1. In March 2015, the Queensland Government approved the commencement of a state-wide clinical review of sentinel events involving individuals with a mental illness, to be managed by Queensland Health (the Sentinel Events Review).
2. An independent review committee was appointed to conduct the clinical review pursuant to the provisions of Part 6, Division 3, of the *Hospital and Health Boards Act 2011.* The Sentinel Events Review Committee was comprised of five members with professional backgrounds in psychiatry, law, psychology, mental health nursing, patient safety and a person with a lived experience of mental illness.
3. In April 2016, the Sentinel Events Review Committee’s Final Report *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services,* was submitted to the Director-General of Queensland Health.
4. The Review Committee concluded that overall the cases reviewed were isolated occurrences and did not identify any widespread patient safety issues. Queensland has maintained a low incidence rate of homicide, including homicides committed by people with mental illnesses.
5. The Review found that significant changes have already occurred within mental health services, such as: the consolidation and availability of consumer information; an enhanced governance and guidance structure; an expansion of services both forensic and non-forensic; and improvements within key performance indicators. The Committee noted the high level of professionalism and commitment to the provision of care to people with a mental illness by staff and all persons with whom the Review Committee consulted.
6. The Review Committee identified a number of areas for improvement in relation to the assessment, formulation, treatment planning and monitoring for those consumers at risk of violence to others.
7. Queensland Health accepted in-principle the recommendations made by the Review Committee, with consultation to occur as a matter of priority with relevant stakeholders.
8. Cabinet noted that the Final Report of the Sentinel Events Review, *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services,* would be publicly released.
9. Cabinet noted that the Queensland response to the key findings and recommendations made by the Sentinel Events Review Committee would be released.
10. *Attachments*
* [*When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*](Attachments/Report.PDF)
* [Queensland Health response to the Report - *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*](Attachments/Response.PDF)