CONFIDENTIAL

RIDLEY REPORT

Concerning a significant critical incident in the Ridley Unit

of the Baillie Henderson Hospital

Darling Downs Hospital and Health Service

on 19 January 2013

and related matters.

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RIDLEY REPORT

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RIDLEY UNIT INVESTIGATION

CONDUCTED BETWEEN MARCH AND AUGUST 2013

1. EXECUTIVE SUMMARY

1.1 Background

At approximately midnight on the night of Saturday 19 January 2013, a critical incident occurred within Ridley Unit (the Unit) of the Baillie Henderson Hospital, within the Division of Mental Health, Darling Downs Hospital and Health Service (Darling Downs HHS). The incident involved seven inpatients and, in the course of the incident, a number of staff were assaulted and injured, some seriously.

On 13 March 2013, the Health Service Chief Executive commissioned an investigation and review of the incident and other matters relating to practices in the Unit.

An investigation team was appointed, consisting of:

Lead Investigator

Mr F Pulsford (Consultant, PulsfordJones Workplace Consultants)

Other Investigators

Dr E Heffernan, Director Queensland Forensic Mental Health Service

Ms K Chettleburgh, Executive Director Mental Health and ATODS, Gold Coast Hospital and Health Service

Mr G Richards, Principal Advisor, Occupational Health and Safety Risk Management, Department of Health

Mr R Green, Program Coordinator, Statewide Community Risk Management Program, Queensland Forensic Mental Health Service.

The Terms of Reference are contained within Appendix A to this report.

Visits to Ridley Unit and Baillie Henderson Hospital were undertaken by the investigators for the purpose of staff interviews and to develop an appreciation of the environmental, cultural and procedural aspects of the Unit's functioning.

In support of the investigation, the investigation team reviewed relevant documents, interviewed stakeholders and reviewed written submissions from interested parties.

Transcripts of interviews, copies of statements to the Queensland Police Service (QPS), written submissions and various documents volunteered to the investigators are delivered in separate volumes.

Several written submissions were received that were outside the scope of this investigation. These submissions were provided to the Darling Downs HHS to be addressed and are not included in the separate volumes.

The investigators were supplied with a document titled "*Ways the Patients think Ridley could be Improved".* There is a handwritten note suggesting that the document was compiled by patients ***[PATIENT #2]***, ***[PATIENT #1]*** and ***[A FORMER PATIENT]*** in 2012.

An interim report was provided to the Health Service Chief Executive on May 7, 2013. This interim report made 11 recommendations and highlighted a number of issues that the investigation team believed required urgent attention. Whilst the interim report stands alone, this final report incorporates key issues and recommendations from the interim report, where considered to still be relevant.

1.2 Key Findings

1.2.1 Ridley Unit profile

Ridley Unit is a 24-bed secure mental health rehabilitation unit (SMHRU). Available data indicates the Unit is comparable to other SMHRUs on the majority of variables. However, Ridley Unit differs on three significant variables. These are:

- Lower participation of patients in rehabilitation;
- Longer median length of stay; and
- Risk assessment and management.

1.2.2. The incident

At approximately midnight on **Saturday 19 January 2013,** a number of staff were assaulted by seven patients. Two staff sustained serious injuries requiring treatment at the Toowoomba Hospital.

All staff involved in the incident conducted themselves with considerable courage and restraint having regard to all the circumstances.

There is no evidence that any of the patients involved were significantly injured. With the exception of ***[PATIENT #1]***, who was in seclusion, the remaining patients were medically screened on the night. ***[PATIENT #1]*** was examined later and all patients were later seen by the Clinical Director, Extended Inpatient Services ***[CDEIS]***.

1.2.3. Staff Issues

There was general agreement from staff that there was good immediate support from senior staff. Problems were identified with the on-call medical response. Some concerns were expressed about the time taken to get appropriate advice about operational processes and staff-related health matters. In general, rostering, resourcing and educational issues were identified as requiring further attention and review.

1.2.4. Patient Issues

Seven patients were directly involved in the incident. Of these patients, all had histories of major mental illness and violence. Four patients were on

Forensic Orders (FOs). Three patients were subject to Involuntary Treatment Orders (ITOs) (two had outstanding criminal charges).

1.2.5. Factors related to the incident

Such incidents are uncommon and usually occur in secure environments. No single event was identified as the cause of the incident. A range of acute and longer term patient factors related to frustration and hopelessness, as well as patient mix, were primary factors. A range of systemic and staff-related factors which could be considered as contributing, but also as areas for improvement, were identified.

1.3 Conclusion

A total of sixty two (62) recommendations have been made by the investigation team. Some of the recommendations are directly related to the incident; however most are related to broader systemic issues.

No adverse findings were made regarding the conduct or behaviour of any individual staff member or group of staff of the Darling Downs HHS.

Whilst it is remarked upon in other areas of the report, the investigation team would like to acknowledge the actions of the staff involved in managing the incident. It is clear that without their swift and courageous actions the incident could have escalated further with even more adverse outcomes for patients, staff and the community.

It is clear there will be a need to assist staff and patients of Ridley Unit to heal and move on from the incident. The investigation team recommend (at 60 below) this report be released to key stakeholders, particularly staff involved in the incident and those staff that have contributed to the investigation. We believe this will assist staff to move on from the incident. The investigation team would like to thank all of those who provided assistance and information in undertaking the investigation.

2. SUMMARY OF RECOMMENDATIONS

1. Data should be routinely collected and reviewed to monitor program participation and address issues associated with low participation rates. This will aid identification of aspects of patient programs, as well as rehabilitation needs and activities, requiring review in order to enhance patient involvement.

2. It is recommended that an audit be conducted to examine the factors associated with length of stay in Ridley Unit.

3. PRIME reports could be used more effectively by the multidisciplinary team to inform clinical decision making and responses to patients who are frequently aggressive. ***[PATIENT #2]*** accounted for 20% of incidents recorded on PRIME from 2011-2012. it is recommended that when a patient accounts for a significant proportion of incidents this triggers a response (e.g. special case review, review of Individual Care Plan) in order to enable consideration of additional monitoring, support and evaluation of interventions. To enact the above, it would be necessary to collate and routinely review both ward and individual patient trends.

4. Recommendation 3 requires improvement in recording aggressive incidents. Training should be provided in this regard.

5. Darling Downs HHS Mental Health Service should review why the medical resources were not available or unable to be prioritised to respond to the incident. If relevant, appropriate training about on-call responsibilities should be undertaken with medical staff.

6. Darling Downs HHS should develop work instructions that clearly outline expectations for meeting ongoing operational requirements during a post-critical incident period, particularly during an investigation. It is important that there is clarity with respect to roles and responsibilities of staff and managers about processes and rights.

7. Darling Downs HHS should review its Emergency Response Manual to include information on the range of staff support programs available post-critical incident and to ensure the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.

8. Darling Downs HHS should establish a staff peer support or 'buddy' system to ensure staff involved in a critical incident are provided with practical support and monitoring during the recovery process.

9. Darling Downs HHS Mental Health Service management should identify a mechanism to ensure there has been mediation and resolution between Ridley Unit staff and patients and that additional support and feedback are provided during court proceedings relating to the incident.

10. Consideration should be given to the referral of ***[PATIENT #3]*** and ***[PATIENT #2]*** to more secure care (and ***[PATIENT #4]*** to either The Prince Charles Hospital (TPCH) SMHRU or the High Secure Unit).

11. Darling Downs HHS Mental Health Service management should consider establishing an escalation process for the re-assessment and alternate placement of Ridley Unit patients whose mental state and related behavioural disturbance can no longer be managed by the resources available within a SMHRU environment.

12. Darling Downs HHS Mental Health Service management should consider ceasing the practice of admitting patients to Ridley SMHRU that are not planned, as outlined in section 3.7.2, until the investigation has concluded. If an emergency internal admission is required, this should only proceed with the approval of the Executive Director Mental Health, Darling Downs HHS.

13. The Mental Health Alcohol and Other Drugs Branch should reinforce the role and function of SMHRUs and the responsibilities of referring services in the ongoing management and discharge planning of patients.

14. Referral guidelines should be developed and include an expectation that patients referred to the SMHRU need to have defined rehabilitation goals (this assumes the patient will also have risk management needs, the two are not mutually exclusive). Acceptance of referrals should be contingent on the understanding that the patient is expected to be discharged back to the referring service.

15. Darling Downs HHS Mental Health Service management should ensure that discharge/external transition of care processes operate in accord with

key components of the model of service (MoS), especially in relation to ensuring discharge planning is a component of each patient's recovery plan.

16. Darling Downs HHS Mental Health Service management should ensure processes are in place to support discharge planning. The MoS identifies a role for the SMHRU's care-coordinator in reviewing recovery plans and for referring district care-coordinators in maintaining a care co-ordination role.

17. Darling Downs HHS Mental Health Service management should ensure all documentation relating to referral and admission processes are reviewed for consistency with the current MoS for SMHRUs.

18. Darling Downs HHS Mental Health Service management should develop a protocol for the management of 16 and 17 year old patients, in the event there is no alternative but to admit them to Ridley Unit, which considers issues of meeting educational and other developmental needs and managing specific risks associated with this client group.

19. Darling Downs HHS Mental Health Service management should develop a 'Gender Sensitive' protocol that will ensure the safety, health and well-being of female patients admitted to Ridley Unit.

20. Specific training should be developed and provided to facilitate a practical understanding of how recovery principles can be applied in a SMHRU.

21. Weekly clinical review meeting processes should be reviewed to decrease the number of patients discussed and thereby facilitating a greater opportunity for detailed discussion. The care review and management plan should be adequately documented in the patient record. Ideally every patient should be discussed once per fortnight, however daily handovers should facilitate the need to address urgent matters.

22. Within the weekly clinical review at least 30minutes per meeting should be allocated for a comprehensive review of a patient's Individual Care Plan (ICP), risk assessment and general progress which must occur on

a 3 monthly basis as required by The National Standards for Mental Health Services (Standard 10 Delivery of Care Assessment and Review Criteria 10.4.6). If two patients have this review each week the 3 monthly requirement would be met.

23. ICPs should include patient recovery goals and identified discharge preference as well as staff identified concerns. Input from the patient, multidisciplinary team and care coordinator should be reflected in the ICP to ensure plans are comprehensive and reflect current issues.

24. The current clinical documentation audit process needs to be reviewed to ensure plans are updated as required and there is an accountable evidence trail. The audit process must include quality and frequency of entries.

25. A comprehensive review of clinical documentation must be undertaken as soon as possible. Some issues that were identified in this investigation that must be addressed include:

a) ICPs and risk assessment are kept in a separate folder in the staff station and separated from the clinical file;

b) Some patients had no entries for several days;

c) The CIMHA minimum dataset does not appear to be adhered to and is not regularly updated; and

d) Aspects of the 'filing system' in the clients' clinical records are a potential source for confusion e.g., the 'Risk Screen" was filed under the Other Investigation tab and MHRT under legal, some care plans are filed under Allied Health.

26. A risk assessment management plan should be developed for each patient. The plan should identify relevant risk factors, early warning signs and risk management strategies. This plan could be incorporated into the ICP.

27. Patients with frequent aggressive behaviour require a positive behaviour management plan. In instances where such plans don't prove

effective further consultation with a specialist forensic mental health service is indicated.

28. Training should be provided regarding developing risk assessment plans. A review of risk management practice should also be undertaken and training provided to address any knowledge or skill deficits. Staff should be familiar with the principles and practices of environmental, relational and procedural security.

29. Use of the DASA-IV should be considered to ensure consistency of assessment and response in relation to aggressive behaviours.

30. Procedures should be established to provide a consistent, accountable approach to management of patient leave within the community that includes patient searches, risk assessments pre- and post-leave and management of items entering Ridley Unit.

31. Priority should be given to the introduction of a comprehensive rehabilitation program that promotes meaningful occupation for all patients and is the core responsibility of all staff and as a minimum all patients have access to vocational, educational, recreational and therapeutic programs.

32. A system that facilitates consumer feedback in day to day operations, as well as strategic planning, should be developed. This can only be achieved through the engagement of the existing paid peer and consumer staff of DDHHS as well as consideration being given to the establishment of a consumer representative position from the existing Ridley Unit patient population.

33. All nursing staff allocated to Ridley Unit should undertake re-skilling programs focused upon improving their skills and enhancing their confidence in providing rehabilitation programs for patients.

34. Opportunities for replacing the functions of the Recreation Officer positions that were recently abolished should be explored. This may include identifying opportunities with the private or not for profit sector in establishing a joint initiative (e.g. YMCA).

35. It is recommended that the practice of having permanent night duty staff at Baillie Henderson Hospital be ceased through negotiation with current staff or through natural attrition.

36. Until recommendation 35 can be achieved it is recommended that Ridley Unit staff on permanent night duty be required to be rostered to a minimum of one four week period of day duty and one four week period of afternoon duty in each Calendar year.

37. It is further recommended that the mandatory training requirements specified by Queensland Health and Darling Downs Executive management are enforced. This can be achieved through either adopting the above recommendation, providing mandatory training for all staff on night duty with appropriate backfill or by rostering permanent night duty staff to day shift mandatory training sessions as a component of their core roster. This should be completed within 6 months.

38. It is recommended that the rostered shift configuration and duration be reviewed to create an overlap period for handover purposes and to allow staff who predominantly work on night duty to have greater contact with clients.

39. It is recommended that the Baillie Henderson Hospital Emergency Response procedure is reviewed to clearly articulate the resources that will respond in an emergency and the acceptable timeframes to receive this response. It is recommended that the skill mix for night duty staffing is reviewed to ensure that unqualified staff are not rostered to night duty, even as an additional staff member or replacement.

40. Resource sharing should occur across units within Baillie Henderson Hospital, or Darling Downs HHS to ensure that access to allied health staff is available during periods of staff shortage in Ridley in recognition of the isolation and vulnerability of SMHRU patients.

41. It is recommended that the Baillie Henderson Hospital Emergency Response procedure is reviewed to clearly articulate the resources that will respond in an emergency and the acceptable timeframes to receive this response. Further a role for a permanent on-site Security Officer

should be included in the Emergency Response that does not duplicate or replace the role of clinical staff.

42. Regular urine drug screens (UDS) to be undertaken on all patients and to screen for illicit as well as restricted prescribed medications.

43. An education program for staff should be provided to enhance the understanding of substance use disorders and the management of associated problems, including drug seeking behaviours.

44. The program already in place in relation to patients identified as at risk of drug use should be expanded for all patients to include capacity to repeat programs as required and to establish a formal evaluation of the program outcomes.

45. The investigation team recommend, as a matter of urgency, that immediate action be initiated to remove the furniture hazard within Ridley Unit, and that substitution of more appropriate items be made. In particular furniture with metal legs should be replaced.

46. Staff interviews identified that staff were placed in a vulnerable position when filling the lighter in the Atrium. Procedures should be established to ensure that either the lighter be checked and filled when no patients are present or an alternative location for the lighter be considered.

47. Consideration should be given to creating a 'sensory modulation' space (possibly in one of the Intensive Care Areas, ICAs).

48. A review should be undertaken of the furniture and ward environment both in terms of security and patient comfort.

49. The use of CCTV cameras should be reviewed to ensure they are placed in locations that enable viewing of areas determined to be sites of the most frequent incidents of concern. Camera use needs to be balanced with the need for staff to be actively monitoring patients and the environment.

50. Staff should be made aware of the processes to escalate required maintenance and repair work through appropriate channels.

51. The contents of this report should be made available to the staff of Ridley Unit.

52. Processes should be established to engage consumers in contributing to all levels of their care (e.g. treatment planning and ward functioning) in order to be consistent with a Recovery model. Utilisation of a current or former Ridley patient representative in this process should be considered.

53. The role of carer facilitator and complaints functions should be separated.

54. Support should be given for participation by patients in surveys such as the CPOC and Benchmarking reviews and establishment of processes to utilise such feedback, as appropriate, in service planning.

55. The aggression management workplace instruction should be reviewed and updated as a priority and staff should be made aware of the instruction.

56. The *Security Nurse Role and Responsibility including Emergency Procedures* should be reviewed to ensure consistency with other HHS and state-wide policies, instructions or procedures.

57. A review of the duress alarm procedure should be undertaken along with a review of implementation of the procedure, including staff use of alarms, staff response and the training staff have received in their use. Code Black responses should in particular be tested at least quarterly in a unit such as Ridley.

58. The dual use of colour codes to denote the movement level of patients and to denote emergencies is potentially confusing. A different code system for movement should be developed as the emergency codes are standard across facilities.

59. The Staff Orientation Manual should be updated to address issues identified above. Hours of operation and supervision of the Atrium area should be clarified in the Staff Orientation Manual.

60. The return of patients to their home communities, where this can be safely progressed should be supported. A range of issues need to be

worked through, the starting point is comprehensive assessments of patients, as discussed in the sections 3.10.1(c) and 3.10.1(d). While there may be a need for a campus based facility for patients to transition out of Ridley, wherever possible this should be avoided and other options should be utilised. This is discussed in section 3.9.

61. The role and value of the SMHRU should be clearly articulated in the Mental Health Service description and planning documents.

62. Patient LCT plans should be reviewed to ensure that they are clear and comprehensive and that they relate to the ICP and discharge planning processes. Patients should be involved as much as possible in the development and review of these plans.

3. RIDLEY UNIT INVESTIGATION REPORT

3.1 Background

At approximately midnight on the night of Saturday 19 January 2013, a critical incident occurred within Ridley Unit (the Unit) of the Baillie Henderson Hospital, within the Division of Mental Health, Darling Downs Hospital and Health Service (Darling Downs HHS). The incident involved seven inpatients and, in the course of the incident, a number of staff were assaulted and injured, some seriously.

3.1.1 Establishment of Investigation and Review

On 13 March 2013, the Health Service Chief Executive commissioned an investigation and review of the incident and other matters relating to practices in the Unit.

An investigation team was appointed, consisting of:

Lead Investigator

Mr F Pulsford (Consultant, PulsfordJones Workplace Consultants)

Other Investigators

Dr E Heffernan, Director Queensland Forensic Mental Health Service

Ms K Chettleburgh, Executive Director Mental Health and ATODS, Gold Coast Hospital and Health Service

Mr G Richards, Principal Advisor, Occupational Health and Safety Risk Management, Department of Health

Mr R Green, Program Coordinator, Statewide Community Risk Management Program, Queensland Forensic Mental Health Service.

The Terms of Reference are contained within Appendix A to this report.

3.1.2 Conduct of the Investigation

The methodology that the investigation team utilised in undertaking this investigation included analysing the following;

- The Queensland Model of Service Delivery for Secure Mental Health Rehabilitation Units (2011);
- A Model of Service Delivery for: Medium Secure Treatment Services in Queensland (2003);
- Baillie Henderson Hospital (BHH) Ridley Unit referral and admission procedures;
- BHH Ridley Unit Orientation Manual;
- Profiles and medical records of patients involved in the incident at BHH Ridley Unit on 19 January 2013;
- Multi-Site Benchmarking of Secure Mental Health Rehabilitation Units (SMHRU) - de-identified report 2012; and
- Interviews and written statements provided by staff and stakeholders.

A general invitation was issued to staff at Baillie Henderson Hospital to attend for interview or to furnish a written statement, or both. A decision was made not to actively pursue any member of staff who was reluctant to participate in the investigation. It was recognised that staff had suffered sufficient trauma and upset without adding to it by insisting they submit to interview if they did not want to. In any case, sufficient information was available and gathered to inform the investigation team, so the investigation did not suffer from the absence of those unwilling or unable to be involved.

In the course of the Investigation the following people were interviewed:

Director of Nursing, Division of Mental Health ***[DONMH***]

Nurse Unit Manager, Ridley Unit ***[NUM]***

[STAFF #1]

[STAFF #2]

[STAFF #3]

Clinical Director, Extended Inpatient Services ***[CDEIS]***

Director of Clinical Services, Division of Mental Health ***[DCSMH]***

Nursing Director, Acute and Community Mental Health ***[NDACMH]***

After Hours Nurse Manager ***[AHNM]***

Security Officer

[STAFF #4]

Psychologist, Ridley Unit ***[PRU]***

Occupational Therapist, Ridley Unit ***[OTRU]***

Nursing Director, Extended Treatment and Rehabilitation ***[NDETR]***

Consumer Consultant for Toowoomba Mental Health Service ***[CCTMHS]***

Written submissions were invited and the following individuals provided a written submission that had direct relevance to the investigation:

Social Worker, Rehab and Recovery Centre ***[SWRRC]***

[STAFF #1]

[STAFF #2]

[CDEIS]

Transcripts of the interviews, copies of QPS statements to the, written submissions and various documents volunteered to the investigators are contained in separate volumes. Several written submissions were received that were outside the scope of this investigation. These submissions were provided to the Darling Downs HHS to be addressed.

The investigators were supplied with a document headed "*Ways the Patients think Ridley could be Improved".* There is a handwritten note suggesting that the document was compiled by patients ***[PATIENT #2]***, ***[PATIENT #1]*** and ***[FORMER PATIENT]*** in 2012. This document is included in the separate volumes at Document 1.

Each member of the investigation team also inspected Ridley Unit with particular, but not exclusive, reference to the scene of the incident.

3.2 Ridley Unit profile

3.2.1 Summary

Ridley Unit was officially opened on February 27, 1992 though had been operational since January 1, 1992 when patients were first transferred there from Gowrie Hall, a ward of the Baillie Henderson Hospital.

The *Ten Year Mental Health Strategy for Queensland* (1996), referred to in the 2003 Model of Service document, articulated the directions for service development. Medium secure units were identified as a "critical component of an integrated system of mental health care". This strategy was superseded by the *Queensland Plan for Mental Health 2007-2017*. In this current plan the model of medium secure unit (MSU) care was replaced by that of a SMHRU. A state-wide model of service (MOS) delivery was endorsed by the Executive Director, Mental Health Alcohol and Other Drugs Directorate on 28/01/2011. Ridley Unit subsequently became one of five SMHRUs in Queensland.

3.2.2 Benchmarking SMHRUs

Comparative data on SMHRUs is available from the Queensland Mental Health Benchmarking Unit which compiles a report every two years. The most recent report was released in 2012: *Multi-Site Benchmarking of Secure Mental Health Rehabilitation Units: De-identified Benchmarking Report 2012.* The 19-bed Redcliffe-Caboolture unit which opened in August 2012 was not included in the recent report.

In the report, Ridley Unit shared features in common with other SMHRUs but did have some distinctive features. The similarities were that it had a similar proportion of patients diagnosed with schizophrenia and admissions from prison, incidents of aggression were not higher than other units, antipsychotic medication doses were comparable as was night staff to patient ratios. In comparison however, the Unit, had a relatively higher proportion of younger male patients, patients on FOs whose histories included less violent and more non-violent offences. Ridley

patient Health of the Nation Outcome Scales (HoNOS) ratings were relatively higher for behaviour problems (not higher for aggressive, disruptive behaviour but for self-injury and substance use) and symptoms and were rated by staff as higher risk.

With the exception of the number of individual patients secluded, the Unit reported fewer seclusion episodes, fewer total seclusion hours and shorter average hours per episode. PRN benzodiazepine use was also low.

Significantly, Ridley patients were identified as having a longer median length of stay, less participation in rehabilitation services, less family contact and were less likely to be discharged to independent living and more likely to be discharged to an extended stay unit.

The above summary information was derived from the 2012 Benchmarking Report. More detailed information from this report used to inform the above summary follows**.**

Bed state and occupancy rate

For the 2011 calendar year, Ridley and SMHRU C had highest occupancy rates, though overall occupancy rates are high across SMHRUs.

Table 1: Bed state and occupancy rate for 2011

SMHRU	Bed state and occupancy rate
Ridley Unit	24 (97.3%)
SMHRU B	34 (90.6%)
SMHRU C	21 (97.6%)
SMHRU D	20 (90.3%)

Staffing

The 2012 benchmarking report indicated that SMHRU B had the most beds and more staff, however, SMHRU C had the highest night staff to patient ratio, otherwise the night nursing staff to patient ratios are similar across the remaining SMHRUs.

Table 2: Nursing staff numbers by shift

SMHRU	Morning nursing shift	Afternoon nursing shift	Nursing night shift
Ridley	7	7	4
SMHRU B	10	9	5
SMRHU C	5	6	5
SMHRU D	7	6	3

Table 3: Total staff establishment

SMHRU	Medical staff	Allied health/ rec officer staff	Nursing staff
Ridley	1.5	2.7	27.52
SMHRU B	2.4	3.0	36.8
SMRHU C	2.0	6.6	31.3
SMHRU D	0.65	4.0	25.10

Demographic characteristics

Ridley had the second highest proportion of males (96%), compared with other SMHRUs (83%, 100% and 83%, respectively). The median ages of Ridley and SMHRU D patients were the same (36) compared to SMHRU B (38) and C (41). Ridley had the second highest proportion of indigenous patients (38%) compared to other SMHRUs (17%, 57% and 11%).

Diagnosis

SMHRU C reported the lowest proportion of patients with schizophrenia (67%). Ridley recorded 92% of patients had a primary diagnosis of schizophrenia. SMHRU B and D reported 93% and 89%, respectively.

Ridley reported the highest proportion of patients with a current drug and alcohol issue (79%) compared to 47%, 38% and 67% respectively.

Mental Health Act status

Ridley patients on FOs (at census) increased from 33% in 2005 to 54% in 2012. All SMHRUs have seen an increase in the proportion of Forensic patients from 2005 to 2012. However, the table below indicates that the proportion of patients on FOs in Ridley is in the mid-range compared to the other SMHRUs. Ridley had the lowest proportion of Special Notification Forensic Patients (SNFPs) Forensic Order patients. Ridley and SMHRU B had higher proportions of patients currently facing criminal charges. Ridley had the lowest proportion of patients on ITOs.

Table 4: Mental Health Act status recorded in the 2012 Benchmarking report

	ITO	Chapter 7, Part 2	Classified	Forensic Order	SNFP
Ridley Unit	21%	25%		54%	4%
SMHRU B	40%	17%	10%	37%	7%
SMHRU C	29%	5%	5%	71%	19%
SMHRU D	28%			56%	17%

Admission source

Table 5: Admission source: 2011

	CMHS	Acute inpatient unit	High secure unit	Prison	Other extended treatment unit
Ridley Unit	11%	56%		22%	11%
SMHRU B		77%		23%	
SMHRU C		33%		33%	33%
SMHRU D	50%		50%		

For the 2011 calendar year, acute inpatient units and prison were the primary referral source for Ridley, SMHRU B and C. SMHRU D had a markedly different pattern for admission sources.

Offending profile

In terms of lifetime and current offending, inpatients present at the 2012 census date indicated that a lower proportion of Ridley patients had violent offences (Homicide, Acts intended to cause injury, sexual offences, dangerous acts or abduction, weapons offences) and proportionally higher level of non-violent offending (unlawful entry, theft, illicit drug use, property damage or public order) in their background.

Table 6: Lifetime and Current admission offences recorded in the 2012 Benchmarking report

	Lifetime Violent	Lifetime non-violent	Current violent	Current non-violent
Ridley Unit	53%	30%	58%	24%
SMHRU B	73%	10%	70%	13%
SMHRU C	81%	15%	86%	10%
SMHRU D	95%	6%	69%	6%

CIMHA risk assessments

The benchmarking report captured risk assessments conducted in the previous three months. Across SMHRUs, Ridley had the lowest number of patients rated as a low risk of aggression (25% compared to 53%, 33% and 28%, respectively) and the highest proportion of patients rated as a high risk of aggression (29% respectively compared to 13%, 19% and 28%). SMHRU B only recorded aggression in 40% of management plans, compared to 79% in Ridley (and 86% in SMHRU C and 78% in SMHRU D).

No SMHRU rated any patient a high suicide risk. Ridley rated 33% as medium risk compared to 13%, 0% and 17%, respectively. Ridley had the lowest proportion of patients with vulnerability included in a treatment plan and lowest proportion rated a low vulnerability risk (58% compared to 40%, 43% and 33%). In these terms, Ridley patients were rated as more aggressive and less vulnerable than patients of the other SMHRU.

HoNOS scores

HoNOS scores of two or more are "clinically significant". Data below was extracted from all HoNOS 2011reviews but doesn't indicate the number of patients with complete or valid reviews. No SMHRU D data was available.

Table 7: Clinically significant HoNOS subscale scores 2011

	Behaviour	Impairment	Symptoms	Social
Ridley Unit	26.55	32.30	50.44	32.25
SMHRU B	23.64	32.28	40.70	37.67
SMHRU C	17.56	50.34	26.97	26.97

Ridley patient Behaviour and Symptom patient scores are notable. Examination of individual scores indicates Ridley patients weren't higher on 'Overactive, aggressive, disruptive or agitated behaviour' (44.07 compared to 44.88 or 43.82). Differences were notable in relation to 'Non-accidental self-injury' (11.86 compared to 7.14 or 3.37) and 'Problem drinking or drug taking' (23.73 compared with 18.9 and 5.48).

Incidents

The table below examines incidents per 100 beds for 2011. Across all domains, relatively fewer or comparable incident rates were reported in Ridley Unit, compared to other SMHRUs. This data does not indicate incident severity. It is important to note there can be differing incident reporting thresholds between HHSs, with some having a culture of under reporting and others reporting all incidents even the most 'trivial'.

Table 8: Incidents per 100 beds 2011

	Aggression	Injury/falls	Medication	Other
Ridley Unit	117	8	8	54
SMHRU B	344	24	24	153
SMHRU C	667*	90	43	29
SMHRU D	135	10		95

** Includes all behavioural incidents.*

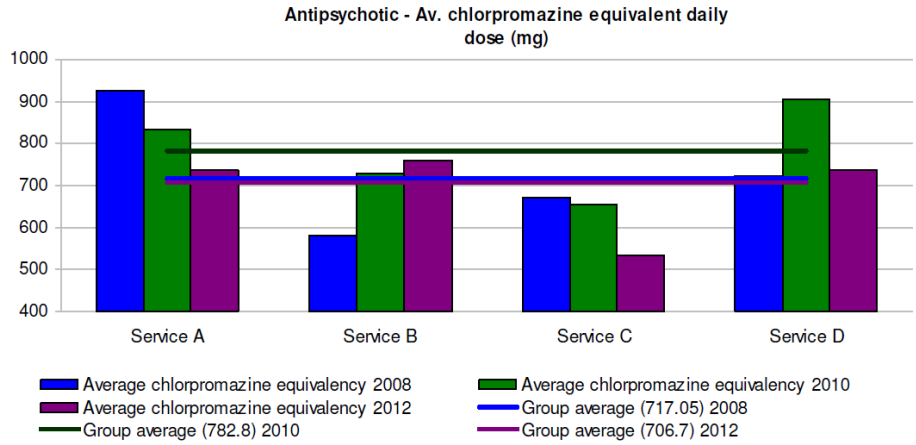
Seclusion

Seclusion was examined for the period July 2011 to December 2011). Ridley Unit was notable for reporting the lowest use of seclusion in terms of average hours in seclusion (9.0 compared to 39.6, 39.1 and 9.4), the number of individuals with only one seclusion episode (6 compared to 9, 0 and 0), total seclusion episodes (49 compared to 204, 195 and 183) as well as total seclusion episodes (441.45 compared to 8084, 7620, and 1722.3). The number of seclusion episodes across all SMHRU had increased from the 2008 and 2010 reports). The only domain where seclusion was higher in Ridley was in terms of the total number of consumers secluded (17 compared to 24, 3, and 14). The proactive use of the Intensive Care Area (ICA) in Ridley and this being used as an alternative to seclusion should be considered when assessing the significance of the seclusion rate in comparison to other services. While this is a positive outcome, it should be recognised that the use of the ICA as opposed to seclusion at Ridley Unit required additional staffing when a client was being managed within the ICA.

Medication

Medication data was collected for one week (March 19, 2012 to March 25, 2012). With the exception of SMHRU C, where 24% were not prescribed antipsychotic medication, all patients in the remaining SMHRUs were prescribed antipsychotic medication. The respective percentages prescribed a single antipsychotic medication were: SMHRU C (62%), Ridley (54%), SMHRU B (37%) and SMHRU D (33%). The table below, extracted from the 2012 Benchmarking report, details the average chlorpromazine equivalent prescribed per SMHRU in the 2008, 2010 and 2012 reports. SMHRU C reported markedly lower average daily antipsychotic medication does. The remaining SMHRU reported similar average daily dose. Benzodiazepam PRN usage was lowest in Ridley (13% of patients) compared to 17%, 19% and 29% for SMHRUs B to D.

Figure 1: Daily prescribed antipsychotic medication (average chlorpromazine equivalent).



Note: 2012 Average chlorpromazine equivalency excluding PRN medication – 685.66

Rehabilitation

In the four weeks prior the 2012 census date, the majority of services offered in Ridley and SMHRU C were on-site. Additionally, Ridley had the lowest proportion of patients engaged in rehabilitation

Table 9: Participation in rehabilitation programs

	Accessed rehab services	On campus	Off campus	Both on/off campus
Ridley Unit	71%	58%	0%	13%
SMHRU B	100%	27%	7%	67%
SMHRU C	86%	71%	5%	10%
SMHRU D	100%	28%	4%	67%

In terms of the programs surveyed, all SMHRUs had high proportions (83% to 100%) of patients not receiving activities in the respective domains surveyed, except skills training where 58% of patients engaged in such a program. However, where activities were provided, generally a low number of sessions (e.g. one to four) were provided. While further education, physical rehabilitation and vocational rehabilitation had low proportions of participants across the board, Ridley was much lower than

other SMHRUs in relation to community links, quality of life/diversional, psychoeducation and health and fitness programs. High levels of not providing consumer, family and carer support programs were noted across all SMHRUs with the exception of SMHRU B.

Family contact

A significant proportion of patients (inpatients at the census date) across all SMHRUs did not have contact with family. Non-contact was categorised as being due to the consumer not requesting contact (only SMHRU B reported this), family not requesting contact (4% respectively compared to 3%, 5% and 11%) as well as the service being recorded as not having contact (29% compared to 7%, 33% and 17%).

Table 10: Contact with family

	Staff contact	Daily/weekly family visits	Monthly	3monthly-yearly family visits	No visits
Ridley Unit	67%	8%	13%	33%	46%
SMHRU B	83%	33%	10%	7%	43%
SMHRU C	62%	14%	0%	38%	48%
SMHRU D	72%	39%	28%	22%	17%

In addition to staff contact, the Benchmarking report reported on frequency of family visits. Significant variability was reported in frequency of family visits, with SMHRUs B and D having higher proportions of patients with daily/weekly visits. Overall, the majority of Ridley patients had infrequent or no visitors. The distance of families from Ridley Unit may well contribute to this.

Length of stay

The median length of stay for Ridley patients at the 2010 census was 1.5 years. By the 2012 census this had increased to 3.1 years. Of the SMHRUs, Ridley had the longest median patient length of stay at the 2012 census date. The median length of stay for remaining SMHRUs was 1.0, 2.1 and

1.7 years, respectively. SMHRU C also reported a significant increase in median length of stay from 2010 to 2012, whereas SMHRUs reported a decrease from 1.4 years to 0.98 years.

Planned discharge destination: 2011

The table below excludes discharges due to AWOP or death. During 2011, there were seven planned discharges. The respective numbers of planned discharges for the other SMHRUs were: 13, 8 and 4. Unlike SMHRUs B and C, Ridley discharges were predominantly to other institutions, which was similar to SMHRU D.

Table 11: Planned discharge destination 2011

	Ridley	SMHRU B	SMHRU C	SMHRU D
Independent		23.1%	25.0%	
Supported		15.4%	12.5%	
Local acute	28.6%			
High secure	14.3%		50.0%	
Other extended	42.8%	15.4%	12.5%	100%
Family	14.3%	23.1%		
Other		23.1%		

3.2.3 Summary of Benchmarking Data

The profile of Ridley Unit is comparable to most SMHRUs on the majority of variables. However, Ridley differs on three significant variables.

These areas are:

- Participation of patients in rehabilitation;
- Length of stay; and
- Risk assessment and management.

Given the importance of rehabilitation in equipping patients for discharge into the general community, Ridley's comparatively lower rehabilitation

participation rates may provide a suggestion, at least, that this may be a contributing factor to the incident under consideration.

Similarly, the fact that, patients stay longer in Ridley than in the other SMHRUs considered, may contribute to the general feeling of hopelessness and frustration commented on in a document prepared by ***[PATIENT #2]*** and ***[PATIENT #1]***.

It is further acknowledged that length of stay will be influenced by a range a factors including patient characteristics, clinical decision making, and system factors such as placement options.

RECOMMENDATIONS

1. Data should be routinely collected and reviewed to monitor program participation and address issues associated with low participation rates. This will aid identification of aspects of patient programs, as well as rehabilitation needs and activities, requiring review in order to enhance patient involvement.

2. It is recommended that an audit be conducted to examine the factors associated with length of stay in Ridley Unit.

3.3 Incidents of aggression in Ridley Unit

The investigation team were led to believe from interviews with staff that incidents of aggression were often not reported in the Unit and thus the use of available reported data sets could underestimate the extent of incidents of patient aggression.

3.3.1 Prime Data and IMS data.

For the period January 1, 2011 to January 30, 2013 there were 109 incidents recorded on PRIME. Two of these incidents involved absence without permission (AWOP) and two actual or intended acts of self-harm without aggression. The remaining incidents involved some form of aggressive behaviour involving staff or patient victims. A small number of incidents involved property damage.

Overall, 32.1% (n=35) incidents were reported in 2011, 56% (n=61) in 2012, and 11.9% (n=13) in 2013. One of the patients involved in the index incident was not recorded on PRIME as involved. It was unclear what the target of aggression was in four incidents in 2012. The number of assaults and threats to staff did not markedly differ between 2011 and 2012. Three of the 'other' incidents in 2012 were attributed to ***[PATIENT #3]*** and three to ***[PATIENT #2]*** – these incidents included punching the nursing station window, throwing water at staff, slamming doors and throwing chairs.

Notable was the increased number of assaults on patients in 2012. A number of these incidents appeared to be fights or "altercations". Some incidents appeared directly related to psychotic symptoms while at other times they concerned a dispute regarding items such as key cards or alleged supply of drugs. At times the victim's identity was recorded but not that of the perpetrator (this was the case for ***[PATIENT #6]*** on two occasions). Overall, no incident was recorded on PRIME as resulting in more than "minimal harm", including the index incident.

Table 12: Staff victims

Year	Threats	Abuse	Spit	Assault	Att. assault	Other
2011	8	2	2	9	3	2
2012	10	8	0	9	1	8
2013	2	1	0	5	1	1

Table 13: Patient victims

Year	Threats	Abuse	Spit	Assault	Att. assault	Other
2011	0	0	0	12	1	1
2012	3	0	1	24	1	2
2013	1	0	0	2	0	0

Of the 105 incidents involving aggression, more than half (50.5%) were accounted for by just four patients, with 38.1% of incidents involving the seven patients involved in the index incident. ***[PATIENT #2}*** alone accounted for one-fifth of aggressive incidents.

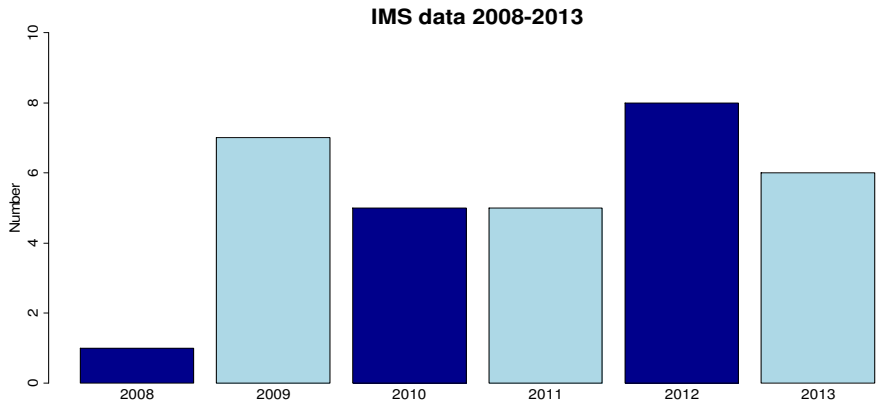
Table 14: Frequency of events per individual patient.

Number of patients	Number of incidents
13	1***
3	2
2	3
4	5***
1	7
1	8
1	10
1	13
1	22*

** Indicates a patient involved in the index incident*

Data from IMS was examined. Thirty-two incidents were recorded from April 2008 to January 2013, with 26 staff reported as receiving an injury rated above superficial or nil. Excluding 2008, for which only one incident was recorded the number of incidents per year ranged from five to 8.

Figure 2: IMS data



Several issues were noted regarding aggressive incidents:

1. On the PRIME documentation no incident was recorded as causing more than “minimal harm” including the index incident;

2. It is well accepted that there is under-reporting of incidents. [PATIENT #3]'s involvement in the incident was not recorded;

3. On 25/12/2012 ***[PATIENT #2]*** was recorded as displaying an escalation of aggression during the day. He was estimated to have thrown 10-20 "aggressive" punches into the Atrium Perspex "that frightened other co-residents and caused them fear and concern for their safety" and then aggressively slammed the sliding door to the Atrium "approx 5 times. This event caused staff to react to his behaviour by removing him briefly to the ICA…".From this account it would seem that ***[PATIENT #2]'s*** behaviour went uncontained for a considerable period of time. A clinical file entry at 17.00 noted: "Several verbal outburst followed by aggressive outburst punching into [sic] window. Said that Co-Res called him a pedaphile [sic]. Offered and accepted PRN …" The PRIME account is a more comprehensive and detailed account than the clinical file; and

4. Incidents reported against patients were more likely to be a physical assault.

RECOMMENDATIONS

3. PRIME reports could be used more effectively by the multidisciplinary team to inform clinical decision making and responses to patients who are frequently aggressive. ***[PATIENT #2]*** accounted for 20% of incidents recorded on PRIME from 2011-2012. it is recommended that when a patient accounts for a significant proportion of incidents this triggers a response (e.g. special case review, review of Individual Care Plan, ICP) in order to enable consideration of additional monitoring, support and evaluation of interventions. To enact the above, it would be necessary to collate and routinely review both ward and individual patient trends.

4. Recommendation 3 requires improvement in recording aggressive incidents. Training should be provided in this regard.

3.4 Overview of the Incident

[STAFF #1]'s statement clearly outlines a series of events immediately preceding the incident. These key events are detailed:

Approximately 23:30 ***[PATIENT #1]*** and ***[PATIENT #4]*** are seen in the Atrium to be deep in conversation and pointing at the nursing station. ***[PATIENT #2]*** approached the nurses' station and asked for the lighter in the Atrium to be refilled (the lighter was found not to need refilling. The group of patients in the Atrium appear to disburse (***[STAFF #4]*** and ***[STAFF #2]*** believed the request to check the lighter occurred at 23:00).

Approximately 23:35 the patients are reported to have returned to the Atrium. Staff turn off the power to the music being played in the Atrium.

23:58 ***[PATIENT #2]*** asks for the music to be turned on again. Around this time the security officer leaves the ward.

Approximately 00:00 ***[STAFF #1]*** is assaulted after approaching ***[PATIENT #3]*** who is attempting to remove a table leg. ***[STAFF #1]*** observed patients ***[PATIENT #7]*** and ***[PATIENT #5]*** proximate to ***[PATIENT # 3]***. ***[STAFF #1]*** was followed by ***[STAFF #3]*** and ***[STAFF #5]*** (***[STAFF #1]*** wasn't aware of ***[STAFF #5]'s*** presence). While speaking to ***[PATIENT #3]*** ***[PATIENT #1]*** followed by ***[PATIENT #2]*** rushed toward ***[STAFF #1]***. ***[PATIENT #1]*** forcefully punched ***[STAFF #1]*** in the face. While ***[STAFF #1]*** was bent over ***[PATIENT #4]*** is reported to have assaulted him several times.

Subsequently, ***[STAFF #3]*** intervenes with ***[PATIENT #1]*** and ***[STAFF #5]*** with ***[PATIENT #2]*** who was reported to be assaulting ***[STAFF #1]***. ***[STAFF #1]*** took ***[PATIENT #4]*** to the ground but reported to be assaulted by ***[PATIENT #5]***, ***[PATIENT #7]***, and ***[PATIENT #6]***. ***[PATIENT #4]*** and ***[PATIENT #3]*** then attempted to assist ***[PATIENT #1]***. ***[STAFF #2]*** and ***[STAFF #5]*** were restraining ***[PATIENT #2]***, and ***[STAFF #6]*** was assigned to take over so ***[STAFF #2]*** could assist ***[STAFF #1]*** in containing ***[PATIENT #1]***. Meanwhile ***[PATIENT #7], [PATIENT #4], [PATIENT #6]*** and ***[PATIENT #3]*** variously assaulted ***[STAFF #3]*** in a bid to free ***[PATIENT #1]***. ***[PATIENT #3]*** had also tried to break off the table leg again. ***[STAFF #1]*** managed to get between ***[PATIENT #4], [PATIENT #6]*** and ***[PATIENT #3]*** and block their access to the restrained ***[PATIENT #1]*** in a stand-off situation until other staff and the AHNM arrived and were able to disburse the patients and staff were able to seclude ***[PATIENT #1]*** and ***[PATIENT #2]*** and place ***[PATIENT #4]*** and ***[PATIENT #3]*** in ICA rooms. ***[STAFF #4]*** was operating the security panel throughout and had the role of contacting backup and facilitating entry to Ridley. Her task was a difficult one of watching what was happening but being unable to directly assist.

There was also reported to be much yelling and chanting from patients while this incident occurred. At least three other patients were identified as being present in the Atrium: ***[PATIENT #8], [PATIENT #9]*** and ***[PATIENT #10]*** though they did not participate in the incident, ***[PATIENT #10]*** was noted to have been chanting.

[STAFF #1] and ***[STAFF #2]*** both made reference to ***[PATIENT #3]*** subsequently telling staff of a toothbrush he had sharpened, to be used as a weapon (colloquially known as a shank). This sharpened toothbrush was subsequently located with the assistance of ***[PATIENT #3]***. ***[STAFF #2]*** reported that he had been told the incident had been planned two weeks prior – no source to substantiate this view was provided. Note also that the security officer denied making comments to staff that trouble was brewing in the ward.

[PATIENT #1] was subsequently placed in seclusion and ***[PATIENT #2], [PATIENT #4]*** and ***[PATIENT #3]*** were nursed in the ICA area.

The above is a simplified account of a complex situation where staff was simultaneously trying to contain three separate centres of violence. Whilst trying to contain the situation, and restrain patients, staff was subjected to assaults from behind by fellow patients. Complicating the situation and instilling anxiety and fear for staff was the yelling, shouting, chanting and general noise coupled with uncertainty regarding how many other patients would become involved in the incident. This was a major incident which staff managed to contain in the face of significant adversity and personal injury.

The evidence establishes overwhelmingly that the staff involved in the incident conducted themselves admirably. This is recognized by the ***(CDEIS)*** and all other senior officers who became involved, in one way or another, after the event.

It is recognized that those involved used no more force than was necessary to defend them and to bring the situation under control. Sight should not be lost of the fact that staff were attacked in what might be described as a premeditated attack. There is no reason to suppose that

the staff were wrong in believing that they were, literally, fighting for their lives.

It has not gone unnoticed that, on the night in question, there were an extra two staff on duty, managing a patient with a history of frequent assaultive behaviour, who had been transferred from Jacaranda Unit. It was quite by chance that special observation was required on the night of the incident for this patient thereby providing an additional two staff members to assist in managing the incident.

It may be concluded that the staff conducted themselves properly and with considerable courage in bringing the situation under control. Insofar as it was possible to employ recognized aggressive behaviour management (ABM) techniques, these were applied, but such a structured response was not always possible in what was, in effect, a 'vicious street brawl'. The consensus among her peers is that the security panel nurse performed her duties properly and effectively.

3.4.1 Staff involved

Staff rostered on the night shift in Ridley Unit on the night in question were:

[STAFF #1]

[STAFF #4]

[STAFF #3]

[STAFF #5]

[STAFF #2]

[STAFF #6]

[STAFF #2] and ***[STAFF #6]*** were added to the normal night roster to attend to a difficult patient sent down from another unit. At all times, this patient was under the observation of two nursing staff, on a rotational basis.

All of the above staff were directly involved in the incident, one way or another.

Staff from outside Ridley Unit who assisted in the immediate aftermath were:

[AHNM]

Registered Nurse ***[RN]*** (not interviewed during the investigation)

Security Officer

3.4.2 *[STAFF #1]*

[***STAFF #1]*** was interviewed on 18 April 2013.

He has also provided a statement to Detective Sergeant Stahlhut of the Toowoomba Criminal Investigation Branch (CIB).

[***STAFF #1]*** also addressed a memorandum to the investigation team.

[***STAFF #1]*** was seriously injured in the incident to which he refers as "The Ridley Riot". He suffered facial fractures and dental injuries. He has required surgical procedures to address his injuries and reports that he has been advised that there are expected to be long term complications associated with his injuries.

[***STAFF #1]'s*** police statement, relevantly to this section of the report, contains the following:

> 20. At the start of my shift I recall a large group of patients milling around socialising with each other in the Atrium area. I was in the nurses' station and I looked over.
>
> 21. ***[PATIENT #5]*** was sitting down on a bench showing all the other persons his biceps and looked over at us.
>
> 22. At 2230 hours I walked out to the sliding door opposite the computer room that leads to the Atrium to speak to ***[PATIENT #7]***. He was sitting on a bench. I was questioning him about a medication query. I then went back to the nurses' station.
>
> 23. At 2300 hours I was standing looking out to the Atrium talking to the Security Officer who was looking out to the Atrium.

24. It was then that the Security Officer said, ***"There's something not right"***, which I took notice of.

25. At the same time [***PATIENT #2]*** came up to the nurses' station slot and asked for the lighter to be refilled in the Atrium. ***[STAFF #5]*** attended.

26. ***[STAFF #5]*** came back and said the lighter was 3/4 full and did not need attention. In hindsight this appeared to be a planned event for what occurred later. I say this because the lighter did not need changing and you need to turn your back to the patients which would place the person at risk. This is also the further most point in the Atrium from the nurses' station.

27. In discussion with my colleagues after the event, we are agreed and of the opinion, they intended to take me out first.

28. It was then that I remember seeing [***PATIENT #11]*** walking from the Atrium to his bedroom in corridor one. He looked over at us (***[STAFF #4]*** and I) in the nurses' station. The look he gave us was unusual and a disturbing look to convey the message ***"you're in for it".*** I can say this based on my experience as a Registered Nurse (RN) and working with these patients regularly.

29. ***[STAFF #4]*** and I discussed our concerns about the patients gathered in the Atrium, when for several minutes they disbursed back to their bedrooms and it was quiet.

30. They all returned. The music was turned on loud. At 2355 hours I turned the power to the music off in the Atrium which is not an unusual practice to encourage patients to sleep.

31. At 2358 hours [***PATIENT #2]*** came back to the nurses' station slot and asked ***[STAFF #3]*** and myself if the power point for the music could be turned on again.

32. I informed ***[PATIENT #2]*** it was getting loud and late and people should start thinking about going to bed. ***[STAFF #3]*** added ***"come back in 30 minutes and we'll see"***

33. At midnight I was ready to relieve ***[STAFF #2]*** and ***[STAFF #6]*** in ICA 2 when I heard a thumping noise. I said to staff in the nurses' station ***"what's that thumping noise?"*** I looked over to the dining room in the servery area and saw [***PATIENT #5]*** and ***[PATIENT #7]*** standing watching [***PATIENT #3]*** with an overturned table working at the steel leg. Knowing ***[PATIENT #3]'s*** violent criminal history I wanted to talk to him to get him to stop. He was attempting to remove the leg.

34. I walked out of the nurses' station to talk to him. When I spoke to him he stopped working on the table, but made no attempt to answer or respond to me.

35. ***[PATIENT #3]*** walked two paces away from the table to the airlock door then stopped. He was eyeballing me, but his eyes were darting back and forth from me to the Atrium area.

36. He took another pace towards the same direction of the door and as I followed him to my right I heard a scuffing noise and out of the corner of my eye, I remember seeing ***[PATIENT #1]'s*** fist within millimetres of my right side of my face, with his eyes of a fixed gaze of intent looking over the top of his fist, which was his striking punch.

37. After being struck, I staggered to the left, bent over at the waist, wondering why he was getting involved. It was then that the other patients started throwing punches striking me. All I could see on the ground around me were feet merging behind me. Blood started to gush from my face and drip on the floor.

38. I heard ***[PATIENT #1]*** yell, "***come on brothers, we've got 'em".***

39. There were punches and hits coming in all over from the patients. The next I recall was ***[PATIENT #2]*** holding by [sic] ***arms*** behind my back. He was trying to hook me up. He was yelling to the other patients ***"come on have a go at him".***

40. I broke out of this hold, only to have ***[PATIENT #4]'s*** elbow hit me on the back of the head as I was standing but my torso bent over. He

then grappled the back of my head with his hands, and as he was kneeing me in the face, yelled, ***"Take this mother fucker".***

41. I also had a fist punch me in the already damaged side of the face by and [sic] unknown person. I then tilted my head up and looked at ***[PATIENT #4]'s*** face as he yelled out and excited ***"yeah".*** He was also grinning broadly.

42. It was then I grabbed ***[PATIENT #4]*** and began wrestling with him and we both fell to the floor, at which time I was swarmed by patients ***[PATIENT #5], [PATIENT #7]*** and***[PATIENT #6]***.

43. I saw all of the other patients and remember thinking ***"this isn't good".*** I thought to myself that I would ultimately be OK, but seeing ***[PATIENT #1]*** was on ***[STAFF #3]***, I feared for ***[STAFF #3]'s*** life.

44. ***[PATIENT #4]*** departed that site and as I stood up and pushed ***[PATIENT #7]*** and ***[PATIENT #5]*** off me I remember seeing a wall of patients from the Atrium to the dining room wall, essentially blocking us off from the nurses' station.

45. The patients were taking on a mob like mentality, excitedly yelling and moving about and participating when able, yet it appeared completely organised.

46. I remember hearing ***[STAFF #3]*** yell, ***"everyone back to the nurse station".*** I instantly thought ***"that aint happening, this will have to end here one way or another".*** I knew we were walled off and had to essentially take control. I was thinking I would have to use extreme means, physical force or any means to gain control.

47. For the first time I was able to stand up and assess what was going on. After I pushed the last few patients off, no one came within three metres of me and made no attempt to come closer.

48. I looked over to my right and saw from my left ***[PATIENT #4], [PATIENT #3]*** in the middle and ***[PATIENT #1]*** on the right cramming in on ***[STAFF #3]*** throwing punches at him. They were standing.

49. I thought straight away he is in for it if I don't do anything. I was aware of the melee going on the right of this group but assessed ***[STAFF #3]*** and being the most critical.

50. I ran over and grabbed ***[PATIENT #4]*** by his left side as he was the closest and he turned around and attempted to strike me. ***[PATIENT #4]*** and I wrestled to the ground and ***[PATIENT #4]*** landed on his back near the sliding door in the dining room. I landed on my knees under each of his armpits with my torso upright looking down at ***[PATIENT #4]***'s face.

51. He looked at me with a shock and said ***"What the"***

52. I then threw a left hook into the right side of ***[PATIENT #4]***'s head, followed by a right jab to the centre of his face. He started to bleed.

53. He began saying ***"I give up, I give up"***, after I hit him 3 or 4 more times. He stopped fighting back and I said ***"You fucken better stay down".***

54. It was then I looked over to my left and saw the back of ***[PATIENT #1]*** attacking ***[STAFF #3]*** who has his back to the dividing wall near the air lock wall.

55. I got off ***[PATIENT #4]*** and ran over to the left side of ***[PATIENT #1]*** who attempted to turn around and strike me. I believe at the time I threw a right hand hook to the centre of ***[PATIENT #1]***'s face which stunned him. I later observed he had blood coming from his nose.

56. I punched him twice more as ***[STAFF #3]*** and I began falling on ***[PATIENT #1]***'s back with ***[STAFF #3]*** on the right. As we were doing this ***[PATIENT #7]*** locked ***[STAFF #3]*** in a choker hold from behind and attempted to reef him off ***[PATIENT #1]***.

57. I leant across and palmed ***[PATIENT #7]*** off and he retreated to the group of patients at which point ***[STAFF #3]***, ***[PATIENT #1]*** and I fell to the ground.

58. ***[PATIENT #1]*** resisted. I then recall ***[PATIENT #4]*** attempting to pull ***[STAFF #3]*** off by his legs. I lunged at ***[PATIENT #4]*** and he departed back to the wall.

59. It was then I became fully aware of the other staff involved. I looked across and under the roller doors to the servery and saw ***[PATIENT #2]*** face down with ***[STAFF #5]*** on his left and ***[STAFF #2]*** on his right placing him in a wrist lock position.

60. ***[STAFF #2]*** was yelling to ***[STAFF #6]*** who was standing at the edge of the divider wall looking shocked, to come over and help him.

61. ***[STAFF#6]*** ran over and took over from ***[STAFF #2]'s*** position in wrist locking ***[PATIENT #2]***. ***[STAFF #2]*** then lunged overt and landed on top of ***[PATIENT #1]*** next to ***[STAFF #3]***.

62. ***[STAFF #2]*** and I then observed ***[PATIENT #3]*** going back to the table right behind ***[STAFF #5]*** and ***[STAFF #6]*** and attempt to work the same steel leg free.

63. ***[STAFF #2]*** yelled out to ***[PATIENT #3]***. I don't recall what he said. I yelled out for him to get away from the table. He complied.

64. ***[PATIENT #3]*** and ***[PATIENT #4]*** then walked in from behind ***[STAFF #3]*** and kicked and yelled at him. ***[PATIENT #4]*** pulled away and ***[PATIENT #3]*** clubbed ***[STAFF #3]*** on the right side of the face with a closed fist.

65. While this was happening ***[PATIENT #1]*** was yelling out intermittently ***"come on get them brothers"*** and on several occasions screamed ***"kill the cunts".***

66. I realised ***[PATIENT #1]*** wasn't getting up. ***[PATIENT #6]*** to my far left and to the far right of the mob kept coming forward and was saying ***"No let's fucken get them",*** as we told them to get back.

67. After ***[PATIENT #3]***'s strike on ***[STAFF #3]*** and seeing ***[PATIENT #6]*** coming in and realising ***[PATIENT #1]*** wasn't getting up I decided to stand between the mob and ***[STAFF #3]*** and ***[STAFF #2]*** who remained and had pinned ***[PATIENT #1]*** down.

68. ***[PATIENT #4]*** was yelling out ***"get off him, get off him"*** and was advancing forward. I stepped forward to ***[PATIENT #4]*** and told him to get back which he did.

69. ***[PATIENT #6]*** attempted to come forward but I clenched my fist and pointed at him with the other hand and said, ***"Fucken get back [PATIENT #6]".***

70. A standoff ensued for about two minutes in which no further physical action was taken by either party, but there was a lot of heightened verbal rhetoric between myself and the group.

71. It was at this stage that the ***[AHNM]*** entered through the air lock doors and confronted the mob.

72. They disbursed [sic] with the ***[AHNM]*** and myself. I asked ***[PATIENT #4]*** why he did it. He replied ***"We just want to fucken get out of this place".***

3.4.3 *[STAFF #2]*

In a statement given to Detective Sergeant Stahlhut of the Toowoomba CIB, ***[STAFF #2]*** gives a useful description of the incident and his involvement in it.

17. I watched the patients through the window of ICA 2 and office window and noticed the same group of patients looking at the Security Officer as he left the building. I could not see the Security Officer leave the building as my vision was blocked by the walls of the ward.

18. Approximately ten minutes after the Security Officer departed, I saw ***[PATIENT #2]*** and ***[PATIENT #1]*** walking quickly from the Atrium through the doors to the dining room area. I lost contact visually as they walked through the doors.

19. Within seconds I heard a plastic item being moved, which I believed at the time to be a patient moving a plastic chair to sit on.

20. Within seconds of hearing that noise I saw ***[STAFF #4]*** (the nurse who was at the time operating the security panel) running from the security panel to the ICA 2 window. I realised that there was trouble in the ward for her to do that.

21. I did not know at that time that ***[STAFF #1]***, ***[STAFF #3]*** and ***[STAFF #5]*** had left the office to attend to one of the patients in the dining room. I called out to ***[STAFF #6]*** to follow me.

22. On opening the door from ICA 2 which leads into the dining room/common area of the ward I saw at least ten to twelve patients in front of me. They appeared to be looking towards the main door entry.

23. I then noticed as I ran forward ***[STAFF #1]*** and ***[STAFF #3]*** standing up trying to restrain ***[PATIENT #1]*** who was approximately three to four metres in front of the main entry to the ward.

24. I saw ***[PATIENT #6]*** throwing punches and kicking at both ***[STAFF #3]*** and ***[STAFF #1]***. ***[PATIENT #4]*** was also hitting ***[STAFF #3]*** from behind. I remember seeing ***[PATIENT #1]*** bleeding from the nose.

25. ***[STAFF #1]*** was bleeding from the nose and had blood all over his uniform and face. As I ran towards them, ***[STAFF #3]*** and ***[STAFF #1]*** collapsed to the floor taking ***[PATIENT #1]*** with them.

26. As I looked to the left of this site, I noticed ***[PATIENT #2]*** punching and kicking ***[STAFF #5]***. ***[PATIENT #3]*** was also hitting and kicking him from behind. ***[STAFF #5]*** was in a crouching position and had hold of ***[PATIENT #2]***. As ***[STAFF #5]*** was by himself and looked like he was imminent danger of being overpowered I turned to him to offer assistance first.

27. As I got near them (***[STAFF #5]***, ***[PATIENT #2]*** and ***[PATIENT #3]***) ***[PATIENT #2]*** turned towards me and threw a punch which connected with my right cheek.

28. At this time ***[PATIENT #3]*** then started to hit me on the right side of my neck. I got ***[PATIENT #2]*** to the ground and eventually got his right

wrist in a wrist lock. During this time ***[PATIENT #6]*** had came [sic] to where I was and was throwing punches at both myself and ***[STAFF #5]***.

29. ***[PATIENT #3]*** was continuing to kick at both ***[STAFF #5]*** and myself intermittently. I looked towards where ***[STAFF #3]*** and ***[STAFF #1]*** were. I remember not being able to see them due to the large number of patients blocking my view.

30. I shouted out to ***[STAFF #4]*** to call the Office and the Police to assist as I was in fear of us being overwhelmed by the large number of patients attacking us.

31. I believed at the time that we were fighting for our lives due to the unrelenting ferociousness of the attack, something of which I had never seen before in 24 years of nursing at this hospital.

32. I then noticed ***[STAFF #6]*** standing near the small dividing wall near the entrance to the ward, he was staring at us, I believe he did not know what to do as he has very limited experience and was overwhelmed by what he saw.

33. I shouted at him to assist me in the restraint of ***[PATIENT #2]***. He came over and I told him how to keep the wrist lock on ***[PATIENT #2]*** and I shouted at him "***don't let go of the wrist lock, no matter what happens***!"

34. During this time I can remember ***[STAFF #5]'s*** glasses being knocked off his face with a punch. I knew it wasn't ***[PATIENT #3]*** or ***[PATIENT #6]*** due to the fair colour of the skin. There was a lot of shouting of abuse from patients throughout this time frame.

35. Once ***[STAFF #5]*** and ***[STAFF #6]*** had both locked onto ***[PATIENT #2]*** I ran quickly towards where ***[STAFF #3]*** and ***[STAFF #1]*** were engaging with ***[PATIENT #1]***. I saw ***[PATIENT #4]*** pulling at ***[STAFF #3]***'s legs lifting his legs and twisting them with extreme force. I took position on ***[PATIENT #1]***'s left hand side, he was face down on the ground.

36. ***[STAFF #3]*** was on ***[PATIENT #1]***'s right hand side. I believe that ***[STAFF #1]*** was at the head of ***[PATIENT #1]***. I cannot remember seeing ***[STAFF #1]*** but I

knew he was still engaging ***[PATIENT #1]*** who was still resisting us with considerable force.

37. ***[PATIENT #5]*** was also standing at the right side of ***[PATIENT #1]*** and was kicking at ***[STAFF #3]***. I pulled at ***[PATIENT #1]***'s left hand so I could get his wrist locked but as I attempted to do this, the sleeve of his jacket ripped off.

38. I recoiled backwards and remember seeing ***[PATIENT #3]*** standing on an upturned table behind ***[STAFF #5]*** and ***[STAFF #6]***. He was pulling backwards and forwards on the steel leg of a dining room table. I believe he was trying to break the weld securing the leg to the table and then use it as a weapon.

39. I called out to him ***"Don't do it [PATIENT #3], don't do it [PATIENT #3]. I'll take you down if you don't, go away, go away" or words to that effect".*** The leg at this stage was nearly free of the table.

40. After a short time, he moved away from the table. I re-engaged ***[PATIENT #1]*** getting his left arm behind him and took control of his left wrist.

41. I saw ***[PATIENT #7]*** kick ***[STAFF #3]***'s legs from behind him. ***[PATIENT #5]*** and ***[PATIENT #4]*** came forward from the crowd and then kicked at my legs and then went back into the crowd. My right shoulder was on ***[STAFF #3]***'s left side, he had also locked up ***[PATIENT #1]***'s right arm wrist.

42. I looked up over ***[STAFF #3]***'s torso and saw ***[PATIENT #6]*** swinging his right leg towards ***[STAFF #3]*** ribs and my head. I shut my eyes expecting to be kicked in the head. I heard ***[STAFF #3]*** cry out, I believe ***[STAFF #3]*** got kicked in the ribs or arm.

43. I then saw ***[PATIENT #6]*** attempting to kick at us again. I blocked at least three kicks with my right arm. ***[PATIENT #4]*** was calling out for us to get off ***[PATIENT #1]***. I kept calling out to ***[PATIENT #4]*** to ***"get back, get back".*** He kept rushing forward but stopped when we had eye contact with him.

44. I heard above the noise of the crowd, ***[PATIENT #6]*** calling out "***Come on, lets get 'em".*** ***[PATIENT #3]*** came forward and kicked my lower legs. ***[PATIENT #1]*** was calling out throughout my engagement with him ***"Come on brothers, get 'em, kill the cunts".*** This was called out numerous times during my engagement with him.

45. Only then, do I remember seeing ***[STAFF #1]*** getting up from in the front of me and moving around ***[STAFF #3]***'s side of ***[PATIENT #1]***. He stood behind ***[STAFF #3]*** and myself (we had ***[PATIENT #1]*** under control) protecting us from further attacks from the patients and shouting at the patients to ***"move back"*** or words to that effect.

46. At this stage, the ***[AHNM]*** entered through the door. He stood with ***[STAFF #1]*** telling the patients to ***"move back".*** The patients started to break up and move away. The Registered Nurse, I believe, then entered the room. Once the crowd started to break up we removed ***[PATIENT #1]*** to Seclusion Room 1. ***[PATIENT #4]*** was escorted to ICA 2. ***[PATIENT #2]*** and ***[PATIENT #3]*** were placed in ICA 1. We checked them for injuries.

3.4.4 *[STAFF #3]*

On 5 February 2013, [***STAFF #3]*** was interviewed by Detective Sergeant Stahlhut of the Toowoomba CIB. Apart from his account of events on the night of 19th January 2013, he gives a useful description of the layout of the relevant part of Ridley Unit.

He says:

6. The nursing station (office) is basically central to the unit. At the front of the office staff are able to look out through larger perspex windows towards the living and dining areas. Sliding doors exiting from the living/dining areas exit into an enclosed, semi-open roofed area called the Atrium.

7. The Atrium is an area approximately twenty metres by twenty metres and utilised by the residents as a meeting/smoking area. Beyond and semi-circling the Atrium, and back in the ward proper, are a number of small rooms utilised by the residents for watching

Television, listening to music, meeting with visitors, occupational therapy, laundry, and large a Gymnasium area.

8. Two wings, or dorms, extend from the living area also. Corridors in these dorms allow for the individual living/sleeping rooms for the residents.

9. The back of the office narrows and has perspex either side allowing supervision of two areas referred to as ICAs.

10. The two ICAs are low stimulus environments utilised temporarily for residents that are acutely unwell, or have caused issues on the open ward.

11. Residents can exit the ICAs, at staff discretion, into two large yards with security fence perimeters for exercise, smoking etc.

12. On Saturday 19 January 2013 I commenced work in Ridley Unit at approximately 2145 hours as the nurse-in-charge. Other staff on duty at the time included ***[STAFF #1]***, ***[STAFF #4]***, ***[STAFF #2]***, and ***[STAFF #6]***.

13. There were quite a few residents still up and wandering, both throughout the general ward, and in the Atrium. The resident in ICA still hadn't settled and we were monitoring him closely due to his high potential for aggression. We had considered giving him PRN (Pro Re Nata, or 'as required') medication but knowing that he had refused all oral medication throughout the day thought that it may only serve to agitate his state further so decided after consultation with the nurses in ICA to continue to monitor in the short term, as he had been re-directable, and hope that he settled of his own volition which he was showing indications of doing and he did soon after 2300 hours.

14. Early in the shift (not sure of exact time) the Security Officer visited the ward to check that we were coping ok with the resident currently in the ICA. I remember his mentioning the number of residents that were still up and either wandering or sitting in the Atrium area.

15. When I stood up and looked towards the Atrium/open ward area I noticed that there were quite a few residents still up, but this was a regular occurrence, particularly during hot weather. Patients could come and go as they wished.

16. As there had been some things to report for that day it took me a little longer than usual to do the stats, right [sic] up the report book, and do a roster for the night.

17. At approximately 2355 hours one of the other nursing staff asked what some of the residents were doing with one of the dining room tables. When I walked over to the office window I saw ***[PATIENT #3]*** leaning over a table that had been turned on its side apparent levering one of the tables legs back and forwards trying to break it off. There were a couple of other residents there also from memory but I didn't know who they were.

18. Three available male staff (myself, ***[STAFF #1]***, and ***[STAFF #5]***) immediately went to investigate what was happening. While crossing to the corner of the dining room where ***[PATIENT #3]*** was; staff called out **"what are you doing** ***[PATIENT #3]*****"** and **"***[PATIENT #3]* **stop". *[PATIENT #3]*** paid no attention and continued to attempt to break the dining table leg off. We got to within a few feet of the table and ***[PATIENT #3]*** when all of a sudden we were assaulted by other residents who had been sitting out in the Atrium, as far as I am aware.

19. I noticed out of my right other side vision ***[PATIENT #1]*** in mid stride throwing a full closed punch with his right hand at ***[STAFF #1]*** (the punch I believe to have caused the major trauma to his face).

20. I immediately grabbed hold of his left arm but he had a slippery velvet type jacket on and I remember my hands slipping from his arm, then grabbing sleeve material and the material tearing at the shoulder.

21. This enabled ***[PATIENT #1]*** to pull away from me and swing with his left arm at myself hitting my right side of face cheek-bone area. I

remember being stunned and swivelling away before being able to re-compose myself and again try to assist co staff.

22. Much of what happened thereafter is not as clear for me. I do remember myself and ***[STAFF #1]*** having ***[PATIENT #1]*** down on the ground and him continuing to struggle. I remember someone grabbing me by the ankle and half lifting my body off the ground at least a couple of times in an attempt to drag me off ***[PATIENT #1]***.

23. I thought at one point ***[PATIENT #1]*** nearly got back on his feet before we were able to again take him down, but was told later on that this never happened. I now believe, based on what I have been told by others involved, that my sensation of losing my hold on ***[PATIENT #1]*** was probably due to another resident placing his arm around my neck and attempting to pull me away from ***[PATIENT #1]***.

24. I remember ***[PATIENT #1]*** calling **"come on, come on"** several times in what I thought and still think was an attempt to "egg" the other residents on.

25. I remember looking to my side while attempting to hold the struggling ***[PATIENT #1]*** down and seeing ***[PATIENT #3]*** standing over me and yelling at me to get off ***[PATIENT #1]*** then seeing him kick me in the side (I can't clearly remember which side, and had tenderness and bruising on both).

26. I remember again looking on and seeing ***[PATIENT #4]*** standing over me while yelling at me and then seeing him kicking at my side (I can't clearly remember which side, and had tenderness/bruising on both).

27. Although I could see these kicks being directed at my person, I don't remember feeling anything. I remember seeing someone's arm thrown across in front of some of the attempted kicks into my side trying to shield me. I now understand that that was nursing staff member, ***[STAFF #2]***.

28. I remember looking up and seeing ***[PATIENT #5]*** leaning over and yelling at me over and over to let go of ***[PATIENT #1]***, although I don't recall him kicking me. I remember calling over and over to ***[PATIENT #5]***

as firmly as I could to ***"keep out of it, keep away".*** I remember thinking to myself, "please ***[STAFF #4]***, I hope you have help coming soon". I also remember seeing someone down on the ground and yelling out ***"who is it"***, as I was concerned it may have been of the staff.

29. Then I remember looking up from the ground while holding ***[PATIENT #1]*** down and seeing the ***[AHNM]*** coming through the airlock doors.

30. I heard him firmly telling all of the residents to leave us (nursing staff) be and to go away. Next thing I remember we were standing ***[PATIENT #1]*** and while maintaining holds escorting him to seclusion.

31. Prior to his being placed in the seclusion room we performed a body search to see if he had any items that may have posed a danger to him or others.

32. As it came to light immediately after secluding ***[PATIENT #1]***, others who had been involved in the assault on staff were each one-by-one escorted to ICA by available nursing staff.

33. These residents included ***[PATIENT #3]***, ***[PATIENT #4]***, and ***[PATIENT #2]***

34. From memory, the ward was under control by approximately 0010 hours.

3.4.5 *[AHNM]*

On 19 January 2013, while working as the ***[AHNM]***, he was physically located away from Ridley Unit.

He was interviewed on 12 June 2013. In the interview he described his involvement in the following terms:

> I had a call from ***[STAFF #4]***. I'm not sure of the time, but it was approximately 12 o'clock midnight, and it was pretty simple, "Get here quick". And I was in the central nursing office located in the Gary Davies Centre, and I am probably, what would you say, 300 metres away. And I was there within probably three minutes.

The *[AHNM]* went on to say that prior to attending Ridley, he made a couple of phone calls. He tried unsuccessfully to contact the Security Officer.

The *[AHNM]* was aware of where other male staff were on duty. He rang the Walwa Unit and told the *[RN]* "to get over to Ridley quick". He then rang Connolly Unit and arranged back-fill for the *[RN]*.

The *[AHNM]* was not involved in the application of restraint or in the melee. In fact, by the time he arrived in Ridley, *[PATIENT #2]* and *[PATIENT #1]* had been restrained and the physical aspects of the incident had run their course. There was still some shouting, some urging the others to continue fighting.

He assessed the situation. He says:

> I looked at the restraint, actually, and I was quite impressed.
>
> Because there was *[STAFF #6*] and I looked at the restraint there, and *[STAFF #5]*, you know, they're both very, very novice nurses in that situation, and they – I thought, well, *[PATIENT #2]*'s not going anywhere.
>
> They had him good and *[PATIENT #1]*, who is an enormous fellow, I had a look at that, and *[STAFF #2]* and *[STAFF #3]* were on them and I knew they were – he wasn't going anywhere, so I was able to stand up with *[STAFF #1]* and sort of direct things and say, "All right, *[STAFF #1]*, I" – well, obviously there was – had been violence, so obviously there was going to be seclusion. "Who are we going to take to seclusion? Well, who initiated this?" And he said, "Well, *[PATIENT #1]*". I said, "Well, he goes into the seclusion room."

The *[AHNM]* took charge of the situation. He said, in the interview:

> I said – I got one up, I got the experienced fellows, you know, like *[STAFF #2]* and *[STAFF #3]*, and I said, "Well, we'll get *[PATIENT #1]* up off the ground first." And I was keeping an eye on *[PATIENT #4]*, of course, 'cause you didn't know whether they were going to come in and have a gutless kick in the head which they were previously doing apparently. So we got *[PATIENT #1]* up and then I watched the boys –

the other boys who were magnificent, get ***[PATIENT #2]*** up, and we marched them into the ICA area. And we – yeah, we allowed ***[PATIENT #2]*** just to go into the ICA area. "You go down there, behave yourself." And ***[PATIENT #1]*** went into the seclusion room. So then we had a bit of a debrief, what went on, and I – and it was apparent that there was all these others involved. And we got two ICAs, so we worked out how we were going to do it. ***[PATIENT #3]***– I went into the office just to see if they were all okay. This is after about five or 10 minutes. The ***[AHNM] …..*** had showed up, so we had reinforcements, fresh reinforcements. Then we went out there, went out into that Atrium area where they all had retreated to. Got ***[PATIENT #4]***. "***[PATIENT #4]***, you here. Out there, out into the ICA area." Left nurses out there with him. Then we got – I don't think – no, ***[PATIENT #7]*** didn't go out, ***[PATIENT #6]*** didn't go out, ***[PATIENT #5]*** didn't go out. So it was just the – just that top four.

He paid tribute to ***[STAFF #1]***. He said [***STAFF #1]*** was coping incredibly well.

> He was very rational, he was – yeah, brilliant.

The ***[AHNM]'s*** presence seemed been decisive in bringing the incident to a close. He knows the patients in Ridley and they know him. He spends 60% of his time as nightshift Clinical Nurse in Ridley and the remaining 40% as After Hours Nurse Manager. He said that the patients know that while he is fair, he does not give patients everything they want.

> Oh, they know me. And I don't give in – I'm a – you know, they ask for favours or privileges, I'm very consistent with what I do with them on nights there. They see who's on tonight. Oh. I just try to be fair and consistent with their demands and their – yeah, the carry-on, but yeah, it's – 'cause that's the thing. You get different staff through there at times and a lot of people just give into their requests if – some of the requests are quite reasonable and you go along with it, you know. But usually when they see me they know they're not going to get everything that they particularly want.

3.5. Support given to staff

3.5.1 Immediately after the incident

3.5.1 (a) *[AHNM]*

As he said in his interview, the *[AHNM]* responded quickly to a call from *[STAFF #4]* and remained at Ridley to assist staff until about 5.00am when he returned to his post. He drove both *[STAFF #2]* and *[STAFF #1]* to the Emergency Department in the Toowoomba Hospital. He is uncertain about whom he took first, but says that he took them individually.

The *[AHNM]* seems to have taken charge upon arrival and did what he considered necessary to settle the patients down giving PRN as required.

3.5.1 (b) *[NDACMH]*

On the night of 19th January 2013, the *[NDACMH]* was on-call.

In response to a telephone call from the *[AHNM]*, the *[NDACMH]* attended Ridley at about 1.00am on 20th January. He spoke to staff and assessed the need for medication for some of the patients involved.

In conjunction with the *[AHNM]*, he decided to call the *[CDEIS]* as the authorization of a psychiatrist was required since seclusion and review for PRN orders. The *[CDEIS]* arrived in about 20 minutes.

At the *[CDEIS]'s* suggestion, the *[NDACMH]* rang the *[NDRSMH]*.

3.5.1 (c) *[NDRSMH]*

The *[NDRSMH]* was the last person interviewed, so details of his involvement were not canvassed. However, his continual involvement is referred to by the *[NDACMH]*. The point of mentioning the *[NDRSMH]'s* involvement without giving details of exactly what he did, is to emphasize the degree to which senior management came to the fore to reassure staff that they were aware of the situation and were concerned for the well-being of staff.

3.5.1 (d) Involvement of the Queensland Police Service

The fact that the Police were called sent a clear message to all staff and patients that, where they had suffered as a result of criminal conduct by

patients, they would receive the protection of law enforcement agencies. It is also a requirement of Queensland Health employees to report criminal conduct to the QPS. It is clear the conduct of the patients involved in this incident met the threshold for criminal conduct. The QPS responded promptly to the call but, as it happened, by the time they, arrived on the scene order had been restored.

3.5.1 (e) Others who attended post-incident

During Sunday 20 January 2013, Ridley was visited by a number of people very senior in the District. The Health Service Chief Executive visited, along with the Chair of the Darling Downs Hospital and Health Service Board (the Board).

These visits were designed to reassure staff that knowledge of the incident had reached the highest local level and that the wellbeing of staff was of paramount importance. This was a very important and welcomed message for staff and reflected a culture within the Darling Downs HHS that the highest level of leadership and governance were concerned and placed staff safety as a priority. The attendance by the Chair of the Board and Health Service Chief Executive on a Sunday is not insignificant in establishing how seriously this incident was viewed by the Darling Downs HHS.

3.5.1 (f) Medical response

The ***[CDEIS]***, in a written submission, (annexed to the transcript of interview), says the medical response to the incident fell short. He reports that the on-call doctor (the Registrar) could not attend as there were "a large number of Emergency Examination Orders waiting to be seen, perhaps six. The Registrar said he could not attend. He did not arrive for five to six hours."

The ***[CDEIS]*** says three attempts were made to call the on-call psychiatrist. He says that he spoke to her about two hours after the incident. It seems that she had been woken frequently that night because of the Emergency Examination Orders. He says "She asked me if she needed to come in and at that stage I said 'no' since I felt she could not do much now."

This is a matter that requires further attention. From all accounts, most people identified that this incident was a 'crisis' for Ridley Unit and was potentially serious, the extent of which was still unclear. It is somewhat perplexing that presenting EEO's to the Emergency Department would be given priority by both the Registrar and the On-call Psychiatrist (who seemed to be indicating that they were responding to the EEO's but not the Ridley incident). As there is a regulated time frame for the response to an EEO, there must be a system in place to ensure that when there are 'surges' in demand or when there are other matters that must also be attended to by the Registrar overnight there is capacity to mobilise additional resources to meet all requirements, e.g., for the on-call Psychiatrist to be recalled and attend on-site.

RECOMMENDATION

5. Darling Downs HHS Mental Health Service should review why the medical resources were not available or unable to be prioritised to respond to the incident. If relevant, appropriate training about on-call responsibilities should be undertaken with medical staff.

3.5.2 Darling Downs HHS response: immediate and longer term

The following accounts by staff members ***[STAFF #2]***, ***[STAFF #1]*** and ***[STAFF #3]*** relate their respective experiences which differed in the timeliness with which appropriate assistance was able to be accessed.

3.5.2 (a) *[STAFF #2]*

In the interview with ***[STAFF #2]*** (with ***[QNU ORGANISER]*** present as a support person), the following is recorded:

All right, that's one point. Have you got any other matters you want heard?

So just on - the support we've got has been excellent.

Excellent?

Yes. I've been involved in other horrible incidents and we've received no calls next day. I'll give you a - this is just one of many. I've been here over

26 years - and I'd hate to think how many incidents I've been in. I can count on one hand the number of times I've been spoken to from a nursing supervisor to see how I was going after being injured, and I'm not the only one. You can talk to nearly any staff member here on the job and it's a rare occasion where someone follows up just to see how you're going, and by the way you did a good job.

And that happened this time?

They acknowledged that we were in a fight. They acknowledged that some of us were hurt, and they acknowledged that it's a difficult time for us. But no-one's turned up to me and said, "***[STAFF #2]***, you did a bloody good job, and so did your mates." Considering what happened down there that's probably the thing that's got to me the most.

All right, well I thought you said the support has been excellent.

On this time here it has been excellent. Work Cover was involved straight away, there was no hiccups, everything's - I mean the level - I've been on a return to work program, they bent over backwards. They've done everything, I believe, that they possibly can to help me. But on other instances it's next to non-existent.

[STAFF #2] expressed in detail significant dissatisfaction with how previous incidents were handled in contrast to the present organisational response. Such past experiences appear to contribute to present staff morale.

All right, and then did the administration, for want of a better word, organise psychologists and counselling for you? Who did that?

A few - I've got diary. I know one day I think the ***[AHNM]*** rung me up and said do you want to come to a group counselling session, and I don't know who organised it, it may have just been the ***[AHNM]***, I don't know. So we all went to a group counselling session.

And where was that?

> We saw ***[OMITTED – CONSULTANT PSYCHOLOGIST***] I think his name was. To be honest most of us left there really angry. I know I was bloody wild by the time I left there.

Did they have a counsellor there?

Yes, ***[OMITTED – CONSULTANT PSYCHOLOGIST]*** was the psychologist.

[QNU ORGANISER]: He's the psychologist.

Oh yes.

We all went as a group.

And what did you - did the psychologist irritate you?

I think he irritated most of us.

Just struck the wrong note?

Yes. I wouldn't say he was brushing it aside, but we just felt as though he had no idea. He asked all of us individually. It was still way too fresh in our minds. We were still - as I said I still can't remember. ***[STAFF #1]*** said he was looking at me and his face was there - to this day - and there was blood all of him. To this day I cannot remember. It was just too - I felt it was probably a little bit too soon.

Too soon?

And then shortly thereafter the ***[NDRSMH]*** rung me up and said if I wanted any counselling I could get in contact with Global Counselling Services, I think it is. I have their name at home. And then I did make an appointment to see a woman there but in the end I ended up cancelling that because I wanted to see ***[PRIVATE PSYCHIATRIST]*** and I got in to see ***[PRIVATE PSYCHIATRIST]***. He squeezed us in.

[QNU ORGANISER]: ***[PRIVATE PSYCHIATRIST]*** used to work here.

[QNU ORGANISER]: So all the old stagers.

I found it good to talk to ***[STAFF #5]*** because he knew the wards, he knew the patients, and stuff like that.

And he would have understood what you were talking about too.

Yes.

Do you think that did you any good?

Yes.

You mentioned some assistance in doing the work cover applications. Were you helped?

Well as I said, generally as a whole I can't fault them. I mean, they gave me the name of the ***[REHAB ADVISOR]*** and she came out and spoke to me.

3.5.2 (b) *[STAFF #1]*

In the interview with ***[STAFF #1]***, the following is recorded:

Let's talk about the event in the matter of support offered to staff by management; do you have any comment on that?

I've got to say from my side, personally, for what I had to go through, it was quite hectic, because I didn't know any of the processes, I didn't have anyone saying, "See this person, fill out this paperwork, do this, do that to get your Work Cover." It wasn't until I saw the ***[QNU ORGANISER]*** here that I finally worked out what to do. I rang up ***[NURSE MANAGER, NURSING ADMINISTRATION]***, I rang up a few other people and no-one knew what I had do, what I had to fill out, who I had to send this to, because I can't go up to a surgeon without my Work Cover number and you've got to fill out their paperwork to have your Work Cover number and I'm not one of these litigious people who says, "I wonder what the process of Work Cover is?" Meanwhile, I've got my face smashed in, I'm feeling like crap and I'm trying to work all this stuff out. I had a series of events which were just annoying, I went to the PA in Brisbane to get reviewed, and didn't know about the paperwork and all that that I needed for Work Cover and I didn't know what surgeon I could chose or what the process was, so essentially it was a waste of time. I came back from Brisbane and then a friend of the family knew maxillofacial surgeons who did this and said, "We can get you in today in Brisbane." I said, "Well, I don't have my Work Cover number and I'm on painkillers and I'm running around town getting a doctor's certificate, getting this." It may sound

stupid, but up until that point I'd lived quite a healthy life, I didn't need to know any of this stuff. And so, I only worked out at the end of the day, when I came and saw the ***[QNU ORGANISER]*** – because I'd spoken to another Union rep prior, and no fault of her own, she didn't really know the process either. It didn't make it easy at all.

Management was not able to assist you in getting the surgery you needed?

They did, apparently there had been some feedback to them and apparently they'd gone to the Chair of the Board and that and they said they would have paid for it and all that stuff, just to get it all through, but by that time I'd got my Work Cover number. That period of time was, what the hell.

You were on your own?

Yeah, you were on your own and the other people around you, who were involved, they were getting frustrated seeing me, getting stuffed around I suppose.

What about counselling?

Yeah, they were offering of that.

So that was satisfactory?

Yeah, particularly ***[PRIVATE PSYCHIATRIST]***, he was very good, really good.

Garth: So you saw the EAS type person?

No. It was just someone appointment – employment assistance. As a group they sent us to psychologist, ***[CONSULTANT PSYCHOLOGIST***], as a great……, that was our first session, then after that we've individually gone to ***[PRIVATE PSYCHIATRIST]***.

And organised by management?

I think so, yes.

That sounds appropriate.

They were good in that area. It's not that. For me, for my situation, I was in the dark basically until I found the ***[QNU ORGANISER]***.

3.5.2 (c) *[STAFF #3]*

In the interview with ***[STAFF #3]***, the following is recorded:

What I'll say is that they asked staff if they were comfortable going back to Ridley.

Oh, did they?

Well, the ***[NDRSMH]*** asked me. He said, "Are you happy to go back to Ridley?" And I said, "Yes." Because, I said, "For me it's therapeutic." I mean, for me, going" – if - the longer I left it the more difficult it would be.

So you had an option?

I had an option. I think everybody else did, too.

3.5.3 Management of Critical incidents

There was general agreement that there was good immediate support from senior staff, other than the on-call medical staff, in the hours and days following the incident. This support was welcomed by staff

However, some concerns were expressed about the time taken to get appropriate advice about operational processes and staff-related health matters following the incident, particularly in relation to available support to assist with Work Cover processes. However, not all staff involved in the incident sought an interview so it is unclear whether the remaining staff feel supported or are experiencing ongoing difficulties.

There has been debate in the professional literature regarding what is the appropriate therapeutic response to people involved in a critical incident. Current thinking is that group based interventions may be unhelpful. Rather, an approach that offers individual care and support and information regarding resources, which an individual may find helpful is considered a more appropriate model. Consistent with this literature, some of the Ridley staff reported not finding the group session helpful.

The staff involved reported some difficulty in obtaining information in relation to Work Cover. At the best of times such processes can be challenging particularly if the staff member is trying to navigate the system for the first time. The Darling Darlings Hospital and Health Service *Emergency Response Manual* (approved August 7, 2012; review date August 7, 2013) outlines a Critical Incident Stress Debriefing (CISD) process.

The Australian Centre for Posttraumatic Mental Health http://www.acpmh.unimelb.edu.au/ is releasing the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder on August 27, 2013. Service practices (such as the *Emergency Response Manual*) should be reviewed in relation to such or other relevant evidence-based guidelines.

Not all staff welcome what they consider to be 'external support' following a critical incident and may therefore avoid engagement with 'management driven' counselling or support processes. This is sometimes further complicated by staff feeling that only the others involved in the incident will truly understand how they feel.

There can also sometimes be a particular attitude within secure environments that to be seen to need additional support is a sign of weakness of some kind and staff need to 'soldier on' so that their colleagues don't lose confidence in their ability to 'control and contain' what is happening within the workplace.

Therefore in providing support to staff following a critical incident, there cannot be a one size fits all approach. There must be a range of programs and interventions available that will be flexible enough to cater to the differing needs of staff. Examples include a Peer Support Program such as the one that has been established at The Park Centre for Mental Health, access to internal and external EAP services, ensuring the person providing individual information and resources is as close to the staff members operational lines of management as possible (e.g., NUM or CN).

A fundamental question that has to be considered is how do staff and clients 'heal' from this type of incident. Issues such as anger by staff who

are required to continue to care for some of the perpetrators of the incident, resentment by the patients involved who may have more onerous conditions placed upon them and potential concern from patients who weren't involved in the incident but who now may have increased anxiety about their well-being given that they have been exposed to an incident that by all accounts could have resulted in the staff 'losing control' of the Unit.

A time of particular stress and potential anger will be the Mental Health Court or other criminal court hearings. This is likely to be a time of stress for staff and has the potential for resentment and anger against the system/psychiatrists depending on which patients receive a mental health defence. Staff expectations should be managed by Darling Downs mental health service leadership to ensure there is not a ‘secondary’ trauma experienced by staff as a result of the legal outcome. The focus should be upon staff being reassured that management support the actions of staff, including the reporting to THE QPS, and the service and individual staff no longer have ‘control’ of what happens from a legal perspective and they should prepare themselves for any eventuality without the outcome being considered a reflection of the level of trauma experienced by staff, their fear and anxiety during and post the incident or whether the staff’s perspectives were believed to be correct.

At times when a serious incident occurs that necessitates an investigation, especially if the investigation is external, there can be a perception by a service that normal functions and activities associated with managing the aftermath of the incident, including ongoing support to staff, implementing immediate actions to clearly identifiable problems, are ‘put on hold’ until the investigation is concluded. This is sometimes due to a misguided belief that actions that are taken by the service are ‘pre-empting’ the outcome of the investigation and in some way contaminating the process. To ensure that this does not occur into the future, development of a work instruction in relation to the interface issues of operational management when there is a concurrent investigation occurring should be developed to establish clear roles, responsibilities and boundaries between the processes.

RECOMMENDATIONS

6. Darling Downs HHS should develop work instructions that clearly outline expectations for meeting ongoing operational requirements during a post-critical incident period, particularly during an investigation. It is important that there is clarity with respect to roles and responsibilities of staff and managers about processes and rights.

7. Darling Downs HHS should review its Emergency Response Manual to include information on the range of staff support programs available post-critical incident and to ensure the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.

8. Darling Downs HHS should establish a staff peer support or 'buddy' system to ensure staff involved in a critical incident are provided with practical support and monitoring during the recovery process.

9. Darling Downs HHS Mental Health Service management should identify a mechanism to ensure there has been mediation and resolution between Ridley Unit staff and patients and that additional support and feedback are provided during court proceedings relating to the incident.

3.6 Specific Patient Issues

The issue of whether the patients involved in the incident should be interviewed was considered in detail. The benefits to be gained from interviewing the patients who were in the process of being charged with criminal offences were weighed against the risk of disrupting patients with a one-off interview. Information pertaining to the patients was obtained from their files and interviews with Ridley staff.

The following patients have been named in various statements given to the QPS at Toowoomba:

[PATIENT #1]

[PATIENT #4]

[PATIENT #3]

[PATIENT #2]

[PATIENT #5]

[PATIENT #6]

[PATIENT #7]

3.6.1 Background history

3.6.1 (a) *[PATIENT #2]* (DOB 10/03/1978)

Diagnosis: Paranoid schizophrenia (Differential diagnosis: drug induced psychosis)

Legal status: Involuntary Treatment Order (made 02/12/2010)

He is also recorded as being subject to Chapter 7, Part 2 of the Mental Health Act in relation to an assault occasioning bodily harm (AOBH) charge (06/05/2012) and breach of a suspended sentence (30/07/2010). The AOBH charge related to either (a) an alleged assault on a co-patient who ***[PATIENT #2]*** stated had taken extra funds from ***[PATIENT #2]'s*** bankcard to purchase tobacco for him or (b) on a staff member, who he alleged was "putting me down". Both assaults occurred on the same day.

Referral source: Maryborough MHU

Background to Ridley admission: 17/01/2011

On September 2, 2010*, [PATIENT #2]* was convicted of the assault of a staff member and damage to hospital property as well as intimidating hostel residents with a knife. His sentence expired early December 2010. He was then admitted to the mental health unit and placed under an involuntary treatment order. He was considered to require review of his medication regime, but due to his resistance to such review and lack of insight regarding his need for medication and likely aggression, a more secure environment than the HDU was sought.

PRIME Incidents

From January 2011 to January 2013 there were 23 incidents recorded. Six incidents in 2011 (patient assaults x 3; threaten staff x 2; AWOP x 1), 16 in 2012 (patient assaults x 7; assault staff x 2; threaten staff x 7; objects thrown etc x 3) and in 2013 the index incident.

Risk assessment (dated 20/05/2012) – Rated as high aggression and AWOP risk, medium suicide/self harm risk and vulnerability risk.

Care Plan

A Mental Health Act treatment plan (04/04/2011) makes reference to a graduated leave program and a Recovery Plan (01/09/2011) were the most contemporary documents provided. The goals of the Recovery plan were 1) improved cognitive activity; 2) reduced aggressive episodes and 3) To better manage own emotions and emotional responses to interpersonal differences of opinions. It describes this as meaning he'll tolerate differing opinions, or at least identify his own inability to modulate behaviour".

3.6.1 (b) *[PATIENT #3]* (DOB 28/01/1962)

Diagnosis: Paranoid schizophrenia and intellectual disability

Legal status: Forensic Order (made 09/09/2010)

He was placed on a Forensic Order following being found of unsound mind in relation to a 23/05/2009 charge of unlawful wounding. The charge related to an incident in which he attempted to stab a nurse in the neck with a pen (the nurse received a defensive wound to the arm) following being told that he would need to wait for PRN medication. Prior to the index offence he had upturned a coffee table, slammed a door when later offered the PRN and threatened to stab the nurse. ***[PATIENT #3]*** had a previous conviction for manslaughter but did not receive a mental health defence for this.

Referral source: Rockhampton MHU/Baillie Henderson Hospital

Background to Ridley admission: 28/09/2006

He was transferred from Rockhampton MHU to Baillie Henderson Hospital on 16/01/2002. Following aggression toward a co-patient in 2003 he was transferred to Ridley Unit. Since that time he has been transferred between Ridley Unit and the Jacaranda unit (an open extended treatment and rehabilitation unit) on multiple occasions due to reported behavioural disturbance and absconding.

PRIME Incidents

Four incidents were recorded on Prime in 2012. These involved throwing a table, punching the nurses' station window and throwing water over staff. In 2013 he kicked a door almost hitting a staff member. His involvement in the Index incident wasn't included on Prime.

Risk assessment (dated 13/01/2013) – Rated as medium aggression, vulnerability and AWOP risk; low suicide/self harm risk

Care Plan

A Mental Health Act treatment plan (undated) which makes reference to a graduated leave program and, a Recovery Plan (11/10/2011) were the most contemporary documents provided. The goals of the Recovery plan were 1) to support ***[PATIENT #3']'s*** independence in his cognitive processes; 2) for ***[PATIENT #3]*** to continue to be compliant with his medication regime in a supervised manner, 3) To support ***[PATIENT #3's]*** sense of self due to his lack of capacity to work; 4) to maintain an adequate level with activities of daily living and 5) for ***[PATIENT #3]*** to deal with intense emotions in an appropriate manner.

3.6.1 (c) *[PATIENT #4]* (DOB 10/02/1981)

Diagnosis: Paranoid schizophrenia

Legal status: Forensic Order (made 09/11/2007)

On February 1, 2007 he was alleged to have thrown a petrol filled container, which he had set alight through a neighbour's window. He believed the neighbours were raping and killing women. In the week prior he was reported to have had a verbal altercation with one of these neighbours. He also believed one of the persons in the house had raped his girlfriend previously.

Referral Source: Prince Charles Hospital SMHRU

Background to Ridley admission 21/12/2012

He had been an inpatient of the Prince Charles Hospital SMHRU unit since 16/11/2007 and was noted to have been AWP on five occasions, had 18

positive UDS (methamphetamine, cannabis, sympathomimetic amines) and following the last period of AWP had assaulted a co-patient. As a result of a second opinion it was recommended that ***[PATIENT #4]*** (a) be transferred to Ridley Unit and (b) be trialled on Clozapine. He was transferred to Ridley Unit on 21/05/2010.

PRIME Incidents

The only recorded incident was the index incident. His role was recorded as unknown. There may have been incidents prior to his transfer.

Risk assessment (dated 30/11/2012) – Rated as high aggression, medium suicide/self harm and AWOP risk; and low vulnerability risk.

Care Plan

His Consumer Care Review Summary and Plan (dated 30/11/2012) lists goals as: 1) maintain optimal mental health; 2) manage aggression and minimize harm and, 3) improve opportunities for employment.

3.6.1 (d) *[PATIENT #7]* (DOB 17/10/1967)

Diagnosis: Paranoid schizophrenia and intellectual disability

Legal status: Involuntary Treatment Order (made 22/09/2011)

Police brought ***[PATIENT #7]*** to hospital under an EEO following sending his sister a text message saying he intended to throw himself under a bus. He refused police entry and barricaded himself into a room.

Referral source: Toowoomba Acute Unit/Baillie Henderson Hospital

Ridley admission: 05/07/2012

He was noted to be aggressive and uncooperative with assessment and racist toward the admitting registrar. After an attempted hanging attempt with a garden hose, he was transferred from Jacaranda Unit to Ridley Unit.

Prime Incidents

The only recorded Prime incident was the index incident. His role was recorded as unknown.

Risk assessment (dated 03/07/2012) – Rated as high vulnerability; moderate aggression and AWOP risk, low-moderate suicide/self harm risk.

Care Plan

The only identified care plan was dated 07/04/2011 and was completed by Charleville MHS. The stated goal was: ***[PATIENT #7]*** would like to feel normal (not taking too many tablets).

3.6.1 (e) *[PATIENT #5]* (DOB 13/12/1965)

Diagnosis: Schizoaffective disorder (Differential Diagnosis Bipolar affective disorder rapid cycling and cognitive impairment secondary to an organic process), Intellectual disability. Post traumatic stress disorder.

Legal status: Involuntary Treatment Order (made 29/10/2007).

In addition to the ITO he is also subject to Chapter 7, Part 2 in relation to charges of Assault occasioning bodily harm (06/05/2012) and breach of a suspended sentence (02/02/2010). On 06/05/2012 it is recorded in his file that he physically assaulted a co-patient.

Referral source: Rockhampton Hospital/ Baillie Henderson Hospital

Ridley admission: 01/11/2012

He is reported to have been admitted to Baillie Henderson Hospital on 01/04/2008 from Rockhampton Hospital in the context of acute psychotic symptoms and suicidal ideation. His most recent transfer to Ridley unit followed an assault on another patient on 31/10/2012. The victim of this assault reportedly incurred multiple facial injuries.

PRIME Incidents

The only recorded Prime incident was the index incident. His role was recorded as unknown.

Risk assessment (dated 15/01/2013) – Rated as medium aggression and self-harm; low AWOP risk, suicide and vulnerability risk.

Care Plan

On his Consumer Care Review Summary and Plan (dated 15/01/2013) the following goals were identified: 1) decrease/minimize incidents of agitated and aggressive behaviour; 2) stabilise mood and decrease suicide ideation/self harm; anda 3) treatment to be provided within legislative guidelines.

3.6.1 (f) *[PATIENT #1]* (DOB 27/05/1986)

Diagnosis: Paranoid schizophrenia (Differential diagnosis drug induced psychosis)

Legal status: Forensic Order (made 27/09/2011)

His forensic order was made in relation to two sets of charges. On 20/07/2010 he incurred the following charges: Assault police, commit public nuisance and obstruct police. These charges relate to an incident when he was walking down a street yelling loudly and trying to access various properties. Numerous 000 calls resulted in the Police being called. On 05/08/2010 he incurred charges of go armed in public to cause fear, serious assault/resists/prevent arrest; threatening violence, wilful damage and wilful damage of police property. He came to police attention after smashing a bottle in a park and threatening a couple with the bottle. He is reported to have also threatened police.

Referral source: Bundaberg MHS

Ridley admission: 21/09/2010

[PATIENT #1] arrived in Bundaberg from Victoria in mid-July 2010. He had just been discharged from the Ballarat MHU following a hanging attempt and delusional jealousy. While an inpatient he was reported to be aggressive. Following further suicidal behaviour and aggressive behaviour he was taken to the emergency department but not admitted. On the day of the first set of charges he is reported to have taken a knife into his room and threatened a co-patient. He remained in hospital but absconded. He incurred the second set of charges while AWP. He was transferred from custody to Bundaberg Hospital HDU. While there he reportedly assaulted another patient and attempted to abscond. In a period of a week prior to transfer to Ridley, he is reported to have destroyed a HDU room, assaulted

a co-patient and staff, and the following day assaulted two more staff. There were concerns about his escalating risk and ability to present reasonably well despite being psychotic.

PRIME Incidents

In 2011 he was recorded as having threatened and assaulted a staff member. In 2012 there were one recorded instance of intimidation of a patient to bring in substances and an assault on a patient. In 2013 there was another incident of intimidation of a patient to bring in substances and the index incident.

Risk assessment (dated 02/12/2012) – Rated as medium aggression and AWOP risk; low suicide/self-harm and vulnerability risk.

Care Plan

On his Consumer Care Review Summary and Plan (dated 02/12/2012) the following goals were identified: 1) abstain from illicit substance abuse; 2) to display socially acceptable behaviours and to abstain from aggression with co-residents; 3) to return to living in the community; 4) understanding Mental Health Act status; and 5) improve insight regarding the illness and promote medication adherence. A Mental Health Act treatment plan (undated) makes reference to a graduated leave program.

3.6.1 (g) *[PATIENT #6]* (DOB 22/02/1988)

Diagnosis: Schizophrenia and intellectual impairment

Legal status: Forensic Order (made 21/08/2006)

He was found permanently unfit for trial in relation to two common assault charges, a charge of assault occasioning bodily harm and wilful damage. The reported victims were two community carers.

Referral source: Fraser Coast MH (Maryborough)

Background to Ridley admission: 30/09/2005

The stated reason for admission was for the purpose of extended inpatient admission and rehabilitation. He was noted to be a high

absconding risk and had outstanding charges (the above charges which were incurred when in the community).

PRIME Incidents

In 2011 he was recorded as being involved in two assaults on patients and was a victim of an assault. He was recorded as a victim of an assault in 2012. In 2013 the only recorded incident was the index incident. His role was recorded as unknown.

Risk assessment (dated 05/06/2012) – Rated as medium aggression, suicide/self-harm, AWOP and vulnerability risk.

Care Plan

On his Consumer Care Review Summary and Plan (dated 05/06/2012) the following goals were identified: 1) improve knowledge of Mx and side effects etc; 2) improve nutrition and lifestyle; 3) improve planning and budgeting skills; 4) maintain abstinence from alcohol; 5) improve standard of hygiene; and 6) improve social skills/self confidence.

3.6.2 Contextual client specific events leading to the incident.

3.6.2 (a) *[PATIENT #2]*

On 18/12/2012 he complained of epigastric pain and reported feeling down since hearing his ex-wife had been diagnosed with lung cancer. Two days later he requested an increase in his consta depot, denied symptoms but reported feeling more religious. The next week he was variously reported as settled or agitated, including an incident where he had a loud verbal outburst and punched the Perspex window in the nursing station. The following day he punched the window again and after a request to cook was refused he threw vegetables on the floor. On 04/01/2013 he reported feeling fearful and bullied by two co-patients (***[PATIENT #1]*** and ***[ANOTHER PATIENT]***). He also sought PRN Chlorpromazine. His Clozapine dose was increased on this day. He may have had a brief seizure on 06/01/2013.

On 7 January 2013 ***[PATIENT #2]*** was reported as "Settled this afternoon. Large period spent in yard attending to garden. Presented to the staff

station requesting coffee wanting 'largactic, I'm angry'". He claimed to be hearing voices and expressed frustration at his continuing hospitalisation. He accused the recording nurse of "having it in" for him. He was given some medication. It is recorded that he was "Dismissive in dealing with staff".

The entry for the 8th January relates to medication and notes "good sleep, he has been sleeping with mattress on floor near to T.V overnight".

On the 9th January there is a report of an interaction with staff concerning his supply of tobacco. It seems that his supply of tobacco was dependent on his being able to attend to purchase it while on escorted leave. Since he did not have any leave, he could not buy his tobacco. The entries for 11 January to 16 January deal generally with routine medication, smoking cessation (nicotine patches) and personal hygiene issues. The team review meeting (14 January) discussed referral to RRC for Smoking Cessation, Blokes Talk, Relaxation, mindfulness, cooking, workshop, Managing my Recovery, Gym and Indoor Cricket in association with a change to category blue. On 15th January the patient reported "feeling edgy". On 16th January he returned a negative UDS.

On 18th January he returned positive for benzodiazepines on UDS despite not having Benzodiazepam prescribed for more than 6/12 being. He attended a health and Hygiene session with the psychologist and the occupational therapist where the prospect of a shopping trip was raised if showering and clean room were maintained.

At about the time of the evening meal, he was verbally abused by another patient which left him "feeling stressed".

In the early hours of 19th January, ***[PATIENT #2]*** fell in his bedroom and hurt his ankle. He was given an ice pack for this.

3.6.2 (b) *[PATIENT #3]*

On 23/12/2012 he reported that every time he rings the Police they say he is monitored. He reported being monitored by various individuals/organisations (e.g., Alazar). On 26/12/2012 PRN diazepam was requested and given. Five days later he requested to be code blue and

said his sister reported him for attempted rape in 1994. On 03/01/2013 after being told a newspaper couldn't be located he "forcefully" kicked a door, nearly hitting a staff member's face. On 10th January he attended a dental appointment and also rang 000.

On 14 January 2013 there was a file entry regarding medication and the entry for 15 January reports an escorted outing to Clifford Gardens where he bought a stereo. The report for this day concludes, "Nil concerns. Appropriate and well behaved throughout". Code yellow was continued.

On 17/01/2013 PRN diazepam was requested and given "delusional content concerning police and scanners".

On 18th January he was escorted to the Toowoomba Hospital for dental work. Later that day he approached a nurse and asked if another patient had "called her a cunt". The nurse assured him that that had not happened. ***[PATIENT #3]*** explained his reason for making the enquiry, "I only want to protect you. I will stab him if he calls you that".

The next note relates to the incident.

3.6.2 (c) *[PATIENT #4]*

Due to complaints of sedation and the planned instigation of treatment for Hepatitis C, Clozapine had been ceased. From at least November 2012, ***[PATIENT #4]*** was becoming increasingly symptomatic, verbally aggressive and aggressive in speech content (references to being an arsonist and stabbing someone). Transfer from the open Jacaranda Unit to Ridley occurred on 21/12/2012. In Ridley, he was voicing persecutory delusions regarding a patient. Immediately prior to the incident he was described as unsettled, stressed, and irritable, and was refusing Lorazepam but seeking PRN Cogentin . On 18 January 2013 he had an escorted walk for 20 minutes. The 19 January entry notes he was "Continuing to refuse Lorazepam medication as it 'makes me dopey'. He was given some medication "for stiffness" with "good effect" and "maintaining low profile today".

3.6.2 (d) *[PATIENT #7]*

On 18/12/2012 he expressed a range of complaints (not enough money, lack of family contact, food quality) as well as racial/verbal abuse toward staff. At the team review on 24/12/2012 he was noted to be volatile and abusive. Three days later he played in a pool competition but was noted to be demeaning toward staff, as well as irritable as he wanted to see his sister. On 03/01/2013 he was noted to be pleasant but irritable about his financial situation. At the team review of 07/01/2013 he was noted to have regular verbal outbursts but to settle quickly. On the same day a tirade of abuse is reported, demeaning of staff expressing frustration that he can't return to Jacaranda. He was placed in the ICA on 08/01/2013 after striking the Perspex window twice. This occurred after being told that the take-away orders were finished. On 10/01/2013 he refused Lorazepam and Sodium Valproate and the next day he reported feeling bored and depressed. He was noted to be tearful but later his mood was reported as brighter.

On 14th January 2013, the patient was noted as "Frustrated. Angry and irritable". On the same day, a referral was discussed to RRC for workshop, mindfulness, cooking, making a calendar and using it, computers, gym, indoor cricket and music and movement.

On 15th January the following is noted, "*[PATIENT #7]* attended indoor cricket utilising his unescorted leave. *[PATIENT #7]* engaged well with this activity and interacted appropriately with staff and co-patients".

On 16th January, he is noted as being "irritable and angry all shift. Expressing frustration at being in Ridley". On the same day a request was sent off to the Public Trustee for funds so that the patient could purchase clothing – a football jersey and football shorts.

On 17th he utilised his unescorted leave to attend gum and recreation centre. "A/senior rec officer reported he engaged well and will develop gym routine tomorrow".

That is the last notation prior to the incident. There were no file entries for 18/01/2013 or 19/01/2013.

3.6.2 (e) *[PATIENT #5]*

On 29/11/2012 he reported being threatened and assaulted by another co-patient. QPS interviewed him on the day. There were no file entries between this date and the team review on 03/12/2013 where it was noted he had withdrawn the charge. On 18/12/2012 he reported feeling anxious and noted to be agitated. He also stated he wanted to go home and was later noted to be irritable and refused his evening medication. There were no further file entries until 24/12/2012. On 27/12/2012 he reported feeling frustrated and feeling like exploding and punching others. He also reported thoughts of self-harm and requested discharge. On 28/12/2012 no "real change" was noted and he was reported to be settled on the ward. On 01/01/2013 changeability in his mood was noted and on 06/01/2013 he was described as losing his temper at a patient who had called him names (it was unclear if he assaulted this patient). A week later he was refusing medication stating he was tired of being in hospital.

The entries for 10 and 11 January 2013 report bus trips and nil behaviour management concern.

The entry for 13 January reports a refusal to take his medication. It records him as saying, "I am tired of being in here, I do not want to take my medications". He was counselled "with good effect".

The patient was discussed by at the clinical team meeting on 14 January and a number of activities are discussed, such as, bike riding in the grounds, making a calendar and gym.

On 14 January he is recorded as "feeling edgy" and "My mind is going round in circles". Medication is noted.

On 16 January, among entries relating to medication (e.g. effects of Modecate wore off after two weeks), it is noted that he reported problems sleeping and that "he felt 'scared of reality' and also of 'death'".

On 17 January, he reported "racing thoughts". On the same day he went on a swimming trip. It is noted that there were "nil behaviour management concerns". Interaction with members of the public are noted as "appropriate".

The entry for 18th January ideals mainly with medication side effects (e.g. constipation) and there is an entry that the patient needs to restrict daytime sleep so that he sleeps better at night.

He later reported feeling like taking his anger out and smashing things and later asked to be taken to the ICA to feel more secure. He later stated he wanted to kill himself and take out all "the coaches ? of stereo and TV". He reported feeling comfortable in the ICA.

3.6.2 (f) *[PATIENT #1]*

On 10/12/2012 the Team Review noted his recent progress. He subsequently received escorted LCT to a shopping centre, spent Christmas day with his family and on New Years Eve went on day LCT shopping with his family. On 8 January 2013, *[PATIENT #1]* was placed on Code Red, with the approval of the *[CDEIS*], after he was reported to have been seen getting out of a car in the company of his brother. *[PATIENT #1]* denied that he had left the grounds.

He was upset by his Code Red status. His mother was also upset "as [he] had been doing so well".

On 9 January 2013, the *[CDEIS*] notes that he was "angry because leave curtailed". He continued to be angry on 10 January.

On 12 January, he was advised that his grandmother had had a fall, "been taken to hospital and is OK".

On 13 January, it is noted that nursing staff were advised by a patient that *[PATIENT #1]* had been "pressuring him to bring in illicit substances whilst he was utilising unescorted on ground leave."

On 14 January, a Team Review "discussed the move to Code Red due to breach of leave conditions and subsequent anger following." It was decided to keep the Code Red. *[PATIENT #1]* was interviewed and told that his Code Red would continue "until at least next week" and any progress on colour would depend on "appropriate behaviour". It is recorded that, initially, he avoided eye contact but eventually did make eye contact with

the NUM as the conversation progressed. He apologised to the NUM for a "verbal tirade against her several days ago."

On 16 January, a positive urine drug screen was recorded. The ***[CDEIS]*** discussed this with him. He did not deny use. The ***[CDEIS]*** notes that he said that he was "bringing in drugs tomorrow but now can't".

On 17 January, a patient reported that ***[PATIENT #1]*** had been pressuring him to pick up "illicit substances". The patient refused and later reported that continued to pressure him and would not take "no for an answer."

On 18 January, the same patient reported that ***[PATIENT #1]*** continued to pressure him to bring in illicit substances while on unescorted leave. "Co-patient stated that while initial request were polite, he would not take no for an answer and requests became demanding and threatening".

Shortly after the foregoing notation, ***[PATIENT #1]*** was observed going into the bedroom of the same patient. When challenged by staff he responded in an "irritable manner". He was later observed to follow the patient into the corner of the Atrium and sit beside him. The patient was observed "to be shaking his head (as in refusal). ***[PATIENT #1]*** appeared annoyed following this interaction".

Less than an hour later, he was placed on ¼ hourly visual observations due to threats to another patient.

He was observed to be on the phone and then to approach the same patient who reported pressure earlier apparently asking for something. He approached staff asking to go out for leave on the grounds. He was told that, as he had already used this leave entitlement for the day his request would not be granted.

The patient who had reported pressure was seen then to approach ***[PATIENT #1]*** who was observed to become angry during the conversation.

There are no clinical notes for 19 January 2013 prior to the incident.

3.6.2 (g) *[PATIENT #6]*

On 28/11/2012 leave with his family was noted. The only file entries between 30/11/2012 and 13/12/2012 were two team review records. On 13/12/2012 he was taken to view Christmas lights and the following day he was taken on an escorted bus outing. His behaviour on both trips was reported as appropriate. On 17/12/2012 he was noted to be progressing well and placed on code blue. The following day his mental state was recorded as "stable". There were no further file entries until 24/12/2012 when he was noted to be "progressing well". Again there were no further file entries until 30/12/2012 when slow improvement was noted and it was recorded that he was requesting more LCT. On 31/12/2012 frequent soiling of his pants was noted and "jelly-like" blood in the toilet. There were no entries until 07/01/2013.

On 10th and 11th January 2013, the patient went on bus trips where there were no behaviour concerns or inappropriate behaviour. Referring to 11 January, he is recorded as saying, "This has been a good day for me".

On 14th, the patient was discussed at a Clinical team meeting and it was noted that the patient was possibly under pressure from co-patients "to pick up substances for co-patients".

The next entry in the Progress Notes is dated 15 January. A co-patient reported "that *[PATIENT #6]* had been riding his bike to 7 Festival Street to pick up and pay for illicit substances. He was placed on Code Red. It is noted that he denied then later acknowledged this. The *[CDEIS]* confirmed the Code Red "pro tem". During the interview with the *[CDEIS]*, "*[PATIENT #6]* clarified that he spent $50.00 on illicit substances – Said he didn't know what the drug was – and he gave same immediately to *[ANOTHER PATIENT]*". There were no further file entries from 15th January until the incident.

3.6.3 Summation of Specific Patient Issues.

The seven patients involved in this incident all had histories of violence. In the days leading up to the incident three patients had refused medication (*[PATIENT #4]*, *[PATIENT #7]* and *[PATIENT #5]*); *[PATIENT #4]* had been admitted after relapsing from a previously stable mental state;*[PATIENT #3]* expressed

violent ideation in the context of chronic psychotic symptoms; in addition anger or irritability had been expressed by (*[PATIENT #4]*, *[PATIENT #7]* and *[PATIENT #5]* and *[PATIENT #1]*. *[PATIENT #6]* and *[PATIENT #1]* had restrictions placed on their LCT due to alleged substance seeking behaviour, while *[PATIENT #2]* and *[PATIENT #1]* recorded positive UDS findings.

A major challenge for staff and patients of Ridley Unit will be negotiating the understandable strong negative feelings that this incident will have generated.

It is considered advisable that *[PATIENT #2]* and *[PATIENT #3]* be considered for referral to the High Secure Unit. With respect to *[PATIENT #2]* this is because of his ongoing significant clinical and risk management needs. With respect to *[PATIENT #3]* similar it appeared that his risk and treatment needs were not adequately met in the SMHRU environment. Dislocating the patient from their community has to be considered a risk, however, his continuing violent ideation and chronic psychosis is a major concern.

[PATIENT #4] should be considered for transfer to either the TPCH SMHRU or the High Secure Unit. Breaking up this cohort of patients makes the provision of future care more manageable within Ridley. Working through what happened will be challenging for both staff and patients.

We should also note that *[PATIENT #1]* went to HSIS and has now been returned to custody where his treatment needs are being adequately met.

RECOMMENDATION

10. Consideration should be given to referring *[PATIENT #3]* and *[PATIENT #2]* to more secure care (and *[PATIENT #4]* to either The Prince Charles Hospital (TPCH) SMHRU or the High Secure Unit).

3.6.4 Staff perceptions of Specific Patient Issues

The *[CDEIS]*, in a memorandum dated 21 January 2013 reports *[PATIENT #1]* told staff “he did it because he couldn’t stand the frustration any longer”.

In his interview, the *[CDEIS]* says:

> There was some planning as far as we can discover, and I discussed with each of the patients why they did it. Some of them said "Well, ***[PATIENT #1]*** told us to. We wanted to break out".

[STAFF #3] says that, when somebody asked ***[PATIENT #1]*** why he did it, he replied, "Because you let me". ***[STAFF #3]*** is of the opinion that they did it because they had nothing to lose. He said:

> Okay. In his file. And that was that he said somebody asked him why did he do it, and he said, "Because you let me." Words to those effect. So – and I felt that we – we didn't – we didn't do our job in his instance. We didn't. He was there for rehabilitation. He was a number, a patient. He was looked at when it was appropriate because he hadn't been an issue, like you'd said, for so long, he was flying under the radar. Nothing was done about him. Nothing, as far as his progress. Why wasn't he being given some future hope, you know? Maybe – and I think another thing – another reason why they did it was because – I think I read in the newspaper, was because he had – had nothing to lose.

The NDRSMH was asked if he had been told why the incident occurred. He said that ***[PATIENT #1]*** told him, in answer to the question, "'Cause I wanted to bring the cunt down a peg or two." The ***[NDRSMH]*** says that the person referred to is ***[STAFF #1]***.

On 20th January 2013, ***[PATIENT #2]*** was interviewed by the ***[DCSMH]***, the ***[CDEIS]*** and several others. The progress notes contain the following:

- ***[PATIENT #2]*** reported that "this had been building up for a long time – the friction between nurses and patients".
- "I don't wanna be here any more".
- "One patient was suicidal the other day".
- "The Yanks are after me".
- "Government is after me".
- "The Yanks and the Australian navy are (indecipherable). I spoke to a Melbourne politician about it and ever since the police is following me".

- “The patients and nurses are out to get me”. “Roy Smith told me that”. “He’s a guy in Maryborough”.
- “I can hear him”. Auditory hallucinations
- The TV is talking about me. They said I have AIDS”.
- When asked about the incident yesterday, Ian accepted that there was some discussions among him and other patients.
- Ian said that he was afraid of ***[PATIENT #1]*** and 2 other patients.
- He agreed that he was given the job of keeping the nurses away. Accepted that ***[PATIENT #1]*** gave him that job.
- He admitted that it got out of hand.
- He accepted that he punched an Indian nurse, “But he came over me first from behind”.

Other accounts provided to staff, including High Secure Unit psychiatrists include:

- an escape attempt, to be achieved by gaining access to car keys in the nurses’ station
- an attempt by ***[PATIENT #1]*** to be transferred to another hospital, based on the perception that he would obtain discharge sooner if transferred
- ***[PATIENT #1]*** manipulating co-patients through intimidation or the promise of escape, to participate while his motivation was to gain transfer to another hospital. The assault on the staff member may have been a means to achieve this or to settle a grudge.
- An escape was planned but not on this night. ***[PATIENT #1]*** perceived a slight on ***[PATIENT #3]*** and initiated the assault earlier than planned.
- In the March 12, 2013 Clinical Report. Forensic Order Review report completed by ***[OMITTED – PSYCHIATRIC CONSULTANTS]*** of the High Secure Unit it is stated: “There were some reports that this had been planned as an escape attempt but more

recently *[PATIENT #1]* has denied this and stated he believed the victim had treated him unfairly".

The attempted removal of a table leg has been variously described as obtaining a weapon to assault staff but also as a means to break into the Nursing station.

The individual patients involved have given different accounts as to why the incident occurred. *[PATIENT #1]* in particular has given conflicting accounts over time. It is likely that individual patients had their own reasons and that there is no single reason.

3.7 Other Factors contributing to the incident

3.7.1 Overview

Incidents such as those that occurred on January 19, 2013 are not unheard of in mental health services. They are, however, very uncommon and therefore as a very low base rate event, extremely difficult to predict. A PsycINFO database search of the literature revealed only two "riot" articles. Both articles were from the 1970s and pertained to adolescent units. The Google search engine identified eight incidents reported as riots which have occurred in the last decade. At least half of these "riots" occurred in child/adolescent facilities. Four incidents occurred in secure units, three of which were adult facilities and the remaining hospital provided services to both adults and children with a learning disability.

The following table outlines basic details of these incidents, which had quite diverse reported causes.

Table 15: Identified riots in mental health facilities

Year	Facility	Population	Number of patients	Harm	Cause
2006	Riverside hospital for children	Child/youth	5 male	Property damage	Staff concerned re patient mix
2006	Intermountain Hospital	Youth	unspecified	Property damage	Unannounced transfer of staff
2008	Ashworth Special hospital	Adult FMH	Unspecified	Property damage; wrestled staff; rooftop protest	Smoking ban
2010	Brooklands secure hospital	Unspecified	unspecified	Property damage	unspecified
2011	Broadmoor special hospital	Adult FMH	15	Property damage; harm to unspecified persons	Argument between patients
2011	Meadows psychiatric centre	Child/youth	2 males/3 females	Staff/police injured	Unspecified
2012	Scott Nolan psychiatric hospital	Child/youth/ Young adults	unspecified	Injuries to staff	unspecified
2012	Linden House secure	Adult secure	3 males	Property damage, threatened staff with weapons	Broke into drugs cabinet

Not included above is an incident in 2010, where two patients attempted to escape from the HDU of the Ipswich acute inpatient unit. The ***[CDEIS]*** and the NDACMH identified previous incidents where more than one patient

collaborated in some form of incident, however, it is understood that these incidents were several years ago, and have not been formally documented as the above incidents have. It is also important to note that 'perceptions' of what constitutes a 'riot' will differ between individuals, services and jurisdictions, therefore comparison is difficult to make.

Aggression and violence are human behaviours that occur in response to stresses and demands, both internal and external to an individual. It is therefore necessary to consider patient factors as well as external contributing factors, which are summarised in Figure 1.

The Investigators have determined that there is not a single "cause" for the incident of 19th January. The trigger to the incident appeared to be the loss of leave and restrictions placed on ***[PATIENT #1]***. However, there was a combination of predisposing factors to this aggressive incident and a growing unrest amongst Ridley patients more generally about their future discharge pathways and the unit management regimen. In their absence, it is unlikely that an incident of this magnitude would have occurred. The combination of factors are categorised below into patient, system and staff factors and are considered below.

Patient frustration (both long and more short term) and the resultant anger and hopelessness expressed by patients was a key factor associated with the incident. Patient hopeless was commented on by some staff and the document titled: *Ways the patients think Ridley could be improved* identified that hopelessness as a "major contributing factor to antisocial behaviour on the ward". Boredom, a factor also generally associated with inpatient aggression, was raised as an issue for patients. This document was reported to have been written by ***[PATIENT #2]***, ***[PATIENT #1]*** and ***[FORMER PATIENT]*** in 2012. This document could be considered as a pro-social and therefore appropriate means to raise and make suggestions about patient concerns.

Patient frustration and anger does not usually result in incidents such as the one that occurred in Ridley Unit. Another contributing factor, was the individual personalities and mental states of the patients. From psychiatrist interviews conducted with the patients soon after the incident

it is evident that ***[PATIENT #1]*** played a significant role in instigating the incident, and staff in their interviews with the Investigators identified that ***[PATIENT #1]*** was actively encouraging other patients during the incident. ***[PATIENT #2]*** and ***[PATIENT #6]*** were also identified as attempting to encourage their fellow patients.

The interview with the ***[PRU]*** identified ***[PATIENT #1]*** as being both concerned about how his family viewed his behaviour and his perceived status as someone who got things done on the ward. The 'Ways the patients think Ridley could be improved' document advocated for ***[PATIENT #1]*** and ***[PATIENT #2]*** to be intermediaries between staff and patients. This document is interesting for a number of reasons. Not only did it identify two of the main players in the incident as being potential 'negotiators' between staff and patients, it also suggested ward 'rules' that created clear structures, processes and consequences for potential negative patient behaviours. It also indicated a clear desire of at least some patients to be more actively involved in Ridley Unit functioning and by inference their own recovery. It is unclear what the status of this open letter held and what response was provided to the patients who allegedly authored the document, if any. How this document was treated may be a subtle indication of the chasm between staff and patients of Ridley Unit and the nature of the recovery culture within the Unit.

[PATIENT #1]'s loss of LCT due to breach of leave conditions and being placed on code red and subsequently being placed on 15 minute observations due to intimidation of other patients in relation to bringing in illicit drugs were all likely sources of anger. The patient profiles summarised above highlight behaviours such as previous use of violence, frustration at being in Ridley, being victimised by other patients, treatment refusal, aggression, mental state instability and anger amongst the group of patients which was able to be harnessed. The patients involved in the incident all had histories of violence, and a range of mental health and other factors that made them predisposed to being involved in such an incident.

The opportunity for an adverse incident was contributed to by having a large number of patients congregated together late at night. The available

evidence suggests a degree of planning rather than a simple triggering event, e.g., a particular action or inaction by a staff member or patient. While this suggests pre-planning this may have been a relatively brief, or the incident itself became an opportunistic response in the context of a more organised plan intended to occur at a later time.

The patient frustration and hopelessness occurred in the context of a setting where there was no clear evidence of comprehensive treatment and discharge planning. There had been attempts to engage both ***[PATIENT #2]*** and ***[PATIENT #1]*** in appropriate interventions though Individual Care Plans documenting ongoing interventions and comprehensive and contemporary risk assessment/management plans were not identified. Discharge pathways for the patients were not documented, reflecting broader issues regarding how Ridley serves as a step-down unit but also problems returning patients to the referring district of origin.

Drug seeking behaviours have been identified as a problem in the unit and documented as such by staff in the 2012 Benchmarking report. A range of reasons, some related to a misunderstanding of what the recovery model or least restrictive practice entails, were put forward to explain why consistent strategies were not being implemented to address the issue of supply of drugs and intimidation of patients to bring in drugs. There were differences among the ward staff regarding the severity of consequences for patients of attempting to bring in drugs or using drugs. The ***[CDEIS]*** observed that having a large number of patients without ground leave added to the ward tension.

The issue of a congregation of a third of the ward's patients congregating in the Atrium at midnight raises a number of other issues related to relational and procedural security and a lack of staff understanding of these terms and the underlying concepts. Underlying this is confusion or misunderstanding of how risk and recovery models can be integrated, and at a service level documentation regarding the MoS is inconsistent and not necessarily in accord with the current model of service for a SMHRU.

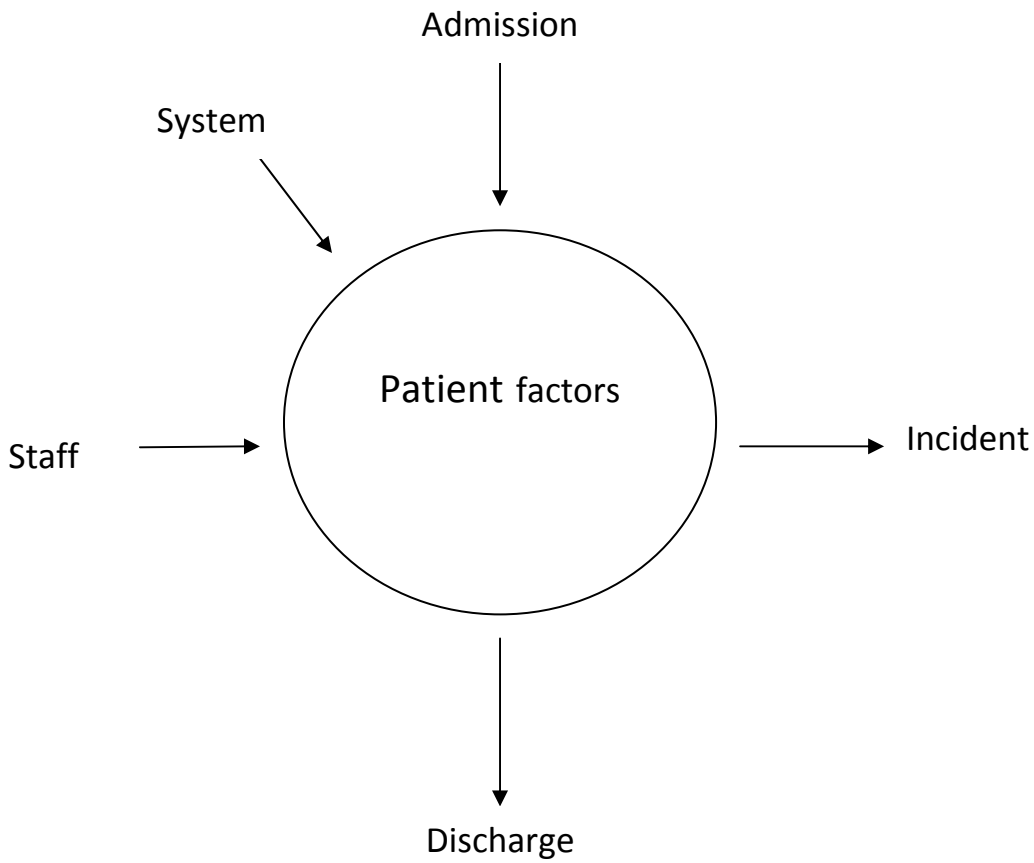
The incident was preceded by a staff refusal to turn music back on, however, the significance of this refusal was unclear and it's importance is

diminished if there was prior planning of the incident. The fact that the incident occurred very soon after the security officer left the ward is unlikely to be a coincidence. A range of contributing factors provided the context for a type of incident that is most likely to occur in a more contained secure facility.

If the patient's assault on staff had an aim (various explanations have been offered at different times by the same or different patients as to the motivation for the incident), it appears this aim became lost as emotions became aroused and staff sought to contain the incident. In the end the focus shifted to causing staff harm or freeing ***[PATIENT #1]***.

The professional literature recognises that inpatient aggression is the result of the interaction of factors related to patients, staff and a unit's culture. Ridley Unit's operation and culture is the result of events occurring both within the unit but more broadly across the HHS and Queensland Health over a number of years. A range of such factors are discussed below. However, it is first necessary to examine the pathways into, and out of, Ridley and the appropriateness of the Ridley admission criteria and how this applied to the specific patients involved in the incident.

Figure 3: Factors contributing



3.7.2 Admission processes and criteria

The investigators identified that there are at least four pathways that can result in admission to the Ridley SMHRU.

3.7.2 (a) Planned versus unplanned referrals and admissions

Below is a break down of the varying admission modes for patients entering the Ridley SMHRU.

1. Planned admissions
2. Unplanned admissions
    a. Acute admissions from other HHS mental health services

b. Acute admissions from other units within the Baillie Henderson Hospital (most commonly former Ridley SMHRU patients whose mental state has deteriorated)

c. Acute admission of patients from acute units within the Darling Downs HHS

1. Planned admissions

These include admissions from custody, other areas of Darling Downs HHS and other mental health services that fall within the geographic catchment area. These referrals follow a comprehensive and standardised referral and assessment process. This pathway provides capacity for a multi-disciplinary, considered assessment of the suitability of the patient for admission. It also enables an opportunity for management planning prior to the patient being admitted and importantly it allows an agreed approach and understanding to be reached between Ridley SMHRU and the 'area of origin' HHS with respect to progress, transition and discharge of the patient. The investigation team considered this to be the most appropriate manner for a patient to be admitted to Ridley SMHRU.

2. Unplanned admissions

a) Acute admissions from other HHS mental health services is at times a necessary, but an undesirable, pathway and should be the 'last resort' option. Ridley SMHRU does not have an environment that is consistent with the requirements of acute mental health care and treatment. It is structured and resourced to function as a SMHRU, therefore any 'crisis' admission would be inconsistent with the SMHRU MoS, design, staff mix and resourcing. Such admissions should only be considered as a time limited option when there are no mental health service alternatives in the area of origin. The objective of the admission should be clearly articulated and include the actions that the referral service will be putting in place to facilitate the return of the patient. The acceptance of the referral is made by the Clinical Director, in isolation from the rest of the multi-disciplinary treating team, and while it is acknowledged this will be unavoidable from time to time, the goal should be to ensure all

admissions engage the multi-disciplinary treating team. From the investigation team's review it would appear that there has not been a consistent approach by the referring services in maintaining responsibility for this group of patients.

b) Acute admissions from other units within the Baillie Henderson Hospital relates predominantly to prior patients of the Ridley SMHRU. It was noted that a practice exists, probably related to the challenges of returning patients to their HHS of origin, of patients being "stepped down" from the Ridley SMHRU to other units in the BHH (most commonly Jacaranda) rather than returning to their referring AMHS. It would appear that this could create an experience for patients of a 'revolving door' between open BHH units and Ridley SMHRU. If these patients were in other less restrictive clinical settings, such as a Community Care Unit or another form of Extended Treatment/Rehabilitation Unit on relapse of their mental illness in a HHS, they would be transferred or admitted to an acute mental health inpatient unit for a brief admission to stabilise their illness. This would also be the more appropriate option for the patients residing in other BHH inpatient units rather than using Ridley SMHRU as an acute inpatient mental health unit. In addition, the cycle of readmission from a BHH unit to the Ridley SMHRU, could be viewed as contrary to least restrictive practice. It could also engender a loss of hope in patients with respect to transitioning back to community care.

c) Acute admission of patients from acute units within the Darling Downs HHS appears to be a pragmatic response by the Darling Downs HHS to the demand upon the acute AMHS. As previously outlined the investigation team do not believe that these are appropriate admissions given that the Ridley SMHRU is not equipped to function as an acute mental health inpatient unit.

3.7.2 (b) Admission and referral data

The Multi-site benchmarking of Secure Mental Health Rehabilitation Units (2012) provides comparative data on admissions and discharges to

SMHRUs in 2011. This document reports the following admission criteria for Ridley Unit:

- Adults with a mental illness who pose a serious risk of harm to self or others (including serious physical violence, persistent assaultiveness or harming behaviour) and whose needs cannot be met in a less secure setting.
- The need for assessment and/or extended treatment that cannot be provided in other acute of high dependency units or other extended inpatient service clinical program setting.
- Adults aged 16 years of age or over who reside within the designated catchment areas.
- Meet the above criteria and are subject to the involuntary treatment provisions of the Mental Health Act 2000

In 2011 Ridley accepted 100% of referrals (n = 9), while SMHRU C accepted 33% and SMHRU D accepted 75%. SMHRU B did not collect data on this parameter. All SMHRUs had a pattern of a declining number of admissions from the 2005 Benchmarking report to the 2012 report. The following table depicts admissions and discharges from Ridley Unit for four reports.

Table 16: Ridley SMHRU admissions and discharges recording

Report	Admissions	Discharges
2005	17	16
2008	10	7
2010	10	10
2012	9	9

Source: Benchmarking reports 2005-2012

Table 17: Identified admission source

Report year	Community MH	Acute unit	High Secure unit	Criminal justice	Extended treatment	Other
2005		88%		6%	6%	
2008		30%		20%	40%	10%
2010	10%	20%		30%	20%	20%
2012	11%	56%		22%	11%	

Source: Benchmarking reports 2005-2012

There is considerable variability from year to year, though this is to be expected given the small number of admissions per annum. Admission sources were broadly similar to SMHRU B which has a similar service configuration (location on a dedicated extended stay hospital campus).

3.7.2 (c) Queensland SMHRU target population

The 2011 SMHRU Model of Service document describe the intended population of a SMHRU as follows:

"The SMHRU provide a safe and structured environment and 24 hour clinical support for adult consumers generally over the age of 18 years with persistent and disabling symptoms of mental illness. The diagnostic profile of consumers admitted to SMHRUs consists mainly of schizophrenia/related psychosis and mood disorders. Consumers often also have complex presentations including issues with personality disorder, drug and alcohol disorders, complex trauma and clinically significant deficits in psychosocial functioning. SMHRU are intended to target people with complex needs who are unable to be adequately treated in less restrictive settings, due to symptoms of mental illness, and associated issues of behaviour and risk which indicate a need for rehabilitation. Behaviour disturbances experienced by consumers include:

- Severely disorganised behaviour leading to difficulty in managing activities of daily living

- Impaired impulse control
- Vulnerability
- Ongoing risk of aggression,
- Significant risk of self harm by commission, omission or misadventure.

Additional services may be provided to individuals under 18 years of age, who are in the above population targets and who cannot be safely managed in less restrictive settings within district mental health services".

It should be noted that the presentation of the individual on admission may also be different to their current presentation. The investigation team have already made a recommendation in relation to processes for review of management and placement in response to deterioration in mental state and associated behavioural disturbance. For the purposes of this investigation, the team have reviewed the referral and admission documentation for the patients directly involved in the incident of 19 January 2013, and has formed an opinion of whether the individuals presentation was consistent with the criteria in place at that time.

RECOMMENDATIONS

11. Darling Downs HHS Mental Health Service management should consider establishing an escalation process for the re-assessment and alternate placement of Ridley Unit patients whose mental state and related behavioural disturbance can no longer be managed by the resources available within a SMHRU environment.

12. Darling Downs HHS Mental Health Service management should consider ceasing the practice of admitting patients to Ridley SMHRU that are not planned, as outlined in section 3.7.2, until the investigation has concluded. If an emergency internal admission is required, this should only proceed with the approval of the Executive Director Mental Health, Darling Downs HHS.

13. The Mental Health Alcohol and Other Drugs Branch should reinforce the role and function of SMHRUs and the responsibilities of referring services in the ongoing management and discharge planning of patients.

14. Referral guidelines should be developed and include an expectation that patients referred to the SMHRU need to have defined rehabilitation goals (this assumes the patient will also have risk management needs, the two are not mutually exclusive). Acceptance of referrals should be contingent on the understanding that the patient is expected to be discharged back to the referring service.

3.8 Admission Summaries of Patients Involved in the Incident

The following summaries focus on factors surrounding the admission of each patient to Ridley Unit and an assessment as to whether the patient met admission criteria. It is important to note that assessment for admission against defined criteria is not always an 'exact science' and there will often be differing opinions dependent upon the clinician's experience and their specific knowledge of a patient. Also of note is that the investigation team have also been conflicted regarding the placement of patients in SMHRU, indicating the variance in views by experienced practitioners and operational managers on this complex issue.

3.8.1 *[PATIENT #2]*

[PATIENT #2] was transferred from Fraser Coast IMHS on 17 January 2011 following a volatile 6 week admission. The clinical documentation provided appears to demonstrate deterioration in ***[PATIENT #2]***'s mental state and behaviours over several years, but particularly following the break down in his marital relationship. A significant amount of his offending appears to relate to violence against his partner/former partner. ***[PATIENT #2]*** appeared to have little insight on admission and the admission notes appear to indicate that he believed his admission was for a second opinion in relation to his medication, specifically the amount of Ritalin that was being prescribed. This issue had been a source of conflict between ***[PATIENT #2]*** and the treating team, however his uncontained aggressive and disruptive behaviour on the acute unit was the catalyst for

the referral. It was viewed that a SMHRU would provide a more contained environment to cease the Ritalin and stabilise his mental state.

Prior to his admission ***[PATIENT #2]*** had a long history of contact with the criminal justice system with charges including; assault, motor vehicle offences, deprivation of liberty, abduction and assault of ex-partner, assault of a mental health staff member and wilful damage. Immediately prior to his admission to Fraser Coast acute MH unit he had served a 3 month sentence for an assault on a mental health staff member.

It is not clear that at the time of his admission to Ridley his history of offending, mental state and associated behaviours would have met the criteria for admission to the High Secure Inpatient Service at The Park, however he had been assessed by Community Forensic Outreach Service (CFOS) who supported the plan to refer to Ridley SMHRU and did not suggest admission to HSIS and therefore they must not have considered HSIS necessary at that time.

Given the criteria in place at the time for Ridley SMHRU it would appear that on admission his presentation was not inconsistent with those criteria.

3.8.2 *[PATIENT #3]*

[PATIENT #3] was admitted to Ridley SMHRU in February 1999. He had a long history of violence and offending, often in the context of alcohol intoxication. He was sentenced to 5 years imprisonment for the manslaughter of his cousin in 1993. He also held a knife to the throat of a stranger at St Vincent de Pauls in 1998 and received a further 12 month prison sentence. Several incidents of use of firearms such as shooting himself in the foot and threatening others with a firearm and threats to kill his sister followed. Prior to his imprisonment for the manslaughter of his cousin his offending had only been relatively minor in nature.

Following a 3 month admission to Rockhampton acute mental health unit he was referred to Ridley SMHRU for longer term treatment in January 1999. The referral was made after several attempts had been made to reintegrate ***[PATIENT #3]*** into the community through a gradated leave

program however this had failed due to ***[PATIENT #3]*** not complying with the leave conditions and abusing alcohol. He had also recently absconded and was frequently assaultive. In 2009, whilst a Ridley inpatient he attempted to stab a nurse.

Given the criteria in place at the time for Ridley SMHRU it would appear that on admission his presentation was not inconsistent with those criteria, however consideration of High Secure Inpatient Service placement would have been beneficial.

3.8.3 *[PATIENT #4]*

On this occasion, ***[PATIENT #4]*** was transferred to Ridley SMHRU from Jacaranda Unit on 21 December 2012 following deterioration in his mental state and aggressive and threatening behaviour. As ***[PATIENT #4]*** had initially been transferred to Jacaranda Unit from Ridley SMHRU on 20/06/2011 when his mental state deteriorated, he was returned to Ridley. This would not be unusual in the current circumstances, however using Ridley SMHRU as an acute treatment unit for any person who has previously had an admission there, may not always be appropriate. Irrespective of this, there is nothing to suggest that ***[PATIENT #4]***'s admission to Ridley SMHRU did not meet the criteria at that time.

There is a question however regarding ***[PATIENT #4]***'s initial admission to Ridley SMHRU in May 2010. In 2007 ***[PATIENT #4]*** was placed on a Forensic Order following charges of Arson and he was admitted to Prince Charles SMHRU. He was subsequently transferred to Ridley SMHRU following an attempted stabbing of a co-patient whilst in Prince Charles SMHRU. Comments made by ***[PATIENT #4]*** in relation to these offences whilst he was being cared for in the ICA would suggest he has not 'worked through' these offences from a forensic perspective.

Given the nature of his history of offending (arson and attempted stabbing), it is unclear if admission to the High Secure Inpatient Service at The Park was considered rather than transfer to Ridley SMHRU. Given the criteria in place at the time of his transfer he would appear to meet the criteria for a SMHRU, although HSIS placement may also have been appropriate.

3.8.4 *[PATIENT #7]*

[PATIENT #7] was residing on Jacaranda Unit. He exhibited a deterioration in behaviour over four days with ruminations regarding access to his finances and concern over how the Public Trustee were administering his money. He went to court on 06/11/2012 and pleaded guilty to assault of a staff member. He received 12 months probation. He appeared to be becoming increasingly frustrated and on 07/11/2012 was found attempting to hang himself. His behaviour did not settle whilst being managed more intensively in the ICA and a decision was made to transfer to Ridley SMHRU. Although no clinical notes were provided regarding *[PATIENT #7]*'s earlier inpatient treatment it is assumed he had earlier been an inpatient of Ridley SMHRU and as with some other patients was transferred back to Ridley following deterioration in mental state- please refer to comments regarding this under *[PATIENT #4]*.

It is not possible to comment on *[PATIENT #7]*'s initial admission to Ridley SMHRU, however this admission appears to meet the criteria.

3.8.5 *[PATIENT #5]*

[PATIENT #5] was transferred to Ridley SMHRU on 01/11/2012 after assaulting a co-patient on Giabal Unit. *[PATIENT #5]* stated that during dinner the other patient taunted him by calling him names and he punched him in the face. It was a single blow, however the patient sustained facial fractures. *[PATIENT #5]* generally appeared remorseful for his actions following the incident (although on one occasion did state that he would punch him again if he had the chance). On 02/11/2012 there is a clinical progress note that states that *[PATIENT #5]* will be transferred back to Giabal Unit after the other patient was admitted for surgery, however the notes over the following days do not indicate that any attempt was made to transfer *[PATIENT #5]* back to Giabal, nor was there any documentation that would suggest an ongoing need for care in Ridley SMHRU. Although the outcome of the assault was serious, a plan for *[PATIENT #5]* to return to a less secure environment as soon as possible would not have been unreasonable.

Given the criteria in place at the time for Ridley SMHRU it would appear that on admission his presentation was not inconsistent with those criteria.

3.8.6 *[PATIENT #1]*

[PATIENT #1]'s first contact with mental health services was in 2010 (in Victoria), in the context of a drug induced psychosis. However over a fairly short, but intense, period of time ***[PATIENT #1]*** had not only created significant angst within the Bundaberg and Maryborough acute admission units he had also had several contacts with The QPS. Over a period of 2 months he assaulted and intimidated co-patients, absconded resulting in contact with QPS as a result of property offences and intimidation through threatening violence to members of the community and was sexually 'inappropriate' with a co-patient. These events occurred in the context of ***[PATIENT #1]*** being acutely psychotic.

On 21/09/2010 ***[PATIENT #1]*** was transferred to Ridley SMHRU as his behaviour could not be contained within the resources available at Fraser Coast IMHS. Although ***[PATIENT #1]*** had been charged with offences, these were not at the 'serious' end of the offending spectrum. Whilst his aggressive behaviour and overall behavioural disturbance was escalating at that time it was not inconsistent with other acute mental health presentations to many mental health services in Queensland. It is also important to note, that although this report was not made available to the investigation team, there is a clinical note made on 22/09/2010 which makes reference to a CFOS (forensic) assessment and report. Given that ***[PATIENT #1]*** was transferred to Ridley SMHRU it is assumed that the CFOS assessment did not recommend admission to the High Secure Inpatient Service at The Park which would have been the only other option available at that time (other than prison).

At the time of admission to Ridley Unit, with the criteria in place at that time, his presentation was not inconsistent with the admission criteria.

3.8.7 *[PATIENT #6]*

[PATIENT #6] was referred from Maryborough acute MH inpatient unit and admitted to Ridley SMHRU on 21/09/2005. He was diagnosed with Schizophrenia in 2003 but also has a significant history of substance abuse including 'chroming' and sniffing solvents. Although only 17 years old at the time of his admission to Ridley SMHRU, he had been in care for many years. He had on two occasions assaulted paid carers in the community and the last was the precipitant for his admission to Ridley SMHRU. It was clear that the Fraser Coast IMHS had concerns in relation to *[PATIENT #6]*'s impulsive behaviour and treatment resistant psychosis in a setting of low IQ and possible ABI associated with his substance abuse. At the time of *[PATIENT #6]'s* admission he met the criteria for SMHRU as he required long term contained care and treatment. It is a concern however that in excess of seven years later he was still an inpatient of Ridley SMHRU.

Table: Summary characteristics of the seven inpatients involved in the incident of January 19-20 in terms of the above criteria.

Table 18: Summary of patient characteristics at admission

Patient	Admis s Age	MHA Invol.	MI	Complexity	Aggression	Self-harm	Poor self care	AWP	Source
# 2	32	ITO	Paranoid Schizophrenia	Drug induced psychosis DX? Needed review of treatment	Y				Maryborough
# 3	44	ITO-FO	Paranoid Schizophrenia	AWP/Mental state deterioration	Y				Rockhampton/BHH
# 4	31	FO	Paranoid Schizophrenia	Mental state deterioration (past AWP, LCT breaches)	Y				Prince Charles SMHRU/BHH
# 7	44	ITO	Paranoid Schizophrenia	Head injury history, Personality Disorder traits	Y	Y			Emergency Department /BHH
# 5	46	ITO	Schizoaffective Disorder/BAD	Intellectual disability/PTSD	Y				Rockhampton/BHH
# 1	24	FO	Paranoid Schizophrenia	Drug induced psychosis DX?	Y			Y	Bundaberg
# 6	17	ITO-FO	Schizophrenia	Intellectual impairment, Substance Use Disorder	Y		Y		Maryborough

All the patients were diagnosed with a psychotic disorder (two also had a differential diagnosis of a drug induced psychosis) and had significant co-morbid disorders. The majority of patients were on Involuntary Treatment Orders at the time of admission (two patients were placed on Forensic Orders post admission). All had histories of violence as well as complex mental health problems and significant mental health care needs.

Although the Mental Health Alcohol and Other Drugs Branch have made it clear that SMHRUs (formerly referred to as Medium Secure Inpatient Units) are not part of the forensic mental health service system, it would appear that at times they are in fact used in that capacity. In addition, without specialist forensic mental health input into the management of patient care and in the managing of these environments, patients with forensic mental health needs are not systematically having these needs addressed.

Given the criteria in place at the time for Ridley SMHRU it would appear that on admission the presentation of the patients was not inconsistent with those criteria. While at least two of the patients involved in the incident had been referred by Ridley Unit at some point following their initial admission to the High Secure Inpatient Service at The Park (and accepted and waitlisted due to problems with bed availability). It is also important to note that both of these patients had been assessed by forensic mental health services prior to their admissions to Ridley SMHRU and it had not been considered necessary at that time to admit them to the High Secure Inpatient Service at The Park. However, it is the view of the investigator team that these referrals to HSIS were appropriate, indicating that at least two patient's risk management needs came to exceed the capacity of the Ridley SMHRU.

In addition, the investigators noted that there were difficulties managing the risk needs of ***[PATIENT #4]*** in the TPCH SMHRU, and it is likely that a referral to the HSIS would have been of benefit. ***[PATIENT #3]*** had a history of major violence both prior to his original SMHRU admission and during his current admission and could have been considered for referral to HSIS in relation to his history of violence and the 2009 offence for which he was placed on a Forensic Order.

On the basis of the available information the above patients' mental health treatment needs at the time of their admission were consistent with the cohort of patients that require SMHRU care.

3.9 Discharge processes and engagement with other HHS's

In the following table, discharge location is reported. In the 2012 Benchmarking report discharges were almost exclusively to inpatient settings. Two of the nine 2011 discharges were unplanned, i.e. due to death or AWOP. In the 2012 report, discharge destinations for SMHRU B were markedly different, 85% were to an "other" location. Discharge locations also displayed considerable annual variability.

Table 19: Discharge destination for Ridley SMHRU patients

Report year	Community MH	Acute unit	High Secure unit	Criminal justice	Extended treatment	Other
2005	31%	31%		6%	31%	
2008	14%	29%			29%	29%
2010	22%	22%	11%	11%	34%	
2012		29%	14%		43%	14%

At the 2012 census date, Ridley Unit reported the longest average (3.5 years) and median (3.1 years) length of stay. The respective figures for SMHRU B were 2.6 and 1.0 years. Data for SMHRU C and SMHRU D are difficult to make comparison with due to exclusion of outliers (patients with either very short or very long stays) from their data. The average and median length of stay for the Ridley patients in the 2012 report was longer than in previous years. Over half (58.3%) of the Ridley inpatients at the 2012 census date were Forensic Order patients, one of whom was an SNFP.

Interviews conducted with the ***[DCSMH]*** and the ***[CDEIS]*** on April 12, 2013 highlighted a number of factors that have relevance to this investigation. Firstly, both the ***[DCSMH]*** and the ***[CDEIS]*** noted difficulties with returning patients back to the referring service. Difficulties discharging patients will lead to increased lengths of stay, as well as pessimism for both staff and patients. As a result of difficulties returning patients, the ***[DCSMH]*** noted a practice that when patients no longer needed the SMHRU level of

treatment that patients would be admitted to a ward in Baillie Henderson Hospital, if there wasn't a community placement option. Several patients involved in the current incident had transitioned out of the Ridley SMHRU to an open ward on the Baillie Henderson Hospital, to be readmitted to the SMHRU at a later date. ***[PATIENT #3]*** had multiple such transitions and ***[PATIENT #4]*** was returned to the SMHRU on 21/12/2012 from Jacaranda ward.

The 2012 Benchmarking report profile of the Ridley SMHRU states: "The Planning for discharge commences when the patient is admitted to the SMHRU and includes liaison with the case manager from the referring district throughout the admission to update and involve those concerned with the plans for discharge. The referring community team is invited to attend case reviews". Review of the individual care plans or Patient Care Review Summary and Plan documents for the seven patients was undertaken. Three patients (***[PATIENT #2]***, ***[PATIENT #3]***, and ***[PATIENT #1]***) had a reference on their Mental Health Act Treatment Plan to LCT: "Graduated leave program dependent on mental state and cooperation with LCT provisions/conditions". ***[PATIENT #1]*** had LCT prior to the incident but his LCT was restricted in the days prior to the incident due to intimidation of other patients and a reported breach of his LCT conditions. ***[PATIENT #1]*** was the only patient with a recorded discharge goal: an individual care plan document (02/12/2012) recorded an objective "To return to living in the community" and the associated strategy: "Eventually move to open ward to begin process of future return to the community". A current care plan for ***[PATIENT #7]*** was not identified. Specific discharge pathways for the patients were not identified.

The ***[DCSMH]*** referred to recent meetings with the Mental Health Branch:

> they are going to start some bi-monthly, quarterly meetings about engagement with the districts, … so that there is engagement between all these four services about how to work on this proposed CCU transition.

While this is in relation to the development of Community Care Units, it is an opportunity to develop processes to facilitate the return of patients to referring districts.

RECOMMENDATIONS

15. Darling Downs HHS Mental Health Service management should ensure that discharge/external transition of care processes operate in accord with key components of the model of service (MoS), especially in relation to ensuring discharge planning is a component of each patient's recovery plan.

16. Darling Downs HHS Mental Health Service management should ensure processes are in place to support discharge planning. The MoS identifies a role for the SMHRU's care-coordinator in reviewing recovery plans and for referring district care-coordinators in maintaining a care.

3.10 System and Staff Factors

3.10.1 Local Factors

3.10.1 (a) Consistency of Ridley Unit Admission Criteria and Model of Service with the current SMHRU Model of Service

On 28th January 2011, the then Executive Director of Mental Health Alcohol and Other Drugs Directorate endorsed the MoS delivery document **'Secure Mental Health Rehabilitation Unit Model of Service'**. This document describes the purpose and functions of Queensland's Secure Mental Health Rehabilitation Units (SMHRUs) as well as the intended patient group. While there will be a degree of service variation in response to local circumstances the Model of Service delivery was intended as a State-wide blueprint for SMHRUs.

SMHRU target population

The SMHRU Model of Service (2011) document describes the intended population of a SMHRU. **Section 2 titled states:**

"Who is the service for?

The SMHRU provide a safe and structured environment and 24 hour clinical support for adult consumers generally over the age of 18 years with persistent and disabling symptoms of mental illness. The diagnostic profile of consumers admitted to SMHRUs consists mainly of schizophrenia/related psychosis and mood disorders. Consumers often also have complex presentations including issues with personality

disorder, drug and alcohol disorders, complex trauma and clinically significant deficits in psychosocial functioning. SMHRU are intended to target people with complex needs who are unable to be adequately treated in less restrictive settings, due to symptoms of mental illness, and associated issues of behaviour and risk which indicate a need for rehabilitation. Behaviour disturbances experienced by consumers include:

- Severely disorganised behaviour leading to difficulty in managing activities of daily living;
- Impaired impulse control;
- Vulnerability;
- Ongoing risk of aggression; and
- Significant risk of self harm by commission, omission or misadventure.

Additional services may be provided to individuals under 18 years of age, who are in the above population targets and who cannot be safely managed in less restrictive settings within district mental health services.

The Mental Health Act 2000 status of consumers in SMHRU includes those on involuntary treatment orders and/or forensic orders as well as a small number of classified and special notification forensic patients.

Length of stay will vary, depending on the needs of individual patients. Ongoing assessment and recovery planning determines when discharge is appropriate for each patient". (pages 3-4)

There are two issues that the investigators would like to raise regarding the admission criteria in force for Ridley SMHRU.

Firstly, the Investigators noted inconsistency across documents that are used to describe Ridley Unit Model of Service (MoS). The Orientation Manual and Business Planning Framework documents (below) appear to place less emphasis on rehabilitation than the 2011 SMHRU MoS. It is important to recognise that the 2011 SMHRU MoS superseded the 2003, 'A Model of Service Delivery for: Medium Secure Treatment Services in Queensland' (2003 MSU MoS). The difference between the

two MoS delivery documents, in terms of target population is in practice, quite significant.

Section 7.3 of the 2003 MSU MoS outlines the target population criteria. The criteria follow.

"Medium Secure services are targeted at adults who:

- Have a mental health problem characterised by acts of serious physical violence, and /or persistent assaultive behaviour, or risk to self and/or others;
- Are assessed as requiring a period of inpatient treatment to achieve clinical improvement;
- Due to severity of disturbance or anticipated duration of treatment required, cannot be appropriately managed within an acute High Dependency Unit
- Do not pose a level of risk at which a breach of security would result in an unacceptable threat to the community". (page 7)

The focus of these criteria suggest that historically a key purpose of MSUs was to manage risk, particularly violence risk, that could not be adequately managed in general acute authorised mental health services (AMHSs). In this regard, conceptually, it could be argued that across the state there was a spectrum of AMHSs for the management of risk, beginning with acute AMHSs, progressing to MSUs and ultimately the High Secure Inpatient Service. The 2011 SMHRU MoS differs, in that there was a change of focus in the role of units formerly known as MSU to SMHRU, with an emphasis on rehabilitation of individuals with complex needs, that may include violence risk.

The admission criteria (see below) and program purpose in the 'Orientation Manual and Business Planning Framework', appear to be based on the 2003 MSU MoS.

Admission criteria outlined in the Business planning framework dated 16/08/2012: page 4 and the Ridley Extended Care Unit: Staff Orientation Manual dated 19/02/2013: page 10:

Admission Criteria

- Adults aged 16 years or over who reside within designated catchment areas.
- The need for assessment and/or treatments in a medium secure inpatient unit that cannot be provided in other acute or high dependency units or other extended inpatient clinical program settings.
- Acts of serious violence or persistent assaulting or harming behaviour toward others or severe disorganisation leading to gross harm to self, associated with mental illness.
- Meeting these criteria and subject to the involuntary provisions of Part III or IV of the Mental Health Act 2000 and subject to a process of negotiation to achieve admission.

Such a contradiction across documents could impact on not only the organisational understanding of admission criteria, but also the function of a unit. There should be consistency and currency across documentation regarding the MS and further, it is important that all staff are clear about the MoS in the environment in which they work.

Secondly, there is potential for confusion about the age criteria for admission to the Ridley SMHRU. The SMHRU MoS defines the age criteria as "generally" 18 years and older, suggesting some flexibility in this regard. The *Referral and Admission to Extended Inpatient Service (EIS) Toowoomba District Mental Health Service procedure* (TDMHSProc03392v4) endorsed on 18 December 2007 with a review date of 18 December 2009 is a generic procedure for all extended inpatient services in Toowoomba, which states "The admission and exclusion criteria for specific program areas are outlined in the Model of Service Delivery". This procedure therefore cross-references to the MoS document. In contrast, the Ridley Extended Care Unit: Staff Orientation Manual (19/02/2013) and the Business planning framework (16/08/2012) refer to the age criteria for admission as 16 and above. The SMHRU MoS does highlight, however, that admission of individuals less than 18 is a 'deviation' from the usual age group.

The investigation team believes that whilst such practice is not necessarily inconsistent with the MOS, there is a risk that young people aged 16 and 17 years old may be managed in the same way as adult patients. The team would suggest that it would be preferable if patients younger than 18 years are accepted for admission a specific management plan cognisant of the increased vulnerability and risk of these young people must be incorporated into the referral and admission processes.

Thirdly, at the time of the incident, Ridley Unit was fully occupied and had 23 male patients and only 1 female patient. The investigation team did not see evidence of specific gender sensitive practices or procedures in place for the Ridley SMHRU. This is not to suggest that such issues were not considered, just that there was no clear documentation to support a clear and consistent approach to the complex issues of managing a mixed gender environment, where female patients will inevitably be the minority.

RECOMMENDATIONS

17. Darling Downs HHS Mental Health Service management should ensure all documentation relating to referral and admission processes are reviewed for consistency with the current MoS for SMHRUs.

18. Darling Downs HHS Mental Health Service management should develop a protocol for the management of 16 and 17 year old patients, in the event there is no alternative but to admit them to Ridley Unit, which considers issues of meeting educational and other developmental needs and managing specific risks associated with this client group.

19. Darling Downs HHS Mental Health Service management should develop a 'Gender Sensitive' protocol that will ensure the safety, health and well-being of female patients admitted to Ridley Unit.

3.10.1 (b) Confusion regarding the recovery model

The concepts of recovery and risk management are central to contemporary mental health provision. While these concepts may seem incompatible, causing harm to others and the consequences of this do not assist recovery. The second consultation draft of the Recovery-oriented Mental Health Practice Framework (Craze 2012)

clearly recognises a need for a balance between positive risk taking to promote recovery and the duty of care staff have. Following the 2006 Butler Promoting Balance in the Forensic Mental Health System report, in relation to forensic patients a staff responsibility for community protection was enshrined in the Mental Health Act.

The *[CDEIS]* made the comment, reflected in the literature that the recovery model "means different things to different people". The way staff on the night shift at Ridley interpreted the rehabilitation model boiled down to other staff letting the patients do what they liked. It was used to justify allowing patients to stay up smoking, listening to music and socializing in the Atrium until they felt like going to bed. Reduced sleep also has a range of consequences such a as the potential to increase irritability, impact on mental state and reduce participation in rehabilitation activities.

Practices such as allowing patients to stay up late at night and not conducting searches or screening visitors, are not hallmarks of the recovery model. It is important that care and treatment acknowledge and seek to facilitate the recovery goals of patients. This does not mean minimising concerns regarding risk and risk management or not making difficult decisions that place restrictions on individuals.

As noted, Ridley staff were not familiar with concepts such as relational security and while some staff had attended recovery related training, the understanding of how these practices relate to each other was not generally evident. It is hoped that an outcome of this review is that both components of contemporary mental health practice can inform the care and treatment of Ridley patients in the future. The UK National Health Service has developed a resource entitled '*Your Guide to Relational Security. See Think Act'* which provides useful guidance regarding developing secure environments that are also therapeutic.

RECOMMENDATION

20. Specific training should be developed and provided to facilitate a practical understanding of how recovery principles can be applied in a SMHRU.

3.10.1 (c) Multidisciplinary team functioning and treatment planning

Interviews with staff did not generally elicit concerns regarding significant interdisciplinary conflict. The ***[CDEIS]*** in his interview referred to differences with nursing staff about the length of time LCT should be suspended following breaches of LCT related to substance use, however he was not critical of nursing staff more generally and nursing staff in the main spoke with respect regarding the ***[CDEIS]***. Similarly, allied health staff was not critical of their colleagues and felt that their contribution to the ward team was welcomed and accepted. However, of the night shift nursing staff interviewed there was a sense of being disconnection from the general team decision making. This is not unusual in a night staff workforce that works exclusively or predominantly night shift and has been referred to in other sections of this report regarding the real and perceived isolation they can experience.

Patient care and progress are reviewed at a weekly multidisciplinary team meeting. These meetings are variously described as running between two and four hours. All patients are reported to be discussed at the meetings and the meeting book excerpt of January 14, 2013 confirms this. However, with maximum efficiency this allows for five minutes discussion per patient (assuming a two hour meeting). Recent incidents, code reviews and patient activities were the matters typically discussed at this meeting. National standards require that individual care plans are reviewed three monthly. The investigators were advised that at the team review this requirement may "fall by the wayside":

> *'…. sometimes you think things probably aren't discussed as in much detail as they should be and that's due to discussing twenty-four people every week. People tend to get overlooked really because sort of long term chronic treatment resistant, schizophrenia nothing much changes in their mental state or anything like that'.*
>
> Each patient's most current Individual Care Plan (ICP) at the time of the incident was requested and reviewed. Only three patients (***[PATIENT #4]***, ***[PATIENT #5]*** and ***[PATIENT #1]***) could be considered to have a current ICP. The ICPs for ***[PATIENT #2]***, ***[PATIENT #3]*** and ***[PATIENT #7]*** were all dated 2011. It is understood that some of the most out of date ICPs have now been updated. Involuntary

patients are also required to have a Mental Health Act Treatment Plan (MHATP). MHATPs were supplied for only three patients. These MHATPs tended to be more comprehensive than the ICPs. Dates for these plans and the risk assessments, which also are required to be reviewed three monthly, are detailed in the following table. Some ICPs were stand alone documents while other ICPs were included in a Consumer Care Review Summary and Plan.

Table 20: Completion date for risk assessments, MHA Treatment plans and Individual Care Plans

Patient	Risk assessment date	MH Act Treatment plan	ICP
# 2	20/05/2012	04/04/2011	01/09/2011
# 3	13/01/2013	Undated	11/10/2011
# 4	30/11/2012	Not located	30/11/2012
# 7	03/07/2012	Not located	7/04/2011
# 5	15/01/2013	Not located	15/01/2013
# 1	02/12/2012	undated	02/12/2012
# 6	05/06/2012	Not located	5/06/2012

The content of these plans, for each patient, are detailed in section 3.6. ***[PATIENT #1]***'s ICP is the only plan that makes reference to "eventually" moving to an open ward before a "future" return to the community. His ICP was included in a Consumer Care Review Summary and Plan document (as was ***[PATIENT #4]***, ***[PATIENT #7]***, ***[PATIENT #5]*** and ***[PATIENT #6]***). The MHATPs of ***[PATIENT #2]***, ***[PATIENT #3]*** and ***[PATIENT #1]*** made reference to graduated leave plans but not other detail is provided other than such a plan is dependent on mental state and cooperation with LCT conditions.

The last team meeting prior to the incident was held on January 14, 2013. Recorded as present were the ***[NUM]***, a Clinical Nurse, the IMHW, the Activities Program Coordinator, the ***[PRU]***, a Registrar, and the ***[OTRU]***. A note in [***PATIENT #2]'s*** file suggests the ***[CDEIS]*** may also have attended. The Registrar advised that he was performing a brief locum at the time.

Discussion regarding the above patients on January 14, 2013 is recorded in the Clinical Team Meeting Book as follows:

[PATIENT #6] Generally doing well. Utilising bike on grounds. Increase Blue 45 minutes x 4/day

[PATIENT #3] Unchanged in ward. Continued issues with $ scanners and police.

[PATIENT #2] O.T and psychologist graphed ADL's. Discussed how hygiene deficiency may effect leave. To discuss with ***[PATIENT #2]*** and make referrals to groups. Code blue for groups. For decrease Clozapine as levels 780 (decrease to 400 mg).

[PATIENT #4] Ongoing frustration at continued stay in Ridley. To follow-up on possible interferon treatment. For code yellow on grounds.

[PATIENT #7] Remains labile in mood. Ongoing frustration at hospitalisation. Trial code blue for groups.

[PATIENT #1] Remain code red. Possible move back through codes once settled. Hostile and angry this a.m.

[PATIENT #5] Generally settled. For blue for groups. Encourage engaging with rec officer for exercise on grounds.

Clinical review meetings rely on having reliable information, including comprehensive accounts of both adverse incidents and progress. Files without entries for several days, especially where a patient is considered a moderate or high risk of violence is of concern. Another example of concern is where a PRIME entry was more comprehensive than the clinical file entry. The clinical file should be a primary source of communication between clinicians.

A further example of this is the manner in which clinical documentation is filed within Ridley Unit. Important aspects of a patients' clinical record are not actually filed in the patients' medical record. There are currently folders divided into specific patient 'cohort teams' and these contain important assessment and care planning documents for most patients (in reviewing these folders there was inconsistency in what was contained within the folder for each patient). These folders were observed to be sitting on the bench in the staff station. It is problematic if all clinical

information is not securely stored within a uniquely identified patient record, which does not appear to be the case at the moment on Ridley unit.

With the greater emphasis on electronic recording of patient records, and with the impending iEMR roll out within the next 18 months, it is important that staff of Ridley unit are beginning to increase their use of available electronic record management systems. For mental health this system is known as CIMHA. Whilst there has historically been clinician resistance to the use of CIMHA and it initially had significant problems in its user friendliness, capacity to pull reports and the level of perceived duplication required in moving between screens and templates, there have been recent enhancements that have improved the functionality of the system. There is an expectation that all Queensland mental health services will use CIMHA for what is called the 'minimum dataset'. In reviewing a sample of Ridley unit clients there is very little data included on CIMHA and often the information that is there, is out of date. In discussing the issue of use of CIMHA staff fed back that they had very limited access to computers in order to increase their confidence in using applications such as CIMHA, but also in inputting necessary information into CIMHA.

RECOMMENDATIONS

21. Weekly clinical review meeting processes should be reviewed to decrease the number of patients discussed and thereby facilitating a greater opportunity for detailed discussion. The care review and management plan should be adequately documented in the patient record. Ideally every patient should be discussed once per fortnight, however daily handovers should facilitate the need to address urgent matters.

22. Within the weekly clinical review at least 30minutes per meeting should be allocated for a comprehensive review of a patient's Individual Care Plan (ICP), risk assessment and general progress which must occur on a 3 monthly basis as required by The National Standards for Mental Health Services (Standard 10 Delivery of Care Assessment and Review Criteria 10.4.6). If two patients have this review each week the 3 monthly requirement would be met.

23. ICPs should include patient recovery goals and identified discharge preference as well as staff identified concerns. Input from the patient, multidisciplinary team and

care coordinator should be reflected in the ICP to ensure plans are comprehensive and reflect current issues.

24. The current clinical documentation audit process needs to be reviewed to ensure plans are updated as required and there is an accountable evidence trail. The audit process must include quality and frequency of entries.

25. A comprehensive review of clinical documentation must be undertaken as soon as possible. Some issues that were identified in this investigation that must be addressed include:

a) ICPs and risk assessment are kept in a separate folder in the staff station and separated from the clinical file;

b) Some patients had no entries for several days;

c) The CIMHA minimum dataset does not appear to be adhered to and is not regularly updated; and

d) Aspects of the 'filing system' in the clients' clinical records are a potential source for confusion e.g., the 'Risk Screen" was filed under the Other Investigation tab and MHRT under legal, some care plans are filed under Allied Health.

3.10.1 (d) Clinical risk processes and risk mitigation

The suite of forms developed for Queensland mental health services contains a Risk Screening Tool (RST). This RST is intended as a screen and where there are significant issues of risk, a more comprehensive assessment is required. It is likely that staff of Ridley Unit undertake regular, informal assessments of risk, however, these are neither consistently, systematically or comprehensively documented.

As Table 21 (section 3.10.1(c)) indicates ***[PATIENT #2]***, ***[PATIENT #7]*** and ***[PATIENT #6]*** had not had an updated risk assessment conducted in the six months prior to the incident. This is of particular concern in the case of ***[PATIENT #2]*** given he accounted for 20% of aggressive incidents for the ward over the period 2011-2012.

It would be expected that the risk assessments undertaken in a SMHRU would be more comprehensive, frequent and sophisticated, than would occur in less secure mental health settings. Such assessments would include the identification of early

warning signs, potential triggers and scenarios where risk is more likely. It is acknowledged that for some patients Community Forensic Outreach Service (CFOS) assessments had been obtained, but these should not be relied upon as the only assessment informing risk and by consequence implementing appropriate and timely risk management. This will always continue to be the responsibility of the relevant treating team.

With the exception of the risk assessments for ***[PATIENT #2]*** and ***[PATIENT #7]***, the remaining risk assessments consisted of simply making a Low, Medium or High rating. There was no evidence of narrative accounts of risk factors, early warning signs or what harm the patient was assessed likely to cause, or to whom.

Table 21: Risk assessment ratings

	Aggression	AWOP	Suicide	Self-harm	Vulnerability
#2	H	H	M	M	M
#3	M	M	L	L	M
#4	H	M	M	M	L
#7	M	M	L	L	H
#5	M	L	L	M	L
#1	M	M	L	L	L
#6	M	M	M	M	M

There did not appear to be risk management plans for the patients. It could be argued that these are incorporated into treatment plans, however, incorporation of such assessments in treatment plans did not appear evident to any significant degree. The absence of documented comprehensive risk assessments or treatment plans limits the scope of risk mitigation strategies, which in the documents reviewed were limited in detail and not individually tailored.

In addition to individually based risk management strategies, practices such as allowing patients to be awake late at night and congregate in large numbers is considered problematic. The other notable opportunity factor associated with risk, is

the metal table legs, which PRIME reports identified have previously been employed, or attempted to be employed in assaults.

It has to be acknowledged that Ridley Unit staff did identify recent tension in the ward and the ***[CDEIS]*** provided a memorandum titled, "Drug used in Ridley". This memorandum dated 17/01/2013 was sent to the ***[DCSMH]***, Director of Clinical Services. Two patients (one of whom was ***[PATIENT #1]***) were identified as intimidating patients to bring illicit substances into Ridley Unit. A request was made to allocate a security officer to the ward to facilitate the separation of the two patients who would be accommodated in the ICA area and monitored by a nurse and a security officer. This was described as a short term plan. It is unclear whether this plan was to be approved. Whilst we acknowledge this was a proactive strategy by staff to manage an increasingly difficult situation, the investigation team would not have advocated the approach outlined. There are a broad and complex range of factors that contribute to drug seeking behaviour within a secure environment and in the absence of identifying and addressing these, segregating two patients within ICAs is unlikely to address the underlying problems.

Additionally, it has to be acknowledged that Ridley Unit has implemented general risk mitigation strategies in line with contemporary practice in some areas (e.g. minimising use of seclusion, as relatively low use of PRN and lower prescription of multiple different drugs of the same class, e.g. antipsychotic medication)- and that in the case of ***[PATIENT #2]*** there was an attempt to develop a positive behaviour management plan to address his aggressive behaviour.

Assessment of imminent risk of violence

In addition to reducing violence risk more generally, responses to imminent violence risk need consideration. This will include consideration of environmental factors (3.10.1(k)), treatment planning (3.10.1(c)) activity (3.10.1(e)) and relational security (3.10.1(b)). Training in identifying behaviours of concern as well as appropriate responses to such behaviours is essential. The Dynamic Appraisal of Situational Aggression –IV (DASA IV) is a short and simple to use risk assessment tool that has effectively been used in the High Secure Unit at Wacol to identify imminent risk of violence. This is a validated tool that has also been used in other secure settings throughout Australia and in Singapore, the United Kingdom and the Unites States of

America. Another consideration is prompt response to aggressive behaviour. Section 3.3.1 (point 2, page 32) included an incident on 25/12/2012 involving [PATIENT #2]. While there may be valid reasons why a response was delayed it is preferable that such outbursts are contained quickly, for the sake of both patients and staff. Further, reducing patient victimisation is a valid strategy to reduce overall violence and ensures boundaries are applied. There is evidence in the documentation reviewed by the investigation team that in the period leading to the incident at least one patient complained of having been intimidated and bullied by a fellow patient to obtain drugs for him during a period of unescorted leave within the community. This is an issue that must be addressed through procedural responses to management of the environment and patient leave. Searching on return from leave, a period of 'segregation' from other patients post leave, requirements for patient accountability for their money and strict adherence to patient property lists are some examples to minimise the risk of such behaviours.

RECOMMENDATIONS

26. A risk assessment management plan should be developed for each patient. The plan should identify relevant risk factors, early warning signs and risk management strategies. This plan could be incorporated into the ICP.

27. Patients with frequent aggressive behaviour require a positive behaviour management plan. In instances where such plans don't prove effective further consultation with a specialist forensic mental health service is indicated.

28. Training should be provided regarding developing risk assessment plans. A review of risk management practice should also be undertaken and training provided to address any knowledge or skill deficits. Staff should be familiar with the principles and practices of environmental, relational and procedural security.

29. Use of the DASA-IV should be considered to ensure consistency of assessment and response in relation to aggressive behaviours.

30. Procedures should be established to provide a consistent, accountable approach to management of patient leave within the community that includes patient searches, risk assessments pre- and post-leave and management of items entering Ridley Unit.

3.10.1 (e) Rehabilitation programs

Meaningful activity is essential for all human beings and is even more important to reducing boredom, which is a factor associated with inpatient aggression, within a secure or restricted environment. Rehabilitation programs also support patient recovery, of which hope for the future is an important factor. The attitudes expressed and inferred suggest that both staff and patients appear to have 'lost hope' for the future of Ridley clients and what they can aspire to and achieve. The following table indicates the activities undertaken by allied health staff before the incident with the seven patients involved in the critical incident. It should be noted that patients with certain codes could also attend programs at the Rehabilitation and Recovery Centre, onsite at Baillie Henderson Hospital. However, availability of these programs has reduced in recent times

Table 22: Allied health input

Patient	Psychologist	OT
# 4	Too unwell	Smoking cessation; self-care; cooking
# 7	Recent admission	Diversional/anger issues; self care; smoking
# 3	Band-aid regarding delusions (challenging, calm); shopping trips; behaviour observations in the community	Managing symptom moments
# 1*	Substance use (10 x MI); smoking cessation	Cooking; walking; diversional
# 6*	Doesn't engage; bus escorts; family escort	Not engaged
# 5	Rapport building	Cooking program; walk; diversional
# 2*	Had been seeing for 18 months x 2 per week: relaxation; mindfulness; stress and coping; anger management; emotional regulation; smoking cessation; behavioural plan –struggled to transfer to daily living	Self-care; cooking; skill development

** Some attendance at rehabilitation and recovery centre*

The ward psychologist reported having worked with ***[PATIENT #2]*** twice-weekly for 18 months on a behaviour management plan, which has lapsed about six months ago, due to patient disengagement. ***[PATIENT #1]*** was also reported to have received 10 sessions of motivational intervening in relation to his substance use. These would appear appropriate interventions but it is also important, and achievable within the secure nature of the environment, that there is some type of evaluation of the success of these interventions as it would appear that they may not have had the desired outcome. This is not unusual and it is often the case that the same program needs to be repeated several times for it to have a longer lasting impact for a patient when their behaviours are entrenched. When there is capacity as a result of the length of stay of a patient to repeat and further refine an intervention this should be seen as an opportunity and not a failure.

> In addition to the above programs**,** the ward psychologist did refer to the provision of individually based substance use and anger management interventions. Such interventions do not appear in ICPs of the above patients.
>
> Allied health staff advised that the social work position for Ridley Unit has been vacant for much of the time from July 2011 (the last social worker on a contract was reported to have ceased in this position in October 2012). Prior to the current social worker commencing early February 2013, the allied health staff reported difficulty providing programs as well as assisting with escorts.

It is important to note that the provision of rehabilitation programs must be the responsibility of all staff, not just Allied Health or off unit Recreational/Rehabilitation staff. Embedding a culture where all staff believe that they can make a meaningful contribution to the daily lives and recovery of patients is essential in instilling the concept of 'hope' for staff. An example of this is The Structured Day that has been developed at The Park, High Secure Unit. This is a program has it's beginnings within the Correctional system but have been adapted to have relevance for a healthcare environment. An important component of The Structured Day is the need for there to be equal collaboration and commitment for its success by staff and patients alike. This means that all staff must be prepared to become involved in facilitating meaningful activity for patients whether this is a therapeutic group or a diversional activity. A formal evaluation of The Structured Day in a high secure forensic mental

health service in Victoria in 2008/09 identified that its implementation saw improvements in job satisfaction by staff (a quote from a nursing staff member was, “I don’t know why we stopped doing these sorts of activities with patients, it makes me feel good to interact with patients in a different way about their lives”) and whilst there was no improvement in patient acute symptoms as measured by HoNOS, there was improvement for patients in viewing staff in a more positive manner and in their overall social and emotional connectedness. Patients reported that they felt less lonely and isolated.

In recent years nursing staff working within mental health environments have lost confidence in their skills and abilities to facilitate meaningful educational, vocational, recreational and therapeutic activities with patients and as a consequence they often are avoidant of this type of activity. It is imperative for mental health nursing staff to reconnect with this aspect of their practice as it has the potential of not only increasing their job satisfaction and promoting recovery of their patients, but also is one of the most important aspects of managing risk within a secure mental health environment- knowing and understanding their patients.

It has been suggested in many forums that it can be difficult to engage patients in rehabilitation programs, however it is important to note that it is a requirement of patients residing in long term mental health care that they must be actively participating in rehabilitation activities in order to continue to qualify for the Disability Support Pension. If there is not an internal motivation and incentive for a patient to participate this can provide an important (if coercive) incentive for patients. It is important for staff and patients to fully realise the obligations associated with income from a DSP.

Another important consideration in instilling a rehabilitation program that emphasises recovery, is the engagement of patients. The investigation team saw two documents allegedly written by patients involved in the incident. These ‘open letters’ to staff outlined what some patients considered to be the issues on Ridley unit. Whether these were accurate or not (although the investigation team did believe that these documents were insightful and quite accurate in their assessment) the most important aspect of their existence is what was done in response to them. The investigation team has no visibility of any actions taken in response to receiving these letters. This would suggest that there is not an environment where patient

feedback is acknowledged or valued. Whilst this may not be the case, in the absence of any evidence to the contrary we must form this conclusion.

RECOMMENDATIONS

31. Priority should be given to the introduction of a comprehensive rehabilitation program that promotes meaningful occupation for all patients and is the core responsibility of all staff and as a minimum all patients have access to vocational, educational, recreational and therapeutic programs.

32. A system that facilitates consumer feedback in day to day operations, as well as strategic planning, should be developed. This can only be achieved through the engagement of the existing paid peer and consumer staff of DDHHS as well as consideration being given to the establishment of a consumer representative position from the existing Ridley Unit patient population.

33. All nursing staff allocated to Ridley Unit should undertake re-skilling programs focused upon improving their skills and enhancing their confidence in providing rehabilitation programs for patients.

34. Opportunities for replacing the functions of the Recreation Officer positions that were recently abolished should be explored. This may include identifying opportunities with the private or not for profit sector in establishing a joint initiative (e.g. YMCA).

3.10.1 (f) Workforce Issues

For a variety of reasons, some staff at Baillie Henderson Hospital has chosen to work permanent night duty shifts. Staff allocated to Ridley Unit night duty, work on a rotational basis – 6 months in Ridley Unit and 6 months in another Unit of Baillie Henderson Hospital, but still on night duty.

It is very clear, and well documented, that working permanent night duty can cause professional and organisational isolation. A number of health services have made a definitive decision to move away from having a permanent night duty workforce to ensure staff are effectively engaged and identify with the organisations 'corporate objectives' as well as ensuring staff have appropriate access to resources such as training and education, clinical and operational supervision and do not become

deskilled in some aspects of nursing (whilst not exclusively, night duty staffing is predominantly nursing) care, for example undertaking therapeutic and group intervention, undertaking mental state and risk assessments, development and presentation of care plans, escorting of patients etc.

This isolation from the broader functioning generally of Baillie Henderson Hospital and in particular Ridley Unit, gives rise to a perception of themselves as a beleaguered minority under constant and imminent threat. Whilst it is clear that efforts have been made by Baillie Henderson Hospital management to ensure that permanent night duty staff are engaged in some education and training as well as significant unit decision making, this does not adequately address the significant marginalisation of the night duty staffing workforce.

This issue is further complicated by what only could be described as the unusual rostering pattern used at Baillie Henderson Hospital and Ridley Unit, specifically. There are three shifts that cover the 24 hour day; 6am to 2pm; 2pm to 10pm and 10pm to 6am. This roster configuration does not allow any overlap between shifts, even for the provision of handover. The investigation team was advised that in order to provide a handover the oncoming shift generally arrives for their shift 15 minutes early and this is when the handover occurs. A shift handover was observed by a Ridley Investigation team member. The handover took place between the morning and afternoon shifts on 29th May 2013. The handover commenced at 1350 hours and concluded at approximately 1415 hours. All afternoon shift staff were in attendance, however the handover discussion was only between the Clinical Nurses from the morning and afternoon shifts. Overall it was a thorough and considered handover with pertinent information in relation to individual patients and their care being imparted in a professional and respectful manner. It was clear however that 10 minutes may not always be an adequate time period for a comprehensive handover. It is also concerning that the only way a handover is possible within the current rostering configuration is to rely upon the 'goodwill' of staff to undertake this activity in their own time. It is also important to note that the current shifts are 8 hours in duration. Unless the nursing staff are working a non-RDO accrual roster, this does not build in what should be a mandatory meal break within the shift. It was suggested that nursing staff on Ridley Unit currently receive 30minutes overtime in lieu of a meal break. Whilst they do take time out of the unit duties to have a quick

meal during the course of their shift, they do not leave the unit to do this so that they are still available in the case of an emergency. When a sample of nursing staff were asked to provide their opinion of whether the current practices regarding their roster configuration were appropriate they were very quick to defend the current practice and all indicated that this was their preference for their rosters and they would not support any change that would result in a 30minute shift overlap.

There is a real sense of grievance by Ridley Unit night duty staff that the effects of the change of system which put an end to locking the doors to patients' rooms at night, were not recognised and reflected in increased staff on night shifts. Their point is that, when the bedrooms were locked at night, 4 staff on night duty were adequate to meet the operational requirements undertaken by night staff, such as observations and some paper work such as chart audits.

With the unlocking of the patient bedroom doors at night, patients are free to move about at any hour during the shift. The character of the duties of the night staff has, therefore, changed, they say, but without a corresponding alteration in the level of staffing.

In the ***[NDRSMH]'s*** opinion a roster of four nurses is sufficient for a normal night in Ridley. (Volume II Document 12 Page 52)

[STAFF #2] in his second interview (Volume II Document 11 page 34), made a comment that does not support the view that the Ridley night duty staffing is inadequate and reinforces earlier comments in this section about the marginalisation and isolation that can be experienced by permanent night duty shift workers. He said:

> *"I believe on night shift I just had too much free time where I could just stew over the whole thing, so they put me back on days for a month, and I'm returning back to work tomorrow night".*

The fact that ***[STAFF #2]*** recognised that there was greater support and activity during other shifts would support a view that the practice of having permanent night duty staff should be ceased or at least reviewed. It is not fanciful to suspect that, while ***[STAFF #2]*** "had too much free time where I could just stew over the whole thing" other night staff may have "too much time" to stew over how vulnerable they are and how

unconcerned management is about the dangers posed by their changed circumstances.

In response to the concern expressed by staff regarding the night duty staffing of Ridley Unit, the investigation team believe that they should make some comment. There are many benefits associated with patients not being locked in their rooms at night. Whilst it does mean that they are less 'contained' within a therapeutic hospital environment it is very important for staff having a positive working relationship with the clients in their care. 'Knowing and understanding' your client is the best possible clinical risk management intervention. Although risk issues form a component of the shift handover and there is capacity to read the clinical notes, this does not compensate for having a personal knowledge of a client's normal routines and behaviours, current stressors, like and dislikes and what strategies/interventions they usually respond to allowing for early identification and intervention if things are beginning to escalate. This aspect of working within a secure mental health environment is referred to as 'relational security'. When there is a combination of permanent night staffing and night duty shift working hours of 10pm to 6am, if patients were locked in their bedrooms just prior to night duty staff arriving for shift there would be very little opportunity for meaningful interaction between Ridley Unit clients and the night duty staff. This in itself introduces an unnecessary risk.

As already outlined, it was suggested to the investigation team that the night duty staffing of Ridley Unit should be consistent with the staffing on morning and afternoon shifts. This is a 'simplistic' view of how staffing profiles should be established. It is unclear if the nursing staff profiles for Ridley unit have undergone a nursing Business Planning Framework (BPF) evaluation and benchmarking exercise with 'like' services. We were provided with a copy of a document that benchmarked a range of Medium Secure Rehabilitation Service processes and activities. However, in determining staffing profiles it cannot be assumed that the other MSRS are 'like' for comparison purposes. For example the physical environment, access to other resources on campus at short notice, unit procedures, patient demographics, programmatic structure, client leave arrangements, client educational, vocational, therapeutic and other rehabilitation activities available etc, all have an impact on determining an appropriate staffing skill mix. For the same reasons, night duty staffing would generally always be at a lower level as a result of reduced client and

unit activities undertaken during the night. At night (unless there is an emergency) there are no patient escorts, there are no therapeutic individual or group activities, there are no case reviews and other clinical administrative processes, there are only limited professional development opportunities, there are no medical or allied health interviews that may necessitate the involvement of nursing staff…. This is not an exhaustive list but an example of the differing levels of activity. In determining staffing levels and skill mix, it is very important to ensure that all staff have an understanding of what are the determinants for establishing a staffing profile and what are not. For example a staffing profile should never be established based upon 'worst case scenario' or 'any eventuality that could arise'. This would lead to a completely 'unaffordable' (and unnecessary) staffing profile, particularly within an Activity Based Funding (ABF) environment. What then becomes critical is looking at the service system as a whole and what resources are able to be mobilised in an emergency situation to respond to any type of incident across the campus.

It was also noted by the investigation team that one of the staff named as having been involved in the incident was listed as a 'Student Nurse'. Whilst we do not make any judgments regarding the skills and expertise of this particular staff member we would suggest that the practice of using Student Nurses as an 'AIN- unqualified nurse' on night duty is not desirable. Whilst we recognise that this staff member was allocated above the normal staffing levels as a result of a patient from another Unit being accommodated in Ridley Unit HDU area, it would be preferential to have all staff allocated to night duty, which is the period of the lowest level of staffing and therefore more reliant upon a workforce that is appropriately qualified and skilled, qualified at either Enrolled Nurse (EN) or Registered Nurse (RN) level. Currently there are no night duty nursing positions classified at AIN level within the staffing profiles and we would support this being maintained. If there is a necessity to employ Student Nurses as AINs for the purpose of attracting them to choose to work in mental health after they qualify and to meet a shortfall in qualified nursing numbers, these AIN staff should be allocated to shifts where there is greater access to education, training and supervision and not to night duty.

Commentary was also made by some staff regarding the physical capacity and capability of some of the staff who currently work on Ridley unit. In some cases this was linked to the age of the individual staff. Whilst we do not support 'age

discrimination' we do believe it is necessary to ensure that staff working within higher risk areas have the ability to meet their full role and responsibilities. There is a view that every interaction with a patient is a therapeutic opportunity and this includes managing a patients aggressive behaviour. Therefore it is necessary for all members of the clinical team to have the confidence to assist in managing patient aggression. The investigation team however was advised of occasions when some staff, who clearly were not confident in their capacity to assist in managing an aggressive incident, withdrew from the situation leaving their colleagues vulnerable. This should never occur as it is potentially harmful to the physical and psychological well-being of all, including the staff member who withdraws as the 'guilt and shame' of what occurred can have a profound impact. It is therefore necessary for the Baillie Henderson Hospital management to review the suitability of staff currently rostered to Baillie Henderson Hospital to either move them to another area, or to identify clearly defined roles within the clinical team that fit with the staff member's capacity and ensure that they are not required to become involved in managing aggressive incidents.

RECOMMENDATIONS

35. It is recommended that the practice of having permanent night duty staff at Baillie Henderson Hospital be ceased through negotiation with current staff or through natural attrition.

36. Until recommendation 35 can be achieved it is recommended that Ridley Unit staff on permanent night duty be required to be rostered to a minimum of one four week period of day duty and one four week period of afternoon duty in each Calendar year.

37. It is further recommended that the mandatory training requirements specified by Queensland Health and Darling Downs Executive management are enforced. This can be achieved through either adopting the above recommendation, providing mandatory training for all staff on night duty with appropriate backfill or by rostering permanent night duty staff to day shift mandatory training sessions as a component of their core roster. This should be completed within 6 months.

38. It is recommended that the rostered shift configuration and duration be reviewed to create an overlap period for handover purposes and to allow staff who predominantly work on night duty to have greater contact with clients.

39. It is recommended that the Baillie Henderson Hospital Emergency Response procedure is reviewed to clearly articulate the resources that will respond in an emergency and the acceptable timeframes to receive this response. It is recommended that the skill mix for night duty staffing is reviewed to ensure that unqualified staff are not rostered to night duty, even as an additional staff member or replacement.

3.10.1 (g) Professional Development

In the absence of SMHRUs being considered as part of the forensic mental health service system their staff do not get access to the specialist training and education necessary to work effectively within this type of secure environment with a large proportion of patients that are on Forensic Orders. An example is the suggestion earlier of the introduction of DASA-IV risk screening tool which is used within the forensic system, but may not be known by the SMHRU system. In addition there is evidence that the rostering configuration is not supporting a culture of staff engaging in professional development and educational activities. There appears to be an approach that relies upon staff participating on a 'goodwill' basis rather than through a structured and accessible program.

3.10.1 (h) Staff Shortages

Staffing shortages were identified by staff as impacting on the capacity to undertake rehabilitation activities, and to allow patients to access external areas as well as the capacity provide psychiatric input and leadership. We have already made commentary in relation to the fact that rehabilitation programs are not the domain alone of allied health staff, and therefore staff shortages within the allied health area should not have had a detrimental impact upon the capacity to provide programs. However, in the current environment and context we must recognise the fact that the Allied Health staff predominantly provide the rehabilitation program input into Ridley unit. Therefore it becomes imperative that there is a proactive strategy in place for a regional service such as Baillie Henderson Hospital to be able to access limited Allied Health resources.

The *[SWRRC]* volunteered a statement containing submissions to the investigating team.

Under the heading "Allied Health Staff based in Ridley Unit" she said:

> The main concern that I want to draw to the attention of the Review Team is that at the time of the incident and injuries to staff which occurred at Ridley Unit, the unit was not fully staffed with Allied Health Staff. In fact it was only half staffed with Allied Health based in the unit.

The *[SWRRC]* set out an analysis of the staffing history in relation to Allied Health.

Her submission concludes with the following:

> Therefore I think that the Half-staffing of the Allied Health at Ridley for a long period before the Ridley Incident and injury to 3 Nurses, needs to be taken into account when you make your investigation into the incident at Ridley. It does not matter that the incident happened at night, as the absence of full staffing of Allied health would have had systemic repercussions on the consumers, that could manifest themselves at any time. The role of Allied Health based in and adequately staffed, in Mental Health, especially in closed wards, such as Ridley is vital and essential.

RECOMMENDATION

40. Resource sharing should occur across units within Baillie Henderson Hospital, or Darling Downs HHS to ensure that access to allied health staff is available during periods of staff shortage in Ridley in recognition of the isolation and vulnerability of SMHRU patients.

3.10.1 (i) Security Staff

The allocation of security officer presence was determined as a valid risk management strategy immediately after the incident in view of the degree of concern expressed by staff. At the time of instituting the placement of security officers within the clinical environment the primary consideration was to allay the safety concerns expressed by staff and patients within the environment. The Investigators have considered this issue carefully and consider that a permanent security presence placed in the Ridley SMHRU is not required and may be contrary to

the intent of the MoS; the maintenance of a safe secure environment provided by three components: physical, relational and procedural security. Whilst the Model of Service does not specifically name which discipline provides this key component it is expressed as a key set of principles that clinical staff provide for patients within the SMHRU environment.

What is critical is looking at the service system as a whole and what resources are able to be mobilised in an emergency situation to respond to any type of incident across the campus. Whilst there is an Emergency Response plan and protocol that covers the Baillie Henderson Hospital campus, it would appear that some staff do not have confidence that the emergency response available is always timely or adequate. An example is the presence of Security staff overnight. Currently there is a Security Officer on duty overnight, but they have responsibilities that take them away from Baillie Henderson Hospital from time to time. As occurred on the night of the incident, when the emergency was called the Security Officer was at another site and therefore not immediately available to assist. We do not advocate that a Security Officer should be considered to be the same or superior to a clinical staff member in managing client related incidents, but they can provide invaluable support to the clinical team during an emergency or clinical incident such as facilitating entry and exit to the Unit, liaising with Emergency Services (although there is also a need for the CNC to provide direction in relation to this), providing an additional resource if needing to contain clients in different areas, ensuring that security related obligations are met (e.g. securing a potential crime scene, etc.). For this reason we would support there being a permanent 24 hour Security Officer presence across the Baillie Henderson Hospital campus.

RECOMMENDATION

41. It is recommended that the Baillie Henderson Hospital Emergency Response procedure is reviewed to clearly articulate the resources that will respond in an emergency and the acceptable timeframes to receive this response. Further a role for a permanent on-site Security Officer should be included in the Emergency Response that does not duplicate or replace the role of clinical staff.

3.10.1 (j) Illicit Substances

Use of illicit substances in a secure environment is not novel or shocking. This is something that, unfortunately, regularly occurs regardless of the level of security afforded by the environment. However, there are risk mitigation strategies that can be implemented. The use of illicit substances within a mental health environment often introduce additional complications to the health and well-being of the patients and the environment more generally. We will refer to the issues we wish to address within this section as 'drug seeking behaviours'.

There are differing views within the literature and amongst clinicians about the impact of prolonged and ongoing use of cannabis by an individual that has a diagnosed mental illness. Regardless of these views within Australia cannabis continues to be an illegal substance and therefore there are legal consequences associated with its possession and use. Therefore, within a secure mental health environment that has a duty to uphold the law, there must be a consistent approach to how the issue of the introduction of illicit substances will be managed. It was the impression of the investigation team that this may not have been the case. There were differing views expressed to us with one end of the spectrum indicating zero tolerance and a behaviour/consequence approach, whilst another group of staff asserting that this was a societal problem, not just related to Ridley unit, and therefore a less 'punitive' approach to illicit substances should be adopted.

In the absence of a proactive approach to engaging patients about the use of illicit substances, understanding the reasons for the use of them and providing alternate approaches for patients to manage the reasons why they use illicit substances, both approaches outlined above will fail.

Whilst there was evidence that the ward Psychologist was attempting to tackle this complex issue with patients through providing 'motivational interviewing' to some, this is not enough. There is a need for all staff to be providing a consistent approach to the issue.

There is evidence that the therapeutic milieu of Ridley unit was adversely impacted by drug seeking and using behaviours in the weeks and months leading to the incident. Records of patients reviewed indicated that they were being pressured into obtaining drugs for other patients whilst they were accessing leave in the

community, patients returning positive UDSs resulting in negative consequences on their leave indicating drug use and patients were expressing a range of symptoms through verbal expression or behaviour to access PRN prescribed medications.

Regardless of personal views about the impact of illicit drug use, there is clear evidence that this was having an adverse impact upon the patients using the drugs, other patients subjected to their drug seeking behaviour and staff required to manage the patients and environment and therefore should have been more proactively managed from an overall 'drug seeking and use' perspective.

RECOMMENDATIONS

42. Regular urine drug screens (UDS) to be undertaken on all patients and to screen for illicit as well as restricted prescribed medications.

43. An education program for staff should be provided to enhance the understanding of substance use disorders and the management of associated problems, including drug seeking behaviours.

44. The program already in place in relation to patients identified as at risk of drug use should be expanded for all patients to include capacity to repeat programs as required and to establish a formal evaluation of the program outcomes.

3.10.1 (k) Environmental Factors

Ridley Unit is now more than twenty years old. Staff reported difficulties in having maintenance issues promptly attended to and the presence of items that could be used as weapons (metal table legs). An environmental review was conducted by DDHHS OHS in company of an inspector from Queensland Workplace Health and Safety (The Regulator) on 21 February 2013. This review in the form of an Occupational Violence Risk Assessment drew on a previously conducted review and supplied updated actions required within Ridley Unit. Furniture within the unit was recommended to be replaced in the activity / dining room area. Recommendations were made to investigate solutions to the hazard presented by the steel legged tables within the environment, and noted that a prior attempt to remove a table leg was made on 4 January 2012. PRIME data indicates that the patient involved was ***[PATIENT #2]*** who was involved in the recent event. PRIME data also indicates that ***[PATIENT #3]*** had thrown a metal legged chair on 22 August 2012. The investigation

team was informed of a fact-finding exercise looking at furniture solutions that had been utilised at The Park Medium Secure Unit, and a resultant business case.

The physical environment has a number of positives that should also be acknowledged, e.g., natural light, open spaces, ADL skills development spaces, open plan but capacity for separate spaces as required (but use is dependent on staff availability), two ICAs that have an interesting dual purpose through the opening of bedrooms into these spaces, large outdoor spaces that support and promote physical activity and cultural sensitivity. However the furniture is minimalist and inappropriate. There are not enough sofa's/lounge type chairs for all patients (maybe 50% at best) within the areas that should be used as relaxing and quiet spaces by patients. The ICAs are completely barren from a furniture view point. Currently patients appear to be 'forced' to congregate in the Atrium as that appears to be the only space (other than the dining area) where there is adequate seating. Although the physical environment has much to make it a therapeutic environment, the actual furnishing and use of the spaces available make it feel much less therapeutic and 'domestic like' than it could be. Whilst there is currently literature that would suggest the creation of a 'home like' environment in mental health units, we do not support this concept. The reality is that a SMHRU will never be a patient's 'home' and nor should it be. It is a transitional environment that will support a patient to return or to establish their home. Whilst we don't support the 'rhetoric' of the creation of a home like environment within a secure setting, we do advocate to have the environment represent a domestic style as much as possible.

During the course of the investigation there was discussion regarding the use and availability of CCTV in certain areas of Ridley Unit. We agree, that CCTV can play an important role in monitoring an environment, however it can never replace the active interaction between staff and patients. CCTV is a passive observation modality that does not establish relationships, and as we have said previously, enhance relational security. There are many secure environments that have come to rely upon this passive form of observation to manage the patients and the environment, but this does not work unless it is complemented by a proactive interactional environment between staff and patients. Staff must deploy themselves as a therapeutic tool rather than relying on a monitor to replace the important role they, as clinicians, play.

Although we have identified earlier that there is appropriate use of the ICA spaces available to minimise the use of seclusion, we believe there is more that can be done. The introduction of sensory modulation spaces also known as Snoezelen) ensures that there are measures in place to not only address the immediate escalating issues of patients, but also to assist them in identifying alternate strategies for 'self soothing' during periods of high emotion. We believe the conversion of one of the ICAs to provide a sensory modulation space would further enhance the environment.

RECOMMENDATIONS

45. The investigation team recommend, as a matter of urgency, that immediate action be initiated to remove the furniture hazard within Ridley Unit, and that substitution of more appropriate items be made. In particular furniture with metal legs should be replaced.

46. Staff interviews identified that staff were placed in a vulnerable position when filling the lighter in the Atrium. Procedures should be established to ensure that either the lighter be checked and filled when no patients are present or an alternative location for the lighter be considered.

47. Consideration should be given to creating a 'sensory modulation' space (possibly in one of the Intensive Care Areas, ICAs).

48. A review should be undertaken of the furniture and ward environment both in terms of security and patient comfort.

49. The use of CCTV cameras should be reviewed to ensure they are placed in locations that enable viewing of areas determined to be sites of the most frequent incidents of concern. Camera use needs to be balanced with the need for staff to be actively monitoring patients and the environment.

3.10.1 (l) Staff Morale

Low staff morale can both increase the risk of violence but also be a consequence of violent incidents. Morale also can impact on staff retention and performance. Several of the staff who were interviewed in this investigation reported that morale

was very low. Several factors directly related to the subject of this investigation were reported as impacting on morale:

Staff pointed to the fact that steel framed tables is still on the ward six months after the event as a failure to recognize the serious threat this style of furniture poses. One staff member suggested that once the immediate drama of the situation died down it was back to business as usual with nothing changed. It is understood that these tables have not been replaced but in mid-July additional strengthening of the table legs was undertaken.

Staff also raised concerns in relation to delays in getting jobs completed in Ridley Unit. The Investigators asked both the Occupational Health and Safety manager and the Maintenance Coordinator (BEMS) Baillie Henderson Hospital to submit a report on jobs logged over the previous 12 months. In general these reports indicated that there were prompt responses to work orders that had been generated. A specific issue that was raised concerned locks on some doors in Ridley that have been either missing or malfunctioning for over 12 months. Although these locks do not form part of the security of the patient area staff interpreted this as a lack of concern. Delays in undertaking remedial works were attributed to the age of the locks (the locks are no longer manufactured and parts are now difficult to locate). Further investigation of the status of work such as faulty locks was requested by the investigation team. The Investigators found it difficult to establish evidence of escalation of concerns through the available channels (e.g. from verbal report to shift coordinator and written report through to logged BEM job and workplace incident report or Generic Risk assessment form completion)

Lack of confidence in the willingness or ability of colleagues to give effective support in a difficult situation was also identified by a number of staff. This was considered to negatively impact on morale and safety. Over several years one staff member identified three instances where he reported being ‘abandoned’ by colleagues. The following is the account of one such instance:

“I was in ICA with one of them, and the patient became extremely aggressive, threw a punch, I eventually took him down. There was two staff in ICA. When I looked around to see where my offsider was, he actually unlocked the door at ICA, shut the door, and placed himself in the office, and I had to deal with this patient by myself.

That staff member doesn't work here anymore, he's retired. But I had mentioned to the *[CDEIS]* and the *[NDRSMH]* that there were some staff members - not through their fault - just probably weren't suited to working in a high risk area".

Another issue impacting on morale which was raised by staff concerned inconsistency in setting limits, this was discussed in relation to a range of practices from drug searches to accessing the Atrium.

A more general point that was raised concerned uncertainly regarding the future of Ridley Unit and Baillie Henderson Hospital. One senior staff member stated: **"**But I think Baillie Henderson, which includes Ridley, has been let run down to a point where it's almost going to be rendered inoperable. And that's a sentiment shared by lots of my senior colleagues".

RECOMMENDATIONS

50. Staff should be made aware of the processes to escalate required maintenance and repair work through appropriate channels.

51. The contents of this report should be made available to the staff of Ridley Unit.

3.11 Consumer and carer involvement

3.11.1 Carer engagement

In addition to speaking with staff directly, carers have two primary mechanisms for providing feedback or raising concerns. Firstly, there is a Complaints and Carer Facilitator, who carers can informally contact to discuss matters of concern.

The key responsibilities of the Complaints and Carer Facilitator (for carer participation) are listed in the position description. Roles specific to carers follow:

- Carer involvement in the strategic mental health service planning and the inclusion of Carer perspectives in processes, policies and procedures
- Provision of educational programs for staff aimed at developing a clear understanding of organisational values and expectations in relation to carer participation and staff knowledge and skills in communicating with carers.

- Support the development of a client-focussed organisational culture which values innovation, continuous improvement and best practice, and participate in quality activities within the Executive Management framework.

The position also has a number of responsibilities in relation to complaints:

- To coordinate the management or, and facilitate the resolution of complaints through personal negotiation and consultation with the parties (includes consumers, relatives/carers, the community and health service providers) concerned, ensuring that service improvement initiatives are followed through.
- To compile and prepare complaint responses consistent with the above protocols for the signature of the Executive Director Mental Health and assist in the preparation of Ministerial responses.

Secondly, a two monthly family and carer advisory forum (MHFCAC) is held. This forum is attended by the Complaints/carer facilitator but is chaired by the Executive Director Mental Health. The Statement of Strategic Intent articulated in the Terms of Reference for this forum, states:

> The MHFCAC will act as an advisory body to the Mental Health Service to ensure the carer perspective is included into service delivery. It will also support the Mental Health Service to provide a family sensitive practice approach by monitoring and advising the Mental Health Service on appropriate staff and family and carer education processes and practices.

3.11.2 Consumer engagement

At interview the *[CCTMHS]* described the role as encompassing:

- Providing a consumer perspective (and sometimes the carer perspective) on various working parties and committees, including executive committees.
- Facilitating a Darling Downs Mental Health Consumer Care Advisory Forum
- Facilitating focus groups and consumer consultant groups.
- Responding to requests from consumers

- Facilitating recovery and peer support training, as well as mental health first aid courses.
- Ad hoc involvement in responding to complaints

In his interview the *[CCTMHS]* also identified a number of issues which he has found of concern:

- His role not being supported and the perception that he is there to cause trouble
- Consumers being afraid to make complaints
- Negative staff perceptions of his role
- Patients being overmedicated
- Staff talking to patients in a disrespectful manner
- Staff spending excessive time in the nursing station and not interacting with patients therapeutically
- Patients not being involved in their care plans
- Patients feeling helpless and without prospect of discharge
- Having the same person being the complaints manager and the carer facilitator
- Patients not having privacy to complete surveys and feeling intimated by staff presence during completion of surveys

The *[CCTMHS]* was interviewed by Ms Chettleburgh and Mr Green.

He described a fraught relationship with nursing staff going back many years. The following exchange relates to his current relationship with nursing staff at Ridley:

> **Ms Chettleburgh: It sort of does but I'll move on anyway. The – you've already answered this question and my question was going to be; how are you engaged by the Ridley treating team? And clearly, you haven't been and do you believe your role is valued by the Ridley treating team and not that I want to put words in your mouth, but I think you've indicated to us that it is**

not valued and that that's demonstrate through intimidation, exclusion and lack of engagement with you. Are those reasonable assumptions?

Yes, well I'd say the last five years since I haven't been doing the surveys we've got along a lot better.

Ms Chettleburgh: Oh, okay.

So everyone wants to be me friend now, you know, they'll joke and everything else with you [indistinct] start those surveys up again, I think things would turn over again, but because there's the consumer's perception of care survey, they don't seem to be as threatened as much by them and the ***[NUM]*** isn't the ***[NUM]*** in there now. He used to be in there before and I got a better – a little better of a rapport with her than I did with the other person. But, yes, since I stopped bringing things to their attention, they've been a lot better.

The CCTMHS raised two other matters in relation to Ridley.

Ms Chettleburgh: …….. So what do you believe are the key concerns of the consumers and/or their carers in relation to Ridley Unit?

I have to be honest with you, one of them is they're overmedicated and that's no surprise to me and even the peer. The workers have commented on that to me. I mean that's just not that unit either, but we'll focus just on that unit. But you go in there and you – [indistinct] used to have focus groups with them. They'd be all falling off the chairs half asleep, because they couldn't stay awake they were that medicated. I'd say something about that, gee I think some of the levels - medications here and they'd say, "Well you're not a clinician. You don't know what you're talking about."

But, as you know, ***[PRU]*** and [indistinct] and those sort of things are an easy way to keep people quiet, but I think that in these times when we're talking about reducing this cause and restraint where possible - I'm not going to say everywhere, 'where possible', I mean, I don't think we've got that right there. I don't know if any service has. I still think that in both my clinical and professional opinion that they're overmedicated to keep them quiet.

Ms Chettleburgh: Okay, so overmedicated is one of the concerns. Are there any other concerns in relation – that the consumers have?

Yes. The way the staff talk to some of the consumers. There used to be, surprisingly enough, a lady out there that was worse than any of the men that they used to say to me, "We're going to kill that bitch" and I reported that to the then EIS manager and I said I reported it to the ***[NUM]***, the nurse unit manager at that time and he just went, "Oh well". I even told the lady herself and she just went, "Oh well. Tell them to have a go" and I thought that's the attitude here. "I don't really give a stuff what they say about me" and she had the most foul mouth you could ever - I just couldn't believe it. She swore more than men and that's what the consumers didn't like; "She's swearing at us more than the men do". She's no longer in that area. She's been out there for a few years now. [I found] what I'm trying to say, it was quite apparent out there, to me, this wasn't any surprise what happened, when I heard. The only surprise to me is that this hasn't happened a dozen times before. You cannot treat people with absolutely little respect and dignity in a place like that and expect that you're going to get away with it forever. It's been a, what do you call it? Waiting to happen and-----

The former of these two concerns relates to a condition in Ridley which was not alluded to or observed in the course of the investigation. In any case, whether patients have been over-medicated or not is a question of empirical fact which can be illuminated by reference to the medication charts. The ***[CCTMHS]'s*** observations on the point are included, not that they are necessarily relevant to the task set for the investigators, but because of their seriousness.

The ***[CCTMHS]'s*** second point may be relevant. If patients are spoken to or treated with a lack of respect and courtesy, that may engender resentment which could find release in the type of outbreak the subject of this investigation.

There is no suggestion the ***[STAFF #1]*** spoke to or treated patients inappropriately, but it may be accepted that he was one nurse that set and enforced boundaries and, for that reason, seems to have been the principal target in the attack. If the majority of staff allowed patients to do what they liked, and one nurse did not, it is easy to understand why there would be resentment towards that person.

Another avenue for obtaining consumer feedback has been the Consumer Perception of Care Surveys. The Mental Health Information Unit, Mental Health Branch website: http://qheps.health.qld.gov.au/mhinfo/cpoc.htm

> CPoC is a quality improvement activity that supports both the National Safety and Quality Health Service (NSQHS) Standards and the National Standards for Mental Health Services (NSMHS). Accreditation against the NSQHSS provides a marker for safe and good quality health care and is considered essential to improving the safety and quality of care for our consumers. Both the NSQHS Standards and the NSMHS have a strong focus on the rights of the consumer and carer to have their feedback taken into account in the planning, delivery and evaluation of services".

The Senior Data Collection Officer (Consumer Engagement) of the Systems and Collections Team advised via e-mail on August 5, 2013 in relation to an enquiry regarding CPoC information pertaining to Ridley Unit, that:

Ridley Unit which seems to be the one he was interested in was not surveyed in either 2010 or 2011. As there was no survey in 2012 the only possible information we may have about this unit is from this years collection. The data for this years collection is still being entered and will not be ready for dissemination until approx October which is the end of the Reporting and Analysis phase.

Another potential avenue for consumers to raise concerns is through the Complaints and Carer Facilitator. The Complaints and Carer Facilitator advised on August 6, 2013 that the process is as follows:

- "All feedback (complaints and compliments) is entered onto PRIME CF data base
- Feedback is received by telephone, letter or feedback forms located in each ward
- Feedback can be received from anyone i.e. consumer, family member, carer, member of the public
- All feedback passes through this position - for facilitation of Prime entry and follow up in required time frame

- 100% acknowledgement within 5 days is required
- 80% resolved within 35 days is required
- Complaints are rated according to severity

Negligible

Minor

Moderate

Major

Extreme

- Executive Director is notified of all complaints rated Mod and above
- Who or what the complaint is about determines who it is forwarded to
- A complaint about a doctor is forwarded to the supervising doctor e.g. Reg is forwarded to Consultant; Consultant is forwarded to Clinical Director. The Clinical Director would be cc'd if the complaint was mod or above
- A complaint about a case manager would be forwarded to Team Leader with Manager included
- A complaint about a nurse would be forwarded to NUM with Nurse Director included
- The NUMs and Team Leader are responsible for completing Prime CF entries and notifying this position of completion
- This position completes Prime entries for all complaints for medical - the information required for Prime entry is supplied by the doctor usually via email
- All complaints rated mod and above are responded to by letter signed by EDMH – I prepare a draft of this response for EDMH signature
- All complaints received externally are responded to by letter

- Feedback forms collected from the wards are responded to verbally by the NUM if rated Neg or Minor
- Risk assessment is mandatory on complaints with a severity assessment of moderate or above".

The most recent PRIME Report was requested, and the report for the period 01/01/2011 – 31/12/2012 was provided. A review of this report indicates that the most frequently raised issues concern: continued hospitalisation/wanting discharge, access to legal representation or other advocacy and feeling safe/being assaulted (by staff or patients). Two complaints pertained to illegal drug use and associated problems. Additionally, there were small numbers of complaints pertaining to issues such as food, money, coffee and tobacco.

Data from these reports are tabled at a monthly Patient Safety and Quality meeting, which in turn provides reports to the DDDHHS Executive Patient Safety and Quality Committee.

A detailed and thoughtful paper prepared in the name of "The patients at Ridley unit BHH" was provided to the investigation team. It is thought that it was written by two of the principal protagonists in the incident, ***[PATIENT #2]*** and ***[PATIENT #1]***. The paper identifies many elements which engender disaffection among patients. Especially relevant to this investigation, it expressly identifies boredom and hopelessness as common experiences of being a patient in Ridley.

Under the heading "**Hopelessness",** the paper says:

> Ridley Unit is full of people who have no hope or goal. This is a major contributing factor to anti-social behaviour on the ward. If people have no hope or any indication on when they might get out they have no reason to look forward to the future making consequences seem irrelevant. They live day to day, one cheap thrill to the next no matter what the persons vice is, be it violence, drugs or any anti-social behaviour, they have no reason to abstain or better themselves when there seems to be no future outside BHH for them. I know many patients with the attitude that they are "lifers" and are never going to get out of Ridley. I find this a very disturbing attitude that could easily be avoided with simple goal setting by the staff. Asking the patients what they

would like to do and working towards achieving it. Having patients actively involved in their discharge planning.

The *[AHNM]* agrees about the hopelessness of patients in Ridley. Additionally, the 2012 Benchmarking Staff survey results regarding MOSD/clinical changes included the following comments:

• bring living skills staff to the unit so patients without the code can attend groups

• provide in-service and education to staff on community supports available and educate them on how to access them

• a progressive care approach with the best philosophy of care

• make faster clinical decisions

3.11.3 Overview of Consumer and Carer Engagement Mechanisms

The Baillie Henderson Hospital has established mechanisms for patients and carers to receive support and to raise concerns. These mechanisms are available to Ridley patients and their carers. However, the Investigators have concerns regarding the implementation of these mechanisms in practice. From the perspective of the consumer representative there would appear to be improvement in the relationship between the consumer representative and Ridley Unit staff. However, this improvement was perceived to be rather tenuous and likely to deteriorate in the event there were criticisms of the ward or staff. While this may be largely based on past experiences it mitigates against active involvement of the consumer consultant with Ridley patients. It would appear that contact is made with patients primarily via peer support workers or if patients make contact off-ward.

To date the Consumer Perception of Care surveys have not included Ridley Unit. While the 2012 Benchmarking report sought to include consumer and carer feedback the response rate from Ridley consumers and carers was the lowest of all SMHRU. A number of factors are likely to affect survey completion rates. Issues were raised by the consumer representative regarding the lack of privacy patients experienced completing surveys and whether surveys or other feedback was accessed by staff.

The carer representative is also the complaints officer. It was the understanding of the consumer representative that there was a plan to separate these functions.

There would seem to be merit in such a decision. The Complaints and Carer Facilitator provided information derived from PRIME complaint reports. Examination of these reports did not reveal a clear picture of the outcome of complaints because rather standard phrases were employed, such as “Explanation given; Concern registered; Remedial action”. It is likely that the proposed Queensland Integrated Safety Information System (QISIS) project will consider such issues. It was also unclear what the formal response was to the document, ‘Ways the patients think Ridley could be improved’.

RECOMMENDATIONS

52. Processes should be established to engage consumers in contributing to all levels of their care (e.g. treatment planning and ward functioning) in order to be consistent with a Recovery model. Utilisation of a current or former Ridley patient representative in this process should be considered.

53. The role of carer facilitator and complaints functions should be separated.

54. Support should be given for participation by patients in surveys such as the CPOC and Benchmarking reviews and establishment of processes to utilise such feedback, as appropriate, in service planning.

3.12 Policy and Procedure compliance

Determining staff compliance with policy is not straight forward. The Mental Health Service Quality Facilitator advised on August 15, 2013 that there was no current HHS workplace instruction regarding the management of aggression. The need for such a workplace instruction had been identified but it had not been developed to date. On August 16, 2013 the A/Occupational Health and Safety Team Leader identified that there was a Policy and Procedure for the management of aggression however it was (a) out of date and (b) therefore not electronically available; and that actions will commence to review them and have them re-instated later in 2013.

The Darling Darlings Hospital and Health Service Emergency Response Manual (approved August 7, 2012; review date August 7, 2013) describes colour codes for various emergencies. Code black refers to Personal Threat/Suicide. A witness to a personal threat is required to dial 3333 and report a code black (however the Ridley Security Nurse Role and Responsibility including Emergency Procedures document

states on Page 6 that between 1945 and 0740 the Emergency phone is manually diverted to Ridley Unit) .

It was raised with the Investigators that the security panel nurse did not specifically ring “Code Black”. It should be noted that colour code system is also used in Ridley to denote patient movements and associated levels of restriction (code red is restricted to unit but is also a fire alarm in the *Emergency Response Manual).* The security panel nurse not specifying ‘code black’ but calling for urgent assistance is not considered to have made any appreciable difference to the response obtained. The advice from ***[DONMH]*** is that calling a “code black” may have been a slower action though one that may have brought more people to the scene, i.e. four people. The security panel nurse also stated that she rang security using a speedy dial function which was assumed to go directly to the security officer, irrespective of whether they were on a call or not. A message was left and then the ***[ANHM]*** was contacted. The ***[ANHM]*** promptly responded when contacted.

The Ridley Extended Care Unit *Security Nurse Role and Responsibility including Emergency Procedures* document (reviewed 01 January 2013) outlines the responsibilities of the security panel nurse. It does not refer to Code Black actions but does outline actions to be taken if there is an aggressive incident, as well as actions to be taken when alarms are activated. It does not have the same status as a Work Instruction, i.e., does not contain an approval signatory or review date.

Page 11 states under the heading, Aggression –actual or suspected, that an “ALL ZONES” button is pressed and an announcement requesting “All staff” is made over the public address system. No reference in the staff interviews is made of such an announcement. Further, interviews with staff knowledge suggested a potential problem regarding use whether staff use the duress alarm and have training in their use. There is no available data regarding the frequency with which staff who are assigned alarms use them. The Darling Downs-West Moreton Health Service District procedure ‘Duress Alarms for Personal Use’ (endorsed 07/05/2009 with a review date of 07/05/2013) describes in detail how the alarms operate but not under what circumstances they are to be used.

The Staff Orientation Manual (reviewed 19 February 2013) contains reference to the documents discussed above. Information regarding use of duress alarms and patient use of the Atrium are not discussed in this document.

Queensland Health is a complex organisation and within the Darling Downs HHS there has been considerable organisational change, with both the introduction of HHS and reorganisation of boundaries with other HHS in recent times. There are also many competing demands in relation to the development and maintenance of up to date workplace instructions and procedures. However, this investigation has identified areas where improvement is required in relation to maintaining up to date, integrated and consistent workplace instructions and procedures, both in terms of content and audit processes to ensure that the instructions and procedures are effective and being complied with.

RECOMMENDATIONS

55. The aggression management workplace instruction should be reviewed and updated as a priority and staff should be made aware of the instruction.

56. The *Security Nurse Role and Responsibility including Emergency Procedures* should be reviewed to ensure consistency with other HHS and state-wide policies, instructions or procedures.

57. A review of the duress alarm procedure should be undertaken along with a review of implementation of the procedure, including staff use of alarms, staff response and the training staff have received in their use. Code Black responses should in particular be tested at least quarterly in a unit such as Ridley.

58. The dual use of colour codes to denote the movement level of patients and to denote emergencies is potentially confusing. A different code system for movement should be developed as the emergency codes are standard across facilities.

59. The Staff Orientation Manual should be updated to address issues identified above. Hours of operation and supervision of the Atrium area should be clarified in the Staff Orientation Manual.

3.13 Mental Health System Factors

3.13.1 Patient Flow

It has been recognised for some time that access to mental health beds across the mental health system can be challenging. The investigators were informed that this was particularly the case with respect to access to secure mental health beds and access to services to support the transition for patients from secure mental health beds. Particularly pertinent in this regard was the challenges faced by Ridley Unit in returning patients to their HHS care providers of origin once they had been an inpatient in Ridley Unit.

With respect to the former issue, at least two of the seven patients have been considered to have required care in a more secure environment. Both patients were considered potentially suitable for admission to the High Secure Unit but this was not able to be organised due to an inability to obtain a high secure bed when required.

With respect to the later issue, while it is generally recognised that care in secure settings should only occur for as long as is clinically indicated, there were substantial challenges transferring patients to less secure settings. It is likely that this was in part due to difficulties obtaining an acute or less secure rehabilitation bed to facilitate community transition. One response to this situation has been for Baillie Henderson to operate as both a step down and step up unit for patients from Ridley Unit. This has resulted in an institution-based model of care where patients can have extended stays as they cycle between Ridley and Baillie Henderson. It has also meant that patients have developed a sense that they cannot progress adequately toward community reintegration.

The proposed development of continuing care units in regional HHS in the Ridley catchment area is understood to be part of the broader agenda of reform of Queensland mental health services. It is understood the intent is to increase the capacity of referring HHSs to provide care closer to where patients reside and enhance recovery and community reintegration.

While there are positive aspects associated with change, the change process can also lead to challenges for staff, particularly if there is uncertainty about the change

implications. This complex dynamic could result in a sense of dissatisfaction and mistrust of 'management'. The *[DCSMH]* identified the complexity of this situation and the struggle to identify a model that addresses the needs of some patients who are unlikely to be able to manage in a less secure setting than Ridley Unit.

The *[DCSMH]* also highlighted in his interview the need to enhance collaboration across the mental health sector, particularly in relation to shared goals for SMHRU admissions and shared discharge planning. It is understood that staff from Ridley Unit have sought to engage referring services (the Benchmarking report reported contact with referring districts for 63% of patients in the previous three months). It is clear however, that there has been limited success in enabling completed discharges to services of origin.

RECOMMENDATION

60. The return of patients to their home communities, where this can be safely progressed should be supported. A range of issues need to be worked through, the starting point is comprehensive assessments of patients, as discussed in the sections 3.10.1(c) and 3.10.1(d). While there may be a need for a campus based facility for patients to transition out of Ridley, wherever possible this should be avoided and other options should be utilised. This is discussed in section 3.9.

61. The role and value of the SMHRU should be clearly articulated in the Mental Health Service description and planning documents.

3.13.2 Limited Community Treatment (LCT)

LCT is the mechanism by which patients on Forensic Orders progress form inpatient care to living in the community. For patients on Forensic Orders, LCT needs to be approved by the Mental Health Review Tribunal which needs to be mindful of the patient's interests and community safety. The *[CDEIS]* noted a trend for staff to have become risk adverse, with SMHRU being used for patients who go absent without permission. Reviews of the forensic mental health system and changes to the Mental Health Act have contributed to longer hospital stays and more gradual approaches by the Mental Health Review Tribunal to approving LCT for patients with more serious histories of violence. Greater attention has also been given to breaches of LCT conditions. These are not necessarily negative changes, though they can result in

patients having slower transitions to community care and treatment. For some patients with more frequent but minor breaches of LCT conditions this can be especially problematic.

RECOMMENDATION

62. Patient LCT plans should be reviewed to ensure that they are clear and comprehensive and that they relate to the ICP and discharge planning processes. Patients should be involved as much as possible in the development and review of these plans.

4. CONCLUSION

We submit our report.

DATED this of October 2013

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