QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Mohamad Ikraam Bahram**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2020/780
DELIVERED ON:	11 February 2025
DELIVERED AT:	Brisbane
HEARING DATE(s):	3 - 5 May 2023, written submissions May 2023 - July 2023. Submissions on draft recommendations October 2024.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, mental health, schizophrenia, treatment authority, community category, capacity to consent, no less restrictive way, advance health directive, family engagement, risk assessment, police shooting, active armed offender.

REPRESENTATION:

Counsel Assisting:	Ms J Pietzner-Hagan
Family:	Mr P O'Connor, Instructed by Caxton Legal
Officers Eiser, Hughes and Kleidon:	Mr S Zillman, instructed by Gilshenan and Luton Lawyers
Commissioner of Police:	Mr M Nicolson, instructed by QPS Legal Unit
Dr Suetani:	Mr J Underwood, instructed by Avant Law
Metro South Health:	Ms F Banwell instructed by Legal Services, Metro South Health (Inquest)
	Ms H Ahern Metro South Health (Submissions)

Contents

Introduction

1. Mohamad Ikraam Bahram (Ikraam) was aged 24. He died after being shot by Queensland Police Service (QPS) officers in Mary Street, Brisbane City, on Sunday morning, 23 February 2020.

2. Ikraam is survived by his mother, Nasera Rane, brother Hamsa, stepfather Hasan, and extended family. Ikraam is remembered by his family as a son, brother, uncle, cousin, and nephew. He was a much loved and valued member of his family. At the inquest, he was spoken of as a fiercely independent and hardworking person with a real sense of family.

3. The statement of his mother, Nasera Rane, emphasised the grief and pain the family suffers. They have been left devasted by the loss of the years they should have had with Ikraam and pray that any lessons from his tragic death will be acted upon. I extend my sincere condolences to his family.

The Investigation

4. Detective Sergeant Green led the coronial investigation. There was a parallel investigation that explored the possibility Ikraam may have been acting subject to radicalisation or ideologically motivated behaviour on 23 February 2020.

5. Based on the evidence available both investigations were adequate and appropriate in the circumstances. I also note the objections raised at inquest in respect of issues of relevance in terms of the parallel investigation.

The Inquest

6. Ikraam's death was a reportable death under section 8(3)(g) of the *Coroners Act 2003* (the Act) as it was a 'death in custody' as defined in section 10 of the Act.

7. In cases such as this, an inquest was mandatory under section 27(1)(a)(i) of the Act. An inquest is intended to provide the public and the family of the deceased, with transparency regarding the circumstances of the death, and to answer questions that may have arisen following the death.

8. A pre-inquest conference was held in Brisbane on 30 May 2022. The initial dates for inquest were vacated to allow further material to be obtained to explore Ikraam's mental health in the lead up to and at the time of his death.

9. An inquest was held in Brisbane from 3 to 5 May 2023. The brief of evidence was tendered at the commencement of proceedings and oral evidence was heard from nine witnesses.

10. The issues for inquest were confirmed as follows:

    1. The findings required by section 45(2) of the Act; namely the identity of the deceased, when, where, and how he died and what caused his death; and:
    2. Consideration of the circumstances leading up to the shooting of the deceased by Police on 23 February 2020, including his mental health treatment:
        a. Ikraam's pharmacological treatment.
        b. The challenges in diagnosing Ikraam and engagement with him by health professionals.
        c. The risk management screening tools used in respect of Ikraam and his deterioration in mental state.
        d. Whether a Police and Ambulance Intervention Plan (PAIP) for Ikraam would have assisted in his mental health care.
        e. Whether the information sharing provisions between the QPS and Queensland Health with respect to persons experiencing a mental health incident were sufficient in the lead up to Ikraam's death.
    3. Whether the police officers involved acted in accordance with the QPS policies and procedures then in force, and whether said actions were appropriate.
    4. Whether the training provided to police officers in responding to similar incidents is sufficient.
    5. The adequacy of the investigation into the circumstances surrounding Ikraam's death.
    6. Whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

11. In an inquest, the relevant standard of proof is the balance of probabilities, with reference to the *Briginshaw*[1] scale. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for the Coroner to be satisfied on the balance of probabilities that the issue has been proven.

[1] *Briginshaw v Briginshaw* [1938] HCA 34 and (1938) 60 CLR 336.

12. As in the Inquest into the death of Hamid Khazaei, I have endeavoured to be mindful of both hindsight bias and outcome bias in these proceedings.[2] Hindsight bias refers to the tendency of those with knowledge of an outcome to overestimate the predictability of what occurred relative to alternative outcomes that may have seemed likely at the time of the event. Outcome bias refers to the influence of knowledge of the eventual outcome on the retrospective evaluation of clinical care.

13. I am satisfied there was sufficient evidence to make the findings required by s 45 of the Act.

14. The submissions of counsel assisting following the inquest identified a number of possible recommendations relating to the care of patients under the *Mental Health Act 2016* (Qld) (the Mental Health Act). A response was received from the Director-General of Queensland Health and Metro South Health on the proposed recommendations.

The Evidence

Personal History

15. Ikraam was born in Eastwood, New South Wales. His father moved to Denmark after separating from Ikraam's mother. Ikraam's brother lives in Sydney.

16. Ikraam lived at Munruben, around 40km south of the Brisbane CBD, with his mother and stepfather of 12 years. Ikraam was unemployed at the time of his death but had previously worked as a meat packer. Ikraam's parents said that in the lead up to his death he was reclusive, rarely leaving his bedroom. When he was working, Ikraam regularly attended a gym located near the Browns Plains Police Station. He had no close associates.

17. Ikraam's history of mental health issues dated back to April 2017 and were well-documented in the material before the Court. At the time of his initial presentation, Ikraam's mother advised that she had become concerned with his outward displays of paranoia and religious ideation. He had auditory hallucinations and refused help. She was also concerned that he was depressed and maybe suicidal.[3]

18. In April 2017, Ikraam reported using cannabis two days before his mental health assessment, and that he had a long history of cannabis use, usually smoking about five cones and two joints a day. He said he ceased heavy consumption in 2016.

[2] At [25].
[3] Exhibit G5, 1.

19. Ikraam was a patient of the Browns Plains Community Mental Health Service (BPCMHS) and subject to a community category Treatment Authority under the Mental Health Act. He had been reviewed by his community treating team on 18 February 2020, five days before his death.

20. Mental health records demonstrated that Ikraam's family was a significant protective factor and a great support to him in the community. His mother, especially, was in regular contact with mental health services and attended appointments with him. During the coronial investigation, Ikraam's mother told police that:

- Ikraam was diagnosed with Schizophrenia and had previously been functioning well under a treatment regime of compulsory injections. However; at some point as he was getting older, this was changed with a negative effect.

- Ikraam would suffer from hallucinations, including seeing people and butterflies in the house when there were none. He was also paranoid, saying the police were watching him and had put a tracker in him with a needle.

- She was concerned about his mental health and suspected he was not swallowing his oral medication and his injected medication was not effective.

- She was worried about him after he abruptly left their home on 23 February 2020, around 9:00am without taking his wallet or tobacco which was unusual for him. Ikraam also made his bed before leaving which was out of the ordinary. Otherwise, Ikraam seemed in good spirits that morning and had helped his father with cleaning the paths the day before.

- Ikraam occasionally attended Friday prayers at the Hillcrest Musallah with his stepfather.

Autopsy results

21. The cause of death listed in the Autopsy report was multiple gunshot wounds.[4]

22. During autopsy, thirteen gunshot wounds were identified. Nine projectile fragments were recovered from eight gunshot wounds. Two of the gunshot wounds damaged internal organs of the chest (heart) and abdomen (liver) and are significant to the death:

Group A (entry wound, no exit wound) left chest, middle, anterior:

> *Entry: Left anterior chest 40mm to the left of the midline.*
>
> *Direction: From anterior to posterior, left to right, superior to inferior.*
>
> *Structures traversed: Skin and subcutaneous tissue, chest muscles, left sternum/anterior 4th rib, right heart, diaphragm, liver.*
>
> *Projectile: 10-11th intercostal space (exhibit PM2).*

Group A (entry wound, no exit wound) left chest, lower, anterior:

> *Entry: Left lower chest 115mm to the left of midline.*
>
> *Direction: From anterior to posterior, left to right, superior to inferior.*
>
> *Structures traversed: Skin and subcutaneous tissue, cartilage of left 6th rib, tip of the heart, diaphragm, left lobe of liver, retroperitoneum in region of coeliac trunk, possible contact with right anterolateral 12th rib body, superior right quadratus lumborum muscle.*
>
> *Projectile: Right posterior perineal space (exhibit PM1)*.[5]

[4] Exhibit A4, 22.
[5] Exhibit A4, 19.

CONCLUSIONS ON INQUEST ISSUES

1) Findings required by s. 45

23. I am required to find, as far as possible, the medical cause of the death, who the deceased person was and when, where, and how he came by his death. As a result of considering all the evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased – Mohamad Ikraam Bahram.[6]

How he died – Ikraam drove to the Brisbane CBD where he stabbed a tourist he had chased across city streets with a knife. When Ikraam was confronted by police officers on Mary Street he rushed at the officers with a knife. Officers tried to retreat but Ikraam did not comply with verbal directions to stop and drop the knife he was holding. He was shot by the police officers.

Place of death – 111 Mary Street, Brisbane City, QLD, 4000, AUSTRALIA.

Date of death– 23 February 2020.

Cause of death – Multiple gunshot wounds.

2) Consideration of the circumstances leading up to the shooting of the deceased by Police on 23 February 2020

24. Around 9:00am on 23 February 2020, Ikraam left his family home and drove to the Brisbane CBD in his mother's red Toyota Corolla hatchback. Ikraam's parents were worried as he left the home abruptly in circumstances that were out of the ordinary for him.

25. CCTV cameras located within Brisbane CBD captured his movements. Around 10:00am, Ikraam parked the vehicle in a driveway on Market Street. He left the vehicle carrying a duffle bag. He was wearing a blue T-shirt, jeans and running shoes.

[6] Ikraam was identified by fingerprints.

Assault on a British Tourist

26. Mr Dennis, a British tourist, was walking along Mary Street with his fiancée, Ms Carter. As they crossed Edward Street, towards Felix Street, Ikraam approached them carrying the duffle bag. Mr Dennis and Ms Carter had not seen Ikraam before.

27. Mr Dennis described Ikraam stopping and looking into the duffle bag before pulling out a knife and shouting words in a foreign language. Mr Dennis was familiar with common Arabic phrases. While Mr Dennis was not sure what Ikraam said, he did not say, *'Alluha Akbar'*.[7]

28. Ikraam ran towards Mr Dennis and Ms Carter outside 169 Mary Street with the knife. Mr Dennis pushed Ms Carter to his right and ran into the street, hoping that Ikraam would pursue him and not his fiancée. Mr Dennis ran up Mary Street and Ikraam followed.

29. Close to 97 Edward Street, Mr Dennis turned to look out for Ms Carter. When Ikraam grabbed his t-shirt, Mr Dennis pulled away and the shirt ripped. At 10:03am Ikraam swung his right hand, holding the knife, hitting Mr Dennis on the nose.

30. Mr Dennis grabbed Ikraam's jacket and punched him in the forehead. Ikraam stumbled and Mr Dennis turned and ran as Ikraam again grabbed his shirt. Mr Dennis felt a sharp pain in his back. He broke free of Ikraam's grip and ran down Edward Street, across Mary Street, and into Felix Street to seek shelter.[8]

31. Ikraam's knife blade snapped during the attack on Mr Dennis.[9] Police found part of the broken knife in a rubbish bin at the corner of Mary and Market Streets. Some of the blade was found outside 97 Edward Street.[10]

32. Front counter staff at Mr Dennis' hotel helped him, and police and ambulance officers transported him to the Royal Brisbane and Women's Hospital.[11] He was assessed by medical staff as having suffered:

    - An approximately 0.5cm laceration/stab wound to the left sub scapular region of the back (consistent with being caused by a bladed instrument);
    - An approximately 0.5cm laceration to the bridge of the nose (glued);
    - A clinically fractured nose (swollen but not deviated), no septal haematoma; and

[7] Exhibit B1 at [13].
[8] Exhibit E30.
[9] Exhibit C7 at [1b].
[10] Exhibit A5 at [8.24] - [8.25].
[11] Exhibit G1, 7.

- A split and swollen upper lip – injuries consistent with being caused by blunt force trauma.[12]

Ikraam's text messages

33. Ikraam sent a text message to his mother around 10:05am that read: *"Jihad*." This was in response to her text message from 9:36am: *"Morning sin, where are you?."*

34. Ikraam's mother responded via text:

- 10:06am: *"Who is jihad?."*
- 10:07am: *"Call me asap."*
- 10:17am: *"You are very unwell. Come home asap please. You didn't take your medication."*
- 10:49am: "*Where are you?? Call me asap."* [13]

Ikraam retrieves a second knife

35. After wounding Mr Dennis, Ikraam returned to the Toyota Corolla on Market Street. After opening the passenger door to have a drink, Ikraam took a serrated bread knife from the car, approximately 30cm in length. He then began walking back down Mary Street.

Calls to triple zero by members of the public

36. After 10:04am several calls were made to Triple zero by witnesses who reported the alleged assault on Mr Dennis, and sightings of Ikraam walking in the Brisbane city with a knife in his hand.

37. The following call was made to the Triple zero call-taker at 10:04am:

- *"Mary Street in Brisbane. Mary and Margaret going around the river there's two men chasing each other. I think one of them might be stabbing the other one. I'm not sure the girl, there was a girl with them she screamed out, he's stabbing my partner! They've kind of disappeared, sorry but uuum…Big boys, a bit Middle Eastern looking maybe I don't know Italian that sort of…*
- *And a woman, a white woman with, a blonde woman running that way…Yeah no they're just running, just fanging it down the street, but I can't see them anymore. They were going towards the river. But they left a bag, I think… the bag's just outside the Buffalo bar.*
- *Oh no he's walking, the guy with the knife is walking up Mary Street, toward Edward Street. He's got a very thick fucking knife in his hands.*

[12] Exhibit G1, 1. Exhibit B1 at [30]. Exhibit B2, 1.
[13] Exhibit C7 at [23]. Exhibit A5, 31.

- *I can see his side…He's walking past me now; he's got a knife in his hand. He's heading toward Edward Street where there's lots of people. Can you hurry?*
- *He's wearing a blue t-shirt, blue jeans, he's got dark hair and a beard. Uumm, he doesn't seem to be really interested in other people but uumm… I'm walking towards his bag… Alright here's the girl, I think the girl, the girl who was running away is coming back."* [14]

Police Communications

38. At 10:05:39am[15] the communications operator called for "*any unit to proceed code two to the corner of Edward and Mary Street for an assault in progress*."

39. At 10:05:50am, general duties QPS officers from the Brisbane City Station, Senior Constable Hughes (call sign C802) and Constable Eiser responded to the communications operator who provided the following information:

    - *Job number 1532, code 2 for a street disturbance/assault.*
    - *Corner of Mary Street and Edward Street.*
    - *Currently outside 133 Mary Street which is a café. Informant saw a male running across the road, bashing and hitting into a second male. Female close by chasing them as well saying, call the police he had just stabbed my boyfriend.*
    - *One of the males had his face covered in blood. No weapons sighted, still on the phone to the informant.*

40. At 10:06:32am Senior Constable Hughes acknowledged the call, reported they were proceeding from the City Beat Code 2, and requested cameras be turned to the incident. At 10:06:48am call sign C401 also stated they were heading to the job.

41. At 10:07:05am a male involved in the assault was described as: *"a large Māori male with dark skin, wearing a ripped black t-shirt and a pair of shorts*."

42. At 10:07:23am the second male involved was described as: *"the one who has the knife, is described as being Arabic in appearance and the knife is described as a big carving knife*."

43. At 10:07:38am call sign Z790 acknowledged they were also proceeding to the job.

[14] Exhibit A5, 26 - 28. Exhibit B4.
[15] Time taken from call logs.

44. At 10:08:41am call sign C803 radioed: *"that male, who has the knife's walking up Mary towards Albert at the moment about twenty metres off the intersection on the Queens Street Mall side."*

45. Constable Eiser and Senior Constable Hughes arrived in Mary Steet in the marked police van, after proceeding under lights and sirens. Senior Constable Hughes was the driver, and Constable Eiser the passenger. As they approached the scene, they were flagged down by members of the public, and provided information about *"the guy with the knife."* They were told *"he is down the end of the street… he's in a blue shirt*." The Officers decided to secure the alleged offender and let another crew locate the injured male. Looking down the road, Constable Eiser saw Ikraam.[16]

46. Senior Constable Hughes parked the police van on an angle across Mary Street and the officers exited the vehicle. Constable Eiser got out of the passenger side of the vehicle. His body worn camera showed Ikraam sprinting with a large knife in his hand directly towards Constable Eiser. It showed Constable Eiser yelling at Ikraam to drop the knife several times before firing his service weapon.[17] The body worn camera footage and statement of Senior Constable Hughes corroborate this.[18]

Shots fired

46. At 10:09:32am the call: *"shots fired, shots fired"* was radioed by police.

- 10:09:35h *"Urgent shots fired."*
- 10:09:39h *"Urgent shots fired, shots fired. We need crews here now, crews here now to secure the scene."*
- 10:09:51h *"We have one male down still in possession of the knife."*
- 10:11:25h *"Confirming we need QAS code one."* [19]

Queensland Ambulance Service (QAS) Response

47. QPS officers immediately provided first aid, while the Queensland Ambulance Service (QAS) initially responded to reports of Mr Dennis' wound.[20] On arrival, QAS were flagged down further along Mary Street where there was a heavy police presence and a report of a male with gunshot wounds.[21]

48. Dr Stephen Rashford, Medical Director for the QAS, was dispatched to attend the scene at 10:19am. He arrived at 10:22am and observed Ikraam: *"in cardiac arrest, laying supine in the middle of Mary Street."*

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[16] Exhibit B27, 5.
[17] Exhibit B27, 7. Exhibit E5.
[18] Exhibit B28. Exhibit E6.
[19] Exhibit A5, 25 - 26.
[20] Exhibit D2 - D6.
[21] Exhibit D7.

49. Dr Rashford observed: *"resuscitation had already commenced by way of basic life support (chest seal applied to chest wound, tourniquet to proximal right thigh), bag-mask ventilation and cardiac compressions. Intravenous access had not been obtained at this point."* Dr Rashford noted: *"penetrating wounds to the left anterior chest, right antecubital fossa and right thigh."*

50. Dr Rashford focussed on the central torso trauma and *"directed the HARU CCP's*[22] *to undertake bilateral chest thoracostomies."* Dr Rashford performed a *"clam shell thoracotomy."* [23]

51. Dr Rashford noted: *"it was immediately apparent that the heart had suffered direct damage from the ballistics injury. The heart appeared macerated with no chance of repair. Immediately ceased resuscitation upon visualising this injury."* [24]

52. Ikraam was declared deceased at 10:27am.[25]

Active Armed Offender

53. During the Inquest, it was put to Detective Sergeant Green by Counsel for the QPS Commissioner that QPS officers engaging with Ikraam on 23 February 2020 were engaging with an '*active armed offender*.' Detective Sergeant Green accepted this proposition.[26]

54. During his directed interview, Constable Eiser was asked, in reference to his training, if there was anything that he considered during this incident? He responded:

> *"I know when…when we talk about essentially, he is an active (UI)*[27] *in a way because he has the ability to access any person on the street. He's shown by reports that he's violent and he's using his weapon to inflict GBH to another person and yeah, he does have an open ah, an open (UI) of people to continue his behaviour. So, I believe that we needed to immediately… take action in relation to him to ensure that he doesn't continue down the street and injuring any other person."* [28]

55. At inquest, Constable Eiser confirmed that when he arrived at Mary Street, the information available to him was from Police Communications. He did not know the name of the 'person of interest' and there was no utility in looking at his QLite device to try to obtain more information.

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[22] High Acuity Response Unit Critical Care Paramedics.
[23] Exhibit D1, 2.
[24] Exhibit D1, 3.
[25] Exhibit D1, 3.
[26] 3 May 2023, T 1-26, LL12.
[27] Unintelligible.
[28] Exhibit B27, 16 - 17.

56. Constable Eiser confirmed his assessment that Ikraam was an active armed offender who had the ability to move quickly and was armed with a knife. There were a lot of unknowns in approaching the scene. The decision-making process occurred in a matter of seconds because of the way Ikraam approached Constable Eiser.[29]

57. I accept the term *'active armed offender'* was a correct characterisation because of Ikraam's behaviours when he came to the attention of police on 23 February 2020.

58. I also accept it was reasonable in the wake of this incident, where persons unknown to Ikraam were assaulted in the Brisbane CBD, for police to pursue a number of possibilities in the investigation of the offending in the interest of public safety, particularly where there were prior intelligence holdings of the type held for Ikraam, in addition to his known mental health concerns, and prior mental health incidents.[30]

59. This is supported by the conclusions outlined in the Queensland Joint Counter Terrorism report[31] dated 20 April 2021, under the hand of Detective Acting Inspector Anthony Conway of the Australian Federal Police (AFP).

60. It is important to note that the Queensland Joint Counter Terrorism report ultimately concluded that Ikraam's actions on 23 February 2020 were <u>not</u> terror related, as defined under the *Criminal Code Act 1995* (Cth).

61. Detective Acting Inspector Conway noted: *"…the investigation produced <u>no evidence to establish:</u>*

    - *Bahram's actions were done <u>with the intention</u> of advancing a political, religious, or ideological cause; and*
    - *Bahram's actions were done <u>with the intention</u> of intimidating the public or a section of the public.*[32]
    - *Despite Bahram sending the SMS 'Jihad' to his mother, shortly before running at responding police with a knife, witness evidence and mental health records better support the assessment that the intention of Bahram's actions was to commit suicide and not done with the wider intention of advancing any religious cause and/or intimidating the public."* [33]

[29] 3 May 2023, T 1-36, LL4 – 30.
[30] Defined below.
[31] Exhibit C7.
[32] Exhibit C7 at [56].
[33] Exhibit C7 at [57].

62. In my view, there was insufficient evidence to conclude Ikraam intended to end his own life on 23 February 2020, despite the conclusion of Detective Acting Inspector Conway.

63. During the execution of a search warrant on 5 March 2020, at the family home, Ikraam's mother was asked about Ikraam's text messages, and the use of the word *'Jihad',* noting the significance of *that* word to the police.[34]

64. Ms Rane noted that Ikraam had three cousins with the same name (and various spelling Jahad, Jahid, Jihad). Hasan Rane acknowledged the stigma and stated:

> *"Just to set the record straight, us as normal Muslims, okay, we do not believe in Terrorism. We see this happening in the world and everything else and as far as we're concerned, that [sic] are not Muslims. As far as we're concerned, they do not believe in God. Because if you believe in God you wouldn't do that. That's the bottom line."*[35]

Ikraam's mental health treatment

Mental Health Incident

65. I accept the submission from counsel assisting that Ikraam may have experienced a *mental health incident*[36] on 23 February 2020 in that Ikraam's behaviour may have been indicative of:

- *A series of events or a combination of circumstances in which a person is demonstrating behaviour that is indicative of a mental health problem;*
- *May involve a serious risk to the life, health, or safety of the person or of another person; and*
- *Requires communication and coordination between the Parties at the earliest opportunity and ongoing communication as required.*

66. Unfortunately, because of the speed at which events unfolded, it was not possible for there to be any communication between QPS officers and Queensland Health about Ikraam's mental health before his death.

67. Examples of Ikraam having experienced mental health incidents in the past were outlined in a timeline of Ikraam's treatment, and care for his mental illness, distributed to parties, as a reference aide, at inquest.

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[34] Exhibit B26, 12, line 633.
[35] Exhibit B26, 12, line 639.
[36] Exhibit I1. Memorandum of understanding between the State of Queensland acting through Queensland Health and the State of Queensland acting through the Queensland Police Service – Mental Health Collaboration, signed 15 June 2017.

68. At the time of his death, Ikraam had a diagnosed mental illness - schizophrenia**.**[37] Schizophrenia may be defined as a chronic mental illness characterised by positive symptoms (such as delusions, hallucinations, disorganized speech, and behaviour), negative symptoms (such as apathy, lethargy, and social withdrawal) and cognitive impairment. The Diagnostic and Statistical Manual of Mental Illnesses-5 (DSM-5) is the leading diagnostic manual.

69. Ikraam was an open patient of the BPCMHS and subject to a community category[38] Treatment Authority under the Mental Health Act. A Treatment Authority is a lawful authority to provide treatment and care to a person with a mental illness, who does not have capacity to consent to treatment (*involuntary patient*)[39]. An *authorised doctor*[40] may make a Treatment Authority[41] where they are satisfied the *treatment criteria* apply and there is *no less restrictive way* for the person to receive treatment and care for their mental illness.

70. ***Treatment criteria*** is defined in section 12(1) of the Mental Health Act:

> *(1) The treatment criteria for a person are all of the following -*
>
> *(a) the person has a mental illness;*
>
> *(b) the person does not have capacity to consent to be treated for the illness; and*
>
> *(c) because of the person's illness, in the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in -*
>
> *i. imminent serious harm to the person or others; or*
>
> *ii. the person suffering serious mental or physical deterioration.*

71. In accordance with section 14(1) of the Mental Health Act:

> *(1) a person has **capacity to consent** to be treated for their mental illness if the person -*
>
> *(a) is capable of understanding in general terms -*

[37] Mental illness is defined in s 10 of the *Mental Health Act 2016* (Qld) as *a condition characterised by a clinically significant disturbance of thought, mood, perception, or memory.*
[38] Section 51 *Mental Health Act 2016* (Qld), if a person is not a classified patient, the authorised doctor must decide whether the category of the TA is inpatient or community.
[39] Section 11(a)(iii) *Mental Health Act 2016* (Qld).
[40] Schedule 3 of the *Mental Health Act 2016* (Qld).
[41] Sections 48 & 49 of the *Mental Health Act 2016* (Qld).

i. that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing; and

ii. the nature and purpose of the treatment for the illness; an

iii. the benefits and risks of the treatment, and alternatives to the treatment; and

iv. the consequences of not receiving the treatment; and

(b) is capable of making a decision about the treatment and communicating that decision in some way.

72. An *authorised doctor* may only decide the category of a Treatment Authority is *inpatient*[42] if, after having regard to all the *relevant circumstances* for a mental health consumer, one or more of the following cannot be reasonably met if the category of the treatment authority is community -

- *The person's treatment and care needs.*
- *The safety and welfare of the person.*
- *The safety of others.*[43]

73. ***Relevant circumstances*** are defined in Schedule 3 of the Mental Health Act as -

- *The person's mental state and psychiatric history.*
- *Any intellectual disability of the person.*
- *The person's social circumstances, including family and social support.*
- *The person's response to treatment and care and the person's willingness to receive appropriate treatment and care.*
- *If relevant, the person's response to previous treatment in the community.*

74. There is a ***less restrictive way***[44] for a person to receive treatment and care for their mental illness if, rather than receiving involuntary treatment and care, the person is able to receive the treatment and care that is reasonably necessary through an ***advance health directive***[45] (AHD), with the support and consent of an appointed personal guardian, with the consent of an appointed attorney, or with the consent of the person's statutory health attorney.

[42] Schedule 3 of the *Mental Health Act 2016* (Qld).
[43] Section 51(3) *Mental Health Act 2016* (Qld).
[44] Section 13 *Mental Health Act 2016* (Qld).
[45] Schedule 3 of the *Mental Health Act 2016* (Qld). *Means an advance health directive under the Powers of Attorney Act 1998.*

75. I accept the submissions from counsel assisting and Dr Suetani that, on the evidence available, there was no less restrictive option for Ikraam than a community category, Treatment Authority.

Ikraam's pharmacological treatment

76. I accept the expert evidence of Dr Reddan that the pharmacological treatment of Ikraam using Aripiprazole (in both depot[46] and oral form), under the Mental Health Act (administered under a Treatment Authority) was appropriate and reasonable in the context of Ikraam's schizophrenia.[47]

77. I agree that the monitoring for his medication by Ikraam's community treating team was appropriate (noting that he was on Aripiprazole as opposed to a medication such as Clozapine).[48]

78. In so far as the issue of oral as opposed to depot medication is concerned, I accept the finding of the Queensland Health investigation report[49] (as opposed to the findings contained in the Clinical Review):[50]

> *"The decision of the BPAMHS[51] treating team to accede to Mr Bahram's request to cease intramuscular medication in October 2019 was carefully considered and clinically appropriate, as well as being consistent with recovery principles."* [52]

79. At the time of Ikraam's death, Dr Suetani was a Community Psychiatrist at BPCMHS. He referred to the recovery paradigm as "*the guiding principle of contemporary mental health care."* [53] He noted that this influenced the decision to switch from depot medication to oral formulation in treating Ikraam's mental illness.[54]

80. Dr Suetani said the pharmacological treatment of Ikraam's schizophrenia (particularly in choosing between oral and depot medication) was not without challenges for the community treating team and the therapeutic relationship with Ikraam.

81. Dr Suetani's evidence at inquest was that: "*depot formulations have much better efficacy in treating a psychotic illness …I don't think there's any question about that."*

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[46] A depot injection is a slow-release form of medication. The injection uses a liquid that releases the medication slowly.
[47] 5 May 2023, T 3-13, LL 18-21.
[48] 5 May 2023, T 3-13, LL 1-14.
[49] Exhibit H2.
[50] Exhibit H1, *Review of the Management of Patient Mohamed Bahram at Metro South Addiction and Mental Health Services*
[51] Browns Plains Adult Mental Health Service (same as BPCMHS).
[52] Exhibit H2 at [6].
[53] Exhibit B43 at [71].
[54] Exhibit B43 at [77].

82. Dr Suetani said that, in practice, the choice was not always between depot and oral medication. The choices are depot, oral, and no medication at all. He said that having oral medication is better than having no medication. When symptoms are obvious and acute and people are coming out of hospital, "*you're going hard on that treatment, so that's what depot and treatment order looks like*." [55]

83. Dr Suetani said that as people get better, as Ikraam was doing, "*people get a job, get a life…the psychosocial functioning gets better, you start giving a little bit more autonomy to the patient and you can start giving them choices in terms of you've got depot injection and you've got oral medication*." [56]

84. Dr Suetani said that when a treatment authority is revoked, the choice of not having any medication at all comes up. People return to the clinic once they stop depot as soon as the order gets revoked. Six months later, they come back. This is what occurred in 2018 with Ikraam.

85. Dr Suetani said BPCMHS works on assertively getting patients to keep taking medication, whether oral or depot, even after there is no legal authority to do that. It was clear that Ikraam's symptoms improved and:

> *"…Somewhat ironically but it happens all the time where when he was…getting better psychosocially, he was less and less inclined to…have the depot medication …. he was a young man, only had the diagnosis for a couple of years, in his 20s. You can see that, like, we find it difficult to get diabetic kids to take insulin… And there's a whole lot of stigma that comes with depot because they have to come to the clinic, they have to see a psychiatrist. So, I think, you can see that it was getting harder and harder as he was getting better and better."* [57]

86. It was clear that Ikraam was reluctant to continue with medication as his mental state improved. I accept the submission from counsel assisting that despite the challenges in the therapeutic relationship, the community treating team made every reasonable attempt to accommodate Ikraam's views, wishes and preferences, in relation to medication. They took into account reported side effects, collateral information from his mother, and the need to administer treatment and care to Ikraam as an involuntary patient, in accordance with the principles contained in the Mental Health Act and Chief Psychiatrist Policies.[58]

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[55] 4 May 2023, T 2-11, L 7-9.
[56] 4 May 2023, T 2-11, L 10-13.
[57] 4 May 2023, T 2-10, LL40 to T 2-11, LL 32.
[58] Chief psychiatrist policies are mandatory for anyone performing a function under the *Mental Health Act 2016* such as authorised mental health service administrators, authorised doctors and authorised mental health practitioners. These policies have been formally made by the Chief Psychiatrist and reflect their responsibility to protect the rights of all patients receiving involuntary (or voluntary) treatment and care in authorised mental health services.

Ikraam's views wishes and preferences

87. In December 2019, Ikraam sought to have his Treatment Authority revoked. This *may* have been indicative of Ikraam's desire to manage his own treatment, as opposed to being subject to the Mental Health Act and oversight by a community treating team.

88. During the inquest, Ikraam's Case Manager, social worker Saputra Mulyadi noted his impression of Ikraam was that *"he always felt that having mental health involvement was rather intrusive…he used to always complain about being on the medication."* [59]

89. Mr Mulyadi further noted, *"this is common with a lot of people who…they're quite symptom free, is that they often don't have the insight to understand that…the illness…the symptoms can come back and the reason why we want people on medication for a bit longer."* [60]

90. At the inquest, Dr Reddan said some medication leads to a degree of *"emotional dulling*." Patients may incorrectly attribute negative symptoms of schizophrenia as side effects of medication. This may *"create a resistance to treatment which is very common and very understandable."* [61]

91. Dr Reddan said that in terms of the therapeutic alliance and the difficulty in seeking to address the issue of potential mistrust from mental health consumers with hospitals and enforcing inpatient stays:

    - *"Developing and maintaining a therapeutic alliance … can be very, very difficult to do. I said at the beginning, one needs time and patience for this and the degree to which – I've said before, the use of the Mental Health Act in this case was appropriate. But there is a little bit of a downside to it and that is that… most people don't like or start to feel like their lives are being controlled by the Act or by the services, and that can actually have the opposite effect of what you want. It can actually drive people away from treatment. So, you have to…try to use some balance about this, which is very difficult to achieve, and it's harder than what perhaps I've said here.*

    - *And it is – one of the objects of the Act is that the Act will always be used in the least restrictive alternative, and I think that's a philosophy that's… it's stated in the Act. It's very important that we do that."* [62]

[59] 4 May 2023, T 2-63, LL 46.
[60] 4 May 2023, T 2-63, LL 41-45.
[61] 5 May 2023, T 3-3, LL 27-35.
[62] 5 May 2023, T 3-31, LL33 to T 3-32, LL2. 2.

Depot recommencement

92. While Dr Reddan considered it *"was unwise for Mr Bahram not to have been placed back on a depot medication during his last admission from 21 December 2019 to 24 December 2019:"*

- *"On 7 February 2020…he was restarted on the aripiprazole depot and although comments were made in the undated Clinical Review about this, it also has to be pointed out that at the time of the autopsy, Mr Bahram had a therapeutic level of aripiprazole in his blood.* [63]

- *…It was at the lower end of normal, but, nonetheless, it was within the normal range. So, he did have aripiprazole there, and, generally speaking, with most patients…you only need 10 milligrams a day to get an adequate level. And for some patients who are what we call slow metabolisers they only need five milligrams a day…there's not as much known about levels and depot preparations…but he certainly did have aripiprazole and he had an adequate amount."* [64]

93. Toxicological analysis of a sample of femoral vein blood showed the level of Aripiprazole was 0.12 mg/L.[65]

94. Dr Reddan said it was often difficult for community staff to reinstitute depot medication, and decisions around that need to be taken in consultation with the usual treating psychiatrist. However, there was no evidence that the inpatient psychiatrist for the last admission (a locum psychiatrist) had discussed this issue with Dr Suetani.[66]

95. Importantly, Dr Reddan noted, *"it cannot be said with any certainty that this would have prevented subsequent events and it is always useful to remember that risk management is not the same thing as risk prediction (in other words, none of the staff could have predicted what happened on 23 February 2020)."* [67]

[63] Exhibit H3, 9.
[64] 5 May 2023, T 3-7, LL 20-25.
[65] Exhibit A4, 23.
[66] Exhibit H3, 7.
[67] Exhibit H3, 9. Emphasis added.

96. The Queensland Health Investigation Report[68] completed under Chapter 10, Part 4 of the Mental Health Act reviewed the treatment and care provided to Ikraam and noted:

> *"The decision by the inpatient locum psychiatrist to continue to manage Mr Bahram without intramuscular antipsychotic medication during the inpatient admission to Logan Hospital from 21 to 24 December 2019 was justified by the lack of evidence of relapse, from both observation of his behaviour during the four-day inpatient admission, and the collateral history obtained. However, the diagnosis of schizophrenia, evidence of poor compliance with oral medication in the past, concerns raised by his family, poor insight and possible signs of relapse meant that this decision should have included more extensive consultation with both Mr Bahram's family and his community team."*

97. I accept the submission of counsel assisting and Dr Suetani that the treatment and care provided to Ikraam was appropriate. I agree that it cannot be concluded that there was an outcome changing opportunity for Ikraam on any single occasion.

The challenges in diagnosing Ikraam and engagement with him by health professionals

Diagnosis

98. Ikraam's diagnosis shifted over time, from a possible drug induced psychosis to a primary psychotic illness (Schizophrenia). Dr Reddan considered the diagnosis of Schizophrenia made by the treating team, was *"more likely than not to be reasonable and accurate*." [69]

99. This conclusion was supported by the fact that Ikraam continued to display signs and symptoms of schizophrenia in the absence of a positive urinary drug screen for other substances. On that basis, I accept the opinion of the treating team, as supported by the expert opinion of Dr Reddan regarding diagnosis.

Engagement with the treating team

100. The Inquest heard evidence about the pressures the community treating team were operating under in terms of caseloads in 2019-20. In exploring the roles of persons involved in Ikraam's treatment and care, evidence was heard from Dr Suetani as the Community Psychiatrist and his Case Managers, Saputra Mulyadi and Registered Nurse (RN) Dawn Davies.

[68] Exhibit H2.
[69] Exhibit H3, 5.

101. Dr Reddan said that the number of patients Dr Suetani had overall responsibility for had the effect that the service model led to the ***"****primary therapeutic relationship being with the social workers and other ancillary health professionals, rather than the psychiatrist*."

102. The evidence was that because of the number of cases needing attention, case managers visit people at home or in other locations and would do most of the face-to face work. Notwithstanding, Dr Reddan said the minimum requirement for patients under the Mental Health Act to be seen by an authorised doctor every three months "*was not enough*." [70]

103. Ikraam's primary Case Manager, Saputra Mulyadi, noted that Ikraam probably *"tolerated"* his involvement. He acknowledged the good relationship he had with Ikraam's family.[71] In distinguishing Ikraam (the person) from his mental illness, Mr Mulyadi described Ikraam in the following way:

> *"I always felt he was someone who…was polite…even when he wasn't happy with what I had to tell him…I felt that he was caring. Like, I think he cared about his family very much…especially his mum…I felt he was…fiercely independent and…hardworking. Like I think he…always tried to go back to work and always to find more work and things like that."* [72]

104. Mr Mulyadi further noted: *"We want to treat, you know, people as people…not to have the diagnosis define them…in terms of recovery as well… we want to look at the person as a whole and that the …illness is…just that. It's just an illness… that can be treated…and people can live, you know, full and normal lives."* [73]

105. When asked by the lawyer for Metro South Health (MSH) to expand on the varying levels of capacity a consumer may exhibit during treatment and care, and ways to support and promote the wellbeing of the individual by ensuring they have a say in their treatment, (such as through supported decision-making processes), Mr Mulyadi responded:

> *"…Part of the Mental Health Act as well is that we are obligated to provide treatment with the least restrictive practice and…so that means…that we give consumers…some form of choice as well in terms of treatment…I usually say to a lot of my clients that…we're happy to work with you if you have issues with the medication and things like that…to an extent…we can sort of try and work with you…but we draw the line of…having no treatment at all…because we are responsible to…provide treatment too."* [74]

[70] I5 May 2023, T 3-14, LL 28-38.
[71] 4 May 2023, T 2-82, LL 9-11.
[72] 4 May 2023, T 2-82, LL 17-23.
[73] 4 May 2023, T 2-82, LL 29-34.
[74] 4 May 2023, T 2-82, LL 36 to T 2-83, LL 2.

106. The treating team's obligation to provide treatment and care to Ikraam in accordance with the objects and principles of the Mental Health Act and Chief Psychiatrist policies cannot be overlooked, or understated, particularly where Ikraam's family may feel that concerns and collateral information provided by them was not sufficiently acted upon. There is no doubt Ikraam's family was a strong protective factor for him. The treating team were conscious of supporting that relationship.

107. Collateral information from a family is a very useful and important tool to assist the treating team in monitoring possible deterioration in a mental health consumer's mental state. However, the treating team is required to make their own assessment of the action to be taken, based on objective clinical observations.

108. To that end, the Queensland Health Investigation Report[75] noted:

- *"Mr Bahram's treatment at BPCMHS was holistic and recovery-focussed, and there was good engagement with his family. The Inspectors found that the clinicians who delivered the care were capable, compassionate and committed to providing high quality care.*

- *Mr Bahram's family made repeated communications to express their concerns about his psychotic symptoms and deteriorating clinical state on a number of occasions, and particularly in the weeks before his death. Mr Bahram frequently dismissed these concerns or denied specific symptoms."*

109. The **main objects** of the Mental Health Act are outlined in section 3:

> *(1) The main objects of this Act are—*
>
> *(a) to improve and maintain the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated; and*
>
> *(b) to enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of committing an unlawful act or to be unfit for trial; and*
>
> *(c) to protect the community if persons diverted from the criminal justice system may be at risk of harming others.*

[75] Exhibit H2.

110. The objects of the Mental Health Act are to be achieved in a way that:

> *(2)(a) safeguards the rights of person; and*
>
> *(b) is the least restrictive of the rights and liberties of a person who has a mental illness; and*
>
> *(c) promotes the recovery of a person who has a mental illness, and the person's ability to live in the community, without the need for involuntary treatment and care.*
>
> *(3) For subsection (2)(b), a way is the least restrictive of the rights and liberties of a person who has a mental illness if the way adversely affects the person's rights and liberties only to the extent required to protect the person's safety and welfare or the safety of others.*

111. The ***principles for persons with a mental illness*** are found in section 5 of the Mental Health Act, and under section 7, a person exercising a power under the Mental Health Act must have regard to the principles in section 5.

112. Mr Mulyadi agreed Ikraam's mother was a fierce advocate for her son in seeking support.[76] It was evident from the medical records[77] that Ikraam's mother maintained regular contact with the treating team, and that the team acted on concerns raised by her. This was done in a way that sought to balance Ikraam's views, wishes and preferences, acknowledging that Ikraam may not have wanted the involvement of the treating team in his life.

113. Counsel for the family examined members of the treating team at the Inquest about specific dates in Ikraam's treatment and care. The family submitted that there were times where the concerns raised by them before December 2019 were not acted upon or not seen as urgently requiring intervention. However, it was submitted that *"the instances to this time appear to have been dealt with in a way that falls within sound clinical discretion."* The family noted:

> *"It is perhaps only with the benefit of hindsight that another course could have been taken, especially in the 9 December 2019 consult and decision to not re-institute the depot injection at that time where Ikraam presented after another lengthy period of non-adherence with the oral medication."*

114. However, in my view no single occasion can be pointed to as a possible outcome changing opportunity for Ikraam.

[76] 4 May 2023, T 2-66, LL 36-41.
[77] Exhibit G5.

115. Particular systemic issues emerged through this inquest, that may be considered to have impacted the ability of the treating team to act proactively, as opposed to reactively, inhibiting the community psychiatrist's ability to see Ikraam for anything other than 'crisis' presentations. Such issues in providing treatment and care to mental health consumers may be considered an issue of public safety.

The risk management screening tools used in respect of Ikraam and his deterioration in mental state

116. In terms of risk management screening tools, two issues were identified at inquest:

- The clinical use and value of such tools; and
- The risk of carrying over incorrect or outdated information because of the 'copy and paste function' in the Consumer Integrated Mental Health and Addiction (CIMHA) database.

117. The Clinical Review noted:

> *"From 2019, risk assessments were uploaded to CIMHA at least every 91 days, consistent with expected practice. However, information had been copied and pasted into new risk assessments, using the copy and paste function in CIMHA, without the information being updated to reflect changes or current circumstances. The information documented in the Risk Screening Tool is not consistent with the documented assessment conducted by the Consultant Psychiatrist on 18 February 2020*." [78]

118. The reviewers concluded this was because of the copy and paste function in CIMHA. However, it was noted that ultimately this may not have changed the assessed risk level for Ikraam at that time:

> *"Documentation issues may not have changed the assessed level of risk across the risk domains, if the risk assessment had been completed as a meaningful clinical process, it may have provided the clinicians with or alerted the clinicians to, information that would have better supported early recognition of deterioration in mental state, which in turn would have supported more timely response to deterioration."* [79]

[78] Exhibit H1, 3.
[79] Exhibit H1, 4.

119. The reviewers also found:

> *"The risk assessments were cross sectional, as opposed to longitudinal, which may have caused the treating clinicians to misinterpret Mr Bahram's anger and frustration as a reaction to current stimuli, rather than as an early warning sign of a deterioration in his mental state. During the last assessment conducted by Dr Suetani, Ikraam was noted to be angry and frustrated about the ongoing involvement of Mental Health Services. Had this episode of frustration been considered in a longitudinal fashion, a possible link may have been drawn between this episode and prior episodes of aggression, where for example, in 2018, Ikraam displayed aggression in the context of a deterioration in mental state, which resulted in Ikraam displaying violent behaviour including kicking a police vehicle."* [80]

120. The reviewers formed the opinion that:

- *"Clinicians did not give weight to symptoms reported by family in formulating the risk assessments, meaning symptoms were treated as reflective of a 'point in time' as opposed to a sign of deterioration in mental state*.

- *Clinicians missed opportunities to identify early signs and symptoms of a relapse or a deterioration in mental state, which could have shifted the risk profile across one or more risk domains and indicated the need for a higher level of care or intervention."* [81]

121. I accept the submission of counsel assisting that the opinion outlined in the Clinical Review (save for the comments regarding the copy and paste function in CIMHA), should not be preferred over the opinion provided in the Queensland Health Investigation Report and the expert opinion of Dr Reddan for the reasons outlined below:

- "*Risk issues in Mr Bahram's care were considered and documented at his final psychiatrist review on 18 February 2020, and decisions made were appropriate. His past behaviour had included only low-level acts of aggression when acutely unwell and there was no clinical indication of Mr Bahram presenting as an imminent risk of physical violence.*

- *Clinical review of Mr Bahram by his psychiatrist on 18 February 2020 considered risk of violence, found no overt acute mood or psychotic symptoms, and decided to continue assertive community management. On the*

[80] Exhibit H1, 4.
[81] Exhibit H1, 4.

information available to the psychiatrist at that time, the Inspectors agree that this decision was based on sound clinical judgement, and there was nothing to predict the subsequent behaviour on 23 February 2020.

- *The Tier 1 Violence Risk Screening Tool conducted on 19 February 2020 contained a number of deficits and inaccuracies and appeared to be largely a replication of the risk screen from the end of the inpatient admission in December 2019. A more accurate screen would have opened the possibility of the multidisciplinary team making a decision to progress to a Tier 2 VRAM. This would not have been an urgent referral, and so would not have affected the actual course of events, but it demonstrates the importance of the risk assessment process."* [82]

122. At inquest, when asked about Ikraam's potential risk of violence and the risk assessments conducted by the treating team, Dr Reddan said:

- *"The check box risk assessments – the last one done in some respects ignored what the psychiatrist had written, to some extent, and it was out of date. And I think the comments made in one of the reviews about the cut and paste function of CIMHA; this has been something that's concerned a number of us for a while…There's an incentive for people to just keep repeating previous statements. That means information can be inaccurate, it can be out of date, and yet it keeps being repeated. It also means, too, sometimes when patients have, in fact, recovered, information about that recovery is not there either. I think it's difficult to answer for everyone.*

- *I find them, as a clinician myself, useless, but I understand why it's there. But it was clear to me when I read Dr Suetani's records, and, in particular, I mentioned, I think, in my report, some notes made by Dr Bowers at the Princess Alexandra…Dr Suetani was aware there were some risks.*

- *In the context of the sorts of range of patients a lot of us see, and he would see – have seen, his risk wouldn't have been regarded as high for aggression or violence compared to others. But this is the whole problem with risk assessments…Risk assessment is not risk prediction. And even if you say someone's risk is high, that sometimes can be heard by people as meaning predictable, more likely than not, but that's not what it means at all. It may mean*

[82] The Tier 2 assessment and response is designed to assess longitudinal risk and inform current and ongoing management. For more information on VRAM, see below.

just a bit more than the general population. Well, that doesn't mean it's predictable, more likely than not, at all.

- *So, I think…they were clearly alive to the risks. They wouldn't have kept him under the Mental Health Act…and done all those things that went on in 2018 – for example, the wellbeing team, the admission to Acmena House. And then later there was a referral to the intensive treatment team. I think they're all part of that understanding. And, as I said, those notes from that last admission, or when that last admission was precipitated and he turned up at Princess Alexandra with the police, there was a comment about that, that was made when the registrar spoke to the treating psychiatrist that clearly illustrates that they were alive to risks. But documentation is only as good as what, you know – and I personally would like to see the cut and paste function in CIMHA disabled."* [83]

123. When asked about the possible rigidity of the risk assessments Dr Reddan said:

> *"You're seeking to place…the box in a particular check – or the risk into a particular checkbox. Is it a mandated requirement that those risks – assessments are completed routinely?---Yes, it is. It is…Risk assessment is only useful if it leads to assistance in management, but you wouldn't think that from looking at the form. So, they're done in such a way that there's not much nuance. You end up with categories – low, medium, high. Well, I don't think that's particularly useful. Now, there's gaps to enable more to be written in, but I think that – look, the vast majority of clinicians probably don't read them. So they're filled out because of KPIs, but whether they're clinically meaningful is a different question."* [84]

124. When asked if perhaps time would be better spent by clinicians in having additional face to face time with consumers as opposed to completing paperwork such as risk assessments, Dr Reddan opined:

- *"Well, the answer is clearly yes…these things are…documentation of this kind can be helpful if it's clinically meaningful, not if it's just merely ticking boxes to fulfill KPIs. KPIs need to be crafted to be meaningful, and what tends to happen is that the KPIs are done and are imposed on every service as if every service is the same, and they're not.*

[83] 5 May 2023, T 3-7, LL 30 to T 3-8, LL 11.
[84] 5 May 2023, T 3-8, LL 17-28.

- *So, the bottom line is that the – the caseloads here are very, very high. Now, the amount of paperwork that everyone requires is enormous too. I was not surprised but somewhat – well, not surprised when I know the numbers, but, you know, for example, Dr Suetani mentioned in his statement that he was doing between 17 to 34 Mental Health Review Tribunal reports a month. That is a huge amount of work on its own."* [85]

125. The expert opinion of Dr Reddan highlighted systemic issues that did not reflect on the actions of the practitioners involved, but rather the system in which they were operating. I agree with the submission from Dr Suetani that he was working in an environment of systemic under resourcing. However, he continued to provide Ikraam with an adequate level of care despite his caseload and reporting requirements.

126. While it cannot be said that Ikraam's risk of violence was not properly considered by the treating team, the caseloads of the treating team, and the possibly 'limited clinical value' of the risk assessment tool, brings into question the use of such tools in supporting meaningful clinical practice and providing treatment and care to mental health consumers. I also note that the completion of the risk assessment tool was the role of the case managers, not Dr Suetani.

127. This is particularly so where the copy and paste function is still available in CIMHA, and where it might be suggested that the risk assessment exercise is more reflective of KPIs, as opposed to having actual clinical value for the safety of the mental health consumer and community.

128. The submission from MSH acknowledged the period between January and December 2019 was a busy time for Dr Suetani and the team in terms of caseload. However, there was nothing in Ikraam's presentation to Dr Suetani on 18 February 2020 that suggested any increased risk of violence or overt acute or psychotic symptoms.

129. MSH submitted that during periods of increased demand/case load, including during 2019, there were systems in place that would prioritise the clinical needs of the consumers to provide appropriate services.

130. MSH submitted that caseloads and staffing are subject to continual review and are related to the ongoing difficulties at a State and national level in recruiting to mental health positions, especially during and since the COVID pandemic, with several experienced clinicians and consultants moving to the private sector.

131. Ongoing workforce and recruitment and retention strategies are being explored and implemented by MSH.

[85] 5 May 2023, T 3-8, LL 30-43.

Whether a Police and Ambulance Intervention Plan (PAIP) for Ikraam would have assisted in his mental health care

132. A Police and Ambulance Intervention Plan (PAIP) is *"a plan ideally developed in consultation with the Consumer, the Mental Health Treating Team and other stakeholders including the QPS. It extrapolates considerations for intervention and outlines potential risks as a means to support both the Consumer and police officers to safely resolve a Mental Health Incident."* [86]

133. I agree with the submission that a PAIP would not have assisted Ikraam or the QPS officers on 23 February 2020, as the involved police officers only had a few seconds to respond to Ikraam's actions.

134. Dr Reddan was asked how important a PAIP may be, in terms of risk management. Her view was that:

- *"A Police and Ambulance Intervention Plan may be useful in terms of risk management for a person such as Mr Bahram, but it would not have been useful on 23 February 2020. It is apparent from the body-worn camera footage retrieved from the police officers who attended that Mr Bahram ran at them so quickly there was really no intervention that would have been effective and there is really no evidence that any PAIP would have changed the outcome in this case.*

- *The other difficulty would have been that the police officers who were called to the disturbance on the street almost certainly did not know Mr Bahram's identity at that point and they would not have had time to look up any intervention plan. Such intervention plans are a nice idea, but in reality, they are often of little value as events can unfold very quickly as they did in this case. They also need to be completed by someone who knows the patient, such as the case manager in consultation with the treating doctor."* [87]

135. A PAIP would not have assisted on 23 February 2020. However, Ikraam had experienced prior mental health incidents such as when he attended the Browns Plains Police Station on 4 July 2018[88] and 31 July 2018.[89] He had also been conveyed to hospital with the assistance of the QPS and QAS on multiple occasions in relation to concerns for his mental health. In those circumstances, I accept the submission of counsel assisting that it is not unreasonable to have expected that a PAIP would

[86] Exhibit I1.
[87] Exhibit H3, 7 - 8.
[88] Exhibit C15.
[89] Exhibit C16.

have been completed for Ikraam at some point during his mental health treatment and care.

136. Since Ikraam's death, it should be noted that the PAIP is now referred to as a Police Advice and Intervention Plan and now includes validity dates to address concerns of outdated information.

Whether the information sharing provisions between the QPS and Queensland Health with respect to persons experiencing a mental health incident were sufficient in the lead up to Ikraam's death

137. In the lead up to Ikraam's death the *Mental Health Collaboration - Memorandum of Understanding* (MOU) allowed information to be shared between Queensland Health and the QPS, recognising that often both parties provide services to the same people experiencing mental illness or vulnerability in the community.[90]

138. The MOU allows for the otherwise prohibited disclosure of confidential information[91] to the QPS, for the purpose of assisting in the safe resolution of mental health incidents, and *"proactive collaboration between the parties for the development of mental health intervention strategies."* [92]

139. Confidential information about Ikraam's mental health was shared between Queensland Health and the QPS at a stakeholder meeting, described by Sgt Luke Kleidon:

> *"I had observed on our police system that there had been a mental health assessment conducted…as a consequence of that…I contacted our mental health liaison officer from Logan…she put me in contact with the treating doctors and psychologists of Ikraam… I engaged with those treating persons, had a sit-down meeting to discuss Ikraam and that incident. Out of that, we had discussed that the incident occurred because Ikraam was suffering from a mental health episode at that time and was seeking help from the police on that day but wasn't able to verbalise what he was seeking."*[93]

140. I accept that the information sharing provisions between the QPS and Queensland Health with respect to persons experiencing a mental health incident were sufficient in the lead up to Ikraam's death. However, both parties should exercise caution in ensuring they are using the same terminology to ensure accuracy in communication and a proper understanding of diversionary pathways.

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[90] Exhibit I1, 2.
[91] As described in section 139 of the *Hospital and Health Boards Administration Act.* See also Schedule 3 of the MOU.
[92] Exhibit I1 at [3.2].
[93] 3 May 2023, T 1-56, LL 1-10.

141. For example, the term *'monitored patient'* is a term used by Queensland Health, but it does not mean a patient is monitored more closely for possible deterioration of their mental state.

142. Mr Mulyadi's evidence was that, *"with monitored patients…that doesn't indicate that the person is being monitored per se, it's more that the records are being monitored in terms of access…so usually when a record…has monitored access, it usually means that…it could be someone who's a client of a service that has…family that works in the service, so they…may have access to the system, or they could be…someone…of public interest. So…the purpose of monitored access is to ensure that…only the people who are providing care or…doing legitimate…administration tasks are accessing the records and not…anyone who isn't supposed to."* [94]

143. Mr Mulyadi also gave evidence at the Inquest that in his experience as a Case Manager, the different understanding between various organisations (such as the QPS and Queensland Health) can affect his ability to provide treatment and care.[95] This was in the context of discussion around an Authority to Transport an Absent Person (ATAP) for Ikraam in December 2019.

3) Whether the police officers involved acted in accordance with the Queensland Police Service policies and procedures then in force, and whether said actions were appropriate.

144. After encountering Ikraam on Mary Street, Constable Eiser and Senior Constable Hughes were faced with an active armed offender and had only seconds to respond. They tried to de-escalate the situation, in accordance with QPS training, by providing assertive verbal directions and attempting to tactically withdraw, while drawing their service issued weapons (lethal force). When Ikraam did not comply, both officers discharged (fired) their service issued weapons in response to the threat.

145. Detective Sergeant Green concluded that both officers acted in accordance with all relevant QPS policies and procedures in interacting with Ikraam on 23 February 2020, that the training provided to them was adequate, and that no changes to policies or procedures are required.[96]

146. Similarly, Sergeant Lucas Finney concluded in his report and at inquest that Constable Eiser and Senior Constable Hughes complied with all policies and procedures in relation to the use of lethal force and that no changes were required to those policies or procedures.[97]

[94] 4 May 2023, T 2-79, LL 33-43.
[95] 4 May 2023, T 2-65, LL 14-16.
[96] Exhibit A5. 3 May 2023, T 1-26, LL 15 to T 1-27, LL 8.
[97] Exhibit C6. 3 May 2023, T 1-52 – T 1-53.

147. As I indicated on day three of the inquest, there can be no adverse comment made about the actions of Constable Eiser or Senior Constable Hughes. The evidence showed they only had a matter of seconds to respond to Ikraam when they arrived at Mary Street. They were not aware of his background in terms of his mental health history and had to respond to the highly dynamic situation that presented at that point in time.[98]

148. I also noted that Sergeant Kleidon's involvement was tangential, and the same comment was extended to him.[99]

149. After considering the evidence of Detective Sergeant Green, Sergeant Finney and the evidence of the Constable Eiser and Senior Constable Hughes (including their body worn camera footage), I conclude that the actions of QPS officers Eiser and Hughes in using lethal force were reasonable, proportionate, consistent with their training and appropriate.

4) Whether the training provided to police officers in responding to similar incidents is sufficient

150. During the inquest, Constable Eiser and Senior Constable Hughes both agreed the training they had received as QPS officers adequately equipped them to handle the situation they faced on 23 February 2020.[100]

151. In addition to the evidence provided by Constable Eiser and Senior Constable Hughes, I accept the opinion of Detective Sergeant Green and Sergeant Lucas Finney in respect of the sufficiency of training provided, and that no preventative changes are required in terms of QPS policies and procedures in relation to use of force options.[101]

[98] 5 May 2023, T 3-2, LL 17-22.
[99] 5 May 2023, T 3-2, LL 36-40.
[100] 3 May 2023, T 1-35, LL 30 and T1-43, LL 25.
[101] 3 May 2023, T 1-53, LL 30.

5) The adequacy of the investigation into the circumstances surrounding Ikraam's death

152. At the PIC on 30 May 2022, and again during consultation with parties regarding the issues for inquest, legal representatives for the family sought to add the issue of *"The conduct of investigating police after the shooting of Ikraam."* [102]

153. In the submissions filed on behalf of the family, in reply to the issues for inquest (dated 21 April 2023), legal representatives for the family noted:

- *"After the death of Ikraam, the police investigation was mischaracterised by investigators as an examination of terrorist-like activity. The justification for such a characterisation is not clear on the brief material, considering the clear and cogent causation between Ikraam's conduct and his poor mental health on any examination of his antecedence.*

- *The decision to proceed with an investigation into terrorism-like activity, at least in a preliminary stage, resulted in emotional impacts to the family including the deprivation of certain religious rights, reputational impact, and significant distress. Moreover, the nature of the preliminary investigation was a distraction to the real issues, and meaningful conclusion to the investigation.*

- *The investigation into terrorism-like activity involved the forced entry (through search warrants) into the Bahram family home, questioning disrupting the early stages of grief, publicity in journalistic media connecting Bahram to terrorism (albeit as suspected terrorism), and reputational damage to the family and likely the practice of Islam in Brisbane.*

- *Given focus of the inquest is on mental health considerations, and those factors were elementary, obvious and pervasive in any examination of the circumstances of the shooting, the family seek to join issue with the conduct of police in the immediate aftermath of the incident, particularly in relation to their contact with the family."*

154. I acknowledge the cultural concerns of the family and the high level of distress immediately following Ikraam's death. I also acknowledge that the experience of having personnel from both the QPS and the AFP in the family home in the immediate aftermath of Ikraam's death was distressing, particularly in terms of Islamic cultural practices.

[102] Submissions in reply to the issues for inquest, filed by the legal representatives for the family, dated 21 April 2023.

155. However, my review of the transcripts provided indicates that the verbal communication with the family by law enforcement officers during the execution of the search warrants was respectful.[103]

156. Hindsight bias cannot be overlooked regarding this issue. The family had clearly and extensively communicated, firmly held concerns about the contribution of Ikraam's mental health to his actions on the day of his death. [104] However, it was not unreasonable to expect that law enforcement officers decided to exhaust all lines of inquiry in relation to Ikraam's motivation for his unprovoked assault on an unknown tourist and subsequent interaction with QPS officers as an active armed offender in the Brisbane CBD.

157. While the issues for inquest were amended in consultation with the parties to further explore Ikraam's mental health and how that may have been connected to and/or influenced his behaviours on the day of his death, this was done with the benefit of hindsight and following detailed analysis of the materials gathered in the coronial investigation. This was done in an effort to understand the circumstances in which Ikraam came to the attention of police and ultimately his death.

6) Whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice

158. S 46(1) of the Coroners Act allows a coroner to comment, whenever appropriate, on any anything connected with the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

159. Dr Reddan's evidence at the inquest was that the systemic pressures under which the community mental health team at the BPCMHS were operating in early 2020 (in terms of caseloads, professional requirements, MHRT requirements, inability to fill positions, and inability to backfill staff on leave) were such that the team were *"reacting, rather than proactive*." [105] Dr Reddan acknowledged that this was a workplace issue.[106]

160. Counsel assisting submitted that I could consider commenting in respect of several systemic issues that relate to matters of public health and safety for mental health consumers, and the clinicians who provide treatment and care. I sought a response from the Director-General of Queensland Health and the CEO of Metro South Health in relation to those topics and the proposed recommendations.

[103] Exhibit B48, B48.1 and B48.2.
[104] Exhibit B48. Exhibit B48.1, 12. B48.2, 1.
[105] 5 May 2023, T 3-14, LL 43-44.
[106] 5 May 2023, T 3-14, LL 21-22.

161. While I was ultimately persuaded that it was not necessary to make recommendations about those matters, it is appropriate that I make the following comments in relation to the issues and how they are being addressed by the mental health system.

Caseloads and staffing at the BPCMHS

162. Ikraam was an open patient of the BPCMHS. Dr Reddan considered that caseloads at that service were too high, and this may have affected the ability of the team to build and maintain a therapeutic relationship with Ikraam, and to provide treatment and care. It was difficult for the Community Psychiatrist to see a mental health consumer, other than when they were in crisis. As noted above, the:

> *"Primary therapeutic relationship'* was *'with the social workers and other ancillary health professionals, rather than the psychiatrist…simply because of the sheer numbers, but also case managers are often visiting people at home or visiting people out in other locations, so they do get to often know them'...'The requirement if patients are under the Act (MH Act) is that they be seen by a doctor every three months…that's not enough. That's been set as a kind of minimum requirement but it's not enough."*

163. During Ikraam's last admission to an Authorised Mental Health Service (AMHS)[107] as an inpatient, given the timing of the admission (Christmas 2019), Dr Reddan said:

> *"It was unfortunate that…this occurred over the Christmas New Year period. February's a very busy period in general business. It is in health services as well. But you can't just look at the last week or so. You've got to look at going back months…this service has very high caseloads. Too high. Insufficient cover, too many things demanded, inability to keep staff. There's a lot of very serious systemic factors here"*.[108]

164. Dr Reddan also conceded that it was not known how many harmful outcomes are prevented and that studies really cannot be done to predict that. Even with well-staffed services, harmful outcomes can still occur.[109]

165. As Dr Reddan noted, risk management is not risk prediction. While Ikraam's actions on 23 February 2020 could not be predicted, the operational environment for the treating team could have been much better. As Dr Reddan further opined:

[107] See Schedule 3 *Mental Health Act 2016* (Qld).
[108] 5 May 2023, T 3-13, LL 28-35.
[109] 5 May 2023, T 3-13, LL 37-40.

"But you certainly, probably improve recovery and reduce negative outcomes where people have more time to think about their patients and have more time to do even, sort of, general basic work." [110]

166. Dr Reddan spoke about the professional requirements of psychiatrists in roles such as Dr Suetani outside the duty to provide treatment and care to mental health consumers. She noted very detailed letters were sent by Dr Suetani to Ikraam's General Practitioner (GP), perhaps more than would be expected. She also spoke of the pressure to catch up on work after returning from leave (as was the case in late 2019 and early 2020). In trying to address what may be a suitable case load Dr Reddan said:

- *"I've been looking in the literature for a few months about, well, what are ideal case numbers…This isn't really known, and it's not really developed, but that's a very high case number, and it means that you never have an opportunity…if things start going wrong – and at any one time, a whole lot of your patients are in some sort of semi or in crisis. You don't have time to think. You don't – it's hard to get time to consult with a colleague. You really don't want to be seeing doctors who don't have time to consult with colleagues*...[111]

- *I think there needs to be a much more in-depth look at…including by experienced clinicians, not people who no longer see patients, but by experienced clinicians at what caseloads are reasonable; what clinical loads people have coverage over periods of time; the mix of stuff …as I said before, a mix of people of varying levels of seniority; the training of registrars, not that that was relevant necessarily here, but…it can be quite onerous if it's done conscientiously, and having two registrars to supervise is just very surprising.*

- *And how you can support people with paperwork. This will vary according to the complexity of patients. If you're in a rural or semirural area, it's going to be more difficult, because you're going to have places…you've got travel. What's …the substance use in the local area. But there really needs to be, I think, a long-term project on this. It's not going to be something you can do overnight. And it needs to be…done looking at research and with a very good understanding of what your patient mix is, what other support services you have.*

[110] 5 May 2023, T 3-13, LL 42-44.
[111] 5 May 2023, T 3-9, LL 30-38.

- *It's actually a very complicated project to do it properly. But I don't think it's helpful to say to an individual clinician, "Well, if you've got too much work to do and there's not enough coverage, you sort it out," as one of the reviews more or less did. I thought that was very unhelpful*." [112]

167. Several recommendations were made in the Queensland Health Investigation Report,[113] including:

> *"Metro South AMHS to ensure adequate workforce capability and distribution across sites, and to consider strategies to improve recruitment in those areas struggling to attract staff. Appropriate governance structures and systems should be established to support equitable allocation of psychiatrists and registrars across all Metro South sites to monitor caseloads and develop plans to manage when caseload thresholds are exceeded."*

168. Counsel assisting submitted that while this may address the issue of staffing, the issue of caseloads for treating teams warrants considerable [emphasis added] further exploration in line with the recommendations of Dr Reddan and there may need to be a project undertaken by Queensland Health as the overarching body, to properly consider the demographics of mental health consumers, and caseloads of treating teams across the state to ensure recommendations are aimed at maintaining the safety of mental health consumers and clinicians as opposed to simply meeting KPI's.

169. Dr Suetani supported this recommendation.

170. Further information was sought from MSH to understand what, if any impact, additional government expenditure has had on mental health caseloads and whether Metro South Addiction and Mental Health Services (MSAMHS) had undertaken any work to address the issue of caseloads.

171. Since 2021, MSAMHS has received $16.3 million in additional funding which has been used to increase Full-Time Equivalent (FTE) positions by 84 FTE. Funding has been directed to recruit and train additional clinicians, which MSH reported had reduced maximum case loads to 29 and average case loads to fewer than 20 across the PAH, Logan, and Redlands.

[112] 5 May 2023, T 3-14, LL 1-22.
[113] Exhibit H2.

172. MSH advised that the introduction of new service models have enabled MSAMHS to redirect mental health consumers (who would previously have been allocated to case management) to clinically appropriate specialist services. The Sub-Acute Model at the Princess Alexandra Hospital was referred to as an example, resulting in a large percentage of consumers being assessed and discharged back to primary care management (such as their GP).

173. MSH has also used additional funding to expand its service models, such as the Early Psychosis model. This means that consumers are allocated to other teams as opposed to case management. MSH also reported that two new Crisis Spaces have opened at Redlands and Logan, offering mental health services as an alternative for mental health consumers attending the Emergency Department in crisis.

174. MSH reiterated the difficulty in recruiting appropriately qualified and experienced mental health staff and identified several strategies in response, including more case manager training roles and clinical education roles.

175. Queensland Health has also identified that through *Better Care Together*, it will develop a dedicated MHAOD workforce plan underpinned by existing strategies including *Advancing health service delivery through workforce: A strategy for Queensland 2017-2026*.

176. Better Care Together will implement recommendations relating to the mental health workforce from the Mental Health Select Committee's Report *Inquiry into the opportunities to improve mental health outcomes for Queenslanders.*

Information sharing among the treating team/s

177. Information sharing among and between treating teams (such as inpatient and community teams) are issues that have been highlighted in connection with Ikraam's last admission to an AMHS in December 2019.

178. The Queensland Health Investigation Report recommended:

> *"Metro South AMHS to develop a process and policy to facilitate case conferences at the time of critical decision-making points, such as the decision to continue to manage Mr Bahram without Long-Acting Injectable medication at the end of his inpatient admission in December 2019. Such case conferences would ideally include members of community and inpatient teams; families/carers; and patients; take a longitudinal perspective; informed by static and dynamic risk factors for violence; take into account the views of the various stakeholders; achieve an agreed management plan; and identify factors which would indicate a*

need to review the plan. The number of such reviews conducted should be audited after 12 months."

179. Further information was sought from the Director-General of Queensland Health in respect of the proposed recommendations regarding education around less restrictive options and AHDs, risk assessment paperwork, and aspects of CIMHA such as the cut and paste function.

180. The response noted that in the Queensland Health Mental Health Alcohol and Other Drug (MHAOD) system, clinical information is recorded in the statewide electronic health record for MHAOD services, known as the CIMHA application.

181. In August 2020, *Comprehensive Care - Partnerships in Communication and Care'* (the Comprehensive Care initiative) was released. The Comprehensive Care initiative focused on streamlining, standardising, and enhancing clinical documentation processes to better support MHAOD services to document clinical care provided to mental health consumers at all stages.

182. Comprehensive care refers to integration across care including screening and assessment, formulation and diagnosis, care planning, clinically appropriate and effective treatment and care provision, care review and transitions of care. Each stage is informed by carer engagement, and social and cultural considerations and supports MHAOD services to meet the *National Safety and Quality Health Service Standards (NSQHS Standards, 2nd ed., 2017)*, Comprehensive Care Standard, Communicating for Safety Standard and Partnering with Consumers Standard.

183. The *Comprehensive Care Documentation Framework* replaced the Standardised Suite of Clinical Documentation (SSCD) and guideline on *The Use of the Standard Suite of Clinical Documentation* that was active in 2019 and early 2020.

184. A core intention of the Comprehensive Care initiative is to support longitudinal assessment, accurate diagnosis, comprehensive and collaborative care planning and review, and treatment to address a mental health consumer's comprehensive care needs. The recording and communication of clinical information across a mental health consumers care team is supported by the clinical documentation. While MHAOD staff are allowed greater flexibility in how care provision is documented, there are some mandatory requirements regarding the provision of care, documentation of care, timing, and use of specific templates across the mental health consumer's care journey.

185. Queensland Health considers that the adoption of a standardised approach to clinical documentation strengthens communication for safety within and across teams, which in turn supports mental health consumers and their carers to partner in care planning and review processes of care. There may be a further added benefit of optimising the use of the CIMHA application reporting capability.

Advance Health Directives for mental health consumers

186. The Office of the Chief Psychiatrist has published resources in relation to treatment criteria, assessment of capacity, less restrictive way, and advance health directives. This includes a flow chart outlining consent to health care for persons who lack capacity and an information brochure (including a guide and form) for advance health directives for mental health.

187. Noting the difficulties for the treating team in engaging with Ikraam, particularly as his illness went into remission, and he sought to exercise more self-autonomy in respect of his treatment and care, counsel assisting submitted that Queensland Health should consider a state wide initiative in relation to education for mental health consumers and health care staff regarding the use of AHDs as a further 'less restrictive' option, to ensure their views, wishes and preferences are canvassed and upheld wherever possible.

188. Metro South Health supported this recommendation.

189. Further information was sought about the proposed recommendation from the Director-General of Queensland Health. In his response, reference was made to the Independent Patient Rights Advisers (IPRAs) established under the Mental Health Act (ss 293, 294 and 295). A function of the IPRA is to assist patients and their nominated supported persons, carers, and family to understand their rights and responsibilities under the Mental Health Act and to assist in ensuring a patient's views, wishes and preferences about their treatment and care are communicated. [114] IPRAs, and clinical staff may provide information to mental health consumers about the benefits of an AHD.[115]

190. An appointment as an *authorised doctor* or an Authorised Mental Health Practitioner (AMHP)[116] requires mandatory completion of the eLearning training *'Treatment criteria and less restrictive way of treatment.'* Refreshment training every two years is required for a clinician to remain appointed as an AMHP or authorised doctor.

[114] *Mental Health Act 2016* (Qld) s 294(b).
[115] *Mental Health Act 2016* (Qld) s 294(g).
[116] *Mental Health Act 2016* (Qld) s 340 Appointment of authorised mental health practitioner. Schedule 3 Dictionary.

191. The Queensland Centre for Mental Health Learning provides free training to Queensland Health and QAS staff aimed at supporting clinicians to understand capacity assessment and AHDs in the context of the Mental Health Act. The suite of training is aimed at mental health clinicians and may be useful for authorised doctors, AMHPs and psychiatric registrars. There are also several publicly available resources that may be accessed by mental health consumers and their support networks.

Risk assessments

192. As submitted by counsel assisting, because of the caseloads of the treating team, and the possible 'limited clinical value' associated with the risk assessment tool, it cannot be said that Ikraam's risk of violence was not properly considered by the treating team. However, the use of such tools in supporting meaningful clinical practice and providing treatment and care to consumers might be questioned, particularly where a copy and paste function is still available in CIMHA, and where it might be suggested that the risk assessment exercise is driven by KPI's, as opposed to having actual clinical value for the safety of the consumer and community.

193. Counsel assisting submitted that I may consider recommending a Queensland Health wide project, (noting that the risk assessment screening tools are not isolated to the BPCMHS) to consider the clinical value of risk assessment paperwork (and its frequency for completion, as opposed to enhancing a treating team's ability to have more face-to-face time with a consumer through regulated caseloads, and appropriate staffing). In line with Dr Reddan's opinion, practitioners consulted in respect of such a project should reflect a mix of skill and experience of clinical practice and expertise.

194. Metro South Health supported this recommendation.

195. Further information provided by MSH confirmed it has updated the *Comprehensive Care Procedure* to establish a coordinated approach to the delivery of care across all MSH facilities. This procedure is built on the *Comprehensive Care Initiative* (above). MSAMHS have established a Comprehensive Care Committee to continuously monitor MSAMHS performance against the NSQHS Standards specifically standard 5 - the Comprehensive Care Standard. This includes identifying patients at risk of harm and delivering strategies to prevent and manage harm.

196. The Committee reportedly drives quality improvement within the service to improve safety and quality outcomes for mental health consumers. Mandatory training for clinicians (*QC54 Foundations of Risk Assessment and Management*) has been introduced. Clinician computers now have a desk top icon for easy access to MSAMHS policies, guidelines, procedures, and work instructions to provide guidance when performing a risk assessment for a mental health consumer.

197. An additional 0.5 FTE has been invested to employ a forensic psychiatrist to support completion of Violence Risk Assessment and Management (VRAMs) for high-risk mental health consumers. This appointment will reportedly provide an additional senior clinician that may solely focus on high-risk mental health consumers.

198. Information provided by the Director-General of Queensland Health addressed clinical risk screening, assessment and management of clinical risk, communicating about risk, assessing and responding to a risk of violence, assessment and risk management committees.

Clinical risk screening

- *Clinical risk screening is an ongoing and dynamic process of identifying the potential for risk across a range of risk domains including suicide, self-harm, violence, Domestic and Family Violence (DFV), treatment non-adherence, risk of harm to children, and vulnerability.*
- *Risk screening is used to determine whether assessment of clinical risk is needed, and to support risk prevention and management planning, which is incorporated into overall care planning.*
- *While it is not possible to identify and eliminate all risks, the objective of good clinical risk management is to minimise the likelihood of an adverse outcome.*
- *Clinical risk screening commences at a consumer's first point of contact with a service and risk state and status is reviewed regularly throughout the consumer's episode of care.*
- *Formal review (and documentation) of risk assessment and risk management plans takes place at planned multidisciplinary meetings however re-assessment of risk and multidisciplinary review of risk management plans should also be completed on an ad hoc basis, whenever there are changes in a consumer's presentation, treatment, or life situation.'*

199. In CIMHA, the Risk Screen template is used to document risk and protective factors. It is not considered to be a comprehensive assessment of risk, but rather, allows for an overview of a mental health consumers current risk to confirm whether a more fulsome risk assessment is indicated.

200. The risk screen tool has several evidence informed prompts relating to the dynamic and static factors for the risk domains. This acknowledges the changeable nature of risk and supports practitioners through prompting with reliable indicators of what may indicate risk. The intention is that the risk screen tool is completed in conjunction with any other assessment and screening tool at a mental health consumers initial assessment and, for those continuing care, updated every 91 days, or as needed, including when care is transferred.

201. Amendments were made to the Risk Screen and Care Review CIMHA templates in September 2023, following clinician feedback and consultation with senior Queensland Health MHAOD staff and review of clinical incident reports. The amendments include:

- *Updating risk factors and aligning identified risk factors with appropriate frameworks, pathways, or referral to specialist services to support linking to the Suicide Prevention Guideline, Assessing and Responding to Violence Framework, and Queensland Health's response to domestic and family violence.*

- *The Care Review template was amended to prompt treating teams to consider appropriate frameworks, pathways or referral to specialist services in the event that elevated risk factors are identified.*

202. The Office of the Chief Psychiatrist is undertaking further work to strengthen risk screening processes.

203. I also note that under the *Better Care Together Digital Information Strategy*, Queensland Health will optimise how information can be collected, used, and shared to deliver safe care efficiently. In partnership with clinicians, work will be undertaken to examine the impact of current administrative and clinical systems, including documentation, on non-clinical workloads, and identify and implement system, policy, and procedural changes to increase time spent on direct care activities.

Assessment and management of clinical risk

204. The more comprehensive process of gathering, reviewing and interpreting information to learn about a mental health consumer and understand their needs is referred to as a clinical assessment. This often follows screening.

205. Strategies to manage risk are incorporated into MHAOD treatment planning and considered during care reviews. Input is sought from the mental health consumer, their carers, other support persons and a multidisciplinary team. As required, specialist input may be obtained from Forensic Liaison Officers (FLOs), Mental Health Intervention Coordinators (MHIC) and the Community Forensic Outreach Service (CFOS).

206. The overall assessment of risk, relevant to a mental health consumer must be used to inform the formulation and holistic care plan, with key information used in other clinical documentation such as the Longitudinal Summary which supports continuity of care.

Communicating about risk

207. Risk factors and management strategies are captured in a range of documents (in addition to the screening and assessment tools) such as Longitudinal Summary, Care Plan, Care Review, Acute Management Plan (AMP), Police Advice and Intervention Plan (PAIP) and Transfer of Care. Clinical risk information is recorded in CIMHA.

Assessing and responding to a risk of violence

208. The VRAM Framework was introduced by Queensland Health in response to the 2016, *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services* report.

209. The VRAM Framework is intended to provide clinicians with a systematic approach for the identification, assessment and management of mental health consumers who may pose a risk of violence towards others, including family members and children. The VRAM framework was implemented statewide in March 2019 following a six-month pilot that spanned 34 teams in five Hospital and Health Services (HHSs) (Metro South, Children's Health Queensland, Mackay, Townsville, and North-West).

210. The VRAM Framework supports structured violence risk assessment and management through a tiered approach, principles of good practice, clinical tools to underpin clinical expertise, training, clinical governance, and a quality assurance cycle for continuous improvement.

211. Where a heightened risk to others is identified through routine risk assessment (which may include children and family members), a more intensive risk assessment and management process is triggered. That process includes expert input, and oversight through local governance processes.

212. When conducting a Tier 2 assessment of violence risk and response, the V-RAM clinical note template is completed by senior mental health clinicians. The tier 2 assessment supports comprehensive assessment of violence risk by examining previous episodes of violence; past, current, and future risk factors; protective factors; and interventions for each risk factor.

213. In the event the multidisciplinary team identify a need for a more specialised risk assessment, a referral may be made to the CFOS to conduct a Tier 3 risk assessment and provide guidance and support with risk management, along with a more detailed assessment of violence risk by a specialist. CFOS recommendations for risk management and ongoing care are supported by local governance processes and multidisciplinary team review. The HHS Assessment and Risk Management Committees (ARMCs) may conduct a review of the plan.

214. Information on the roles and responsibilities of Queensland MHAOD clinicians in providing advice and support to families, carers, and other service networks, where concerns for their safety have been identified, can be found in the: *At risk of violence: a safety planning information and resource guide* (published November 2019). This resource is currently under review.

215. In 2024, the Office of the Chief Psychiatrist undertook an evaluation of the VRAM Framework to review the implementation and application of the Framework across HHSs between July 2019 and June 2023. The findings of the evaluation have informed the development of an educational *MHAOD Assessing and Responding to Violence Framework Poster* resource. The purpose of that resource is to provide an accessible overview of the tiers, to outline required clinical information related to violence risk, and to provide key contacts for clinical staff.

Assessment and Risk Management Committees

216. The ARMC functions as a clinical peer review of the treatment and care of mental health consumers subject to a forensic order or treatment support order made under the Mental Health Act and other mental health consumers (whether subject to a treatment authority or voluntary) whose risk profile is assessed as high by their treating team.

217. In 2020, the *Chief Psychiatrist Policy for the treatment and care of patients subject to a Forensic Order, Treatment Support Order or other identified higher risk patients* was revised to include an additional requirement for persons identified on the basis of risk of harm to others to have an ARMC review when there is an increase in risk (VRAM tier 2 or tier 3), material changes in circumstances, or at any other time the clinical director, administrator of the AMHS or Chief Psychiatrist determines a review is required. These changes were made with the hope of strengthening risk management.

218. The Chief Psychiatrist policies (including the *Treatment and care of patients subject to a Forensic Order, Treatment Support Order, or other identified higher risk patients*) are under review to ensure they are fit for purpose.

Copy and paste function in CIMHA

219. Counsel assisting submitted that I may consider a recommendation as to a Queensland Health project (noting that the function is not isolated to the BPCMHS) to consider restricting or disabling the copy and paste function in CIMHA, noting the issues identified in respect of inaccurate documentation for consumers and the possibility that carrying forward old information has the potential to upset or stigmatise consumers where the reports generated do not accurately reflect recent progress in recovery (which may in turn inhibit the therapeutic relationship between consumers and their treating team).

220. Metro South Health supported this recommendation.

221. Information provided by MSH confirmed that while CIMHA has a copy function, education and guidance is provided to CIMHA users confirming the importance of reviewing, updating, and checking the accuracy of information copied, prior to electronically signing the record.

222. Information provided by the Director-General of Queensland Health confirmed the copy and paste function referred to was built into the Windows operating system, rather than a feature enabled by the CIMHA application.

- *CIMHA Clinical Note templates have a range of functions that will enable the entry of some information into a clinical note with ease. Import functionality is dependent on the template and template field selection. Not all import functions are available for all fields within a template.*

- *These functions are intended to assist clinicians to reference well documented information, in a timely manner.*

- *The CIMHA functionality, data tags and import options, as well as the ability to copy static historical information from previous CIMHA entries or external sources (e.g. copy and paste), are intended to promote continuity of care and minimise the documentation burden and have been endorsed by appropriate governance to allow clinicians to spend more time in direct clinical contact with the consumer.*

- *It is important to note that the information imported by these functions requires clinical confirmation of its validity, accuracy and importance to the document being signed and its intended audience.*

223. Information about the import functionality in CIMHA can be found in the *Clinician's Handbook Volume 7: Clinical Notes & Secure Transfer.* When an author electronically signs a clinical note, they take responsibility for the accuracy of the information within it. Reportedly, Queensland Health will communicate to all users of the CIMHA application a reminder of the existing policy.

224. On that basis, I do not consider that any further recommendation is required.

Recommendations proposed in relation to information sharing for MHS Addiction and Mental Health Service consumers

225. Metro South Health submitted that it had fully implemented all recommendations made in the Clinical Review that was conducted after Ikraam's death and further:

- Reflective practice meetings were held with Ikraam's treating team.

- Findings were communicated to the Risk Assessment and Safety Planning Group.

- Key findings regarding medication management were referred to the MSH medication management committee for their review and to identify opportunities for improvement.

- The Care and Recovery Planning Committee developed a qualitative audit of Care Plans. This was rolled out in February 2021 and now forms part of the quarterly audit schedule.

- 7 day follow up rates are regularly reviewed and monitored by the clinical teams as well as at the Executive level monthly during the performance meetings. Any variance in the follow up rates are discussed to address the gaps identified.

- 7 day follow up trend data was added to the Patient Flow Dashboard and is regularly discussed at the Patient Flow Optimisation Working Group. The data suggests that the MSH Addiction and Mental Health Service are in line with the State-wide key performance indicators.

- A Ryan's Rule process for community patients was raised at the State-wide Patent Safety and Quality Improvement Service.

- The Quality Use of Medicines Procedure was updated to include specific information regarding withdrawal or modification of prescribed psychotropic medications and monitoring requirements.

- Leave for medical doctors is now only approved by the Divisional Director or Line Manager when appropriate arrangements are available to cover clinical and operational requirements.

226. Metro South Health's submission noted that discharge planning now occurs in partnership with consumers, carers and family and the multi-disciplinary team. This is an integral component to the efficient and effective transition of consumers across the care continuum.

227. The *Work Unit Guideline of Addiction Services Academic Clinical Unit and the Inpatient Multidisciplinary Team Review Meeting Procedure* outlines the service accountabilities for case reviews to ensure compliance with evidenced informed practice standards. This includes assessments for consumers in addition to the regular assessments to identify and escalate clinical risks which require additional support to manage when there is significant change in the clients presentation or when identified that another person is at an increased risk of harm to self or others, or by others.

228. I close the inquest.

Terry Ryan
State Coroner
BRISBANE

Schedule of Abbreviations

AFP	Australian Federal Police
AHD	Advance Health Directive
AMHP	Authorised Mental Health Practitioner
AMHS	Authorised Mental Health Service
AMP	Acute Management Plan
ARMC	Assessment and Risk Management Committee
ATAP	Authority to Transport Absent Person
BPCMHS	Browns Plains Community Mental Health Service
CFOS	Community Forensic Outreach Service
CIMHA	Consumer Integrated Mental Health and Addiction
DSM-5	Diagnostic and Statistical Manual of Mental Illnesses-5
FLO	Forensic Liaison Officer
FTE	Full-Time Equivalent
GP	General Practitioner
HHS	Hospital and Health Service
IPRA	Independent Patient Rights Advisor
MHAOD	Mental Health Alcohol and Other Drug
MHIC	Mental Health Intervention Coordinator
MHRT	Mental Health Review Tribunal
MOU	Memorandum of Understanding
MSH	Metro South Health
MSAMHS	Metro South Addiction and Mental Health Services
NSQHS	National Safety and Quality Health Service
OCP	Office of the Chief Psychiatrist
PAIP	Police Advice and Intervention Plan (formerly a Police and Ambulance Intervention Plan)
QAS	Queensland Ambulance Service
QPS	Queensland Police Service
RN	Registered Nurse
SSCD	Standardised Suite of Clinical Documentation
VRAM	Violence Risk Assessment and Management