviour	Risk taking Self harm and suicide Substance misuse	is year who lives in . Recent contact with and was discharge 2018. was found by to have taken life by asphyxiation. Emergency Services were called. VPU - QPS notified family and have provided them with linkage with Standby Service (Post suicide Support Service)	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	Opiate team staff learned of clients passing as QPS had requested clients medical records due to finding a deceased person believed to be on /18. had successfully reduced and ceased with his last dose of mg on /18. Pls note the above behaviour of self harm and suicide has not been confirmed nor time of event.	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	had been away in visiting family, expected to return by /18. PSP attempted contact via phone and H/V /18 without success. QPS contacted , TL) 18 at approx. hrs advising had been located deceased in home by . Suspected suicide via hanging	Death

(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Patient discharged from ED with community follow up and initial review not attended. Treating team notified by the of the consumer that had passed away and the police were investigating. No other details are known at this stage	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	Suspected Community Suicide	Death
(None Entered)		2018		No	Behaviour	Self harm and suicide	The patient was brought to on a EEA for deliberate self harm. The patient was under the care of the The patient presented with lacerations to both arms requiring suturing The lacerations were dressed and was awaiting a mental health assessment in As was at capacity the patient was required to wait in The patient then absconded from The patient completed suicide on 2018	Death
(None Entered)		2018		Yes	Behaviour	Self harm and suicide	After initial admission, returned into care of GP/Private psychiatrist, but was experiencing break through symptoms, voices/paranoia/ thoughts of suicide. Prior to the admission medication was ceased and then recommenced with some improvement. Due to exacerbation of psychotic symptoms a second admission occurred in . Multiple discussions with consumer, , to trial . Offered voluntary inpatient treatment, due to distressing thoughts to jump and the offer of commencing . , requesting discharge, and deemed to have capacity when reviewed by MO, discharge occurred. Inpatient consultant did offer re-admission the next day but declined by , and opted for community solution. Community team notes reflect nil issues risk, deem to still have capacity, and had booked medical review post with Community psychiatrist. by , of , on approximately , that had found deceased, method was hanging. had then called QPS, and then MHS to inform of discovery. Pacer and QPS/QAS subsequently attended.	Death

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

- The Chief Psychiatrist is authorised to require mandatory notification of specified incidents.
- The policy *Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Mental Health Act 2016*, prescribes the events to be notified to the Chief Psychiatrist.
- This form has been designed for private sector authorised mental health services to capture the notification of clinical incidents and does not cover all notification requirements for critical incidents outlined in the policy.
- Facilities should refer to the policy and *Chief Psychiatrist Practice Guidelines Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Mental Health Act 2016* for key information, definitions and procedures for notification requirements.

1. Person's details

Surname:	Given name(s):

Residential address:

Town / Suburb:	State:	Postcode:

Date of birth:	Sex:	Indigenous status:

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

- ☑ Voluntary
- ☐ Treatment authority
- ☐ Treatment support order
- ☐ Forensic order
- ☐ Judicial order
- ☐ Detained from interstate
- ☐ Classified patient
- ☐ Detained under a recommendation for assessment

3. Incident details

Date of incident:	Time of incident (24hr):	Incident identification number as allocated by facility (if applicable):
2018		

Location where the incident occurred (such as facility name, ward, location, home, community):

Community

Patient type:

Receiving services in the community

4. Incident type

- ☐ The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
- ☑ The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury
- ☐ An incident resulting in significant mental or physical harm to an inpatient
- ☐ Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
- ☐ A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

18 Notification via e-mail from Psychiatrist in the Public sector who had received a call from the Statewide MHI Coordinator to advise that had committed suicide earlier that day. (was found in a garage in with the car engine running)

On examining the notes the psychiatrist noted that had been a patient at and an e-mail was then sent to advise of the patients death.

The patient had been a voluntary admission to the on the 2018 and had self discharged on the 2018

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

- Briefly describe the patient outcome. Include:
  - level of harm sustained
  - treatment required.

Following the patients death in the community [redacted] will be conducting an internal investigation.

Severity Assessment Code (SAC) rating:

SAC 1: Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner? ☑ Yes ☐ No ☐ Not applicable

Type of analysis planned:

Internal investigation

7. Clinician's details

Name: [redacted]	Designation: [redacted]	
Contact number: [redacted]	Signature: [redacted]	Date: [redacted] 2018
AMHS address: [redacted]		
Town / Suburb: [redacted]		Postcode: [redacted]

CP006 v1.00 - 02/2017

Hospital Name:		
Date of event: 2018	**Date of notification:** 2018 via Coroner's request for a copy of the patient records.	**Investigation report date:** 2018
Reporters Name/Signature/Designation:	Quality & Safety Manager **Attendees:** • , Medical Director • , Treating Psychiatrist • ,Director of Clinical Services • , Nurse Unit Manager • , Quality & Safety manager.	

THE EVENT

Please provide a description of the incident (it may be useful to also consider a cause and effect diagram and chronology of events)

- Incident: Notification of a Death of a recent in-patient via the Coroner's office (request for records)
- Patient:
- UR number:
- Riskman:
- Date of Birth
- Date of Death: 2018
- Place of death: at home
- Treating Psychiatrist:
- Cause of death: Currently unknown.

- Diagnosis:

History:

Context of admission: (*From referral from*)

- confronted about ago. Since then expressing suicidal ideation.
- was angry and left the house

- [redacted] was later found at home by the police.
- [redacted] was brought in to the [redacted] via QPS under an Emergency Examination Authority on the [redacted]. [redacted] was later transferred from the [redacted] to [redacted] on the [redacted] 2018 after a brief [redacted] admission there. The referral letter stated [redacted] current mental state was stable with moderate risk of suicide and [redacted].
- On [redacted], after a 5 day admission [redacted] self-discharged against medical advice from [redacted] as wanted to be with [redacted] on [redacted] and would not wait to see [redacted] treating psychiatrist. Nursing staff advised Dr [redacted] [redacted] treating psychiatrist, of his intention to discharge. [redacted] signed the NFC Discharge at Own Risk Against Medical Advice form at [redacted] hrs. [redacted] assured staff [redacted] will follow up with [redacted] GP appointment scheduled the next day and with Dr [redacted], at [redacted], who [redacted] has been seeing previously to this admission. [redacted] was given 2 days medication as per Dr [redacted] advice. ([redacted])
- The treating psychiatrist and nursing staff followed all [redacted] protocols for assessing safety.
- Progress notes indicated [redacted] is focused on working through [redacted] relationship issues.
- [redacted] did not attend any groups during [redacted] brief stay at [redacted].
- Targeted risk assessment on discharge was low for self-harm and suicide risk. [redacted] denied any safety concerns and stated [redacted] would keep [redacted] scheduled appointments.

CONTRIBUTING FACTORS AND ROOT CAUSES			
1.	Communication Were issues relating to **communication** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	Provide details:

	Communication issues between staff		
	Communication issues between staff and patient / family / carers		
	Documentation		
	Patient assessment		
	Information not provided		
	Misinterpretation of information		
	Other		
2.	**Knowledge / Skills / Competence**		
	Were issues relating to **knowledge / skills / competence** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	Provide details:
	Staff training / skills		
	Staff competency		
	Staff supervision		
	Use / not using / misuse of equipment		
	Other		
3.	**Work Environment / Scheduling**		
	Were issues relating to **work environment / scheduling** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	Provide details:
	Work place design		
	Suitability of work environment		

	Environmental stressors		
	Safety assessments / evaluations / procedures		
	Shortage of beds / rooms / resources		
	Staff timetabling		
	Other		
4.	**Patient Factors**		Provide details:
	Were there issues relating to **patient factors** in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	Targeted risk assessment was low on discharge. Denied any safety concerns.
	Communication difficulties		
	Medical history / known risks		
	Patient's condition		
	Personal issues		
	Other		
5.	**Equipment**		Provide details:
	Were issues relating to **equipment** (including the use or lack of use) a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	
	Suitability / availability / lack of equipment		

	Safety / maintenance		
	Appropriate use of equipment		
	Emergency provisions / back-up systems		
	Other		
6.	**Policies, Procedures, Guidelines** Were issues relating to **policies, procedures and guidelines** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	Provide details:
	Absence of relevant, up-to-date policies, procedures or guidelines		
	Implementation issues		
	Education / training		
	Issues in applying policies, procedures or guidelines		
	Absence of audit / quality control system		
	Other		
7.	**Safety Mechanisms** Were issues relating to **safety mechanisms** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	NO	Provide details:
	Lack of appropriate safety mechanisms / systems in place		
	Breakdown of safety mechanisms		

	No evaluation of safety mechanisms		
	Other		
8.	**Other**	No	Provide details:

Hospital Name:		
Date of event: 18	**Date of notification:** 18	**Investigation report date:** 18

Contributing factors/ Description of item	Description of recommendation addressing contributing factor(s)	Outcome measure	Measure date	Executive concur Yes/No	Executive notes if No

Hospital Name:		
Date of event: 2018	**Date of notification:** 2018 (via	**Investigation report date:** 2018
Reporters Name/Signature/Designation:	**Attendees:**	

THE EVENT

Please provide a description of the incident (it may be useful to also consider a cause and effect diagram and chronology of events)

- Incident: Notification of a Death of a recent in-patient
- Patient:
- UR number:
- Riskman:
- Date of Birth:
- Date of Death: 2018 aged
- Place of death: located in bed at home
- Treating Psychiatrist: Dr
- Cause of death: TBA. ?suicide

- Diagnosis: [redacted]

History:

- [redacted]

Last admission [redacted] 2018- [redacted] 2018.

- Presenting problem: a decrease in mood; increase in anxiety, fluctuating suicidality and increase in pain. Recent
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]: After request by treating psychiatrist to contact patient directly to confirm patient status in [redacted] and to discuss admission to [redacted] Co-ordinator phoned patient's mobile on [redacted] at [redacted] which was answered by [redacted]. [redacted] advised that [redacted] had found [redacted] in bed, unable to wake [redacted] up and that [redacted] had passed away.
- Dr [redacted] was advised by [redacted] that on the [redacted] was acting bizarrely and [redacted], prior to being taken to [redacted] for assessment, and that [redacted] also advised that despite advice to [redacted] Hospital re [redacted] suicidal ideation, that they discharged [redacted] home on the [redacted] and that [redacted] had been left alone in [redacted] and gained access to [redacted] medications. [redacted] advised [redacted] was frustrated with [redacted] staff for not listening to [redacted] and discharging [redacted] to [redacted] care.
- Cause not yet known ? intentional overdose.

CONTRIBUTING FACTORS AND ROOT CAUSES			
1.	Communication	No	Provide details:
	Were issues relating to **communication** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*		
	Communication issues between staff		
	Communication issues between staff and patient / family / carers		
	Documentation		
	Patient assessment		
	Information not provided		
	Misinterpretation of information		
	Other		
2.	**Knowledge / Skills / Competence**	No	Provide details:
	Were issues relating to **knowledge / skills / competence** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*		
	Staff training / skills		
	Staff competency		
	Staff supervision		
	Use / not using / misuse of equipment		
	Other		

3.	**Work Environment / Scheduling**	No	Provide details:
	Were issues relating to **work environment / scheduling** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*		
	Work place design		
	Suitability of work environment		
	Environmental stressors		
	Safety assessments / evaluations / procedures		
	Shortage of beds / rooms / resources		
	Staff timetabling		
	Other		
4.	**Patient Factors**	Yes	Provide details: Chronic suicidality and plans for 'hanging'.
	Were there issues relating to **patient factors** in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*		
	Communication difficulties		
	Medical history / known risks		
	Patient's condition		
	Personal issues		

	Other		
5.	**Equipment** Were issues relating to **equipment** (including the use or lack of use) a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	Provide details:
	Suitability / availability / lack of equipment		
	Safety / maintenance		
	Appropriate use of equipment		
	Emergency provisions / back-up systems		
	Other		
6.	**Policies, Procedures, Guidelines** Were issues relating to **policies, procedures and guidelines** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	Provide details:
	Absence of relevant, up-to-date policies, procedures or guidelines		
	Implementation issues		
	Education / training		

	Issues in applying policies, procedures or guidelines		
	Absence of audit / quality control system		
	Other		
7.	**Safety Mechanisms** Were issues relating to **safety mechanisms** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	NO	Provide details:
	Lack of appropriate safety mechanisms / systems in place		
	Breakdown of safety mechanisms		
	No evaluation of safety mechanisms		
	Other		
8.	**Other**		Provide details:

		No	

Hospital Name:		
Date of event: 18	**Date of notification:** 18 ( )	**Investigation report date:** /18

Contributing factors/ Description of item	Description of recommendation addressing contributing factor(s)	Outcome measure	Measure date	Executive concur Yes/No	Executive notes if No

Hospital Name:		
Date of event: 2018	**Date of notification:** via coroner request for information	**Investigation report date:** 2018
Reporters Name/Signature/Designation:	**Attendees:**	

THE EVENT

Please provide a description of the incident (it may be useful to also consider a cause and effect diagram and chronology of events)

- Incident: Notification of a Death of a recent in-patient
- Patient:
- UR number:
- Riskman:
- Date of Birth:
- Date of Death: /2018 aged
- Place of death: located at home
- Treating Psychiatrist: Dr
- Cause of death: TBA. ?suicide

- Diagnosis: [redacted] Chronic suicide ideation [redacted]

History:

- [redacted]

Admission to [redacted] 2018- [redacted] 2018. (first and only admission to [redacted]

- Presenting problem: Admitted for suicide risk (worsened by [redacted] increase in anxiety due to recent separation from [redacted] of [redacted] years and for a medication review.
- [redacted] admission was pre-determined in [redacted] when Dr [redacted] saw [redacted] after being referred to [redacted] by Dr [redacted]. [redacted]
- No real change in treatment- [redacted] helpful but was experiencing [redacted] and [redacted] Decision to cease [redacted] to reduce these symptoms.
- Despite [redacted] Dr [redacted] actually felt [redacted] mood was better than previously noted. [redacted] had plans of going to [redacted] to visit [redacted] in [redacted] Was not happy that [redacted] couldn't [redacted] now financially compromised post separation.
- Was going to look after [redacted] at the [redacted] after discharge and have follow up with [redacted] psychiatrist Dr [redacted]. Mental state was stable with no suicidal intent on discharge.

- 2 days post discharge a Dr [redacted], registrar, from the [redacted] contacted [redacted] Afterhours Clinic Manager (AHCM), wanting to know if [redacted] was a risk to discharge. The registrar wished to speak directly to Dr [redacted] however Dr [redacted] instructed the AHCM to fax through the discharge summary to the registrar instead since [redacted] is not actually [redacted] regular treating psychiatrist and advise that Dr [redacted] is [redacted] treating psychiatrist. Dr [redacted] was satisfied with this response.
- Cause not yet known ? intentional overdose.

CONTRIBUTING FACTORS AND ROOT CAUSES			
1.	Communication		Provide details:
	Were issues relating to **communication** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	
	Communication issues between staff		
	Communication issues between staff and patient / family / carers		
	Documentation		
	Patient assessment		
	Information not provided		
	Misinterpretation of information		
	Other		
2.	**Knowledge / Skills / Competence**		Provide details:

	Were issues relating to **knowledge / skills / competence** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	
	Staff training / skills		
	Staff competency		
	Staff supervision		
	Use / not using / misuse of equipment		
	Other		
3.	**Work Environment / Scheduling**		Provide details:
	Were issues relating to **work environment / scheduling** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	
	Work place design		
	Suitability of work environment		
	Environmental stressors		
	Safety assessments / evaluations / procedures		
	Shortage of beds / rooms / resources		
	Staff timetabling		
	Other		
4.	**Patient Factors**		Provide details:

	Were there issues relating to **patient factors** in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	Yes	Chronic suicidality.
	Communication difficulties		
	Medical history / known risks	✓	
	Patient's condition		
	Personal issues		
	Other		
5.	**Equipment**		Provide details:
	Were issues relating to **equipment** (including the use or lack of use) a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	
	Suitability / availability / lack of equipment		
	Safety / maintenance		
	Appropriate use of equipment		
	Emergency provisions / back-up systems		
	Other		
6.	**Policies, Procedures, Guidelines**		Provide details:

	Were issues relating to **policies, procedures and guidelines** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	No	
	Absence of relevant, up-to-date policies, procedures or guidelines		
	Implementation issues		
	Education / training		
	Issues in applying policies, procedures or guidelines		
	Absence of audit / quality control system		
	Other		
7.	**Safety Mechanisms** Were issues relating to **safety mechanisms** a factor in this event? (Circle) *If yes, tick the appropriate boxes below and provide details:*	NO	Provide details:
	Lack of appropriate safety mechanisms / systems in place		
	Breakdown of safety mechanisms		
	No evaluation of safety mechanisms		
	Other		
8.	**Other**		Provide details:

		No	

Hospital Name:		
Date of event: 18	**Date of notification:** 18 (	**Investigation report date:** 18

Contributing factors/ Description of item	Description of recommendation addressing contributing factor(s)	Outcome measure	Measure date	Executive concur Yes/No	Executive notes if No

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

- The Chief Psychiatrist is authorised to require mandatory notification of specified incidents.
- The policy *Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Mental Health Act 2016*, prescribes the events to be notified to the Chief Psychiatrist.
- This form has been designed for private sector authorised mental health services to capture the notification of clinical incidents and does not cover all notification requirements for critical incidents outlined in the policy.
- Facilities should refer to the policy and *Chief Psychiatrist Practice Guidelines Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Mental Health Act 2016* for key information, definitions and procedures for notification requirements.

1. Person's details

Surname:	Given name(s):	
Residential address:		
Town / Suburb:	State:	Postcode:
Date of birth:	Sex:	Indigenous status:

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

- ☑ Voluntary
- ☐ Treatment authority
- ☐ Treatment support order
- ☐ Forensic order
- ☐ Judicial order
- ☐ Detained from interstate
- ☐ Classified patient
- ☐ Detained under a recommendation for assessment

3. Incident details

Date of incident:	Time of incident (24hr):	Incident identification number as allocated by facility (if applicable):
2018		yet to be allocated

Location where the incident occurred (such as facility name, ward, location, home, community):
Patients home

Patient type:
Outpatient

4. Incident type

- ☐ The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
- ☑ The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury
- ☐ An incident resulting in significant mental or physical harm to an inpatient
- ☐ Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
- ☐ A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

Patient was admitted to on 18 for a deterioration in mood and anxiety. Diagnosis: was discharged home with on 18.

were contacted by patients on 18 to advise the patient was at the following

intake coordinator phoned patient at approx hrs on 18 to clarify patient status at in order to arrange admission scheduled for 18, dependent on medical clearance from the

Patients answered the phone and advised that patient was found deceased that morning, when went to wake
No further information has been provided to at this time.

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

- Briefly describe the patient outcome. Include:
  - level of harm sustained
  - treatment required.

Death

Severity Assessment Code (SAC) rating:

SAC 1: Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner? ☐ Yes ☐ No ☑ Not applicable

Type of analysis planned:

Clinical system review

7. Clinician's details

Name:	Designation:	
Contact number:	Signature:	Date: 18
AMHS address:		
Town / Suburb:		Postcode:

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

- The Chief Psychiatrist is authorised to require mandatory notification of specified incidents.
- The policy *Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Mental Health Act 2016*, prescribes the events to be notified to the Chief Psychiatrist.
- This form has been designed for private sector authorised mental health services to capture the notification of clinical incidents and does not cover all notification requirements for critical incidents outlined in the policy.
- Facilities should refer to the policy and *Chief Psychiatrist Practice Guidelines Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Mental Health Act 2016* for key information, definitions and procedures for notification requirements.

1. Person's details

Surname:	Given name(s):

Residential address:

Town / Suburb:	State:	Postcode:

Date of birth:	Sex:	Indigenous status:

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

- ☑ Voluntary
- ☐ Treatment authority
- ☐ Treatment support order
- ☐ Forensic order
- ☐ Judicial order
- ☐ Detained from interstate
- ☐ Classified patient
- ☐ Detained under a recommendation for assessment

3. Incident details

Date of incident:	Time of incident (24hr):	Incident identification number as allocated by facility (if applicable):
2018		

Location where the incident occurred (such as facility name, ward, location, home, community):

Patient type:

Inpatient - on ward

4. Incident type

- ☐ The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
- ☑ The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury
- ☐ An incident resulting in significant mental or physical harm to an inpatient
- ☐ Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
- ☐ A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

is an admitted to on the 2018.
has a history of
physical examination on admission was unremarkable.
On the 2018 at hrs, staff noted that the patient was exhibiting minor difficulty breathing. Staff initiated oxygen therapy and supported the patient so as to promote efficient oxygen exchange.
Initial physical observations indicated critical oxygen saturation levels, hypo-tension, and tachycardia.
The patient's clinical condition continued to deteriorate and QAS were called who transported to the for medical assessment.
Notification was received from on that the patient has passed away on their care.

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

- Briefly describe the patient outcome. Include:
  - level of harm sustained
  - treatment required.

Death

Severity Assessment Code (SAC) rating:

SAC 1: Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner? ☐ Yes ☑ No ☐ Not applicable

Type of analysis planned:

Clinical system review

7. Clinician's details

Name:	Designation:	
Contact number:	Signature:	Date: /2018
AMHS address:		
Town / Suburb:		Postcode:

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

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- Facilities should refer to the policy and *Chief Psychiatrist Practice Guidelines Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Mental Health Act 2016* for key information, definitions and procedures for notification requirements.

1. Person's details

Surname:	Given name(s):	
Residential address:		
Town / Suburb:	State:	Postcode:
Date of birth:	Sex:	Indigenous status:

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

- ☑ Voluntary
- ☐ Treatment authority
- ☐ Treatment support order
- ☐ Forensic order
- ☐ Judicial order
- ☐ Detained from interstate
- ☐ Classified patient
- ☐ Detained under a recommendation for assessment

3. Incident details

Date of incident:	Time of incident (24hr):	Incident identification number as allocated by facility (if applicable):
2018		

Location where the incident occurred (such as facility name, ward, location, home, community):

Patient type:

Inpatient - on ward

4. Incident type

- ☐ The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
- ☐ The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury
- ☑ An incident resulting in significant mental or physical harm to an inpatient
- ☐ Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
- ☐ A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

On visual round patient was noted not to be in room, bathroom locked but no response to knocks.
Bathroom door was forced open and patient was found hanging from bathroom handle by
Patient found unresponsive.
Second staff member attended, obtained ligature cutters and removed ligature.
Duress alarm activated and nurse response team attended the incident.
Patient was removed from bathroom into the bedroom area.
Basic life support commenced and continued until taken over by QAS who then transferred patient to the
NOK , Treating psychiatrist, Director of Clinical Services, Nurse Unit Manager and acting Intake Coordinator contacted.

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

• Briefly describe the patient outcome. Include: ▪ level of harm sustained ▪ treatment required.
ICU admission at [redacted] day of incident followed by transfer to a medical ward. No confirmation from treating team at [redacted] as to patients condition.
Severity Assessment Code (SAC) rating: SAC 2: Temporary harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner?	☐ Yes	☐ No	☑ Not applicable
Type of analysis planned: Internal investigation			

7. Clinician's details

Name: [redacted]	Designation: [redacted]	
Contact number: [redacted]	Signature: [redacted]	Date: [redacted] 2018
AMHS address: [redacted]		
Town / Suburb: [redacted]		Postcode: [redacted]

v1.00 - 02/2017

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

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1. Person's details

Surname:	Given name(s):		
Residential address:			
Town / Suburb:		State:	Postcode:
Date of birth:	Sex:	Indigenous status:	

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

☐ Voluntary ☑ Treatment authority ☐ Treatment support order ☐ Forensic order
☐ Judicial order ☐ Detained from interstate ☐ Classified patient ☐ Detained under a recommendation for assessment

3. Incident details

Date of incident:	Time of incident (24hr):	Incident identification number as allocated by facility (if applicable):
2018		

Location where the incident occurred (such as facility name, ward, location, home, community):

Inpatient unit, patient's ensuite

Patient type:

Inpatient - on ward

4. Incident type

☑ The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS

☐ The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury

☐ An incident resulting in significant mental or physical harm to an inpatient

☐ Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient

☐ A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

A who was admitted to on 2018 with a diagnosis of 2018 was found in bedroom ensuite on 2018 at hours. Despite nursing staff's attempts to resuscitate the patient, was pronounced dead at hours by the paramedics who attended the scene. The patient was on 15 minute visual observations at the time of the incident and a member of nursing staff had observed in bedroom at .00 hours. The cause of death is suspected suicide.

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

- Briefly describe the patient outcome. Include:
  - level of harm sustained
  - treatment required.

The patient was pronounced dead by the paramedics who attended the incident at [redacted] at [redacted] hours on [redacted] 2018.

Severity Assessment Code (SAC) rating:

SAC 1: Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner? ☑ Yes ☐ No ☐ Not applicable

Type of analysis planned:

RCA

If the RCA was stopped, indicate by whom:

☐ Section 102 of the *Hospital and Health Boards Act 2011* (stopped by RCA Team)

☐ Section 103 of the *Hospital and Health Boards Act 2011* (stopped by RCA Commissioning Authority)

☐ Office of the Health Ombudsman notified

7. Clinician's details

Name:	Designation:	
[redacted]	[redacted]	
Contact number: [redacted]	Signature: [redacted]	Date: [redacted] /2018
AMHS address: [redacted]		
Town / Suburb: [redacted]		Postcode: [redacted]

CP006 v1.00 - 02/2017

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

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1. Person's details

Surname:

Given name(s):

Residential address:

Town / Suburb:

State:

Postcode:

Date of birth:

Sex:

Indigenous status:

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

- [x] Voluntary
- [ ] Treatment authority
- [ ] Treatment support order
- [ ] Forensic order
- [ ] Judicial order
- [ ] Detained from interstate
- [ ] Classified patient
- [ ] Detained under a recommendation for assessment

3. Incident details

Date of incident: 2018

Time of incident (24hr):

Incident identification number as allocated by facility (if applicable):

Location where the incident occurred (such as facility name, ward, location, home, community):

Patient type:

Inpatient - on ward

4. Incident type

- [x] The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
- [ ] The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury
- [ ] An incident resulting in significant mental or physical harm to an inpatient
- [ ] Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
- [ ] A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

patient voluntarily admitted to on 2018. On admission the patient had a diagnosis of On the 2018 the patient was sighted by nursing staff at approximately hours and noted to be sleeping and snoring. Following the change of shift the night duty staff conducted their first round of the night and at approximately hours a member of nursing staff entered the patients room and noted Upon investigation found the patients The patient was examined and found to not be breathing and with no pulse. A code blue emergency was called. CPR was commenced. QAS contacted and arrived on scene. The patient was pronounced deceased by QAS at hours.

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

• Briefly describe the patient outcome. Include: ▪ level of harm sustained ▪ treatment required.
Severity Assessment Code (SAC) rating: SAC 1: Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner? ☑ Yes ☐ No ☐ Not applicable

Type of analysis planned:
RCA

If the RCA was stopped, indicate by whom:
☐ Section 102 of the *Hospital and Health Boards Act 2011* (stopped by RCA Team)
☐ Section 103 of the *Hospital and Health Boards Act 2011* (stopped by RCA Commissioning Authority)
☐ Office of the Health Ombudsman notified

7. Clinician's details

Name:	Designation:	
Contact number:	Signature:	Date: 2018
AMHS address:		
Town / Suburb:		Postcode:

CP006 v1.00 - 02/2017

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

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1. Person's details

Surname:	Given name(s):	
Residential address:		
Town / Suburb:	State: QLD	Postcode: 4066
Date of birth:	Sex:	Indigenous status:

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

- [x] Voluntary
- [ ] Treatment authority
- [ ] Treatment support order
- [ ] Forensic order
- [ ] Judicial order
- [ ] Detained from interstate
- [ ] Classified patient
- [ ] Detained under a recommendation for assessment

3. Incident details

Date of incident:	Time of incident (24hr):	Incident identification number as allocated by facility (if applicable):
2018		

Location where the incident occurred (such as facility name, ward, location, home, community):

At home

Patient type:

Outpatient

4. Incident type

- [ ] The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
- [x] The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury
- [ ] An incident resulting in significant mental or physical harm to an inpatient
- [ ] Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
- [ ] A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

the patients' private treating psychiatrist was notified by family of death.
suffered from and has been treated for
was being seen monthly by the Community Outreach Team-last seen 18, and stated to the case manager that had decided didn't need Outreach services anymore and will be 'Ok' on own. was discharged from Outreach Team services at that point after consultation with Dr

Suspected suicide.

v1.00 - 02/2017

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

- Briefly describe the patient outcome. Include:
  - level of harm sustained
  - treatment required.

Death

Severity Assessment Code (SAC) rating:

SAC 1: Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner? ☐ Yes ☐ No ☑ Not applicable

Type of analysis planned:

Clinical system review

7. Clinician's details

Name:

Designation:

Contact number:

Signature:

Date: 2018

AMHS address:

Town / Suburb:

Postcode:

v1.00 - 02/2017

Queensland Government

Notification of Critical Incidents
(Private Sector Authorised Mental Health Services)

Mental Health Act (MHA) 2016, Section 305(2)(l)

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1. Person's details

Surname:

Given name(s):

Residential address:

Town / Suburb:

State:

Postcode:

Date of birth:

Sex:

Indigenous status:

2. Treating AMHS and MHA status

Name of authorised mental health service (AMHS):

MHA status:

- [x] Voluntary
- [ ] Treatment authority
- [ ] Treatment support order
- [ ] Forensic order
- [ ] Judicial order
- [ ] Detained from interstate
- [ ] Classified patient
- [ ] Detained under a recommendation for assessment

3. Incident details

Date of incident: 2018

Time of incident (24hr):

Incident identification number as allocated by facility (if applicable):

Location where the incident occurred (such as facility name, ward, location, home, community):

Patient type:

Inpatient - on ward

4. Incident type

- [ ] The death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
- [ ] The death, or injury resulting in likely permanent harm, of a person who, within 30 days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury
- [x] An incident resulting in significant mental or physical harm to an inpatient
- [ ] Allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
- [ ] A serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm

5. Incident description

- Briefly describe the incident that occurred. Include:
  - a factual account of the incident
  - state any immediate actions taken to prevent reoccurrence.

patient had an unwitnessed fall in patient room. Staff found patient laying on the floor in bedroom. Patient stated experienced head knock to ground - small reddened area to left side of forehead noted. Right elbow/ arm area deformed. Assisted to chair by nursing staff. Doctor notified. Neurological and neurovascular observations commenced. Sling aplied. Ice applied. Next of kin notified.

Queensland Government

Department of Health Mental Health Act 2016

Notification of Critical Incidents

(Private Sector Authorised Mental Health Services)

• Briefly describe the patient outcome. Include: ▪ level of harm sustained ▪ treatment required.
CT head and X-ray right arm attended. CT head NAD. X-ray of right arm showed fractured distal humerus - Orthopaedic surgeon reviewed patient. Surgery performed [redacted] 2018 - Open reduction Internal Fixation to fracture. Patient recovered satisfactorily and was discharged from hospital [redacted] 2018.
Severity Assessment Code (SAC) rating: SAC 2: Temporary harm which is not reasonably expected as an outcome of healthcare

6. Actions taken

Referred to Coroner?	☐ Yes	☑ No	☐ Not applicable
Type of analysis planned: Human Error and Patient Safety analysis			

7. Clinician's details

Name: [redacted]	Designation: [redacted]	
Contact number: [redacted]	Signature: [redacted]	Date: [redacted] 2018
AMHS address: [redacted]		
Town / Suburb: [redacted]		Postcode: [redacted]

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