QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Manmeet Sharma**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2016/4532
DELIVERED ON:	27 October 2023
DELIVERED AT:	Brisbane
HEARING DATE(s):	14-16 March 2022, written submissions to August 2022.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, mental health, killing of a bus driver by mentally ill person, discharge from Intensive Treatment Order, discharge from voluntary treatment, bus driver safety.
REPRESENTATION:	
Counsel Assisting:	Ms R Helsen
Mr Sharma's family:	Mr P Wilson, instructed by Caxton Legal Service

Queensland Health, Office of the Chief Psychiatrist:	Ms J Franco, Crown Law
Metro South Health:	Mr D Schneidewin, instructed by MSH
Metro North Health:	Ms J Fitzgerald, instructed by MNH
Dr De Souza-Gomes:	Mr A Luchich, instructed by Avant law
RN Gourlay:	Ms S Robb, instructed by QNMU Law
Brisbane City Council:	Mr C Murdoch KC, instructed by City Legal Group
Dept of Transport and Main Roads:	Mr Ben McMillan, instructed by DTMR
Rail, Tram and Bus Union:	Mr Tom Brown

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Introduction

1. Manmeet Sharma was just 29 years of age at the time of his death. He was working with the Brisbane City Council (BCC) as a bus operator. He had been working for BCC for just over three months.[1]

2. On the morning of 28 October 2016, Mr Sharma was driving a Volvo B7 Bus, which had been designated to travel Translink route 125 from the Garden City Shopping Centre along Beaudesert Road, Moorooka to Fortitude Valley. The bus was fitted with CCTV cameras, which recorded to an on-board hard drive.

3. At around 8:55 am, Ms FD was waiting for the bus at the stop 32 outside the Lifeline store on Beaudesert Road. She recalled seeing a male standing close to the road and the bus stop. He had a black backpack, and appeared to have his hand inside the backpack holding something.[2] He looked stressed and worried, pacing quickly on the footpath. She heard him talking loudly at passers-by.[3] Ms FD felt scared of the male and avoided eye contact with him. She saw him move away from the bus stop as the bus approached.[4]

4. Mr NP, who was also waiting at the bus stop, recalled seeing a male who was talking at passers-by, making comments in relation to 'tourists'.[5]

5. At around 9:00am, the bus pulled into stop 32, Beaudesert Road at Moorvale, Moorooka, just north of the intersection with Mayfield Road. A number of passengers boarded the bus at this time, including Mr Anthony O'Donohue. Passengers recalled that Mr Sharma was very friendly. He greeted each passenger as they entered the bus.[6]

6. Mr O'Donohue held a black backpack as he approached Mr Sharma, who was seated in the driver's seat of the bus. The backpack contained a plastic bottle filled with a mixture of diesel and petrol. Using a BBQ lighter, Mr O'Donohue lit a wick inserted in the bottle. He then tipped the bag and its contents onto Mr Sharma who instantly became engulfed in flames. CCTV footage of the incident was captured on a camera located above the driver's seat. Within seconds, the camera view was obscured by smoke due to the intensity of the fire.

7. There were 14 passengers on board the bus at the time of the incident, including three children. Ms FD was seated in front of the rear door on the passenger side, She saw Mr O'Donohue enter the bus before taking something from his backpack, which he appeared to flick at the driver.[7] She said there was immediately a large fire on the bus driver, and on the wall up to the ceiling, with lots of dark smoke.[8] All the passengers started screaming and moving towards the rear doors.

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[1] Ex B103, [5]
[2] Ex B7, [23]
[3] Ex B7, [24]
[4] Ex B7, [27]
[5] Ex B14, [15]-[17]
[6] Ex B9, [21] & [22]
[7] Ex B7, [35]
[8] Ex B7, [37]

8. The exit doors located halfway along the left side of the bus were closed at the time of the incident. They were fitted with an emergency release mechanism but this was not activated. The passengers approached the rear doors and tried to open them. However, they were held closed by the standard pressurised mechanism.

9. Mr MA was on the bus with his 3-year-old son. He recalled shortly after entering the bus hearing another passenger yelling about a fire. He turned around and saw flames and smoke in the area where Mr Sharma was sitting. Mr Sharma was waving his arms in the air.[9] He immediately dragged his son to the doorway in the middle of the bus, which other passengers were unsuccessfully trying to kick open. Mr MA recalled that one passenger was able to push themselves through the very small opening between the two doors, after which he assisted other passengers to escape.[10] He was able to exit the bus with his son through this opening and called 000. By that time, there was a lot of smoke within the bus and it was hard to see.[11]

10. A passing Taxi Driver, Mr Nyok, saw that the passengers were stuck on the bus. He managed to force the rear doors open, allowing them to escape the smoke and fire.[12] Two passing motorists also saw the fire and approached the bus. They tried to extinguish the flames around the driver's seat using several extinguishers.[13] They continued until emergency services arrived. One of the motorists said that as he arrived at the scene and saw the bus was on fire, he saw a male exit the bus with his left leg on fire.[14] He described thick smoke pouring out of the door, with the inside of the bus full of smoke.[15] He saw Mr Sharma, clearly deceased, in the front of the bus. If not for the bravery of Mr Nyok and other passers-by, it is almost certain that some or all of the passengers would also have been killed as a result of the actions of Mr O'Donohue.

11. Queensland Fire and Emergency Services (QFES) attended a short time later and managed to extinguish the flames. Mr Sharma was deceased. A majority of passengers, including Mr O'Donohue, had stayed in the vicinity of the bus stop. CCTV footage depicted Mr O'Donohue stepping off the bus before taking a seat at a nearby bench.[16]

12. Queensland Ambulance Service (QAS) officers also arrived at the scene. They triaged the passengers before commencing treatment. Mr O'Donohue was treated for a burn to his lower right leg.

[9] Ex B4, [8]
[10] Ex B4, [9] & [10]
[11] Ex B4, [10]
[12] Ex B96, [19] – [21]
[13] Ex B79 & Ex B93
[14] Ex B79, [17]
[15] Ex B79, [25]
[16] Ex B7, [41] & [42]

Personal History

13. Mr Sharma was born in the Alisher village in the Indian state of Punjab in 1987. A very moving video prepared by his family was played at the inquest. His family said that he had lived his life like any high spirited young man. He was a beacon of hope for his parents and an ally and support for his siblings, the life of every party for his friends and a truly compassionate individual. His one dream was to repay his parents' hard work.

14. Mr Sharma worked as a radio announcer in Brisbane, he was a singer and an actor. His family said he was more than a son, brother and friend. He was a beautiful human being, loved and respected by everyone.

15. Mr Sharma's family questioned why someone as unwell as Mr O'Donohue, whose actions proved his level of danger, "*could have been allowed to have* remained*, essentially untreated, in the community*". They agonised over whether something could have been done to prevent Mr Sharma's tragic death.

16. Mr Sharma's family also expressed concerns about the delay in finalising proceedings in Queensland's criminal justice system and in this Court. They were concerned about the apparently lenient treatment given to Mr O'Donohue. It is their perception that he was not made accountable for his actions after being referred to the Mental Health Court.

17. I extend my sincere condolences to Mr Sharma's family and friends.

The inquest

18. Mr Sharma's death was a reportable death under the *Coroners Act 2003* (Qld) as it was a 'violent or otherwise unnatural death'. I determined that it was in the public interest that an inquest be held into his death. The Mental Health Court had also flagged that an inquest might consider matters such as bus safety and access to community treatment by Mr O'Donohue.[17]

19. The purpose of an inquest is to provide the public and the family of the deceased person with answers about the matters required by s 45 of the *Coroners Act*, including how the person died and what caused the person to die. In appropriate cases, a coroner may also make comments or recommendations to prevent similar deaths, or on matters relating to public health and safety and the administration of justice. A coroner must not make any finding that a person is civilly liable or may have committed an offence.

20. In the context of this inquest I have been mindful of hindsight bias and outcome bias. Hindsight bias refers to the tendency of those with knowledge of an outcome to overestimate the predictability of what actually 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. As Dekker and Hugh note, outcome bias is particularly likely to occur when medical practitioners give opinions on the care provided by other medical practitioners. Where there is a severe outcome

[17] G2 , 21

the harshness of judgements and the willingness to make judgements, both increase.[18]

21. The inquest was not able to commence until the criminal proceedings involving Mr O'Donohue were finalised in August 2018. The inquest was commenced with a pre-inquest conference on 12 December 2019 and was scheduled to proceed in March 2020.

22. Unfortunately, the inquest was delayed due to the COVID-19 pandemic which prevented Mr Sharma's family from travelling to Australia for the proceedings. The inquest was eventually held at the Coroners Court at Brisbane over three days from 14 to 16 March 2022 with members of Mr Sharma's family in attendance. I am grateful for the assistance provided by Queensland Health in facilitating their attendance. The delivery of the inquest findings was also deferred to enable the family to attend, in conjunction with the anniversary of Mr Sharma's death.

23. A brief of evidence, which included the Coronial investigation report, as well as over 350 statements, audio and video exhibits, photographs and other materials gathered during the coronial investigation, was tendered at the commencement of the hearing.

24. In total, 13 witnesses were called to give evidence during the inquest. Many of Mr Sharma's family and friends attended the hearing.

25. In addition to the findings required by s 45 of the *Coroners Act*, the issues considered by the inquest into Mr Sharma's death were:

    - Consideration of the Mental Health treatment provided to Mr O'Donohue by the various Mental Health Services in Queensland.

    - Consideration of the circumstances and decision to discharge Mr O'Donohue from the Metro South Mental Health Service in 2016.

    - Consideration as to the actions taken, and those proposed, since October 2016, by the Queensland Government to Mental Health Services for high-risk consumers.

    - What further actions, if any, could be undertaken to prevent a similar tragedy from occurring again in Queensland, including any further changes necessary to address bus and bus operator safety?

26. It is not possible to outline in detail all the material tendered at the inquest. A summary of the relevant written and oral evidence which informed my findings is provided.

[18] Hugh TB, Dekker SWA. *Hindsight bias and outcome bias in the social construction of medical negligence: A review*. J Law Med 2009;16:846–57.

Investigation

27. Queensland Police Officers (QPS) attended and established a crime scene on 28 October 2016. I attended the scene. Several passengers had identified Mr O'Donohue as the perpetrator, and he was subsequently approached and spoken to by Detectives. Mr O'Donohue was placed in a forensic suit with gloves before being arrested and transported to the Princess Alexandra Hospital (PAH) for further treatment for his burns.[19] He was 'agitated and stressed', and initially refused to speak to Police.[20] He provided his driver's licence as identification.[21]

28. While at the PAH, Mr O'Donohue was assessed by the Mental Health Team, including two psychiatrists. Detectives were advised that he had previously been treated for mental health issues. He was warned and spoken to by Detectives at length about his work history and personal life. During this interview he suggested that there was a conspiracy to keep him unemployed and make his life difficult.

29. Eventually, Mr O'Donohue was deemed medically fit to remain in police custody and released from the PAH.

Queensland Fire and Emergency Services Fire Investigation Report

30. On 28 October 2016, Queensland Fire and Emergency Services (QFES) were called to respond to a bus on fire outside 149 Beaudesert Road, Moorooka. A 000 call was received by the Brisbane Fire Communications Centre at 9:05 am.[22]

31. Crews from the Rocklea Fire Station arrived at the scene at 9:14 am. The fire was located at the front of the bus with one person remaining inside. Two firefighters entered the bus. Mr Sharma was located and confirmed deceased. At 9:17 am, the crew informed Firecom of the fatality. The information was relayed to the QPS. The fire was declared to be 'out' at 9:20 am.[23] The remainder of the bus was searched, and no other occupants were located.

32. Fire Investigator, Mark Dorman, arrived on the scene at 10:04 am and, with the QPS, attempted to establish the cause of the fire.

33. A crime scene was established after the fire was extinguished.[24] The QPS Bomb Squad also conducted a search of the bus and immediate area, declaring it safe to conduct the investigation. The initial examination of the bus was conducted by QPS officers who were provided with atmospheric testing equipment by the QFES for safety.[25]

34. A report detailing the findings of the investigation conducted by Mr Gorman was subsequently provided.[26] A summary of the findings is outlined below.

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[19] Ex B67, [14] – [18]
[20] Ex B21, [17] – [22]
[21] Ex B21, [24] & [25]
[22] Ex D1, pg. 10
[23] Ex D1, pg. 10
[24] Ex D1, pg. 11
[25] Ex D1, pg. 12
[26] Ex D1

External observations

35. The northbound bus was parked curb-side adjacent to the footpath at the Moorvale bus stop. The passenger side of the bus was facing west towards the footpath. The bus was headed north.

36. The windscreen of the bus displayed a large crack that ran horizontally from in front of the driver position over towards the north-side then down to the base of the windscreen. The inside surface of the windscreen and lower from the north-side corner displayed smoke staining.

37. The visible damage to the exterior of the bus was restricted to the front end. The driver's side sliding window was broken due to heat and flame impact from within the bus.[27] The V pattern of smoke staining to the side of the bus emanated from mid-way of the window opening up to the roof line. The patterns had been caused by the products of combustion venting out of the window opening from within the bus.[28]

38. Observations of the location and intensity of the fire related damage across the exterior of the bus indicated the fire had initially developed inside the front area of the bus.[29]

Internal observations

39. The internal layout of the bus consisted of a front door for passenger entry, egress and communication with the driver. A small waist height door provided access for the driver into their 'driver compartment space'. No other path of egress was available to the driver.[30]

40. The driver compartment is elevated one step above the front entry floor. The driver is semi-encapsulated by a moulded plastic console and dashboard. A Perspex wall is fitted behind the driver's seat.

41. Entry was gained to the bus for the purpose of the investigation by the rear entry doors. It was noted that within 3 metres of the front of the bus the ceiling damage intensified to the extent that panels had melted and dropped due to direct flame and heat impact.[31]

42. The front area of the bus had suffered the greatest level of fire damage, and a large, melted ceiling panel was hanging down in line with the rear of the driver's compartment. The Perspex panel behind the driver's seat, as well as the upholstery and foam padding of the driver's seat backrest, displayed a tapered burn pattern.[32]

[27] Ex D1, pg. 14
[28] Ex D1, pg. 14
[29] Ex D1, pg. 14
[30] Ex D1, pg. 14
[31] Ex D1, pg. 15 & picture on pg. 16
[32] Ex D1, pg. 16

43. Fire damage was observed to the non-slip flooring material at the entry to the bus, the bottom of the front folding entry/exit door and an access panel.[33] The dashboard surface and instrument panel facing the driver's seat were fire damaged through direct flame contact and radiated heat.[34] Plastic components above and forward of the driver's seat were melted and fire damaged from direct flame contact.

44. Mr Sharma was seated with his body partly angled towards the access door and path of egress. His knee was up against the inside of the access door.

45. Following the removal of Mr Sharma's body, the bus was transferred to a secure site. On 29 October 2016, Mr Dorman, QPS Scientific Officer Carl Streeting and Scenes of Crime Officer Kelly Loth conducted a further examination of the bus.[35]

46. The driver's compartment was examined, including a layer search of floor level fire debris around the driver's seat. At floor level, between the base of the driver's seat and the small entry door to the compartment a partly melted plastic bottle was located, similar to a 2L plastic milk container.[36] The floor area under the plastic container still displayed the 'blue' colour of the vinyl floor covering. This indicated the container was in this location during the early stages of the fire.

47. A molten plastic item, which resembled a butane gas wand type lighter with a trigger action was found adjacent to the plastic bottle.[37]

48. Electrical cabling and components around the driver's seat were examined and found not to be the source of the ignition.

49. Fire patterns found on the aluminium footrest, the driver's seat back-rest and base all indicated that the fire intensity was to the left-hand side of the driver's compartment facing the front entry door.[38] Observations of the location and intensity of the fire related damage across the internal areas of the bus indicated the fire developed at the driver's compartment.[39]

Path of fire travel

50. Mr Dorman concluded that an ignitable liquid had been applied to the front area of the bus and driver's compartment. Excess ignitable liquid spilt out of the entry area and down the gutter in a state of flaming combustion. The driver's seat compartment had sustained a greater level of fire damage than the entry area. Mr Dorman concluded the fire started at or about the drivers' compartment.[40]

51. Convective heat rise projected radiated heat and direct flame contact towards the ceiling and adjacent windows. This caused melting of the plastic ceiling lining and cracking of the windscreen and side glass. As the fire continued to develop,

[33] Ex D1, pg. 17
[34] Ex D1, pg. 17
[35] Ex D1, pg. 19
[36] Ex D1, pg. 19
[37] Ex D1, pg. 20
[38] Ex D1, pg. 20
[39] Ex D1, pg. 23
[40] Ex D1, pg. 23

flames and concentrations of heated smoke particles would have been projected laterally within the upper sections of the bus, progressing towards the rear.[41]

52. The developing fire continued to escalate and was directed laterally out through the front door and the driver's side window. Further, smoke and heat have been projected rearwards causing melting damage to the ceiling lining back to the rear door and smoke staining throughout the interior.[42]

Safety features

53. The bus was fitted with a number of safety features for emergency situations, including:[43]

- A portable DCP fire extinguisher mounted in the front entry area.
- Between the front and rear doors, large windows on either side of the bus were designated as an 'emergency exit,' with a life hammer mounted adjacent to the windows to break the glass. It was noted that these two exits would have been exposed to high heat and smoke.
- Two roof mounted hatches were installed, one above the driver's compartment and one above the walkway near the rear of the bus, both of which were in the closed position.
- Two safety devices were fitted in the path of egress front and back for passengers inside the bus to use in case of an emergency. Inside the front of the bus, low on the left side of the front entry area is an 'emergency exit' red push button to open the front door. This exit button had been exposed to heat and direct flame contact.
- A similar red 'emergency exit' push button was located internally above the red exit door, provided to open the rear door in case of an emergency. This button was not activated during the fire.
- Externally, both doors had a button to press to open the doors in an emergency situation, located to the right of each door at floor level.

Fire Investigation Conclusions

54. The conclusions reached by the Investigator were based on extensive examination of the scene, processing areas of intense fire damage, fire patterns, and consideration of eyewitness and fire responder accounts and other exhibits, including CCTV footage.

55. The area of origin of the fire was identified as being the driver's compartment at the front of the bus, with the point of origin at and about the left side of the driver's seat.[44] The source of the ignition was found to be a portable gas BBQ lighter.

[41] Ex D1, pg. 23
[42] Ex D1, pg. 24
[43] Ex D1, pg. 24
[44] Ex D1, pg. 26

56. The fact the fire was purposely lit was demonstrated through the location of the plastic container in the driver's compartment with a high reading of accelerant residue of 117 parts per million (ppm). The fire pattern across the entry floor of the bus continued down the gutter (104 ppm) outside the bus, indicating a running liquid fire.[45] The location of what appeared to be a BBQ lighter at the scene indicated it was introduced as a portable ignition source to ignite the original fuel package. The fact that Mr Sharma was still seated indicated an unexpected and rapid escalation of fire development. There was no time for him to escape.

57. The available witness accounts, observed fire patterns and evidence located on-scene indicated the cause of the fire was "an act of incendiarism through malicious human intervention."[46]

QPS – Fire Scene Investigator, Snr Sgt Streeting

58. Snr Sgt Streeting provided a detailed statement. He is a forensic scientist and examined the scene in conjunction with Investigator Dorman to determine the cause and origin of the fire.[47] Snr Sgt Streeting concluded the cause of the fire, which originated in the front entrance and driver's compartment of the bus, was the human initiated combustion of an ignitable liquid.[48] The ignition source could not be conclusively identified at the time. However, the remains of what appear to be a BBQ lighter were located in the area of origin.

Further Police Inquiries

Interview with Mr O'Donohue

59. At around 5:45 pm on 28 October 2016, Mr O'Donohue was transported to the Upper Mt Gravatt police station where he was offered the opportunity to participate in a record of interview with Detective Senior Constable Denis Silk and Plain Clothes Senior Constable Alex Whittle.[49] He was appropriately warned.[50]

60. While Mr O'Donohue refused to speak directly about the fire,[51] he provided the following relevant information about his circumstances and history:

- His residence at Moorooka was subsidised and he received a Disability Support Pension.[52]
- He did not take any medication or use illicit drugs. However, he was prescribed Paliperidone some time ago for a delusional disorder.[53]
- He worked for Queensland Rail in 2009/2010.[54]

[45] Ex D1, pg. 27
[46] Ex D1, pg. 27
[47] Ex B60
[48] Ex B60, [58]
[49] Ex B67, [22]; Ex B4
[50] Ex B4, pg. 3
[51] Ex B4, pg. 29
[52] Ex B4, pg. 7 & 8
[53] Ex B4, pg. 10
[54] Ex B4, pg. 12

- He did not have his Go Card out when he went to get on the bus and was not able to describe the bus driver in any detail.[55]

- There were no other devices at his residence that may be harmful.[56]

61. It seemed from the information provided by Mr O'Donohue that he suspected there was a detailed conspiracy against him.

Search of Mr O'Donohue's residence

62. A search was conducted of Mr O'Donohue's residence at Beaudesert Road, Moorooka. The unit complex consists of 27 residences, providing accommodation for those with high needs, including mental health issues.[57]

63. Explosive Ordinance Response Team Officers conducted an initial security search of the residence.[58] A plastic petrol container with cloth in it (similar to that used in the bus attack) was located on the verandah, along with handwritten notes detailing bus numbers on the kitchen table.[59] Notebooks were seized as well as various other items, including a laptop, USB drives and digital cameras. These items did not reveal any further relevant evidence.[60]

64. Police canvassed residents of the unit complex. No relevant information was obtained.

65. Police also obtained statements from staff at the Services Union at South Brisbane. They described an incident involving Mr O'Donohue on 23 August 2016. He attended the office demanding to speak to a Union official. He was threatening and abusive, expressing the desire to get 'retribution against the union.'[61] He was asked to leave the premises and demanded information about other union offices in the area.[62] He then attended the nearby Electrical Trades Union office where he threatened and abused staff.

66. Mr O'Donohue's long-time friend, Mr Gray, told police he presented as paranoid, spoke frequently about the Workers Union being out to get him, as well as people walking on the street.[63] He never disclosed threats to hurt other people.[64] Mr O'Donohue had also disclosed previous suicide attempts by way of pills, as a way to rid himself of the voices he was hearing.[65]

67. While concerns were raised with Police that the incident may have been racially motivated, investigations suggested this was not the case. This concern was reiterated during Mental Health Court proceedings.

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[55] Ex B4, pg. 33-35
[56] Ex B4, pg. 43-45
[57] Ex B83, [13]
[58] Ex B36, [13]
[59] Ex B36, [14]; Ex B40, [19]; Ex B62, [16]
[60] Ex B26, [5]; Ex B40, [12]
[61] Ex B98, [22]
[62] Ex B98 & B90
[63] Ex B86, [21]; Ex B94, [17]
[64] Ex B94, [35]
[65] Ex B86, [30]

Criminal Charges

68. Mr O'Donohue was transported to the watch house where he was formally charged with the following offences:

    - Murder.
    - Attempted murder.
    - Arson.
    - Wilful Damage.

69. Mr O'Donohue was subsequently remanded in custody, before being transported to The Park Centre for Mental Health on 29 January 2017. He was assessed and treated at this facility under an Involuntary Treatment Order.

Autopsy results

70. An external and full internal post-mortem examination was performed by Dr Nathan Milne on 30 October 2016 at Queensland Health Forensic and Scientific Services.[66] Histology and toxicology tests, as well as a CT scan, were also undertaken. Dr Milne attended the scene on the day of the incident. He also viewed CCTV footage.

71. The external post-mortem examination revealed severe burns to 84% of the total body surface area. It could not be determined to what extent the burns occurred before death. Identification was undertaken by use of dental records. There were no identifiable injuries unrelated to the fire.

72. The internal post-mortem examination revealed a mild degree of smoke inhalation. There was no pre-existing natural disease.

73. Histology showed some soot present on the tongue, however, not on the epiglottis or in the passages of the lungs.

74. Toxicology testing of blood samples taken showed a normal carbon monoxide level (less than 5% haemoglobin saturation). The cyanide level was higher than normal, but below toxic levels. This was found to be consistent with a degree of smoke inhalation, as cyanide can be produced by combustion of materials, such as plastics. No drugs or alcohol were detected in the blood or urine.

75. The cause of death was found to be effects of fire. In addition to the direct thermal effects of the fire, Dr Milne noted that other possible effects included smoke and gas inhalation and the exclusion of oxygen.

[66] Ex A2

Mr O'Donohue's Mental Health Treatment History

76. A summary of Mr O'Donohue's relevant mental health treatment history and engagement with services was extracted from the records and reports provided for the purpose of the coronial investigation.[67]

77. Mr O'Donohue maintained he did not have contact with any mental health professional before 2010.[68]

78. From 23 March 2010 – 9 April 2010, Mr O'Donohue was admitted to the Redlands Mental Health Unit following a suicide attempt by overdose and a car crash in Kyogle, New South Wales. His suicidal ideation was related to 'paranoid delusions,' related to a conspiracy associated with trade unions. This stemmed from his employment with New South Wales Rail in around 2006. He was diagnosed with Delusional Disorder, Persecutory Type, and prescribed Risperidone. He was discharged to community care. Within a few months, he had moved from Wynnum to Alderley and ceased treatment.

79. In mid-July 2010, Mr O'Donohue's General Practitioner offered him a referral to the Acute Care Team (ACT) at the RBWH after he had expressed suicidal ideas. Mr O'Donohue refused the assessment.

80. On 24 August 2010, Mr O'Donohue's General Practitioner wrote to the Valley Mental Health Clinic. Mr O'Donohue had stopped his medication as he felt there were significant side effects and he had experienced little improvement. He was linked with a psychologist at Stones Corner due to chronic suicide risk.

81. Between September and November 2010, Mr O'Donohue was repeatedly assessed and treated by the RBWH Acute Care Team. He missed or cancelled some appointments. He was assessed as being psychotic and insightless. He was placed on a trial of aripiprazole from late October 2010. He was closed to the ACT in November 2010 and referred to the RBWH Homeless Health Outreach Team (HHOT).

82. On 28 October 2011, Police obtained an Emergency Examination Order (EEO) under the *Mental Health Act 2000* for Mr Donohue after he was threatening to kill other people and himself.[69] At the time, he had a tyre lever, hammer and box cutters in his possession. He admitted that the tyre lever was intended to be used to hurt someone.

83. From 29 October 2011 until 22 November 2011, Mr O'Donohue was admitted to the RBWH under an EEO after being brought in by the police after making threats to kill public sector workers, including police, and presenting to police with a weapon fashioned from a tyre lever.

84. He was further assessed and received treatment subject to an Involuntary Treatment Order. He expressed the idea of hitting a police officer on the head, stealing his gun before shooting the officer and himself.

[67] Ex G4-G10
[68] Ex G10, pg. 9
[69] Ex B65

85. He also expressed the specific plan of attending the Australian Services Union on Peel Street, Brisbane and killing as many people as possible, as he considered all public sector workers as 'fair game.' He claimed that he would kill a family member in an instant as he blamed his problems on them. His psychotic symptoms were said to have had an appreciable response to Olanzapine, and he was switched to Paliperidone depot weekly. Records captured descriptions of delusional beliefs and paranoia. While he was largely behaviorally settled and cooperative, he reportedly remained fairly insightless. Mania, a mood disorder, and paranoid schizophrenia were also considered diagnostic possibilities. He was assisted to apply for a Disability Support Pension. He was discharged still subject to an ITO, and resided in a hostel. He was referred for follow up by the RBWH HHOT.

86. In December 2011, Mr O'Donohue saw a HHOT Psychiatrist, who recorded his diagnosis as Paranoid schizophrenia, and noted that he was 'superficially settled'. The ITO and Paliperidone depot medication were continued at this time.

87. In 2012, Mr O'Donohue was offered psychotherapy to help manage his symptoms and distress (including recurrent suicidal thoughts) which he reportedly found helpful. Ongoing issues with unemployment, weight gain, sexual side effects of medication, impermanent accommodation and social isolation troubled him.

88. In April 2012, Mr O'Donohue reportedly told mental health staff he had priced a handgun and had ongoing ideas to kill union officials. A Community Forensic Outreach Service (CFOS) risk assessment was arranged.

89. In May 2012, a CFOS desk top assessment was conducted, which involved a case discussion with the treating team.[70] It was noted that engagement was a key factor in attempting to manage patients with the features exhibited by Mr O'Donohue. All threats were to be taken seriously. It was noted that it would be important to watch for any increased signs of risk, such as last resort thinking, suicidal ideation or more specific homicidal thoughts or plans. Treatment of his psychosis was a key factor in maintaining his safety in the community. It was considered that, *'it is quite possible that he may experience a decrease in the degree of preoccupation, intensity and associated behaviour with consistent treatment over a prolonged period of time.'* Ensuring long term follow up via maintaining his ITO to minimise the risk of him defaulting on treatment in Queensland was considered important.[71] It was recommended that a low threshold for readmission and reassessment be applied if his risk was considered to increase.

90. In June 2012, Mr O'Donohue was moved into a shared unit at Kedron with the assistance of the Transitional Housing Team. He was assessed as functioning well in terms of activities of daily living by an occupational therapist.

91. By November 2012, Mr O'Donohue was relocated to the independent subsidised public housing unit in Moorooka. Though he remained insightless, his mental state was assessed as stable. He continued to have longstanding delusions of persecution directed towards his relatives.

[70] Ex F4, pg. 199-202
[71] Ex F4, pg. 200 & 201

92. On 15 December 2012, Mr O'Donohue's care was transferred to the Continuing Care West (CCW) Team, which operated out of the Burke Street Clinic. At the time, he was an involuntary patient and prescribed antipsychotic medication via injection every four weeks.

93. Mr O'Donohue's management was primarily overseen by Psychiatrist, Dr De Souza-Gomes, and RN Gourlay with additional support provided by Psychologist, Ms Little. The team model was 'collaborative' in terms of the care and treatment provided to patients.[72] It was observed that he had chronic delusions related to trade unions and these had 'incorporated homicidal ideation.' While his delusional system was noted, as were his beliefs that he did not have a mental illness and did not require antipsychotic treatment, he was assessed as being a low risk. He engaged in regular contact with RN Gourlay via telephone and home visits. He was clinically risk assessed through three monthly case reviews by the team.

94. In May 2013, Dr De Souza-Gomes reviewed Mr O'Donohue and confirmed the diagnosis of delusional disorder, assessed the risk and reiterated the need for involuntary treatment and ongoing medication by way of depot. He was not thought disordered during her review. She noted that he was in stable accommodation and back in regular contact with old friends.

95. In November 2013, a female neighbour contacted the housing agency with concerns about Mr O'Donohue's mood and suicidal ideas. He responded angrily, suggesting she was just trying to cause trouble. Dr De Souza-Gomes noted his 'hostility' and 'anger' towards the 'conspirators.'

96. In November 2013, Mr O'Donohue indicated he wished to travel to Thailand. He remained insightless, particularly about the need for medication and the presence of any mental illness. Arrangements were made for his medication regimen to transfer from IMI depot preparation to oral Paliperidone so he could travel. He remained subject to the ITO. He travelled overseas in January 2014 and returned in March 2014.

97. On 31 March 2014, after the trip to Asia, Mr O'Donohue was assessed again. While his 'rigid thinking,' ongoing delusions about unions, poor motivation and resistance to try rehabilitative measures were noted, a lower dose of depot was considered.

98. Between June 2014 and July 2015, Mr O'Donohue attended 23 sessions of psychotherapy with Psychologist, Ms Little. He then abruptly stopped attending. Despite these sessions, he continued to have limited insight into his delusional beliefs. Although not preoccupied by them, the delusions still permeated his daily life.

99. Notes from a clinical review on 15 September 2014 by Dr De Souza-Gomes stated that Mr O'Donohue was compliant with medication and had been attending regular appointments with Ms Little. He was noted to be suffering from a delusional disorder, secondary chronic suicidal ideation with a stable mental state. He was assessed as being a 'low risk to others or self at present.' He continued to engage with RN Gourlay by way of home visits and had built a solid rapport.

[72] T1-43

100. On 9 December 2014, following a clinical review by Dr De Souza-Gomes, it was documented that he Mr O'Donohue suffered from a delusional disorder, which was in partial remission. It was thought that psychological interventions were improving his ability to identify emotional states and attend to them in contact with staff. The future plan was to revoke the ITO and continue current medication and psychology input.

101. On 16 December 2014, Mr O'Donohue's ITO was revoked.

102. In March 2015, following a clinical review, Dr De Souza-Gomes noted that Mr O'Donohue's mental state was stable with a 'chronic sense of hopelessness re the future, resulting in low grade suicidal ideation without active plans.' He was said to be compliant with 6mg of Paliperidone and had been attending and engaging with Ms Little. It was documented that Mr O'Donohue had a delusional disorder, which was partial remission, with his chronic suicidal and homicidal ideation presenting a low risk due to his moral code. A trial to reduce his Paliperidone to 3 mg was commenced. He was scheduled for review in 3 months' time.

103. In June 2015, after a clinical review, Dr De Souza-Gomes noted that Mr O'Donohue continued to deny any psychotic symptoms and refuted his diagnosis. He did not raise any delusional ideas or express any homicidal ideation. He was thought to be stable with euthymic mood, compliant with his medication. However, he continued to have chronic suicidal ideation with no immediate plan. His diagnosis of a delusional disorder with possible narcissistic traits was maintained. A plan to liaise with Ms Little as to the viability of further therapy was noted, with the possibility of a withdrawal of this engagement. His medication was maintained, with RN Gourlay to review goals and foster engagement with his General Practitioner. Mr O'Donohue had previously rejected any notion of the treating team engaging with his General Practitioner.

104. In October 2015, Mr O'Donohue was seen by Dr De Souza-Gomes for a clinical review. He denied any illness and was 'enraged' when treatment options were raised with him. He continued to express chronic persecutory delusional ideation and was insightless into his illness. It was determined that he should be reviewed in three months' time (or as needed). Consideration was to be given to discharge from the service in light of Mr O'Donohue's resistance to engage in rehabilitation focused treatment. His long-term risk of suicide was acknowledged.

105. Clinical notes for the first part of 2016 indicate that Mr O'Donohue had a 'stable' mental state with ongoing chronic delusions, no insight, and relative social isolation.

106. On 8 March 2016, Dr De Souza-Gomes clinically reviewed Mr O'Donohue. It was noted that he had delusional disorder with narcissistic traits and chronic suicidal ideation. He was prescribed 3 mg Paliperidone. He remained ambivalent about mental health service involvement and expressed both anger and anxiety about being discharged. It was concluded that overall, he was stable. The plan to discharge him was to continue, following two more clinical reviews. RN Gourlay was to commence a reduction in the frequency and duration of contact. A graduated plan for discharge was formulated and commenced by the CCW Team.

107. On 18 April 2016, Mr O'Donohue was reviewed by Dr De Souza-Gomes. He was said to be stable. Plans to discharge him from the service were to continue. He maintained his refusal to consent to the CCW Team writing to his GP. This was the last occasion Mr O'Donohue was medically reviewed before his discharge.

108. On 2 May 2016, Mr O'Donohue was treated at the Emergency Department of the PAH for chest pain.

109. On 5 May 2016, RN Gourlay conducted a home visit. Mr O'Donohue mentioned that unions would get what was coming to them. He did not elaborate further. He denied any homicidal ideation towards trade unionists. He did not appear 'too concerned' about his upcoming discharge and was assessed as a low risk to himself and others.

110. On 3 June 2016, Mr O'Donohue was seen by Ms Little after he presented for an unscheduled psychology appointment. The reasons for his presentation were unclear. However, it seems he felt more unsettled. There were vague paranoid themes and problems around trust and interpersonal issues. He reported ongoing suicidality.

111. On 14 June 2016, Mr O'Donohue did not attend the final review clinic with Dr De Souza-Gomes. She documented that he was suffering from a delusional disorder, with narcissistic traits and chronic suicidal ideation. It was noted that Mr O'Donohue's chronic delusions had been contained by medication, which was said to have modified the affective tone of these (anger, resentment). However, he remained functionally impaired due to chronic adjustment issues, which related to a lack of insight, denial of illness and denigration of the value of mental health interventions. Dr De Souza-Gomes' impression was that he was likely to be experiencing difficulty with discharge. She noted, *'I would postulate the impending loss of support has triggered anxiety and anger in the context of feelings of abandonment.'* While he had refused a referral to a private psychiatrist or GP for follow up, he was provided with prescription for 4-5 months' medication.

112. A letter was subsequently written to Mr O'Donohue confirming that as his mental health had been stable for quite some time, he no longer required treatment within the service. However, he was strongly recommended to seek alternative care through his GP, including continuation of his medication, Paliperidone 3 mg daily. A further appointment was scheduled with Mr O'Donohue on 26 July 2016.

113. On 20 July 2016, RN Gourlay visited Mr O'Donohue during which time he voiced his intention not to attend his final appointment with Dr De Souza-Gomes. In relation to unions, he again indicated they would get what was coming to them, but did not elaborate.

114. On 25 July 2016, Mr O'Donohue was again seen by RN Gourlay at home. His mood seemed good with no formal thought disorder. He indicated he did not think he would attend the final appointment with Dr De Souza-Gomes as he did not see the point. He did not express any concern about being discharged from the mental health service. He referred to the unions and said *'they would get what was coming to them'* but again would not elaborate. There were chronic suicidal thoughts, without formal thought disorder. He again refused consent for information to be given to his GP. RN Gourlay considered that Mr O'Donohue appeared to be a low risk to self and others despite voicing chronic suicidal thoughts but had no plans.

115. On 1 August 2016, Mr O'Donohue was discharged from the service.

116. On 31 August 2016, Mr O'Donohue called CMHS to make an appointment with Dr De Souza-Gomes. However, he was told that by then he had been closed to the service. RN Gourlay tried to return the call, but received no answer.

EVIDENCE FROM THE CCW TREATING TEAM

117. Mr O'Donohue remained a client of the CCW Team from December 2012 until his discharge from the service on 2 August 2016. As noted above, he was provided with a '*collaborative model of multidisciplinary care,'* delivered by the CCW Team. Dr De Souza-Gomes, RN Gourlay and Ms Little were called to give evidence during the inquest.

Evidence of RN Gourlay – Case Manager

118. RN Gourlay was Mr O'Donohue's Case Manager while he was linked to the Metro South Addiction and Mental Health Service between December 2012 and July 2016. As a Case Manager, he was part of a multidisciplinary team responsible for the care and treatment of consumers. In this role, RN Gourlay would assist and assess consumers who entered the system, either on a treatment order or voluntarily. His role was to facilitate their independence, providing them with requisite support depending on their condition. This was often practical in nature, including assisting with appointments and matters of daily living.[73] When he was allocated Mr O'Donohue's case management, RN Gourlay reported having between 25 to 30 clients within his care with varying levels of demand in terms of the necessary level of involvement.[74] While RN Gourlay was an experienced case manager by this time, Mr O'Donohue was his first client suffering a delusional disorder.[75]

119. RN Gourlay provided a statement for the purpose of the coronial investigation,[76] was interviewed for the purpose of the Mullen Review[77].

120. Relevantly, RN Gourlay said:[78]

- As Mr O'Donohue's case manager he visited him at his residence around once a fortnight, which included transporting him to appointments.
- The main concern with respect to Mr O'Donohue was chronic suicidal ideation.[79]
- He established a good rapport with Mr O'Donohue fairly quickly, and this endured throughout his case management.

[73] T1-15, 15-35; T1-19
[74] T1-16
[75] T1-17
[76] Ex B103
[77] Ex H16.1 & H17.1
[78] Ex B103
[79] T1-18

- Every three months, Mr O'Donohue's case was reviewed by the Psychosis team, which consisted primarily of himself, Ms Little and Dr De Souza-Gomes. His progress, medications, and the ongoing plan to assist in his recovery and improvement were discussed. Each of the team members would have input into decisions about Mr O'Donohue's ongoing management. Decisions about medication and remaining on an ITO rested with Dr De Souza-Gomes.[80] RN Gourlay noted that as he had the most face to face contact with the consumer, his observations would assist the Psychiatrist to make the requisite decisions in terms of ongoing management.[81]

- Mr O'Donohue voiced chronic suicidal thoughts although no express actual plan. He held a complex delusional system of beliefs regarding unions and their infiltration of the public sector, which he believed had impacted negatively on his life.

- From the time Mr O'Donohue commenced oral paliperidone, he reported that he was compliant with taking his medication and the scripts provided were dispensed.

121. RN Gourlay said discussions about the revocation of Mr O'Donohue's ITO commenced in early 2014. During the inquest, he explained that the assessment of consumers and whether they meet the criteria to remain on an ITO was ongoing and the case manager plays an integral role.[82]

122. During a home visit on 3 December 2014, Mr O'Donohue spoke of his plans to travel overseas, he had been reportedly socialising at a hotel, and displayed no formal thought disorder.[83] While his delusional disorder remained, he expressed no homicidal intent, and reportedly did not think about 'them' all the time. He appeared stable and settled and was consistently engaging with the team.[84] RN Gourlay subsequently planned to discuss revocation of the ITO with Dr De Souza-Gomes.

123. Following revocation of the ITO in December 2014, RN Gourlay continued to case manage Mr O'Donohue. From April 2015, a plan for discharge from the service commenced. RN Gourlay noted that from this time until July 2016, when Mr O'Donohue was formally discharged, he conducted approximately 16 home visits. During these visits he consistently noted:[85]

    - No formal thought disorder.

    - No perceptual disturbances.

    - Mr O'Donohue was happy to engage.

    - Mr O'Donohue stated he was compliant with medication.

[80] T1-20
[81] T1-21
[82] T1-22
[83] Ex B103.2
[84] T1-25 & 26
[85] Ex B103 [32]

- Mr O'Donohue had constant thoughts of suicide but expressed no intent or ideation.

124. Leading up to the time of discharge, RN Gourlay noted that he reduced the frequency and length of his home visits. Despite ongoing encouragement, Mr O'Donohue refused to engage with his General Practitioner, and refused to consent to any discharge information being provided to the GP.[86]

125. On 14 July 2016, Mr O'Donohue was given a letter from RN Gourlay, which confirmed his discharge from the service and recommended that he seek alternative care through his General Practitioner, including the continuation of his medication.[87]

126. RN Gourlay's last home visit took place on 20 July 2016. The following notes were recorded:[88]

    - No formal thought disorder was displayed.

    - During discussion about his discharge from the service, Mr O'Donohue '*didn't appear to be too concerned*.'

    - In relation to the topic of unions, Mr O'Donohue stated that *'they would get what's coming to them but wouldn't elaborate further on this.'*

    - He indicated that he did not intend to attend his last scheduled appointment with Dr De Souza-Gomes on 26 July 2016, *'as he doesn't see the point and that things will work themselves out in the end*'. He did not reject the idea, however, of contacting the unit in future should he feel that he needed to.

127. RN Gourlay considered Mr O'Donohue appeared to pose a low risk to himself and others despite voicing suicidal thoughts.[89] In evidence at the inquest, RN Gourlay said the comment made about unions was similar to previous comments indicating he was disgruntled generally, but did not express any specific plan or intent.[90]

128. On 1 August 2016, RN Gourlay completed a discharge summary in the Consumer Integrated Mental Health and Addiction (CIMHA) application. He noted that Mr O'Donohue failed to attend his appointment with Dr De Souza-Gomes in July 2016 and there was no follow-up plan in place as he had refused to consent to the treating team to send correspondence to his General Practitioner.[91]

129. With respect to the phone call made by Mr O'Donohue on 31 August 2016, RN Gourlay attempted to call him back. However, the call went unanswered, and he did not leave a message.[92]

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[86] Ex B103, [35]
[87] Ex B103, [37]; Ex B103.4
[88] Ex B103.5
[89] Ex V103, [38]
[90] T1-28 & 29
[91] Ex B103 [41]; Ex B103.6
[92] Ex B103, [44]

130. At the inquest, RN Gourlay gave evidence that consumers can now easily 're-engage' with the service by way of contact after discharge. Clinical notes can be recorded and a grace period allowed for such engagement. This has improved since 2016.[93] General Practitioners are also incorporated into the discharge process by way of a letter, as are family members to allow for continued support to the consumer.[94]

Evidence of Dr De Souza-Gomes

131. Dr De Souza-Gomes is an experienced Senior Psychiatrist. She became a fellow of the Royal Australian and New Zealand College of Psychiatrists in 1997.

132. Dr De Souza-Gomes provided a statement for the purpose of the coronial investigation,[95] was interviewed for the purpose of the Mullen Review,[96] and gave evidence during the inquest.[97]

133. Dr De Souza-Gomes first saw Mr O'Donohue on 27 May 2013. He presented with persecutory delusional beliefs centered around a conspiracy by unionists, which had systemised, and now involved his family and friends. He was the victim of the conspiracy.[98] He described recurrent fantasies of wanting to kill unionists as revenge but denied any plan or intent to act on these thoughts.[99] He also presented with long term intentions of killing himself.

134. Based on her own interactions with Mr O'Donohue and the collateral information available, including relevant records, Dr De Souza-Gomes diagnosed him with Delusional Disorder, persecutory type.[100] It seems that the onset of symptoms occurred between 2003 and 2005 while he was working for New South Wales Rail.[101] He had been stabilised on the antipsychotic, Paliperidone via an intramuscular injection every four weeks for some time. However, before and following a trip to Thailand in 2014, he was placed on oral Paliperidone.[102] He was thought to be compliant with this medication and no decline in his mental state was observed as a result of the change.

135. Dr De Souza-Gomes noted the following with respect to Mr O'Donohue during his engagement with the CCW Team:

- He had persistent vengeful thoughts towards the unions, and union and public sector workers. These presented with varying intensity during his first engagement with mental health services in 2010.

- From April 2012 onwards, his anger and resentment associated with these delusions, as well as the intensity of the emotions felt, gradually reduced and at a times were absent altogether, although the delusions themselves remained fixed. He described the thoughts associated with

[93] T1-31
[94] T1-31
[95] Ex B102
[96] Ex H14.1
[97] T1-42
[98] Ex B102, pg. 2
[99] Ex B102, pg. 2
[100] Ex B102, pg. 3
[101] Ex B102, pg. 4
[102] Ex B102, pg. 11

these delusions, such as shooting union officials, as 'fantasies' which only occurred at night.

- He consistently presented with depressed mood and chronic thoughts of suicide.[103] He was referred to Ms Little for help with the long-term risk of suicide, and to explore unresolved issues of grief and loss.

- Mr O'Donohue had clinical risk assessments at each review by a member of the treating team, as well as formal assessments based on the completion of a Risk Screen every 91 days, which was completed by his Case Manager.[104]

- The CFOS referral and assessment conducted in May 2012, while Mr O'Donohue was under the care of other treating teams, was not known to the CCW Team. Neither were the recommendations made at the time.

- A referral by the CCW Team to CFOS was first made in May 2013, with another referral taking place in 2014. It was then determined by CFOS that Mr O'Donohue did not require formal review as he was likely a 'low-moderate risk' at that time.[105] A further referral was not sought given the previous refusal by CFOS before Mr O'Donohue's discharge from the service.

136. Dr De Souza-Gomes noted that had the CFOS assessment of Mr O'Donohue conducted in May 2012 been available to the CCW Team, the recommendations made would have carried great weight and better informed the approach the treating team took as a whole, including the need for an ITO to remain in effect.[106]

137. In terms of the decision to revoke Mr O'Donohue's ITO in December 2014, Dr De Souza-Gomes noted:[107]

    - Careful consideration was given to the progress he had made since his referral in December 2012 and clinical presentation at this time.

    - While he remained insightless, he had remained compliant with medication and consistently engaged with treatment while with the service.

    - His mental state had remained stable.

    - He had been amenable to engaging with Ms Little.

    - Mr O'Donohue had indicated that he did not believe his engagement with the team would change if his ITO was revoked.

138. Having considered the above and the requirements of s14 of the *Mental Health Act 2000* (Qld), Dr De Souza-Gomes formed the view that Mr O'Donohue no longer met the criteria for involuntary treatment under the Act.

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[103] Ex B102, pg. 10
[104] Ex B102, pg. 7
[105] Ex B102, pg. 8 & 9
[106] Ex B102, pg. 8
[107] Ex B102, pg. 12 onwards

139. In terms of the decision to discharge Mr O'Donohue from the CCW Team and service, Dr De Souza-Gomes relevantly noted:[108]

- The discharge decision was made by the treating team, which included months of preparatory discussions with Mr O'Donohue.
- All relevant clinical and risk factors were considered, including the revocation of the ITO and his continued engagement voluntarily with the team for an extended period of time, as well as his apparent compliance with medication. He appeared stable and was consistently assessed as a low-medium risk to himself and others.[109]
- Mr O'Donohue also had a history of seeking help when he became acutely unwell.[110]
- Discussion was had with Mr O'Donohue about the referral to a private psychiatrist on a number of occasions. He refused.
- It was expected that Mr O'Donohue would continue to attend his GP to ensure his prescription for his medication was issued and up to date.
- While Mr O'Donohue displayed some anxiety about being discharged, his mental state did not appear to significantly change.
- Mr O'Donohue subsequently missed the last two scheduled appointments with Dr De Souza-Gomes.

140. In relation to the notation about unions made by the Case Manager, RN Gourlay on 5 May 2016, Dr De Souza-Gomes initially indicated in her statement that it suggested a slight shift in paranoia, and had she been made aware of it, it may have prompted her to ask further questions about the interaction and the possible presence of paranoid ideation and the chronic delusions at any subsequent reviews.[111]Further, it may have changed her response to his nonattendance at the last scheduled appointments with direct contact being made with the patient.[112] During her evidence, Dr De Souza-Gomes qualified the importance she would place on such a statement. She said she had elevated the statement with the benefit of hindsight, noting that it would not have carried any particular weight at the time in terms of being persecutory or paranoid.[113]

141. With respect to Mr O'Donohue's refusal to allow the team to engage with his General Practitioner, Dr De Souza-Gomes acknowledged that encouragement in this regard continued regularly but was unsuccessful.[114] It was Dr De Souza-Gomes' understanding that it was a longstanding clinical practice that the Service required the written consent of a patient before their treating team could correspond directly with a GP.[115] She acknowledged, in her written statement

[108] Ex B102, pg. 15
[109] Ex B102, pg. 18 & 19
[110] Ex B102, pg. 19
[111] Ex B102, pg. 18
[112] Ex B102, pg. 18
[113] T1-79
[114] Ex B102, pg. 19
[115] Ex B102, pg. 20

and during evidence at the inquest, that she had since been made aware that it was Queensland Health policy that information could be provided to GP against a patient's wishes in certain circumstances, such as where it was necessary for the consumers ongoing care and treatment.[116]

142. Dr De Souza-Gomes noted the benefits of the new policies implemented following Mr Sharma's death, including a practice circulated after the Mullen Review requiring the patient's GP to be included as part of the treating team. This has improved the frequency of communication with patient GPs. The uploading of assessments by CFOS to CIMHA has also assisted in ensuring all information is captured and available to a treating team.[117]

143. However, Dr De Souza-Gomes thought that none of the legislative or policy changes would have changed the clinical care given to Mr O'Donohue in any substantive way. Although the family submitted that Dr De Souza-Gomes said changes to the *Mental Health Act* have made it less likely that Mr O'Donohue would have been more strictly supervised, she clarified in her evidence that this would depend on the clinical circumstances and decisions of the Mental Health Review Tribunal in a particular case.

Evidence of Ms Little, Clinical Psychologist[118]

144. At the time of the inquest hearings Ms Little was employed as a Senior Clinical Psychologist at Metro North Health, and as an independent contractor. She was registered in 2012. During 2016 and 2017, Metro South Health employed Ms Little as a Mental Health Clinician.

145. Ms Little was employed as a Mental Health Clinician (Psychologist) between May 2014 and July 2016 for the PAH Mental Health Service, Psychosis Academic Clinical Unit, Metro South Health. Her main duty in this role was case management of individuals with psychotic illness.[119] In addition, she also received internal referrals for psychological services from mental health clinicians, psychiatry registrars and consultants working within the PAH Mental Health Service, Psychosis ACU. These referrals were for consumers currently being case managed by the service. While this case management continued, additional psychological support would be provided.[120]

146. It was in this role at PAH that Ms Little first engaged with Mr O'Donohue. On 27 May 2014, an internal referral for psychological services was provided to Ms Little from Mr O'Donohue's Case Manager, RN Gourlay. The focus was to assist him to return to work, although further clarification indicated that it was also to assess his ability to engage in therapy, poor motivation and address issues of grief and loss.[121] At this time, Mr O'Donohue was being treated under the *Mental Health Act 2000,* having been diagnosed with delusional disorder.

[116] Ex B102, pg. 20
[117] Ex B102, pg. 24
[118] Ex B98
[119] Ex B98, [4]
[120] Ex B98, [5]
[121] Ex B98, [8] & [9]

147. Ms Little noted that Mr O'Donohue did not agree with his diagnosis and refuted that he had a mental illness.[122] However, he attended voluntarily for 23 sessions with Ms Little between June 2014 and July 2015.[123]

148. Ms Little described the therapeutic approach with Mr O'Donohue as *'integrative'* and '*supportive, mostly non-directive.'*[124] The goals of therapy were to develop emotional awareness and coping, processing interpersonal issues (mostly those within the therapeutic relationship), process grief and loss and improve motivation and engagement in goal-orientated, meaningful activities.[125]

149. Ms Little noted that Mr O'Donohue presented with symptoms of depression, such as low mood, poor sleep and a loss of interest in activities. He reported chronic suicidal ideation, and a sense of hopelessness about his future.[126] Information about the content of the sessions was provided to Mr O'Donohue's treating team.

150. Ms Little noted:[127]

> *Due to his lack of insight about his mental health condition, and the strength of his belief that he had been persecuted, I did not concentrate on the delusional beliefs during the sessions. Dr De-Souza-Gomes and I agreed that psychological intervention focusing on the psychotic symptoms was likely to be unsuccessful and result in disengagement in therapy.*

151. Ms Little's assessment of mental state and risk was integrated into the sessions by way of verbal questioning and observation of behaviour. The degree to which such assessments were carried out was based on Mr O'Donohue's presentation, behaviour and response to questions.[128] He often '*self-disclosed information pertaining to risk assessment'.*[129] He would express content about his delusional beliefs, including that he believed that he was set up to fail at his past place of employment, that there was a conspiracy against him and that unions were to blame.[130] Mr O'Donohue denied experiencing perceptual disturbances during the course of therapy.[131] He did express anger towards unions and his family with respect to perceived injustices, which Ms Little characterised as '*homicidal ideation*'.[132] He spoke of the idea of wanting revenge, which he said he thought about at night before he went to sleep.[133]

[122] Ex B98, [11]
[123] Ex B98, [12]
[124] Ex B98, [17]
[125] Ex B98, [17]
[126] Ex B98, [14]
[127] Ex B98, [16]
[128] Ex B98, [20]
[129] Ex B98, [20]
[130] Ex B98, [21]
[131] Ex B98, [23]
[132] Ex B98, [29]
[133] Ex B98, [29]

152. Ms Little could only recall one occasion where he described a plan whereby he had thought about stealing a police officer's gun to shoot someone connected to the union.[134] Ms Little's assessment of Mr O'Donohue's intent to act on his homicidal thoughts consistently found that when these thoughts were expressed he understood the seriousness of the consequences of such actions.[135] She specifically recalled, *'Mr O'Donohue stating that he would not act on homicidal thoughts because he did not want to go to jail as that would not help him'.*[136]

153. Mr O'Donohue's reported mood fluctuated during therapy. He expressed feelings of hopelessness and helplessness about his life situation and suicidal ideation.[137] He would reportedly discuss his thoughts of suicide, including non-specific suicide plans.[138] Ms Little recalled that Mr O'Donohue did not discuss homicidal ideation as much as his suicidal ideation.[139]

154. Following the 22nd session, Mr O'Donohue called to cancel any further psychology appointments. When Ms Little spoke to him about his wish to cease therapy, he expressed ambivalence about returning. He agreed to attend a final follow-up session.

155. During the final session, on 2 July 2015, Mr O'Donohue indicated that he did not wish to continue with therapy in the community or privately, as he thought they had come to an impasse as he was seeking more social interaction.[140] He declined the offer of being referred to a private psychologist. Ms Little noted that Mr O'Donohue was, *'a chronic risk of suicide…continues to experience contempt and desire for revenge but has insight into the consequences of such actions…'*[141] Ms Little had no further contact with Mr O'Donohue. He was formally closed to PAH Mental Health Service, Psychosis ACU on 28 August 2015.[142]

156. Ms Little indicated that at the time Mr O'Donohue disengaged from therapy there were no acute risk concerns. He expressed suicidal ideation with no specific plans and no intention to act at that time. While she acknowledged there was homicidal ideation, she noted that *'Mr O'Donohue understood the seriousness of consequences of such actions.'*[143]

157. On 3 June 2016, Ms Little received a phone message from Mr O'Donohue. He subsequently attended the clinic unannounced asking to see her. Ms Little was able to accommodate him. Mr O'Donohue was reportedly vague about his reasons for attending and there were some paranoid themes on which he did not elaborate. Ms Little noted that it was not clear why he attended. He appeared nervous and said that he was feeling more unsettled. He denied having any concerns about his upcoming discharge from the service. Ms Little noted that, *'Anthony remains to have fixed, delusional beliefs surrounding the unions but was not preoccupied with these today and there was no reported homicidal*

[134] Ex B98, [30]
[135] Ex B98, [31]
[136] Ex B98, [31]
[137] Ex B98, [24] – [26]
[138] Ex B98, [26] & [27]
[139] Ex B98, [33]
[140] Ex B98, [45] & [46]
[141] Ex B98, [47]
[142] Ex B98, [52]
[143] Ex B98, [50]

ideation.'[144]

158. During this unplanned session, Mr O'Donohue did not ask to reengage in psychological therapy. A referral to a private psychologist or psychiatrist was discussed but he declined the offer.

159. Ms Little concluded that no further input was required for Mr O'Donohue from PAH Mental Health Service, Psychosis ACU for the following reasons:[145]

- There was no indication of deterioration in his mental state or acute risk concerns.
- He did not ask to reengage with psychological services and declined the offer to be referred privately.
- He had capacity to make his own decisions about engaging in psychological therapy.
- He was still in the care of the CCW team she was aware he had upcoming appointments with Dr De-Souza-Gomes and RN Gourlay.

MENTAL HEALTH ASSESSMENT AND TREATMENT FOLLOWING ARREST

160. On 28 October 2016, following his arrest, Mr O'Donohue was assessed in the PAH Emergency Department by Director, Community Forensic Outreach Service, Psychiatrist, Dr Darren Neillie and Dr Sean Tracy, Psychiatrist at the PAH. He reported that he had ceased medications and did not want to provide any details of the incident.[146]

161. As a result of these assessments, Mr O'Donohue was transferred, subject to an ITO, to Kuranda Unit at the High Secure – The Park, Wacol.[147] He was assessed on admission by Consultant Psychiatrist, Dr Angela Voita, who noted his long history of persecutory beliefs and delusions, as well as his insightlessness and homicidal ideation for some time. He indicated that he had ceased seeing mental health services in the preceding three months '*because of a bullshit diagnosis*.'[148] He blamed Dr De Souza-Gomes for destroying his life. He claimed she knew Mr O'Donohue's situation and had written false information in his clinical record.[149] While he had told his treating team at the Bourke Street clinic that he had been compliant with his prescribed anti-psychotic medication, he never actually took it.

162. Mr O'Donohue indicated that he had targeted Mr Sharma's bus as it was '*the first bus that came along.'* He denied that he had particularly targeted Mr Sharma or that his actions were racially motivated.

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[144] Ex B98, [60]
[145] Ex B98, [63]
[146] Ex G9, pg. 16
[147] Ex G4, pg. 15
[148] Ex G5, pg. 7
[149] Ex G9, pg. 17; Ex G5, pg. 9

163. Dr Voita commenced treatment with aripiprazole, and Mr O'Donohue was placed on constant observations for just under a week. During his treatment immediately following the incident he continued to dispute a mental illness diagnosis. When interviewed on 1 November 2016, Mr O'Donohue stated:[150]

> *'I know it's a terrible thing but I feel justified…he was part of that group that has been torturing me…I just knew he knew who I was and what my situation was…in those last couple of seconds I felt some kind of acknowledgement…I felt there was a recognition, he recognised me, even though I didn't recognise him…if anything I feel calmer now.'*

164. On 3 November 2016, Mr O'Donohue acknowledged that his actions had '*crossed the line'*. However, he maintained there was no other option and he had been misdiagnosed with a mental illness.[151]

165. While receiving treatment at The Park, Mr O'Donohue indicated he had experienced delusions of reference and auditory hallucinations for some months before the incident, including fears his computer had been hacked by trade unions. He was hearing voices in Arabic and English from his computer even when the internet was not running.[152] He believed he was under surveillance by the unions for some months beforehand, and he had been receiving 'messages' for months.

166. During the course of successive assessments, it became clear that Mr O'Donohue's paranoid delusional thinking had affected interactions between friends and workmates since at least 2005 and led to total social isolation. He also reported lower mood again, with thoughts of suicide. His diagnosis was revised as paranoid schizophrenia.[153] He remained insightless and delusional, refusing various antipsychotic medications.

167. In an interview with Dr Voita on 26 September 2017, Mr O'Donohue indicated that on the day before Mr Sharma's death he had travelled to the city by bus where he consumed a number of beers. He did not sleep well that night. He claimed that he continued to receive messages. On the morning of the incident, Mr O'Donohue decided to make a Molotov cocktail using a bottle, which he placed in his backpack. He took a BBQ lighter with him. He felt *'he was losing it and just wanted all the persecution to stop.'*[154] He believed that up until the last minute someone would intervene, and the persecution would stop. He stated that he walked to the bus stop and became really agitated because he had not been stopped and he was unsure what would happen next. Mr O'Donohue entered the bus and claimed that the driver was 'smirking' at him. He lit the bag and lifted it.

168. Dr Voita diagnosed Mr O'Donohue with paranoid schizophrenia, which was likely present for 10 years. She considered that he was deprived of the capacity to know that he ought not to do the act in relation to the alleged offences. However, he was fit for trial.[155] She recommended that he be placed on a forensic order if he was found to be of unsound mind by the Mental Health Court.[156]

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[150] Ex G9, pg. 17
[151] Ex G9, pg. 17
[152] Ex G4, pg. 16
[153] Ex G5, pg. 21
[154] Ex G5, pg. 19
[155] Ex G5, pg. 21 & 22
[156] Ex G6, pg. 4

MENTAL HEALTH COURT PROCEEDINGS

169. Criminal charges against Mr O'Donohue with respect to this incident were referred to the Mental Health Court (MHC) pursuant to *Mental Health Act 2016*.

170. On 9 August 2018, the reference to the Director of Mental Health in respect of Mr O'Donohue was heard by the Justice Dalton, assisted by Psychiatrists, Dr McVie and Dr Frank Varghese.

171. On 10 August 2018, Justice Dalton found that Mr O'Donohue was deprived of the capacity to know he ought not do the acts in relation to all of the charges before the Court.[157]

172. Justice Dalton noted that the power to make a non-revocable forensic order had never been exercised by the Court. In this case, it was the shared view of all four psychiatrists who gave evidence and the two assisting psychiatrists to the Court to recommend a non-revocation order. Consequently, a non-revocable forensic order for 10 years was imposed. Her Honour noted that Mr O'Donohue had a poor prognosis and remained very ill and very dangerous.[158]

173. Justice Dalton noted that she did not believe the attack had been racially motivated. The reason for this view was that he got on the first bus that arrived on the morning with a Molotov cocktail without any knowledge of the race of the bus driver. Further, the delusions expressed by Mr O'Donohue, of which he talks about excessively, did not disclose any racist motivation.[159] However, the attack on Mr Sharma was consistent with his delusions, which involved the Transport Workers Union.

> *He came to believe that all government agencies were against him. He saw the city council buses in that context, as part of a government agency. He thought there were messages for him in the advertisements on the side of buses. He thought bus drivers beeped their horns to draw his attention to these messages. He had no car and he spent a lot of time on buses. He thought that bus drivers and bus passengers gave him messages. None of this makes sense in an ordinary way. I do think, though, that so far as we can analyse the defendant's thinking, there is a connection between his delusions and the attack on a bus driver.*

[157] Ex G3, pg. 7
[158] Ex G3, pg. 8
[159] Ex G3, pg. 8

QUEENSLAND HEALTH REVIEWS AND ACTIONS

174. Shortly before Mr Sharma's death, Queensland Health was reviewing homicides involving people with mental illness to determine whether there were issues with the standard of clinical assessment, care and treatment of those individuals. In May 2015, the Mental Health Sentinel Events Review was commissioned. The findings of that review were handed down in September 2016, shortly before Mr Sharma's death. Issues with the fragmented nature of mental health services in Queensland were highlighted.

175. A specific review into the care and treatment provided to Mr O'Donohue by MHS was also commissioned following Mr Sharma's death, the findings of which were outlined in the Mullen Report.

176. In response to the Mullen Review, Metro South Health also undertook a further review to examine issues of the leadership culture, risk management processes and safety and quality processes. The RCL report detailing the findings of this review was subsequently released.

177. A summary of each of the Reviews undertaken, and the actions implemented by Queensland Health to address the issues identified, is outlined below.

Mullen Review

178. Following Mr Sharma's death, the Director-General of Queensland Health ordered an independent investigation into the mental health treatment provided to Mr O'Donohue. The purpose of the Health Service Investigation, as detailed in the terms of reference, was to investigate and report on matters relating to the management, administration and delivery of Queensland public sector mental health services provided to Mr Donohue.[160]

179. Pursuant to s190 (1) of the *Hospital and Health Boards Act 2011* (Qld), Professor Paul Mullen (Forensic Psychiatrist), Ms Angela Karooz (Consultant in Nursing) and Dr Leanne Beagley (Consultant) were appointed as Health Service Investigators. The Mullen Report was released on 7 September 2018, shortly after the Mental Health Court's decision.

180. The Investigators examined the quality of care Mr O'Donohue had received from 2010 to 2016, to consider processes and review their effectiveness, and to ascertain whether this may have influenced the incident which resulted in Mr Sharma's death. Consideration was also given about what could be learned from this particular case in order to reduce the chances of a similar tragedy occurring in the future.[161]

181. The Investigators formed the view that Mr Sharma's death was a tragedy that could not have been predicted.[162]It was acknowledged that had different decisions been made at certain times during his treatment the killing may not have occurred. However, the Investigators were unable to conclude that any issues identified with respect to handover of information between services, management of risk, management of the discharge from the service in 2016 and handling of Mr O'Donohue's attempt to reengage with the service in 2016, would

[160] Ex H2, Appendix 1
[161] Ex H2, pg. 5
[162] Ex H2, pg. 7

have changed the outcome.[163] Notwithstanding, it was acknowledged there were lessons to be learnt as a result of the tragedy.

182. Mr O'Donohue was said to suffer from delusional disorder characterised by beliefs that trade unions and public servants were persecuting him. It was noted that delusional disorders were uncommon, occurring in less than 2% of those with psychotic illnesses. There was difficulty associated with managing these conditions, as opposed to more common schizophrenias, as they only respond partially, at best, to medication and often actively resist attempts at treatment and rehabilitation.[164]

183. The Mullen review noted that Mr O'Donohue was first admitted under an ITO in 2010 following a suicide attempt. He was readmitted a year later when he told police that he was afraid he would attack those he believed were persecuting him. Following his discharge, he was treated in the community, initially at Metro North Health and later Metro South Health.

184. In May 2012, CFOS provided a well formulated guide to managing Mr O'Donohue's risk of violence. While he refused to engage face to face with the team (despite being on an ITO), an assessment was conducted based solely on a case review and discussions with the treating team. Importantly, the CFOS opinion noted the following:[165]

- Managing risk that continued engagement is a key factor, and clinical interactions should include strategies to manage his delusions 'appeal to his self-interest by aiding him to see the costs to him of pursuing his ideas.'
- The need to try and assist Mr O'Donohue to find a 'face saving exit' from the delusional ideas, which have dominated his life for years.
- All threats were to be taken seriously and the need to be alert for signs of an increase in risk as displayed as last resort thinking, suicidal ideation or more specific homicidal intent or plans.
- Management of delusions was considered a key factor, and to regularly address the current state of his delusional beliefs.
- Management of Mr O'Donohue was emphasised as being long-term and consistent, and likely to require that he remain on his ITO.

185. The Investigators considered the CFOS assessment outlined the best practice in managing a delusional disorder associated with the risk of becoming violent towards others. It was said to have significant clinical value, offering specialist expertise and guidance.[166]

186. The Investigators noted that responsibility for carrying through the CFOS' recommendations fell to the community mental health services, who most likely lacked the resources, and necessary depth of experience to put those recommendations into practice. With the benefit of hindsight, it would have been preferable if Mr O'Donohue had been managed with ongoing input from

[163] Ex H2, pg. 7
[164] Ex H2, pg. 5
[165] Ex H2, pg. 23 & 24; Ex F4, pg.199-217
[166] Ex H2, pg. 24

experienced forensic mental health clinicians. Unfortunately, the recommendations of the CFOS Psychiatrist were not handed over when Mr O'Donohue's treatment was transferred from Metro North Health to Metro South Health. This seems to have occurred in part because of concerns over privacy associated with forensic assessments.

187. It was further noted that on no occasion was a CFOS face to face assessment undertaken, despite referrals being formally made on two occasions and discussed within team meetings on at least four occasions (14/01/13, 27/05/13, 16/12/13, 07/01/14 and 25/07/14) over a two-year period.[167]

188. The Investigators found that this apparent inaction appeared to be related to Mr O'Donohue's determination to refuse such assessments. It was noted that despite the lack of engagement with specialist forensic services, such an assessment may have provided additional support for the treating team's decision making and understanding of both the suicide and violent behaviour risks posed by Mr O'Donohue's illness.[168]

189. It appears that during the interviews conducted for the Mullen Report, comment was made about the unrealistic nature of the CFOS recommendations. The Investigators were of the view these comments suggested the need to assess the implications of such recommendations for a general mental health community clinic.[169] Had the recommendations been followed, it would have required:[170]

- Mr O'Donohue to be maintained in long-term, potentially indefinite care and supervision.
- A clinician with the time and experience to provide essentially psychotherapeutic management of a delusional disorder.
- A clinician with the time and experience to assess and manage the risk in someone who is paradoxically making reassuring comments about not acting violently and recounting fantasies of bloody revenge.
- Someone with the time and persistence to eventually re-engage Mr O'Donohue with social activities able to give his life some meaning.

190. These requirements were well beyond the resources of Metro South Health at the time of their engagement with Mr O'Donohue. However, they could have been met by a well-resourced community forensic mental health service.[171]

191. The importance of risk assessment in identifying factors, which may suggest an individual is at a higher risk of committing violence was recognised.[172] Among the clinicians interviewed for the Report, the primary role risk assessments had in the development of suitable risk management strategies was widely accepted. There was generally low confidence and satisfaction found with the current mental health risk screening tool, which was incorporated into the Consumer

[167] Ex H2, pg. 16
[168] Ex H2, pg. 16
[169] Ex H2, pg. 24
[170] Ex H2, pg. 24
[171] Ex H2, pg. 24
[172] Ex H2, pg. 17

Assessment, as well as other risk evaluations set out in the involuntary treatment order review documentation. Specifically, one of the most robust critiques of the current approach identified a disconnect between risk assessment and risk management.[173] Many of the mental health professionals interviewed by Investigators found the relevant documentation had insufficient value in the proper assessment and management of risk.

192. The Mullen Report referred to the findings of the 2016 Mental Health Sentinel Events Review Committee titled, '*When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services'* (the Review Report).

193. Investigators noted the findings of the Review Report, which indicated that while there was widespread use of risk screening, there was little evidence of more comprehensive risk assessment being conducted, even when the consumer had a history of violence.[174] A three stage approach had been suggested by the Review Report, which involved an initial screening stage of all consumers entering a service, followed by an assessment in those where the risk of violence might be elevated, conducted by a senior clinician. The final stage was to be a referral of those still considered to be of high risk for an assessment by a forensic mental health professional experienced in assessing and managing risk.[175]

194. In terms of how consumers, such as Mr O'Donohue, could be better evaluated and managed, the following steps were cited:[176]

- First, inquire about past episodes of violence or threatening behaviour.
- Second, obtain information about past episodes of violence, to determine the consumer's motivation, state of mind at the time etc.
- Third, ascertain whether substance abuse, conduct disorder, prior offending in general or a history of physical and sexual abuse in childhood was present.
- All these factors should then be put together to identify the factors active in previous violent episodes whose recurrence will increase risk, together with any factors likely to predispose to violent behaviour in any context.

195. The Investigators noted that one area, which required close monitoring was the use of *risk ratings.* The level of risk recorded in Mr O'Donohue's notes reflects an unwillingness to rate any but the most immediately threatening consumers as high risk. Investigators noted that there was limited utility in using a 3-point scale if the top rating was not being used in a case such as Mr O'Donohue's, at least on some occasions.[177]

196. Mr O'Donohue's assessment and treatment had been frustrated by his uncooperative behaviour. For much of his treatment history, he was an involuntary consumer. It was noted by the Investigators that it is difficult to strike a balance between the rights of the consumer and the need to protect those with

[173] Ex H2, pg. 17
[174] Ex H2, pg. 17
[175] Ex H2, pg. 17 & 18
[176] Ex H2, pg. 18
[177] Ex H2, pg. 19

serious mental illness from harming themselves or others. The best solution was said to be mental health professionals with the time and skill to persuade, or at least 'wear down' the consumer's resistance to what is in their own, and the community's, best interests.

197. The Investigators considered that based upon the information available before the treating team, the actions taken were reasonable with respect to decisions made relating to involuntary and voluntary treatment.[178] However, engagement with Mr O'Donohue appeared from the clinical notes to be, at times, less than optimal. This would have impacted on the adequacy of the risk management.[179]

198. Investigators found with respect to findings related to risk assessment and management plans that while Mr O'Donohue was engaged with Metro South Health there was limited evidence in the clinical notes of consideration of the previous care and treatment afforded by Metro North Health, previous history of violence, or the complexity of managing a delusional disorder.[180]

199. It was found that there was also limited pursuit of a comprehensive forensic assessment or critical evaluation of treatment planning formulated by longitudinal assessment, treatment evaluation and consumer or GP collaboration. Investigators considered Metro South Health did not seem to adequately focus at times on his delusional ideas, which is a central part of managing a consumer with a disorder of this type.

200. Significantly, it was stated that *'there is little to suggest that the team regarded Mr O'Donohue's mental disorder as something unusual and outside of the experience of any of the clinicians involved in his care. This despite some of those interviewed acknowledging unfamiliarity with the specifics of his condition.'*[181]

201. In Mr O'Donohue's case, the only evidence of involvement with Forensic Liaison Officers (FLO) in each Health Service was in the authoring of the CFOS letter, which never made its way to Metro South Health. The FLO had no identified role in Mr O'Donohue's management.[182] The FLO role appeared to have a gatekeeper function, mediating between the treating team and CFOS with no discernable contribution to patient care.

202. It was noted by Investigators that a second referral was made in May 2014 to CFOS but was rejected on the basis that Mr O'Donohue did not warrant formal review and 'would probably rate as a low moderate risk at present'.[183] This was said to be less than ideal.

203. The diagnostic complexities associated with mental health, which involve describing and classifying the patient's disorder (diagnostic formulation) and the management, therapy and care of the patient (providing treatment), were recognised by the Investigators.[184] It was noted that violence in delusional

[178] Ex H2, pg. 6
[179] Ex H2, pg. 19, Investigators acknowledged that medical notes may say "less about practice and more about the clinician's enthusiasm for keeping full records of interactions".
[180] Ex H2, pg. 19
[181] Ex H2, pg. 19
[182] Ex H2, pg. 25
[183] Ex H2, pg. 25
[184] Ex H2, pg. 14

disorders is closely linked to the patient's morbid beliefs. The risks of acting on their delusions increases as the levels of distress and anger associated with the ideas increases. The absence of social supports, valued relationships, and having things in life they value and are protective increases the risk.[185]

204. In terms of Mr O'Donohue's risk of violence, given the nature of his delusions and intention to seek retribution, Investigators considered in relation to the potential severity of any apprehended violence this may not at times have been given sufficient weight by those managing him.[186] While Mr O'Donohue may at times have been assessed as a low probability of acting violently, the apprehended violence should he do so, would have been likely to be severe.

205. Investigators noted Mr O'Donohue's clinical notes over the five years that followed his initial admission indicated that he continued to express the same intentions with regard to suicide and harboured the same delusional conviction about persecution and desire for retribution towards public servants.[187] Accordingly, his indicators to assign a medium to high risk of aggression, and a medium risk of suicide remained essentially unchanged throughout his period of care. Despite this, his recorded level of risk did change and was assessed as gradually decreasing.[188] Investigators noted that it was not yet a part of normal clinical practice to understand risk in terms of probability, proximity and potential severity.[189] The Report noted:[190]

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

206. It was noted that the current approach to risk assessment often fails to take a longitudinal perspective. In Mr O'Donohue's case it seemed from the clinical notes that emphasis was placed on his "current cross sectional functioning and present state of mind, to the virtual exclusion of his history of the episode of suicidal behaviour and the other incident of behaviour suggestive of homicidal intent".[191] While an excellent guide on how to assess and manage the violence risk was provided by CFOS in May 2012, this letter was not handed over and the consequent failure to apply the principles articulated therein is an *'unfortunate aspect of this case'.*[192]

207. Investigators thought that if Mr O'Donohue had been managed in light of these recommendations, it is possible that Mr Sharma's death could have been prevented on the basis that they provided an evidence-based clinical practice framework for managing someone with the issues presented by Mr O'Donohue. Investigators considered the inability, in the present service model, for CFOS to take on any ongoing role in Mr O'Donohue's long term management was a lost opportunity. However, ultimately the investigators were unable to conclude that

[185] Ex H2, pg. 15
[186] Ex H2, pg. 21
[187] Ex H2, pg. 21
[188] Ex H2, pg. 21 & 22
[189] Ex H2, pg. 22
[190] Ex H2, pg. 22
[191] Ex H2, pg. 22
[192] Ex H2, pg. 22

this would necessarily have changed the outcome.[193]

208. The Investigators also considered the circumstances surrounding the clinical decision not to continue Mr O'Donohue's ITO. It was noted that the difficulty in this decision was whether there was a legal basis to maintain such an order in light of the fact that at the time, Mr O'Donohue had been attending appointments, was cooperating with the case manager, and was believed to be taking his medication.

209. However, objectively, Mr O'Donohue's compliance was only partial as he refused to cooperate with CFOS evaluation, an external Medicare Psychiatrist, allow contact with his GP or family and friends for collateral information. The Investigators noted that *'it appears the treating team became somewhat used to working within the boundaries set by Mr O'Donohue that they ended up seeing this as him being complaint and cooperative.'*[194] His behaviour was typical of those with delusional disorders who control and limit access by mental health professionals to independent information and attempt to prevent information sharing or the involvement of other agencies.

210. With the benefit of hindsight, Investigators concluded that revocation of the ITO in December 2014 was an important step leading to the events that occurred on 28 October 2016. This decision was based on what was believed to be the case at the time. Had the report recommendations by the CFOS in May 2012, been available to the treating team, the assessment and management of the risk of aggression would have been better informed.[195] Had it been known Mr O'Donohue was not taking his medication it is unlikely the ITO would have been revoked. However, it was noted that the decision to move Mr O'Donohue to oral antipsychotics rather than depot was defensible in the circumstances.[196]

211. Consideration of Mr O'Donohue's discharge from the CCW Team's service in June 2016 was also examined by Investigators.[197] It was noted that he was voluntarily engaged with his treating team up until the time from discharge, and there was no indication he was pushing to be discharged. The Report noted:

> *The move towards closing his case and transferring his ongoing treatment to a GP we can only assume was based on the assessment of the clinical situation and appropriate next move. Team members did not report to the investigators that they experienced any direct pressure in this case, or any other, from management to expedite discharge. Whether a role was played by the more subtle influences of the recovery model, and an awareness of the pressure of new referrals, is not knowable.*[198]

212. Mr O'Donohue had engaged actively in a long-term period of care, and seemed to be relatively stable when the decision to discharge him from the service was made.[199] Investigators considered the decision was reasonable based on the clinical situation perceived at the time. However, it would have been better managed by making full communication with the GP service, to which he was

[193] Ex H2, pg. 22 & 23
[194] Ex H2, pg. 29
[195] Ex H2, pg. 29
[196] Ex H2, pg. 31
[197] Ex H2, pg. 32 - 34
[198] Ex H2, pg. 33
[199] Ex H2, pg. 34

transferred, a condition of discharge.

213. Investigators considered the attempt by Mr O'Donohue to reengage with the service should have been managed as though he was seeking help. These two failures conspired to leave Mr O'Donohue in the community untreated and unsupported.[200] However, it was noted that the clinical judgement in Mr O'Donohue's case emphasised the current presentation and underplayed the collateral information and history.[201]

214. Ultimately, even without hindsight, the Investigators noted that discharging a long-term patient without ensuring any viable transfer of care, ongoing support and treatment, as was the case with Mr O'Donohue, could not be regarded as best practice.[202] There were clear indicators that he was anxious about losing this support, which he had relied on for three years. This seems to have been missed by clinicians, which the Investigators deemed an oversight.[203]

215. Significantly, it was noted by the Investigators that Queensland did not have a state-wide forensic mental health service able to offer ongoing care and treatment for consumers who present a significant risk of serious offending in the future. Support was indicated for the recommendations of the Review Report, as summarised below.

New Mental Health Legislation & other associated reviews

216. The Report acknowledged that in 2017, the *Mental Health Act 2016* would come into effect and would impact on the involuntary treatment regime for patients going forward.

217. Standardisation in relation to clinical documentation was previously recommended in the *Achieving Balance: Report of the Queensland review of fatal sentinel events: A review of systematic issues within Queensland Mental Health Services 2002-2003.*[204] In early 2016, an Expert Panel of senior mental health clinicians reviewed the core suite of clinical documents and made 25 broad recommendations for changes to the forms, based on feedback from clinicians.

Summary of findings

218. The Mullen Report did not make any adverse findings against individual clinicians or other Queensland Health officers. The care of Mr O'Donohue was found to have been broadly compliant with legislation and the broad parameters articulated for service delivery. Where deficiencies were identified, they were attributable to the prevailing culture, practices and protocols within the service. The investigators did not attribute any deficiencies to any identified individual involved in the management of Mr O'Donohue.[205]

[200] Ex H2, pg. 34
[201] Ex H2, pg. 34
[202] Ex H2, pg. 35
[203] Ex H2, pg. 35
[204] Ex H2, pg. 10
[205] Ex H2, pg. 41-43

219. The Investigators made the following findings:[206]

- *Risk assessment and risk management:* In relation to Mr O'Donohue's management by the CCW Team, clinical judgement tended to emphasise a one-dimensional view of the current presentation and underplayed the collateral information and history, which may have impacted on decisions made about the management of Mr O'Donohue.

- *Diagnosis:* There was no good evidence to doubt the diagnosis of Delusional Disorder made by those managing Mr O'Donohue over many years and they would caution from moving away from such a diagnosis.[207]

- *Engagement and therapeutic relationship:* Engagement with Mr O'Donohue by the CCW Team was impaired by his refusal to provide access to, or the sharing of information, and his resistance to engaging in any rehabilitation efforts. This seemed to reflect his delusional disorder. Metro South Health, and on one occasion CFOS, tended to acquiesce in the limits he set rather than actively challenge and manage this impediment to good clinical care. In prioritising Mr O'Donohue's right to privacy and self-determination, the Team's capacity to identify family history and collateral information, to generate a network of community and social supports, to manage risk and to ensure ongoing treatment and care was effectively compromised.

- *Treatment Planning and Review:* The outpatient service for Mr O'Donohue from the Metro North Health Homeless Health Outreach Team appeared thorough with sound multidisciplinary team interactions and case review.

- *Medication compliance:* It seems that Mr O'Donohue only took his oral medication for a short time. He was unlikely to have been taking any medication for much of 2014, 2015 and 2016 up until the time of the tragedy.

- *Transition between Health Services:* The critical transition between the Metro North Health HHOT and Metro South Health community teams was sensitively managed and met the policy and practice expectations.

- *Revoking the ITO:* Removing Mr O'Donohue from the ITO at Metro South Health was based upon incomplete information. It was recognised, however, that there is a legal and clinical imperative to revoke an ITO when the consumer has demonstrated a willingness to comply with management on a voluntary basis, which appeared to be the situation in this case.

- *Decision to discharge in 2016:* Given the clinical situation as perceived at the time by the treating team, the decision by Metro South Health to move Mr O'Donohue toward discharge was in line with current practices and it was clinically defensible. However, Investigators found that the lack of contact with an identified GP in order to transition care while at the same time relying entirely on a GP for follow up care was not acceptable, and should have been better managed through full communication with the GP service to which he was to be transferred, as a condition of discharge.

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[206] Ex H2, pg. 41

[207] Compared to the majority of Psychiatrists in the Mental Health Court who were of the view he suffers from Paranoid Schizophrenia.

- *Re-Entry to the service:* Mr O'Donohue's attempt to reconnect with the service soon after discharge in 2016, was met by Metro South Health with a cursory but superficially justifiable response in the sense that pathways had been provided for re-entry and Mr O'Donohue was evidently not using the right one. Investigators considered that this should have been better managed through active follow up.

- *Communication between Queensland Health Officers and other agencies:* In the period from entering care in 2010 to transition to Metro South Health in December 2012, there was comprehensive engagement with relevant services where it was required based on appropriate to care treatment and recovery plans. Communication was appropriate and consistent with policies as indicated.

- *Compliance with Policies:* Access, assessment, treatment and discharge were broadly compliant with the *Mental Health Act 2000* including proper clinical review before extension of any ITO, and also broadly consistent with policy and practice guidelines. Investigators found that the incident of 31 August 2016, when Mr O'Donohue called the Metro South Health seeking help and was not provided with help was unfortunate. Investigators noted that Metro South Health has assured that procedures and practices have since been amended to prevent recurrence.

- *Information sharing:* Documentation was not always easy to find. While this might have been a function of the lack of familiarity with the CIMHA system, it may also indicate a general challenge for clinicians navigating case file material effectively. However, compliance by CFOS in relation to leaving the assessment reports out of CIMHA and therefore only forming part of the hard copy file may have contributed to the oversight in not handing the CFOS report on Mr O'Donohue from Metro North Health HHOT team to the Metro South Health at the time his care was transitioned.

- *Role of CFOS:* The current fragmented structure of Queensland's Forensic mental health services does not make optimal use of the resources in that service and in CFOS in particular.

- *Role of Forensic Liaison Officer:* Despite there being a FLO embedded within both clinics managing Mr O'Donohue, they played no identified part in his clinical management. The lack of integration between the existing CFOS and the clinic-based FLO impeded what might have been the more effective clinical outcomes for Mr O'Donohue.

Metro South Health Investigation Report

220. Following the Mullen Review, Metro South Health commissioned its own investigation into the prevailing culture, risk management activities and service leadership within its mental health services. Associate Professor Richard Newton (the Newton Review) headed this investigation. The Final Report titled, *Risk Management, Culture and Service Leadership Metro South Addiction and Mental Health Services* (the RCL Report), was released on 21 August 2017. [208]

[208] Ex H4

221. In addition to reviewing an array of documentation, records, and written material, including policies and procedures, the Metro South Health Investigators interviewed a range of staff, including members of the MSAMHS, executive senior medical, nursing, allied health, forensic officers and the Director of Metro South Health Clinical Governance Unit.[209]

222. Ultimately, the Metro South Health Investigators were not able to find any specific deficiencies in risk management, culture and service leadership which would suggest that staff, current and future clients and the community at large were at any higher risk of tragedy than in any other mental health service in Australia. However, opportunities for improvements within the RCL were identified.

223. Investigators made 22 recommendations following the review, namely:

    1. Ensure all clinical staff including FLOs are trained in assessing clinical risk.

    2. Ensure that client risk assessments are achieved through collaboration with all members of the interdisciplinary treating team, including the concerns of carers. All opinions should be sought and no one voice should dominate.

    3. Interdisciplinary teamwork training should be instituted for all clinical teams.

    4. Take steps to integrate the Princess Alexander Addictions and Other Drugs Service into a single MSAMHS for AOD.

    5. It would be good practice to have an external approach to assessing risk of forensic patients on a periodic basis, to avoid staff becoming desensitised to client risk due to overfamiliarity.

    6. Ensure the quality of risk assessments and management plans are reviewed regularly by psychiatric leaders in teams.

    7. Work with CFOS to ensure CFOS recommendations are made in much closer collaboration with the treating teams at MSAMHS.

    8. The clinical governance and risk reporting structures should be organised to ensure that collaboration and a collaborative leadership style is fostered at all levels of the system.

    9. Implement a more structured and rigorous approach to incident review and associated management planning within the M&M and SIRC committees. This should include transparent processes to allocate levels of incident reviews, use of SMARTER goals and a focus on robust implementation strategies and critical evaluation.

    10. Develop criteria for determining if a SAC1 incident is reviewed as an RCA under the *Hospital and Health Boards Act 2011* or HEAPS review, not under the legislation.

    11. Use an adaptation of the medical emergency and falls review structured document to assist in the discussion of psychiatric incidents.

[209] Ex H4, pg. 10

12. Supplement current risk management strategies with service wide improvement projects that address recurrent risk factors (common causes) that emerge thematically from incident reviews and prioritise and address these.

13. Build the capability of local clinical teams and the Executive Leadership Team, in structured improvement methodologies and prospective patient safety tools such as FMEA.

14. Empower and support local improvement champions to lead quality improvement projects that align with the values and key priorities of MSAMHS.

15. Empower local clinical service providers to take a more proactive role in patient safety and quality improvement and provide them with skills and permission to act.

16. MSAMHS needs to establish a patient centred clinical model of care that considers the recovery model and chronicity and complexity of its clients.

17. Obtain support from Metro South Health to continue to address the environmental deficits that are still ongoing with Princess Alexandra Mental Health Unit.

18. Take a range of steps to improve relationships and reporting lines between MSAMHS, Metro South Health and QLD DOH.

19. Develop a robust process to ensure participation by current consumers and carers of the service in clinical service provision and in all levels of clinical governance.

20. The leadership program (Leadership pipeline) should articulate across to the values and behaviours expected of staff, including the medical staff, with respect to patient safety and clinical quality improvement.

21. Build on the strengths of the Leadership Pipeline Line approach and explicitly delegate decision making power to appropriate levels in the service in order to address the perception of a strongly hierarchical structure.

22. Take steps to improve engagement, accountability and leadership by medical staff of quality and safety activities including educational programs.

224. In conclusion, the RCL Report noted that investigators had given due consideration to the concerns expressed in the Mullen review. However, they formed the view that the leadership culture, risk management process and safety and quality processes were a similar standard to those in most mental health services, and in fact, were better than many.

When Mental Health Care Meets Risk: A Queensland Sentinel Events Review into Homicide and Public Sector Mental Health Services, September 2016

225. In May 2015, the Mental Health Sentinel Events Review was announced by the Minister for Health and the Minister for Ambulance Services. The Review Committee was tasked with considering homicides and attempted homicides involving people with a mental illness, as well as fatalities as a consequence of police use of force interventions where the person may have had a mental illness.

226. The aim of the review, which included events from January 2013 to April 2015, was to examine and assess the standard and quality of clinical assessment, treatment and care provided to those individuals, and the compliance with relevant clinical and administrative policies and procedures. The Committee was tasked with making findings and providing recommendations to improve systems and clinical practice with respect to reducing and where possible preventing such events.

227. In September 2016, the Committee, chaired by Professor Ogloff and Associate Professor Peter Burnett, released the report titled, '*When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services'.*[210] This Report provided a comprehensive background for mental health service providers on the complexity of the challenges in providing care. It described the current forensic mental health service system as 'decentralised and fragmented' with aspects of the health service system located administratively in no less than six different Health Services.

228. The Review Report articulated concerns in relation to the assessment of risk of violence and the provision of appropriate treatment options for such people with mental health calling for more action to improve outcomes, including:

- Improvements in risk assessment and management.
- Enhancing information sharing practices between the mental health service and others.
- Building on the competencies, capacity and support of clinicians working within this very complex consumer cohort.

229. It was recommended that an integrated state-wide forensic mental health service, with a governance structure independent of the existing Health Services, be established. This was to ensure the effective operation and maintenance of an integrated service across Queensland. This service was to be provided to consumers assessed as being at high risk of violence in addition to consumers on forensic orders under the *Mental Health Act 2000.*

230. Other recommendations of note included:

- The role of Forensic Liaison Officer positions located with mental health services be quarantined for undertaking assessments and management of forensic mental health consumers and other consumers who pose a high risk of violence.

[210] Ex H2, pg. 13

- Develop collaborative relationships between forensic mental health services and Health Service mental health staff and obtain knowledge of the models of mental health service delivery and available services/resources within the Health Service region, by ensuring that identified Community Forensic Outreach Services teams are attached to specific Health Services.

- Develop a categorisation system to differentiate lower risk from higher risk consumers on forensic orders and adjust the treatment and monitoring requirements accordingly.

- That comprehensive assessments conducted by clinicians must be informed by collateral information obtained from families/carers. Prompts to obtain this information are to be added to the State-wide Standardised Suite of Clinical Documentation.

- Engagement with families to occur at the initial contact with the consumer and throughout the consumer's episode of care.

- Prompts are to be included in comprehensive assessment, risk assessment and treatment planning.

- Mental health services need to undertake a comprehensive mental health assessment for all new consumers accepted into treatment.

- Comprehensive mental health assessments should, insofar as possible, be a longitudinal assessment informed by a consideration of historical, contextual and current factors.

- Mental health services should ensure appropriate training, supervision and auditing of comprehensive mental health assessments.

- Implement the 3-tier level of violence risk assessment (initial risk screen on presentation, risk assessment and specialist risk assessment).

- Consultant psychiatrists, and other senior clinical staff, are required to actively review and be involved in the development of management plans that expressly address violence risk factors for all consumers rated as Risk Level 3.

- Forensic Liaison Officer Positions should be quarantined from non-forensic mental health, or management of consumers at high risk for violence, service demands in order to maintain role, presence and expertise.

- Management plans are to be informed by issues identified in the risk assessment and include proposals to address these issues including referrals to relevant agencies that can provide services that are outside of the scope of mental health services.

- All consumers must have a completed care review and summary plan within six weeks of being accepted into the mental health service. A Recovery Plan should also be developed at this time, or explanation for its delay.

- Include within the state-wide Standardised Suite of Clinical Documentation a mechanism to trigger a comprehensive ad hoc review where indicated.

- Greater consideration by clinicians is required during the comprehensive mental health assessment for the identification of dual diagnosis and co-occurring conditions (substance misuse, personality disorders, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury) to ensure referral pathways are initiated.

- Treatment plans should address and provide for the integrated management of complex consumers. Where required services fall outside the remit of mental health services, appropriate referrals should be made and, insofar as possible, the provision of external services should be monitored.

- Use one consistent integrated state-wide clinical information system for mental health information.

- Training in violence risk assessment, including the administration and interpretation of validated violence risk assessment measures, needs to strengthen formulation skill development and capability to ensure recommendations and care planning meet the consumers' needs rather than being passively identified in documents.

- Create a state-wide mental health Quality Assurance Committee to oversee the safety and quality of mental health services through formal assessment and evaluation processes.

231. Ultimately, the Review Report identified no concerning trends or emerging system issues, however, made findings across 11 key areas and provided 63 recommendations within the report. The Review Report and the Queensland Health response, accepting in-principle all 63 recommendations and outlining actions to address the recommendations, was released in September 2016.

232. The immediate Queensland Health response undertook to generate an options paper to analyse existing systems and processes, and to consider the benefits and risks associated with existing forensic mental health service models within other jurisdictions. In addition, a number of further actions were proposed:

    - A review of core documentation within the state-wide standardised suite of clinical documentation was completed by March 2016 to coincide with the release of the commencement of the *Mental Health Act 2016.*

    - A clinician user guide to be developed to inform clinicians on how these revised documents can be used to assist with comprehensive assessments.

    - The Guideline on the use of the state-wide standardised suite of clinical documentation was amended to accompany the release of the revised core documents.

    - The Department of Health developed an evaluation framework with audit tools to support Hospital and Health Services with the clinical audit process.

    - A twelve-month project was undertaken to develop state-wide clinical documentation and guidelines on a three-level risk assessment framework. In addition, this was supported by enhancements to risk assessment and management training.

- Consideration was given to the expansion of the draft Chief Psychiatrist policy on treatment and care of forensic and high-risk patients to include the requirement for psychiatrists to actively review, and be involved in the development of management plans, for all consumers rated as Risk Level 3 but who are not required to be reviewed by the (Assessment and Risk Management Committee) ARMC.

- The Department of Health was to establish a Mental Health Alcohol and Other Drugs Quality Assurance Committee.

233. The Department of Health led the implementation of the Queensland Health response. The governance structure comprises of a Steering Committee, supported by Advisory and Working Groups.

234. A key initiative being progressed is a Violence Risk Assessment Management Framework (VRAM) for mental health services. The framework provides mental health services with a systematic three-tiered approach for the identification, assessment, and management of consumers who pose a risk of violence towards others, and is supported by principles of good practice, clinical tools and training.

235. In addition, in line with the investigation findings regarding the fragmentation in forensic mental health services, the Director-General approved a staged approach to the development of a state-wide integrated forensic mental health service model. This follows an independent consultancy of forensic mental health experts engaged to develop options for the service model.

236. The following further actions were implemented:

- *Review of Forensic Mental Health services and models for an integrated service to improve the system's responsiveness proposed for consideration.*

  An options paper delivered in February 2018, noted that while there were many positives in the establishment of Hospital and Health Services, decentralisation had created challenges for state-wide specialist services, such as the forensic mental health service, which lacks a unified service model and a clear governance structure. Three possible models for consideration were detailed, which would address the three key issues identified, namely; the need for forensic services to work collaboratively, to have clearly defined lines of accountability and authority; and to be integrated – both within the forensic mental health service system and with mental health services.

- Completion of a draft three-tiered Violence Risk Assessment and Management framework to improve mental health service responses for consumers who pose a risk of violence towards others. This framework provides a structured three-tiered approach for the identification, assessment and management of consumers who pose a risk of violence towards others. It aligns service responses with the level of risk identified, and actively engages senior clinicians, including consultant psychiatrists, in the assessment, management and review of consumers with an elevated risk profile. The Framework was supported by enhancements to clinician training on risk assessment and management at each of the three tiers.

- Existing training was updated and new training packages were developed to enhance clinician's skills in identification, assessment and management of risk.

- The Mental Health Alcohol and Other Drugs Quality Assurance Committee was established to review critical events involving suspected homicides and serious acts of violence to drive ongoing improvements to the safety and quality of service delivered.

237. By June 2019, the following further activities were actioned:

    - The Violence Risk Assessment and Management Framework – mental health services was rolled out.

    - A mechanism was identified to provide oversight on the regularity and suitability of case reviews and care plans for consumers assessed as requiring a Tier 3 response within the Violence Risk Assessment and Management framework.

238. In 2016, the Queensland Government released *Connecting care to recovery 2016-2021* which detailed the direction, plan and investment in the State-funded mental health, alcohol and other drug service system. The purpose was to strengthen collaboration and effective integration across the treatment service system to respond to individuals more effectively with the most severe mental illness or problematic substance misuse. This has since been superseded by *Better Care Together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027* which was published in October 2022.

239. In August 2018, the Clinical Excellence Division of Queensland Health released a response detailing the *Actions relating to investigation into the treatment and care of Anthony O'Donohue.*[211] The Key State-wide Initiatives, which were being undertaken, were outlined as follows:

    I. *Mental Health Sentinel Events Review Committee recommendations implementation* (as outlined above).

    II. *Review and implementation of standard clinical documentation* – 25 broad recommendations were made to change the core suite of clinical documents following the review in early 2016 by a panel of expert senior mental health clinicians.[212] These clinical documentations include triage and rapid assessment, risk screening tool, child and youth assessment, general assessment, substance use assessment, case review, care plan and transfer of care. These changes were implemented as of 5 March 2017.

    III. An acute management plan was also revised and is in use throughout mental health services. It is designed for consumers with complex needs, involving multiple service providers, with a history of regular contact with the police and ambulance service, and/or frequency presenting to ED.

[211] Ex H5
[212] Ex H5, pg. 2

IV. *Mental Health Act 2016 implementation* – On 5 March 2017, the new Act commenced. Practice Guidelines and policy were published at this time, including the *Chief Psychiatrist Policy for the treatment and care of forensic order, treatment support order and high-risk patients.*

This policy provides governance arrangements and escalation pathways for treating teams, along with the clinical directors of the service, to review the treatment and care being provided to high-risk consumers.

The policy prescribes that an Assessment and Risk Management Committee must be established at each service to review the care given to particular consumers on a regular basis.

The Act also enhanced the relationship between CFOS and Health Service treating teams with the Chief Psychiatrist Policy, *'Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients'* issued under the Act, mandating a role for CFOS in assessment of new forensic patients charged with a prescribed offence.[213]

V. *Mental Health Alcohol and Other Drugs Quality Assurance Committee*[214] – In September 2017, a Quality Assurance Committee was established with the specific purpose of improving the safety and quality of public mental health alcohol and other drugs services. The Committee will review and analyse relevant investigation and audit findings to monitor deaths, suspected suicides, significant incidents, suspected homicides, acts of violence and the management of risk to identify trends and system level improvements.

VI. *Service Development* – New funding of $106.4 million was allocated in the 2018-19 budget over four years to support individuals with severe and complex mental illness through recurrent enhancements to community mental health treatment services provided by Health Services.

240. Many other policy and procedural changes, including resourcing, have been made by Queensland Health and specifically by Metro South Health since this time. While not exhaustive, the further changes to policy and procedure made by Metro South Health, include:[215]

I. *Communication with GPs:*[216]

- A memorandum has been circulated to all staff reiterating the need for regular communication with GPs, with a reminder about the Queensland Health guideline *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Significant Others* as well as the other possible actions that can be taken if a consumer refuses information sharing with GPs or external providers. Monitoring consumers that have GPs within the service has also been taking place, with the implementation of the

[213] Ex B101, [53]
[214] Ex H5, pg. 2
[215] Ex B104
[216] Ex B104, pg. 6 & 7

integrated electronic medical records assisting to facilitate timely communication.

II. *Re-entry processes*[217]

- A brochure has been developed to assist consumers who are being discharged from the service about how to reengage and provide further information relevant to discharge. Further, the relevant Procedure was updated with the requirement that consumers now have the ability to contact their treating team directly within 6 months of being discharged, the process by which is outlined in the applicable brochure. A 24-hour telephone mental health clinician led call service has also been introduced to give consumers an opportunity to seek assistance.

III. *Risk management*[218]

- To enhance the risk assessment and management of high-risk consumers the Mental Health Alcohol and Other Drugs (MHAOD) Service developed the state-wide ARMC and VRAM framework.

- The ARMC monitors and reviews forensic orders, treatment support order and high-risk patients, with legislation to support introduced under the MHA in 2017. For those consumers that fall within these categories, processes for assessing, monitoring, and developing management plans have been developed and are done so through the ARMC Committee.

- The VRAM framework provides a three-tiered approach to violence risk assessment and management to support clinical practice and governance by all Queensland health mental health services. The aim is to ensure there is a supported, structured and standardised approach to risk assessment and management through the provision of principles of good practice, clinical tools to underpin clinical expertise, training and a quality assurance cycle for continuous improvement.

- The MSAMHS case review procedure has been modified to ensure that the Tier 1 risk assessment for discussion and determination of the management of risk are under the VRAM module.

- Dashboards have also been developed to support reflective practice for case managers in the planning of care and to provide an oversight by the Team Leader to ensure monitoring of risk assessments and care plans in consumers who are open to the service.

241. In response to the Newton Review, a number of recommendations were implemented including:[219]

    - Forensic Liaison Officer positions have completed Risk Assessment HCR20 training and are all VRAM trained.

[217] Ex B104, pg. 8
[218] Ex B104, pg. 9
[219] Ex B104, pg. 11

- A new model of care for FLO positions was developed in consultation with CFOS, which aims to facilitate consistent role responsibilities and integration within the service.

- A Patients Needs Framework – A Psychosis Model of Care has been implemented across the psychosis team in Metro South Health. This provides measurement of the severity of illness and assessment of individual patient needs.

242. Significant changes have also been made to the operational and governance structures of the MSAMHS since July 2019, which are intended to ensure better clinical leadership, clearer decision-making principles, as well as a better integration of services across a consumer's journey through the service with internal and external stakeholders with the benefit of stronger input from clinical sites.[220]

243. Training modules have also been extensively updated, with new packages developed in order to develop a clinician's skills in the identification, assessment and management of risk.[221]

EXPERT REPORT – DR JILL REDDAN, CONSULTANT PSYCHIATRIST

244. Consultant Psychiatrist, Dr Jill Reddan, was asked to consider and provide an expert opinion to the Coroners Court about the adequacy of the mental health care and treatment provided to Mr O'Donohue in the years leading up to Mr Sharma's death, including the decision to discharge him from the community mental health service in 2016. Expert comment and recommendations about the subsequent changes made to the mental health system in Queensland since Mr Sharma's death was also sought.[222]

245. Having considered all the relevant clinical records and associated reports, Dr Reddan was of the view that before the decision to discharge Mr O'Donohue from the service in 2015-2016, the care provided was reasonable.[223]

246. Mr O'Donohue had been provided with a psychosocial management plan that not only included medication but also active attempts by the team to impact on his cognitive processes, which extended to consistent case management visits, engagement with an experienced psychiatrist and ongoing consultation with a psychologist.[224]

247. Dr Reddan considered that the decision to discharge Mr O'Donohue from the service in 2015, and what occurred in the discharge process up until the time of its implementation in mid-2016, including his subsequent responses, were where concerns about his management first arose.[225]

[220] Ex B104, pg. 16 & 17
[221] Ex B101, [71]
[222] Ex P1
[223] Ex P1, pg. 9; T3-43, lines 15-30
[224] T3-43, lines 18-25
[225] T3-43, lines 26-40

248. Dr Reddan noted that it appeared that staff had a better therapeutic alliance with Mr O'Donohue than they appreciated at the time of his discharge from the service. This had perhaps served to contain his delusional thinking and behaviour during the course of treatment more so than was appreciated.[226]

249. Mr O'Donohue's expressed anxiety about discharge, his dismissal of other sources of treatment, and his attempt to re-enter the service, particularly in August 2016 shortly after discharge, coupled with the lack of communication with his General Practitioner, all point to an '*opportunity lost at the time of discharge'.*[227] The fact that he continued to voluntarily engage with the service and other supplementary supports recommended by the service, despite denying that he was suffering from a mental health condition, also suggested the degree to which treatment was helping him.[228]

250. While reliance seems to have been placed by the team on the apparent insight Mr O'Donohue had verbally demonstrated about recognising when his state deteriorated and he may then need to seek reengagement with services, Dr Reddan noted that insight can deteriorate rapidly with a relapse and cannot be '*solely determined from an individual's statements*'.[229] As such, 'therapeutic nihilism' was not called for in Mr O'Donohue's case particularly given the objective benefits treatment seemed to be having, that is containing the delusions and associated behaviour for some time .[230]

251. Dr Reddan noted the importance of having a proper and practicable discharge process from public mental health services, that could assist in guiding services to identify a patient that is suitable for discharge and one that may require a prolonged discharge from the service.[231] As to the changes made in this regard following Mr Sharma's death, while Dr Reddan said that some of the guidelines created have been useful, they do not provide any guidance to clinicians, particularly those more junior, about referring patients to the private sector for patients who would benefit from longer term management.[232] However, the changes made to allow patients to reengage with the service via their previous treatment team in terms of direct contact, as have been implemented by Metro South Health, do serve to address that potentially missed opportunity in this case.[233]

252. Dr Reddan stressed the need for the General Practitioner of a patient like Mr O'Donohue, who struggled to develop therapeutic alliances, to be seen and included as part of the treating team, which was lacking in this case by way of his own refusal.[234] However, she recognised that there had been improvement in this regard in recent years.

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[226] Ex P1, pg. 9; T3-43, lines 31-47
[227] Ex P1, pg. 9
[228] T3-45, lines 4-25
[229] Ex P1, pg. 9
[230] T3-46, lines 10-35; T3-61
[231] Ex P1, pg. 9
[232] Ex P1, pg. 11
[233] T3-47, lines 24-45
[234] T3-48, lines 28-45

253. Dr Reddan highlighted the lack of a link between private and public mental health services in Australia and emphasised the need for more imaginative steps to be taken to enable this to occur.[235] For patients like Mr O'Donohue, who are seriously mentally ill and require longer term care, such a link would have allowed for continuity of care and transition to the private system that would have ensured he was not left in the community without any therapeutic support, reliant solely on his own recognition of a deteriorating mental state.[236]

254. Dr Reddan suggested that a longer-term project creating the linkages between a number of select private psychiatrists and public mental health services for a small subgroup of patients requiring very long term therapeutic engagement would be beneficial.[237]

255. In addition, Dr Reddan suggested that there would be value every so often in long term patients, like Mr O'Donohue, being seen by another senior Psychiatrist for a second opinion, for the purpose of identifying whether there may have been any 'gaps' missed, and could potentially to assist with the discharge process, should it be being considered.[238]

256. In terms of the changes that have been made to the Mental Health System following Mr Sharma's death, Dr Reddan noted that while such changes were worthwhile, particularly with respect to the area of risk management, others proposed, particularly with respect to the need for a standalone forensic mental health service did not rectify the shortcomings raised in this case.[239]

257. This was primarily because Mr O'Donohue was not a forensic patient. Having considered the applicable *Assessment and Risk Management Committee High Risk Patient Referral,* Dr Reddan thought it was unlikely that he would have met the criteria for management via that mechanism either.[240]

258. Dr Reddan reiterated in her report and during her evidence that cases involving persons such as Mr O'Donohue are '*very rare*' and that considering clinical decision making in such cases must be done with the risks of hindsight bias firmly kept in mind.[241] Risk assessment does not equate to risk prediction in terms of homicidal and violent behaviour, and in such cases do not reflect whether a tragic event, such as that involving Mr Sharma, was foreseeable.[242] Dr Reddan disagreed with the proposition put to her by Counsel for Mr Sharma's family, that it was foreseeable Mr O'Donohue would have gone on to commit an act of violence.[243]

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[235] Ex P1, pg. 9 & 10
[236] Ex P1, pg. 10
[237] Ex P1, pg. 12
[238] T3-54, 30-47
[239] Ex P1, pg. 10 & 11
[240] Ex P1, pg. 11
[241] Ex P1, pg. 11& 12; T3-42, lines 33 onwards; T3-53
[242] T3-53 & 54
[243] T3-63

259. In response to the suggestions made by Dr Reddan about the need for better linkages between the public and private sectors, Director of Medical Services, Metro South Mental Health Addictions Services, Dr Balaji Motomarri agreed that this was wise and necessary.[244] Chief Psychiatrist, Dr Reilly, acknowledged that there were challenges in this regard, and it was difficult to establish systematic links with individual practitioners.[245]

BUS OPERATOR SAFETY

Brisbane City Council Review of Bus Driver Safety

260. Prior to October 2016, Brisbane City Council had a range of measures in place to address bus operator and passenger safety. This included panic alarms for operators, silent alarms for operators, anti-shatter windows, a physical barrier at the rear of the cabin area, critical incident response, security guards on some services and emergency exits/releases.

261. Following Mr Sharma's death, the Council engaged Mr Trevor Love from AusSafe Consulting to provide an expert report addressing work health and safety and risk related matters for bus drivers.[246]

262. The main areas the AusSafe investigation focused on were:

    (a) Protection and safety of bus operators from personal attack; and

    (b) Emergency evacuation for passengers.

263. Ultimately, three key recommendations were made by AusSafe, namely:

    (1) Conduct a review of Council's safety in design processes for bus design and ensure that an adequate design review was undertaken in relation to driver protection measures, which was to consider future design requirements (if deemed necessary), including administrative and engineering controls.

    (2) Conduct a review of Council's safety in design processes for bus design and ensure that consistent with those processes an adequate design review is undertaken in relation to bus emergency provisions, which included consideration of firefighting equipment, emergency exits, emergency doors, door release buttons and handles and signage and communication for passengers.

    (3) Conduct an overall risk assessment of the Council bus transport system, which was to include additional firefighting controls, better signage of emergency doors, more and easier to identify signage for emergency door release buttons and additional training for operators to manage disputes and threats.

[244] T3-15 & 16
[245] T3-36
[246] Ex I1

264. Council administration subsequently asked the Chief Executive Officer to take the following actions:[247]

- Upgrade emergency exit signage throughout the bus fleet. This was completed in August 2017.[248]

- Prepare and roll-out an education program for bus passengers about emergency procedures, including the location of emergency exits. Rollout was commenced on 16 November 2017.

- Expand Council's driver training program to better equip drivers to respond to violent situations. This Program was in place as of 26 September 2017, with the roll out completed in June 2018.

- Install an additional emergency exit in the rear of all buses which do not have rear window emergency exits. All 706 buses, which required a 3rd emergency evacuation exit were fitted with window by June 2018.

- Provide findings about barriers to the State Government for consideration as part of its ongoing review.

265. Further measures have also been implemented by Council following this incident and the AusSafe Review, including:[249]

- A risk assessment was undertaken to determine if additional firefighting equipment was required at the front and rear of the bus. It was determined that the existing fire-fighting equipment was sufficient to manage the risk and that additional equipment would introduce other risks around potential misuse.

- A risk assessment was undertaken as to the likely causes for bus evacuations and appropriateness of the controls available. It was determined that the risk was very small, and the controls were appropriate.

- A risk assessment was undertaken to consider the risk posed to bus operators of an unprovoked criminal intruder or member of the public inflicting a fatal injury in an escalating situation. The assessment determined that the risk was low and existing controls were appropriate.

- Over a two-week period in June 2017, briefs were provided to bus operators about the AusSafe Report findings.

- A review was undertaken of Council's safety in design processes for bus design, which indicated that the current safety in design and governance structures are robust, industry leading and effective for ensuring appropriate consideration of driver protection and emergency evacuation.

- A review of Council risk assessment processes was undertaken, which found that the current processes were robust and effective by the standards of the Council and the public transport industry.

[247] Ex H5, pg. 2
[248] Ex H5, pg. 3
[249] Ex H5, pg. 3 & 4

266. External experts, Marsh Risk Consulting were engaged to produce risk assessments, including quantitative risk assessments on the risk of an inadequate evacuation and of an assault on a bus operator causing a fatality. Subsequent Equivalent Fatality Assessment and a Semi-Quantitative Risk Assessment found that the risk to bus operators of an assault or inadequate bus evacuation were extremely low, and the existing controls that fall under the responsibility of the Council are comprehensive.[250]

267. However, it was recognised that the nature of the interactions and open nature of the public transport system means that there would also be a degree of risk, which will need to be managed by bus operators or subject to controls for which other organisations have responsibility.

268. The Brisbane City Council has also enacted a series of further engineering controls to enhance the safety of bus operators, including:[251]

- Installation of driver's door latch exit decals to facilitate quicker identification of the latch and improve the speed of exiting in an emergency.
- Verification of bus emergency full exit functionality during scheduled servicing.
- New photo luminescent material for internal emergency exit decals.
- External emergency door release buttons to be flush with external panels to make them easier to identify and operate in an emergency.
- Change to specifications for advertising film to align to changes in the National Heavy Vehicle regulatory requirements. This ensures appropriate emergency window functionality and compliance by allowing the glass to break effectively during an emergency evacuation.

269. The Council has also increased its investment in the number of security guards on the Council bus network.[252]

270. A trial of commercially available barriers in a number of vehicles across all depots has been conducted by the Council since June 2018.[253] One element of this plan includes the recommendation for the installation of driver safety barriers on applicable Queensland buses by mid-2020. A trial of different barrier types was commenced in August 2018.[254]

271. Since this time, a range of safety measures have been implemented across the bus fleet, which included:[255]

- Closed circuit television has been fitted in all buses.

[250] Ex H5, pg. 4
[251] Ex H5, pg. 4 & 5
[252] Ex H5, pg. 5
[253] Ex I1, pg. 5
[254] Ex I1, pg. 6
[255] Ex I4

- All existing analogue radios are being replaced with a digital radio network that provided improved performance and coverage.

- Council finalised the installation of a partial driver protective barrier on its buses in December 2020 and has continued to undertake investigative work in the area of protective barriers. In September 2020, a Driver's Door and Security Screen Specification was developed for inclusion in future bus procurement. This was trialed and issues associated with glare were to be examined with a view to being resolved.

- On 14 December 2021, the Transport Minister approved Driver barriers as mandatory on new buses, with mandatory risk assessments by delivery partners with operators to develop and determine barrier fitment.

- Investment continues to be made in security guards on the bus network.

272. Mr Matthew Anderson, Executive Manager, City Standards within the Brisbane City Council told the inquest that BCC had a Bus Design Security Consultative Committee which included the RTBU. He said that safety barriers were one element of an overall systems approach to the management of risk. It was important not to generate additional risk by implementing safety barriers (such as glare from Perspex screens). As a consequence, the narrow partial screen was selected for existing buses. Mr Anderson said that full encapsulation was not viable in the existing fleet.

273. Mr Karl Hain is the Manager, Fleet Engineering and Asset Management with BCC. His evidence was that the Council's work in respect of driver protection barriers is ongoing. Council had finalised installation of a partial driver protective barrier in December 2020, and has continued to undertake investigations in the area of protective barriers for operators. He noted that the Driver's Door and Security Screen Specification has been endorsed by the RTBU. This provides an almost complete driver protection barrier. BCC has included this Specification in its specifications for future bus procurement contracts. Mr Hain said this will be updated where necessary, subject to the outcomes of trials and consultation with bus operators and the RTBU.

274. Mr Hain's evidence was that in November 2021 a survey of bus operators participating in the trial of the Specification was conducted. The results were generally favourable, with 53% of bus operators agreeing the barrier made them feel safer while driving. However, 44% of bus operators agreed the full barrier introduced new safety risks, the key risk being glare/reflection that can affect an operator's ability to see the left hand side mirror and left hand side of the bus. Camera technology was being explored to overcome the glare issue.[256]

Queensland Bus Driver Safety Review and Further Actions

275. In September 2016 (before Mr Sharma's death), the Queensland Government initiated a review into driver safety as an increase in incidents involving verbal and physical aggression towards bus drivers had been observed. [257]

[256] Ex I4.
[257] Ex H5, pg. 5

276. The Queensland Bus Driver Safety Review was released in August 2017.[258] The final response was provided by the Queensland Government in June 2018. A commitment was made to implementing 20 initiatives recommended in the Review to improve bus driver safety, which were primarily focused on actions that mitigated common triggers of violence, including safety interventions that were in line with State and international best practice.[259]

277. On 8 June 2018, the Minister for Transport and Main Roads, the Honourable Mark Bailey MP announced a five-point safety package for bus operators in Queensland including funding for safety barriers and anti-shatter window film, introduction of a code of conduct for passengers, sharing of industry best practice in training and recruitment, simplified incident reporting to assist deployment of resources, and improved education and safety awareness including development of a public awareness campaign and expansion of a school education campaign.[260]

278. On 30 September 2019, the Queensland Government announced it would introduce additional measures to bolster safety on South East Queensland buses. This included a 12-month trial of an increasing presence of officers on Westside services, a television campaign highlighting the zero-tolerance policy towards violence against bus drivers, as well as more safety barriers to target violence against bus drivers.

279. Currently, a range of measures are in place to promote safe travel on public transport, including:[261]

- Guards, busway safety officers, Queensland Police Service Railway Squad members patrol public transport services and stations.
- Help phones located on all busway platforms, inside trains and on all City Cats.
- Security cameras located at busway stations, train stations and on all City Cats.

280. Ms Sally Stannard, Deputy Director-General (Translink), Queensland Transport, told the inquest that TransLink contracts with service delivery partners to deliver public transport services across Queensland.

281. Delivery partners such as BCC had the opportunity to seek funding to retrofit existing buses with safety barriers. The type of barrier chosen was a matter for each operator. All BCC buses and around half of the Caboolture Bus Lines fleet were fitted with barriers by June 2020. Other delivery partners had installed barriers outside the scheme. Up to 90% of Queensland's contracted urban bus fleet now have a safety barrier installed.

[258] Ex J6, [5]
[259] Ex J6, [6]
[260] Ex I1, pg. 5
[261] Ex J6, [10]

282. Ms Stannard noted that an increased focus on reporting incidents is supporting the evidence-based deployment of Senior Network Officers (SNOs), providing a heightened presence in areas where incidents are occurring. SNOs are employed by Transport and Main Roads (TMR) to undertake compliance and enforcement activities on the SEQ public transport network. In March 2022, there were 52 SNOs operating in the greater Brisbane and Gold Coast areas. SNOs work with Queensland Rail Authorised Officers, Queensland Police Service Rail Squad Officers and Gold Coast Light Rail Customer Service Officers (CSOs) to conduct station lockdowns and patrols, educate public transport users, and issue penalty infringements and warning notices.

283. Ms Stannard said that under the endorsed approach, barriers were required on vehicles ordered or purchased after 1 July 2022. The type of barrier would be a matter for service delivery partners, following a risk assessment with their workforce. The Queensland Government will fund installation.

284. On 2 March 2022, TMR held a bus industry roundtable on implementation of a best practice approach to bus driver safety barriers. There was general support for a mandatory approach to driver barriers, noting the current trials of full protection barriers. After the roundtable, the Minister announced that driver safety barriers would be mandatory for all new urban public transport buses.

CONCLUSIONS ON CORONIAL ISSUES

Findings required by s. 45

285. I am required to find, as far as possible, the medical cause of 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 – Manmeet Sharma

How he died – Mr Sharma died while driving a Brisbane City Council Bus that had been traveling north along Beaudesert Road, Moorooka. Anthony O'Donohue, who had an untreated psychotic illness, boarded the bus at around 9:00am following other passengers. He was holding a black backpack which concealed a mixture of petrol and diesel contained in a plastic bottle. He lit the fuel and tipped the contents of the bottle on to Mr Sharma, who was seated in the driver's seat. Mr Sharma was immediately engulfed in flames. Mr Sharma sustained burns to 84% of his body. There is no evidence the attack was racially motivated.

Place of death – Beaudesert Road, MOOROOKA QLD 4105 AUSTRALIA

Date of death– 28 October 2016

Cause of death – The effects of fire.

Other Issues

The Mental Health treatment provided to Mr O'Donohue by the various Mental Health Services in Queensland.

The circumstances and decision to discharge Mr O'Donohue from the Metro South Mental Health Service in 2016.

286. The evidence in relation to these matters is discussed at length in these findings.

287. Mr Sharma's family submitted that "*the evidence shows that there was an accumulation of failures within the systems in place around Mr O'Donohue's mental health treatment. The accumulation of those features contributed to Manmeet's death. But for those failures, there is a chance that Manmeet might be alive today*." The Rail Tram and Bus Union supported the family's submissions.

288. It is important to note that the family did not attempt to apportion blame to individual health care professionals. However, the family submitted that "*systemic failures present in the system ultimately resulted in a dangerous man being untreated in the community and Manmeet was the unfortunate victim of those failures*."

289. The family's submission placed considerable weight on the CFOS desktop assessment conducted in May 2012, over four years before Mr Sharma's death. It was submitted that it is "*profoundly regrettable that the opinions contained in that assessment were not shared with the treating practitioners who were involved with Mr O'Donohue in later years. Had those recommendations been followed, Mr O'Donohue's treatment may have been materially different*."

290. The family also expressed concern that after Mr O'Donohue's care was transferred to the CCW Team in December 2012, he continued to hold chronic delusions in relation to trade unions which incorporated homicidal ideation. He also believed that he was not mentally ill and did not need treatment. Notwithstanding his history, he was assessed as being a low risk, and in December 2013 it was determined he should be allowed to travel to Thailand for a holiday, and at the same time transition to oral medication.

291. Mr O'Donohue's level of compliance with his oral medication regime was unknown. He told his treating team that he was compliant, but after Mr Sharma's death said he had not been taking his medication for some time. However, as a voluntary patient there was no mechanism to require him to submit to any tests to determine if he was taking his prescribed medication. There was also no evidence that such testing was reliable.

292. In December 2014, a plan was developed to revoke Mr O'Donohue's ITO but to continue with voluntary treatment and medication. This voluntary engagement continued throughout 2015 and 2016. In March 2015, Dr De Souza-Gomes noted Mr O'Donohue's "chronic sense of hopelessness" and the ongoing suicidal and homicidal ideation that he experienced. However, Mr O'Donohue continued to accept regular home visits from RN Gourlay and participated in 23 counselling appointments with Ms Little. As a consequence, it was planned to discharge him from the CCW Team.

293. I accept the submission from Dr De Souza-Gomes that the fact Mr O'Donohue remained engaged on a voluntary basis with the CCW Team for 18 months after the ITO was revoked confirms the correctness of that decision. I agree that by December 2014, based on the information then known to Dr De Souza-Gomes, Mr O'Donohue no longer met the criteria for involuntary treatment under the *Mental Health Act 2000*.

294. The family were concerned that Mr O'Donohue was discharged from the service on 1 August 2016, even though he had expressed anger and anxiety about the prospect of discharge. He had also refused to allow the CCW Team to contact his General Practitioner. He continued to tell RN Gourlay about his ongoing delusions about unions and made a generalised threat about them getting "what was coming to them." He attended upon Ms Little unannounced on 3 June 2016. His reasons for being there were unclear, but he reported ongoing suicidal ideation. He failed to attend his final review with Dr De Souza-Gomes and unsuccessfully tried to reengage on 31 August 2016. Within three months of discharge he had killed Mr Sharma.

295. The family referred to the opinion provided by Dr Russ Scott to the Mental Health Court. Dr Scott noted that when discharged from the CCW Team, Mr O'Donohue had a "very substantial loading of current risk factors for future violence." These factors included the absence of insight into his mental illness or need for treatment, and symptoms of an active untreated mental illness including recurrent violent ideation. Mr O'Donohue also had no supports in the community.

296. Dr Scott said that when Mr O'Donohue was discharged from the CCW Team without any follow-up or support, "there was a foreseeable and not insignificant risk" that:

- His mental state would deteriorate further.
- He would not re-present to the Metro South Mental Health Service for treatment.
- He would make some kind of violent protest and cause harm to himself or to a third party.

297. It is clear that Mr O'Donohue had a longstanding and severe mental illness. His illness presented in the form of chronic suicidal ideations, persecutory delusions that were systematised into his everyday life with some homicidal intent targeted at trade unions, union workers and public servants. These had been present for some 10 years.

298. I accept that consumers like Mr O'Donohue are 'very rare' and make up a small percentage of those within the mental health system. The gravity of the potential risk posed by such persons can be catastrophic, as was seen in the violent and tragic death of Mr Sharma.

299. I agree with the submission from the family that Mr O'Donohue should not have been assessed as being at low risk prior to discharge from the CCW Team. To some extent, the risk assessments performed by the CCW Team were hampered by a lack of access to the clinical notes arising from his treatment at Metro North Health, including his history of violence and the persistence of his delusions.

300. I also agree with the observation in the Mullen Review that the CCW Team had permitted Mr O'Donohue to set the boundaries of his treatment in such a way that his compliance with those boundaries was assessed as being "compliant and cooperative."

301. However, I do not agree that it could have been predicted that Mr O'Donohue would have gone on to kill someone, particularly in the manner that he killed Mr Sharma.

302. As Dr Reddan noted, risk assessment does not equal risk prediction in terms of homicidal and violent behaviour. I also agree with Dr Reddan that risk assessment is not about foreseeability. Coroners and mental health professionals are aware that many of those who commit a serious violent offence, homicide, or die by suicide, have been assessed as low risk patients.

303. The primary function of risk assessment should be to inform effective responses to persons with a major mental illness. Risk assessment should be managed as part of a systemic response rather than seeing it as a separate process. Some consumers, such as Mr O'Donohue, will need to be managed on a long-term or indefinite basis. This does not mean that risk can be eliminated.

304. I accept the submission from Counsel Assisting that the care and treatment provided to Mr O'Donohue by the CCW Team, before the decision to discharge him from the service, commencing in 2015, was reasonable. This includes his diagnosis of delusional disorder. In my view, he was provided with consistent case management and regular clinical engagement that included medication and attempts to improve his cognitive thinking. This was done in a cohesive and collaborative manner by a team of experienced professionals.

305. With the benefit of hindsight, it appears the therapeutic alliance established with the CCW Team may have served to contain Mr O'Donohue's delusional thinking and behaviour during the course of his treatment, which he continued on a voluntary basis, although he appeared to lack insight into his condition and had ceased medication.

306. I also agree that the decision to discharge Mr O'Donohue from the mental health service, which took place over a 10-month period leading up to August 2016, was not satisfactory. However, that conclusion is reached with some hesitation and only with the benefit of hindsight.

307. From the perspective of the CCW Team at that time, Mr O'Donohue was a long-term voluntary patient who appeared to be stable, he had no history of criminal charges, and there was no CFOS assessment available to the Team. He was an intelligent man who appears to have struggled with the stigma of mental illness.

308. However, what was also known to the CCW Team was that Mr O'Donohue was socially isolated and effectively had very few other supports in the community. The CCW Team did not engage directly with his General Practitioner for a handover as they respected his right to confidentiality. This was not best practice and was a missed opportunity. I agree that his discharge failed to objectively recognise the degree to which treatment was benefitting him despite the lack of 'improvements' seen. Mr O'Donohue was clearly anxious about being discharged and tried to reengage with the service in August 2016.

309. I agree that the public mental health system must have an avenue for most consumers to be discharged and, where necessary, provided with long-term care in the community by a General Practitioner or other mental health professional. It was assessed that this pathway was suitable for Mr O'Donohue. Unfortunately, following his discharge from the service in August 2016, Mr O'Donohue was left in a vacuum without any social or mental health support, after refusing engagement with his General Practitioner.

310. In effect, this meant reliance had to be placed on his capacity and insight to recognise his deteriorating mental state and the need to seek support. It is unfortunate that the call he made to the service in August 2016 went unanswered, although an effort was made to contact him. In the past, Mr O'Donohue may have asked for help or acted out in order to receive support. However, he relapsed without intervention in the three months after discharge before killing Mr Sharma.

311. The family also submitted that the evidence demonstrated there were a number of issues which amounted to failures in the management of Mr O'Donohue's mental health treatment:

> *The causal link between the identified failures in Mr O'Donohue's management and the death of Manmeet is necessarily speculative, but the evidence suggests that, but for those failures, Manmeet may be alive today.*

312. Mr O'Donohue's mental health treatment has been comprehensively reviewed. I agree with the conclusion of the Mullen Review that Mr Sharma's death might not have occurred if different decisions been made at certain times during the course of his treatment.

313. Although he was a very unwell man seemingly obsessed with getting revenge against his perceived persecutors, up the point of his discharge from the CCW Team, Mr O'Donohue was the beneficiary of a compassionate response to his mental health needs which was very effective in keeping him and the community safe for over six years.

314. Consistent with the findings of the Mullen Review I am not able to conclude with any certainty that the systemic issues identified with respect to matters such as the handover of the 2012 CFOS recommendations, information sharing, risk assessment, and the discharge from the CCW Team in 2016 establish any direct causal link to the killing of Mr Sharma.

315. Some of the family's expressed concerns about Mr O'Donohue's treatment by the justice system after Mr Sharma's death may relate to the unique nature of Queensland's Mental Health Court. It is not the role of that court to punish but to determine criminal responsibility in relation to the availability of a mental health defence.

316. As in Mr O'Donohue's case, where a defendant is found to be of unsound mind, criminal proceedings are discontinued and a forensic order may be imposed, detaining the person in an authorised mental health service for involuntary treatment and care.

317. A forensic order detaining a mentally ill person signals that the patient has offended the criminal law and that caution must be exercised before permitting the person to have contact with the community. Mr O'Donohue was found to be suffering a very severe psychotic illness when he killed Mr Sharma. He has been detained for a minimum period of ten years. There is no rational explanation for what he did.

The actions taken, and those proposed, since October 2016, by the Queensland Government to Mental Health Services for high-risk consumers.

318. Queensland Health's submission agreed that Mr Sharma's death was a tragedy that could not have been predicted. However, Queensland Health accepted with the benefit of hindsight, the evidence demonstrated that at the time of Mr Sharma's death, there were missed opportunities in relation to Mr O'Donohue's mental health treatment "*from a broader Queensland Health perspective*." Queensland Health acknowledged there were lessons to be learned from this tragedy.

319. The inquest received a significant amount of evidence from Queensland Health in relation to the reviews and actions taken since Mr Sharma's death, as well as the responses to reports and updates in relation to the implementation of recommendations from the following:

- Mental Health Sentinel Events final report and Queensland Health's response to that report;
- the Health Service Investigation Final Report (the Mullen Review);
- the Risk Management, Culture, and Service Leadership Report, Metro South Addictions and Mental Health Services (RCL Report) (the Newton Review); and
- Queensland Health's Clinical Excellence Division, Actions relating to investigation into the treatment and care of Anthony O'Donoghue report.

320. Dr Reilly, Chief Mental Health Alcohol and Other Drugs Officer within the MHAOD Branch in Queensland Health, and Chief Psychiatrist, gave evidence at the inquest about the reviews and subsequent actions, and those matters are set out in detail earlier in these findings.

321. Dr Motamarri also provided detailed evidence about changes implemented by Metro South Health in conjunction with Queensland Health, particularly in relation to discharge processes, information sharing with GPs, patient reengagement and the management of high-risk and forensic consumers.

322. I agree that there have been significant systemic changes to the mental health landscape following Mr Sharma's death. These developments are reflected in the evidence before the Court, as well as in the ongoing work being done by Queensland Health.

323. For example, the 2022-23 Queensland Budget committed an additional $1.64 billion to be invested in new and expanded services over the next five years, with $28.5 million in capital investments, and more than 1,400 new dedicated mental health, alcohol and other drugs staff being employed to deliver services to respond to the Mental Health Select Committee inquiry.[262] [263]

324. In particular, the need to have appropriate discharge processes from public mental health services has been recognised by Queensland Health and highlighted consistently in the extensive reviews of Mr O'Donohue's management and treatment.

325. I am satisfied that sufficient steps have been taken, both by Queensland Health and by the relevant Health Services at the local level, to address the identified systemic shortcomings and areas for improvement identified with respect to issues such as prevailing cultures, the need for leadership in clinical decision making, detailed and consistent risk assessment practices, protocols, and policies, particularly with respect to consumer discharge, sharing of information, reengagement processes and the oversight and management of high-risk and forensic consumers by establishing Assessment and Risk Management Committees within each Authorised Mental Health Service.

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262 *Better Care Together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027*

263 Report no. 1, 57th Parliament - Inquiry Into the Opportunities to Improve Mental Health Outcomes for Queenslanders

326. The improvements made serve to address the potentially missed opportunities in this case. It is encouraging that such extensive changes have followed Mr Sharma's death.

327. The family submitted that Dr De Souza-Gomes' evidence supported a conclusion that commencement of the *Mental Health Act 2016* and revised policies would make it less likely that a person such as Mr O'Donohue would be maintained on an ITO or supervised in the community.

328. I appreciate that there is a concern that persons such as Mr O'Donohue will continue to be assessed as low risk and that nothing has changed. However, I accept the Queensland Health submission that the *Mental Health Act 2016* and the policy changes implemented after Mr Sharma's death do not mean a person subject to an ITO under the *Mental Health Act 2000* would not be subject to a treatment authority under the current Act. I also note that the number of persons subject to involuntary treatment continues to grow.

329. Dr Reilly's evidence was that that Mr O'Donohue might have been considered as a higher risk of aggression or violence in 2011/2012. In those circumstances, under current approaches to risk management, there may have been consideration by the service system for the need to escalate to a tier 2 violence risk assessment or direct referral to a CFOS Assessment.

330. The evidence was that referral to a tier 2 violence risk assessment is now structured by the Violence Risk Assessment Management Framework. This provides Authorised Mental Health Services with a systematic approach to the identification, assessment and management of consumers who may pose a risk of violence towards others. The VRAM Framework is a direct response to recommendation 22 of the Mental Health Sentinel Events report and provides Health Services with a systematic approach for the identification, assessment and management of consumers who may pose a risk of violence.

331. I also accept that the *Mental Health Act 2016* enhanced the relationship between CFOS and Health Service treating teams with the Chief Psychiatrist's 'High Risk Policy' - now known as '*Treatment and care of patients subject to a Forensic Order, Treatment Support Order or other identified higher risk patients*'.[264] This policy has adopted the terminology "higher risk" as opposed to "high risk". This is to ensure there was not a dichotomous view of risk, and that patients could be captured by the policy where necessary following a clinical assessment.

332. The Community Forensic Outreach Service now has a mandated role in the assessment of new forensic patients charged with a prescribed offence, as well as patients whose risk profile is assessed as 'higher risk' by the treating team. This would apply to a patient such as Mr O'Donohue who was never charged with criminal offences in relation to his presentations to the QPS.

[264] https://www.health.qld.gov.au/__data/assets/pdf_file/0028/635932/cpp-forensic-policy.pdf

333. The High Risk Policy also established Assessment and Risk Management Committees within each Authorised Mental Health Service. The ARMC functions as a clinical peer review of the treatment and care of patients subject to a forensic order, treatment support order and other patients (whether subject to a treatment authority or voluntary) whose risk profile is assessed as high by their treating team.

334. The High Risk Patients Policy requires both the Health Service Forensic Liaison Officer and CFOS to be members of the ARMC, along with senior clinical staff of the AMHS. This membership provides an opportunity for CFOS and the Health Service FLO to be consistently involved in monitoring forensic patients and high-risk voluntary and involuntary patients when their care is reviewed.

335. The translation of CFOS recommendations into treatment and care planning is also supported by the High Risk Policy, through the inclusion of a requirement that CFOS provide any recommendations to the AMHS in writing. Before these are provided, the CFOS clinician must discuss the recommendations with the patient's treating psychiatrist.

336. Within 14 days of receiving the CFOS recommendations, the treating psychiatrist must incorporate the recommendations into the consumer's Care Plan and detail how the recommendations will be implemented. An escalation pathway has been included in the High Risk Patients Policy if the treating psychiatrist is unable to implement the recommendations.

337. The ongoing Forensic Liaison Officer and CFOS involvement with Health Service treating teams through the ARMC for monitoring and reviewing high risk patients is particularly relevant for the management of patients with clinical presentations similar to Mr O'Donohue.

338. With respect to the issue of the 2012 CFOS report not being available to the CCW Team and the CFOS Team in 2014, a multiple step process was developed to ensure all historical CFOS records are located for incoming referrals. An audit undertaken in 2017 indicated at that time, 92% (1085) of all CFOS reports (1179) undertaken since May 2014 have been uploaded onto CIMHA. This audit included CFOS state-wide services.

COMMENTS AND RECOMMENDATIONS

339. The final issue considered by the inquest was "*what further actions, if any, could be undertaken to prevent a similar tragedy from occurring again in Queensland, including any further changes necessary to address bus and bus operator safety*"?

340. Section 46 of the *Coroners Act* provides that a coroner may comment on anything connected with a death that relates to:

    a. public health and safety,
    b. the administration of justice, or
    c. ways to prevent deaths from happening in similar circumstances in the future.

Links between public and private mental health services

341. Counsel Assisting submitted that there is the need for a link between private and public mental health services for consumers like Mr O'Donohue, who require longer-term care for a serious mental health condition. It was submitted that while there are challenges creating such a link, it would have facilitated a continuity of care and transition to the private system, which would have ensured that Mr O'Donohue was not left without any therapeutic support in the community. Counsel Assisting submitted a longer-term project could be created to determine how such a linkage can be made, the need for which was emphasised by Dr Reddan during the inquest.

342. Given the concerns raised in this matter about the lack of linkages between the public and private mental health systems in Queensland, and the evidence provided during this inquest, Counsel Assisting submitted that I might make the following recommendation:

> *That Queensland Health consider creating a project, with relevant stakeholders and other associated HHS, to determine how a link can be created, facilitated, and supported between the public and private sectors for a subgroup of select mental health patients, like Mr O'Donohue, who require ongoing long-term therapeutic engagement. This continuity of care and transition from public to private services recognises that while a consumer cannot simply remain in the public system indefinitely, there is a necessity to create mechanisms, processes and procedures to allow for such a transition to take place thereby ensuring these consumers continue to receive ongoing therapeutic support.*

343. While Queensland Health supported the intent of the proposed recommendation, it noted there are existing processes in place to support linkages between the public and private sectors. Dr Reilly noted there are challenges in supporting the continuity of care of high risk patients from the public to the private sector, because it is very difficult to find individual private psychiatrists willing to take on the care of these patients.

344. Queensland Health reiterated the work done on standardising comprehensive care, including care planning and case review, which is intended to extend to transfers of care. Adoption of structured comprehensive care processes by Health Services and clinicians is an ongoing process.

345. Queensland Health submitted that supporting Health Service leaders and staff with implementation of Comprehensive Care improves care in general, including shared care between providers, including across the public, private and non-government sectors, by supporting a culture of learning and support for continuous quality improvement. This results in collaborative care planning being strengthened which ensures comprehensive clinical information is provided at times of transition.

346. The planned continuation of evidence-informed implementation of the Comprehensive Care initiative provides an opportunity to focus on stepped care linkages between multiple service providers, including private psychiatrists, across multiple episodes of care over time, including longitudinally sharing information related to risk.

347. The Queensland Health submission noted the increased and additional funding allocated under the State Budget to enhance mental health community support services. The funding is aimed at increasing mental health community support programs delivered by non-government organisations for individuals experiencing a severe mental illness. These support services are offered one to one, peer to peer or group based, and can provide programs in a non-clinical, holistic recovery-focused psychosocial wrap around support service according to an individual's recovery needs.

348. In relation to information sharing and General Practitioners, a subset of core clinical documentation from CIMHA is shared with The Viewer and Health Provider Portal (HPP). The Viewer and HPP collate data from multiple Queensland Health systems, enabling healthcare professionals, including General Practitioners, to access patient information quickly, without having to log in to different systems.

349. Further system enhancements for 'Secure Transfer' of documents in CIMHA have been developed and were to be released in the 2022-2023 financial year. These enhancements will allow the electronic delivery of clinical documentation to General Practitioners in a secure, timely and standardised format.

350. With respect to the implementation of the recommendation proposed by Counsel Assisting, Queensland Health submitted that a project of this nature would require a significant investment and the involvement and cooperation of both public and private stakeholders, but focus on a relatively small number of consumers.

351. It was submitted that this may not be an efficient use of resources and there may be greater benefit in Queensland Health continuing to educate and support services to follow best practice with respect to shared care and transition of care between providers. I agree with this submission.

Bus Operator Safety

352. There is a strong public interest in ensuring that bus operators and passengers are safe. A perception that bus travel is not safe will lead to challenges in the recruitment of bus operators and a reduced use of this form of public transport by the community.

353. I agree with the submission of Counsel Assisting that changes in relation to bus driver safety made by the Queensland Government and the Brisbane City Council, in both a practical and policy sense, are extensive and commendable.

354. Following consideration of the AusSafe report, a whole of system approach was taken by Brisbane City Council to enhance bus operator and passenger safety. This included additional driver training in de-escalation, passenger education information and videos, work across the fleet to ensure, for example, that emergency exits are highly visible, implementation of driver protection barriers, as well as a substantial increase in security across the network through provision of more security guards, hopper guards, static security at bus interchanges and building on the existing liaison with the Queensland Police Service and Senior Network Officers.

355. A great deal of consideration and further work has been undertaken by way of additional measures that may serve to protect public transport workers as best as possible within resource constraints.

356. The Queensland Bus Safety Forum meets three times each year to provide opportunities for its members to consider and discuss bus driver and bus passenger transport safety related issues. Membership of the forum includes industry body representatives, bus drivers, academics and representatives of government agencies. The focus areas for the forum include delivering safe services for customers and sharing industry best practice to manage bus safety risk.

357. The RTBU submitted that the security arrangements in place are not sufficient for the size the BCC bus network, and that budgets should be increased to employ more security guards and authorised officers on the network.

358. The RTBU also submitted that partial screens that have been installed on BCC buses are not adequate, and have not brought down the number of assaults on drivers. While the Union has agreed to specifications with the BCC for future screens, it submitted that retrofitting full screens should be mandated and funded by the State Government. The RTBU provided data indicating that by June 2020, 1150 screens had been installed on BCC buses but the number of assaults on drivers had not reduced.

359. I note that in January 2023, the Queensland Government announced $60M funding for full driver protection barriers, together with extra network officers to patrol public transport services on high risk routes, while the QPS would increase its focus on public transport services in the Brisbane metropolitan area. This will see police officers travelling on Brisbane buses.

360. The 2023-24 Queensland State Budget papers indicate that $12.7M has been committed over five years for the roll out of driver protection barriers on up to 600 buses to improve driver safety.

361. I agree that given the extreme nature of the attack by Mr O'Donohue, it is likely that only a complete encapsulating barrier would have prevented or reduced the severity of the attack on Mr Sharma.

362. I also note the evidence was that bus operators may be required to leave their seat to assist passengers from time to time, such as passengers requiring assistance with wheelchairs and prams.

363. The BCC provides over three million bus services each year. While the RTBU data indicated that the assault of bus operators is an ongoing concern, the AusSafe Report commissioned by BCC identified that the death of Mr Sharma was an isolated, extreme and rare event. It was unprecedented in the history of public transport in Brisbane.

364. Given the ongoing dialogue between the RTBU, BCC and the Queensland Government, the implementation of recommendations from previous reviews, and the announced commitment of the Queensland Government to fund full driver protection barriers, as well as extra network officers and a police presence on high risk routes I make no additional recommendations with respect to bus driver safety.

365. I close the inquest.

Terry Ryan
State Coroner
BRISBANE