[2024] WACOR 3

JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA

ACT : CORONERS ACT 1996

CORONER : MICHAEL ANDREW GLIDDON JENKIN, CORONER

HEARD : 6 - 7 FEBRUARY 2024

DELIVERED : 7 MARCH 2024

FILE NO/S : CORC 2826 of 2020

DECEASED : PETROVA-CIZEK, PETYA EVGENIEVA

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)

Cases:

Briginshaw v Briginshaw (1938) 60 CLR 336

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Ms D. Van Nellestijn (State Solicitor’s Office) appeared for the East Metropolitan Health Service and the Mental Health Advocacy Service.

Mr I. Murray (Blumers Personal Injury Lawyers) appeared for Mr J. Cizek.

Ms J. Lee (Belinda Burke Legal) appeared for Ms M. Finney and Ms L. King.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Petya Evgenieva PETROVA-CIZEK*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 6 - 7 February 2024, find that the identity of the deceased person was* ***Petya Evgenieva PETROVA-CIZEK*** *and that death occurred on 16 December 2020 at Bentley Health Service, 18-56 Mills Street, Bentley, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

1. Ms Petya Evgenieva Petrova-Cizek (Petya)[1] died on 16 December 2020 at Bentley Health Service (BHS) from ligature compression of the neck. She was 41-years of age.[2,3,4,5,6] At the time of her death, Petya was the subject of an inpatient treatment order made under the *Mental Health Act 2014* (WA)[7] (MHA), and was thereby an "*involuntary patient*" and a "*person held in care*".[8]

2. For those reasons, Petya's death was a "*reportable death*", and in such circumstances, a coronial inquest is mandatory. Where (as here) the death is of a person held in care, I am also required to comment on the quality of the supervision, treatment and care that the person received.[9]

3. On 6 - 7 February 2024 at Perth, I held an inquest into the circumstances of Petya's death, which was attended by Petya's husband (Mr Cizek). The documentary evidence adduced at the inquest comprised one volume, and the following witnesses gave evidence:[10]

i. Ms Maria Janssen (Mental health advocate);
ii. Dr Jarrad Paul (Trainee registrar, BHS);
iii. Ms Megan Finney, (Registered nurse, BHS);
iv. Ms Louisa King, (Registered nurse, BHS);
v. Mr Remigius Maphumulo, (Registered nurse, BHS);
vi. Dr Winston Choy (Consultant psychiatrist, BHS);
vii. Dr David Stevens (Consultant psychiatrist, BHS);
viii. Dr Vinesh Gupta (Medical Co-director, BHS); and
ix. Dr Adam Brett (Independent consultant psychiatrist).

4. The inquest focused on Petya's supervision, treatment and care while she was an inpatient at Bentley Health Service, and the circumstances of her death.

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[1] Ms Petrova-Cizek's husband (Mr Cizek) requested that his wife be referred to as "Petya" at the inquest and in this finding
[2] Exhibit 1, Vol. 1, Tab 1, P98- Mortuary admission form (16.12.20)
[3] Exhibit 1, Vol. 1, Tab 2, P92 - Identification of deceased person by visual means form (21.12.20)
[4] Exhibit 1, Vol. 1, Tab 3, P100 - Report of death form (02.12.22)
[5] Exhibit 1, Vol. 1, Tab 4, Death in hospital form (16.12.20)
[6] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (24.10.22)
[7] Exhibit 1, Vol. 1, Tab 24.7, Form 6A - Inpatient treatment order in authorised hospital (10.12.20)
[8] Section 3, *Coroners Act 1996* (WA)
[9] Sections 3, 22(1)(a) & 25(3), *Coroners Act 1996* (WA)
[10] The position titles shown reflect the positions held by the relevant witness at the time of Petya's death

CONTEXTUAL ISSUES

Hindsight bias

5. In reviewing the supervision, treatment, and care Petya received while she was an involuntary patient at BHS, I must be mindful not to insert any hindsight bias into my assessment of the acts or omissions of clinical staff. Hindsight bias is the tendency after an event, to assume that the event was more predictable or foreseeable than it actually was at the time.[11]

6. In this case, the event I am referring to is Petya's death. I acknowledge that it is very difficult to make an assessment of Petya's presentation and care without being impacted by the obvious fact of her death. Nevertheless, I have attempted to do just that in this finding.

Relevant standard of proof

7. In relation to deciding whether a finding which is adverse in nature to any person is open on the available evidence, I have applied the standard of proof set out by the High Court of Australia in its decision in a case known as ***Briginshaw v Briginshaw***[12].

8. That case is authority for the proposition that when assessing the quality of the supervision, treatment and care that Petya received at BHS, I must consider the nature and gravity of the relevant conduct when deciding whether a finding which is adverse in nature has been proven on the balance of probabilities.

Ward 6 environment and routines

9. As I will explain, Petya was admitted to Ward 6 at BHS, Ward 6 is a 12-bed ward at BHS, "*a fully accredited public hospital located in Bentley*". BHS is part of the Royal Perth Bentley Group (RPBG) and managed by the East Metropolitan Health Service (EMHS). BHS provides: "*specialist care in rehabilitation, community child and adolescent health, aged care and mental health*".[13]

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[11] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10
[12] (1938) 60 CLR 336, per Dixon J at pp361-362
[13] See: www.bhs.health.wa.gov.au/About-Us

10. In his statement, Mr Nguyen (who was Petya's allocated nurse on 10, 12, and 13 December 2020) said patients on Ward 6 were "*the most acute at BHS*". He explained there were three shifts on the ward, namely: morning shift (7.00 am - 3.30 pm), afternoon shift (1.00 pm - 9.30 pm), and night shift (9.30 pm - 7.30 am).[14] The overlap between morning and afternoon shifts allows nurses to conduct a handover of their allocated patients, and also enables staff to complete administrative tasks and attend training sessions.[15]

11. In his statement, Dr Choy explained that on assuming the role of consultant psychiatrist on Ward 6, he had adopted and continued many of his predecessor's practices, which he regarded as "*sensible and practical*". Dr Choy said he would hold a "*stand-up meeting*" each morning at 8.30 am, that was attended by registrars, interns, nurses and allied health staff. At the meeting Dr Choy says: "*we would run through the patient list and work out what needed to done that day*". Dr Choy also said he would also conduct a weekly multidisciplinary team meeting that was longer, to go through each patient's care "*in detail*".[16][17]

12. Mr Nguyen said during "*day shift*" on Ward 6 there would be six nurses on shift, each of whom would be allocated two patients "*if all beds were occupied*". Mr Nguyen also said that this allocation regime "*comes from the WA Health Nursing Hours per Patient Day ratio*".[18] In his statement, Dr Choy noted that Ward 6 was a high turnover ward, "*with roughly 50% of the patients turned over in a week*".[19]

13. Mr Nguyen also explained that two outdoor areas were available to patients on Ward 6. The first was a courtyard where ball sports can be played, and the other was a "*little garden gazebo*" area. Mr Nguyen said that these outdoor areas were usually locked "*due to the risk of patients absconding and concern regarding branches in the area*", and that both areas would not be opened at the same time.[20]

[14] Exhibit 1, Vol. 1, Tab 30, Statement - Mr P Nguyen (01.02.24), paras 10-12
[15] Email - Ms D Van Nellestijn to Mr W Stops (13.02.24)
[16] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 19-23
[17] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 19-26
[18] Exhibit 1, Vol. 1, Tab 30, Statement - Mr P Nguyen (01.02.24), paras 13-14
[19] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 17
[20] Exhibit 1, Vol. 1, Tab 30, Statement - Mr P Nguyen (01.02.24), para 21

14. At the inquest, Ms Finney (who was Petya's allocated nurse on 15 and 16 December 2020) said that the outdoor areas on Ward 6 would usually be opened for two hours in the morning, and two hours in the afternoon. However, Ms Finney said that during Petya's admission she did not recall the outdoor areas having been opened due to the levels of patient acuity on Ward 6.[21]

15. At the inquest, Ms Janssen[22] says she had asked a nurse to "*open up one of the back gardens*" and also suggested that Petya "*grab her towel or a blanket and lay on the grass*", but that Petya's response was "*just negative*" and she (Petya) "*just wanted to go for a walk...and was frustrated that she wasn't able to…*".[23]

16. It is unfortunate that the outdoor areas on Ward 6 appear to have been closed during at least part of Petya's admission. Petya had persistently expressed reluctance to be on the ward in the first place, and made repeated requests for escorted grounds access (EGA). Had this been granted, Petya would have been permitted supervised access to areas outside the ward. As it was, Petya's requests for EGA were refused because she was deemed to be an absconding risk.

17. In terms of physical facilities, I note that the first stage of Bentley Hospital (now referred to as BHS) was completed in April 1967,[24] and as Dr Stevens noted in his statement:

> BHS is an aging facility. With the measures that need to be taken to minimise ligature risk, the rooms on Ward 6 are bare, with the bed as a block in the middle of the room, with a mattress on top. Additionally, the disinhibited or disordered behaviour of patients at the Ward meant that the environment could become untidy and the patients did not have cleaning up after themselves as a top of their mind. For example, I know that at the time when (Petya) was admitted, there was another patient on Ward 6 who routinely poured drinks on the floor of the common area.[25,26]

[21] ts 06.02.24 (Finney), pp129-130
[22] Ms Janssen is employed by the Mental Health Advocacy Service and was Petya's allocated mental health advocate
[23] ts 06.02.24 (Janssen), p20
[24] See: www.inherit.dplh.wa.gov.au
[25] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 57-59
[26] See also: ts 06.02.24 (Finney), pp133-134

18. Mr Nguyen confirmed that at times, patients would "*make a mess*" in the communal areas of Ward 6, but that "*the cleaners do their best to keep the ward clean and the nursing staff do their best to assist with this*".[27]

19. Both Petya and Mr Cizek made a number of complaints about the cleanliness of Petya's room on Ward 6 (Room 9) and also raised an issue about the positioning of an air-conditioning vent which made the room "*very cold*". On 10 December 2020, Petya and Mr Cizek told Ms Janssen that Room 9 was "*very dirty*", and Ms Janssen says she raised these concerns with nursing staff.[28,29]

20. At the inquest, Ms King (who was Petya's allocated nurse on both 9 and 10 December 2020)[30] said Mr Cizek had asked her to cover the air-conditioning vent in Room 9 with cardboard, which: "*she couldn't do*". However, Ms King she gave Petya extra blankets, and spoke to the ward coordinator who lodged a maintenance request.[31]

21. As to the cleanliness of Room 9, Ms Janssen said Ward 6 was "*always being cleaned*", and that cleaners were on the ward daily, cleaning "*every room*" including "*patient rooms and ensuites*".[32] Ms Janssen also said: "*I can recall thinking that* (Petya's) *room was clean and tidy. I did not think that the complaints about the cleanliness of the room were fair, although I did not tell* (Petya) *or Mr Cizek that*".[33]

22. Petya's complaints about the cleanliness of her room may have had more to do with her unhappiness about being on Ward 6. In her statement, Ms Janssen said her general impression was that Petya and Mr Cizek were not happy Petya was an involuntary patient and also that she could not be transferred to a private hospital. Ms Janssen said she recalled feeling Mr Cizek was: "*egging (Petya) on about matters relating to her room, and treatment plan and was adding to the discomfort she felt on the Ward*".[34]

[27] Exhibit 1, Vol. 1, Tab 30, Statement - Mr P Nguyen (01.02.24), paras 36-37
[28] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), paras 44-49
[29] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p3 and ts 06.02.24 (Janssen), pp17-18
[30] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 26-29 & 97-100
[31] ts 06.02.24 (King), pp150-151
[32] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), para 30
[33] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), para 31
[34] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), para 32

Acuity and staffing

23. The evidence before me establishes that during the time of Petya's admission on Ward 6, the level of acuity of patients on the ward was higher than usual, and that the situation had worsened by the latter part of her stay. By 15 December 2020, the evidence makes it clear that Ward 6 was housing 12 "*very complex*" patients, including Petya.[35,36]

24. In his statement, Dr Stevens said that in December 2020, Ward 6 "*was quite acute*" and "*there were a lot of unwell patients*". On 15 and 16 December 2020, Dr Stevens says the patients on Ward 6 included: two patients requiring 2:1 security guard specials to manage risk of aggression; one patient requiring a 1:1 nursing special; one patient who required seclusion on three occasions to manage their risk to self or others; one patient requiring female nurses because of repeated allegations of sexual assault by male nurses, and at least one patient with disorganised/disruptive behaviour.[37,38]

25. At the inquest, Ms Finney, said that in her opinion, the acuity level on Ward 6 at the relevant time was "*one of the worst*" she could recall in her six years of working there.[39] For her part, at the inquest Ms King said that at the relevant time, the ward was "*quite a dangerous place*" and it "*felt very unsafe*". Ms King also said that various requests for additional nursing support had not been responded to.[40,41]

26. In his statement, Dr Paul noted that Ward 6 was a busy locked ward, and although he felt "*very well supported*" while working on Ward 6, it was "*one of the most acute wards I have worked on*". Dr Paul also said it was not uncommon for there to be two or three security guards "*constantly on the ward*" to keep staff and patients safe, and that "*There was pressure to move patients on to less secure wards, so we could free up beds for more acute patients*".[42]

[35] ts 06.02.24 (Stevens), pp213 & 219
[36] ts 07.02.24 (Maphumulo), p161
[37] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 31-33
[38] See also: Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 106-108
[39] ts 06.02.24 (Finney), pp110 & 118
[40] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 20-25 and ts 06.02.24 (King), p145
[41] See also: ts 06.02.24 (Paul), pp78-79 and ts 07.02.24 (Gupta), pp231-232
[42] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 18 & 31-33

Leave cover and handover

27. At the time when Dr Choy (the consultant psychiatrist on Ward 6) went on annual leave on 11 December 2020, there was no "*formal*" policy for covering the position of a consultant psychiatrist taking leave. In his report, Dr Gupta[43] explained that this was "*due to the chronic shortage of psychiatrists which has existed for a long time and is continuing*".[44] Dr Gupta said that although RPBG has funding for 37 full-time equivalent (FTE) psychiatrists, it has been operating with 19 - 20 (FTE) psychiatrists.[45]

28. In an effort to address this shortfall, Dr Gupta said that staff from EMHS had attended conferences in Perth and the United Kingdom to recruit additional psychiatrists. At the inquest, Dr Gupta said that seven FTE psychiatrists had now been recruited and that procedures relating to their engagement were being finalised. Dr Gupta also said that funding was being sought so that staff could attend mental health conferences in 2024 to continuing these recruitment efforts.[46]

29. Quite apart from the shortages of consultant psychiatrists I have just mentioned, Petya's admission coincided with the COVID-19 pandemic, which added to the difficulties in obtaining locum staff.[47] Dr Gupta said that in addition to an ongoing recruitment drive, efforts were now made to minimise the number of psychiatrists taking leave at "*peak*" times.[48]

30. In the absence of any other options, Dr Stevens (who had previously been the consultant psychiatrist on Ward 6) agreed to provide cover during Dr Choy's leave. However, in addition to providing cover on Ward 6, Dr Stevens was also expected to manage his usual full-time community based role. As Dr Stevens explained in his statement, due to his existing clinical commitments (including patient appointments he was "*not able to spend much time on Ward 6*".[49,50,5152]

[43] Dr Gupta is the Medical Co-Director, Mental Health Division at BHS
[44] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3
[45] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3 and ts 07.02.24 (Gupta), p231
[46] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3 and ts 07.02.24 (Gupta), p236
[47] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 35
[48] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p4
[49] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 29-35
[50] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 15-24
[51] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3
[52] See also: Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 36-40

31. At the inquest, Dr Stevens made the following comment about the adequacy of these leave cover arrangements:

> I think, it's difficult to say that this is adequate cover, and, I guess, you step up when the need requires, but…I was particularly mindful that the ward was particularly acute and that has been mentioned many times by other witnesses.[53]

32. I accept that Dr Stevens was doing his best to provide cover to Ward 6, but as he freely acknowledged in his statement:

> I would have had a limited opportunity to see a limited number of patients, and my recollection is that the patients on nurse specials were occupying a lot of the time of Ward 6 staff, including mine. While I was covering the consultant psychiatrist position in Ward 6, I felt that I could not give the role the attention it deserved. I feel this much more with hindsight, but even at the time I did not feel that I had the time to do all my roles to my satisfaction.[54]

33. As mentioned, Dr Stevens had previously been the consultant psychiatrist on Ward 6 and so he knew many of the staff well and "*had a lot of trust in their judgement*". However, as he acknowledged, Dr Stevens was relying on Dr Thomas (an intern) and Dr Paul (a trainee registrar in his first year)[55,56] to raise "*patients of concern*" with him. Dr Stevens also acknowledged that: "*In hindsight, I can see that I should have been more proactive*".[57]

34. However, in my view, Dr Stevens was placed in an impossible situation because he was being expected to discharge two busy full-time positions simultaneously.[58] To make matters worse, Dr Stevens "*did not receive a formal handover process*" before he began providing leave cover on Ward 6.[59] In my view the failure to provide Dr Stevens with a comprehensive handover was a serious error, especially given the fact that Dr Stevens could not be on Ward 6 on a full-time basis.

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[53] ts 07.02.24 (Stevens), p213
[54] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 34-37
[55] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 34
[56] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 18
[57] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), para 40
[58] ts 07.02.24 (Stevens), pp209-211
[59] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), para 41

35. It is also my view that the explanation Dr Choy provides in his statement as to why a handover did not occur is unsatisfactory. Dr Choy's explanation is as follows:

> From memory, I spoke with Dr Stevens, in connection with his providing leave cover, about Ward 6, but did not handover individual patients. This was because the ward staff, especially Dr Paul, were to provide continuity in the care of the patients on Ward 6.[60]

36. In my view, the fact that Dr Paul (a trainee registrar) was aware of the patients on Ward 6 is completely irrelevant. Dr Stevens should have been provided with a formal handover so that he had the benefit of Dr Choy's first-hand assessment of the patients on Ward 6 (and their treatment plans), before he (Dr Stevens) assumed responsibility for the care of those patients.

37. In his statement, Dr Stevens said that in hindsight, he believed that the "*handover process at this time was inadequate*",[61] and at the inquest, he made the following observation about the value of clinical handovers:

> Look, I think that a clinical handover from a colleague is always helpful information. So you're better off with than without it. Obviously, as time goes on it becomes less relevant because, you know, patient's circumstances change, their presentation changes. But yes, I think we all value having a handover from colleagues in this situation.[62]

Observations regime[63]

38. At the inquest, there were a number of questions about the "*observation regime*" Petya was subject to. Throughout her admission Petya was the subject of hourly "*observations*", however that term is somewhat misleading. That is because at the relevant time the so called "*observations*" were little more than a "*head count*" conducted by whichever nurse happened to be free at the time.[64]

[60] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 36
[61] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), para 43
[62] ts 07.02.24 (Stevens), p228
[63] See also: Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 154-167
[64] ts 06.02.24 (Finney), p100

39. At the inquest, Mr Maphumulo (a nurse on Ward 6) said the hourly observations (known as "*Rounding*") took two to three minutes to complete, and that: "*It's a matter of locating the patients and making sure that the number which is on the board inside the nursing station correspond with all the heads that are in sight in the ward*".[65]

40. Mr Maphumulo also confirmed that the Rounding was conducted by whichever nurse happened to be free at the time, and could often be completed without talking to the patient. Mr Maphumulo also said:

> Sometimes you can just see some patients while you are standing in the nursing station because it has glass around. You can actually see patients - the ones you can see you can tick without having to actually go to actually see them inside their rooms".[66]

41. I note the superficial nature of the Rounding and that "*observations*" for all patients were carried out by whichever nurse happened to be free. This meant if Ward 6 was full at least 10 of the 12 patients on the ward would be "*observed*" by someone other than their allocated nurse. For that reason, it seems likely that any interactions that did occur during the Rounding were brief and had had limited (if any) therapeutic benefit.

42. The evidence establishes (and I accept) that there were numerous undocumented daily interactions between patients on Ward 6 and their allocated nurses.[67,68] However, because Petya remained withdrawn and suspicious during her admission, her interactions with her allocated nurses appear to have been somewhat superficial and perfunctory.

43. At the relevant time, the results of the hourly Rounding were entered into a single document for all patients on the ward.[69] However, the current practice (which I note with approval) is that observations are carried out by the patient's allocated nurse, and the results are entered into a separate sheet kept for each patient.[70]

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[65] ts 07.02.24 (Maphumolo), pp161-162
[66] ts 07.02.24 (Maphumolo), p162
[67] ts 06.02.24 (Finney), pp103 & 128-129
[68] Exhibit 1, Vol. 1, Tab 30, Statement - Mr P Nguyen (01.02.24), paras 95-99
[69] See: Exhibit 1, Vol. 1, Tab 19.3, Rounding Checks and ts 06.02.24 (Finney), pp116-117
[70] ts 06.02.24 (Finney), p116

44. In my view these important improvements are important are important, and are consistent with the following observation in BHS's observations policy:

> What keeps people safe is not the act of being under surveillance (observation); rather it is the quality of engagement between that individual and staff".[71]

The predictability of suicide

45. Several witnesses at the inquest agreed that suicide is very difficult to predict, and that a person's suicidality (meaning their risk of suicide) can fluctuate, sometimes on relatively short time frames.[72] This evidence is consistent with the following observations in a document entitled "*Clinical Care of People Who May Be Suicidal Policy*" which was attached to Dr Gupta's statement:

> A person's suicidality or self-injurious behaviour can fluctuate in duration and intensity over small periods of time, and can have a significant impact on changes in mental state and risk. Suicide is a rare event and there is no known set of risk factors that can accurately foresee/predict/prevent suicide and/or related/suicidal behaviours in patients. Meaningful collaboration with the person and their significant other(s)/personal support person (PSP) is essential (wherever possible) in the care and assessment of those who may be suicidal.[73,74]

46. In 2017, the Department of Health published a document entitled: *Principles and Best Practice for the Care of People Who May Be Suicidal* (the Document). The Document points out that clinicians assessing a person who may be suicidal confront two issues. The first (as noted above) is that suicide is a rare event, and the second is that there is no set of risk factors that can accurately predict suicide in an individual patient. The Document also noted that the use of risk assessment tools containing checklists of characteristics has been found to be ineffective.[75,76]

[71] Exhibit 1, Vol. 1, Tab 28.9, Special and Supportive Observations Policy, p3
[72] See for example: ts 07.02.24 (Choy), p202
[73] Exhibit 1, Vol. 1, Tab 28.6, Clinical Care of People Who May Be Suicidal Policy, p1
[74] At the inquest, Dr Choy concurred with this policy: ts 07.02.24 (Choy), p204
[75] Principles and Best Practice for the Care of People Who May Be Suicidal, (Dept. of Health - 2017), pp2-3
[76] See: www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Mental-health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf

47. A clinical practice guideline published by the Royal Australian and New Zealand College of Psychiatrists (the Guideline) deals with the management of deliberate self-harm. In relation to the usefulness of risk management tools, the Guideline notes:

> There are no widely accepted tools for clinically assessing a patient's risk of subsequent deliberate self-harm or suicide. No empirical studies have demonstrated that categorising patients to be at low risk or high risk of future fatal or non-fatal self-harm can contribute to a reduction in overall rates of these adverse events…Despite this, many health service jurisdictions mandate regular risk categorisation of mental health clients in order to determine follow-up care.[77,78]
> [Footnotes omitted]

48. Finally, in relation to the widespread community belief that suicide can be accurately predicted, the Document notes that this belief:

> [H]as led to the assumption that suicide represents a failure of clinical care and that every death is potentially preventable if risk assessment and risk management were more rigorously applied. However the evidence is clear that, even with the best risk-assessment practices and care, it is not possible to foresee and prevent all deaths by suicide.[79,80]

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[77] RANZCP Clinical practice guidelines for the management of deliberate self-harm, p37
[78] See: www.ranzcp.org/getmedia/19124a28-c8d8-4e36-ab78-03c03f32f9b7/deliberate-self-harm-cpg.pdf
[79] Principles and Best Practice for the Care of People Who May Be Suicidal, (Dept. of Health - 2017), pp2-3
[80] See: www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Mental-health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf

PETYA

Background[81,82,83,84]

49. Petya was born in Bulgaria on 30 July 1979 and she was 41-years of age when she died on 16 December 2020. Petya had come to Australia about 10 years earlier, and had been married to Mr Cizek (who was her second husband) for about two and a half years.[85,86]

50. Mr Cizek says he noticed a decline in his wife's mental health after he sustained a workplace injury in early March 2020, which: "*put a mental strain on both Petya and I*". Mr Cizek says that this mental strain was exacerbated by the couple's concerns about whether their plans to travel to Canada and Bulgaria (to visit their respective families) would be impacted by restrictions related to the COVID-19 pandemic.[87]

51. Mr Cizek says Petya had become "*withdrawn and downcast*" and was "*suspicious of everyone*", and that in October 2020, he took her to see her GP. Petya complained of severe insomnia, headaches, memory lapses, and poor functioning at work. The GP ordered an MRI scan,[88] and Mr Cizek says that although the scan reportedly showed "*some minor issue in relation to the deep white matter*" and Petya "*continued to get headaches*" her GP "*was not concerned*".[89,90]

52. Although Petya had some time off work and periodically took lorazepam and diazepam "*with some settling effect*",[91] her "*behaviour did not seem to be improving*". For that reason, Mr Cizek says he enlisted the help of a family friend to "*organise a home visit from a private doctor for Petya, hoping that a prescription could be made to improve her condition*".[92,93]

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[81] Exhibit 1, Vol. 1, Tab 8, Report - Det. Snr. Const. S Rogers (02.12.22)
[82] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21)
[83] Exhibit 1, Vol. 1, Tab 24-WC.1, Mental Health Triage form (09.12.20), p3
[84] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), pp9-10
[85] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), paras 4-5
[86] Exhibit 1, Vol. 1, Tab 3, P100 - Report of death form (02.12.22)
[87] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), paras 8-14
[88] Exhibit 1, Vol. 1, Tab 20.1, GP Notes - Dr D Harun (02.10.20)
[89] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), paras 8-14
[90] Exhibit 1, Vol. 1, Tab 19.1, Perth Radiological Clinic MRI Brain scan report (03.10.20)
[91] Exhibit 1, Vol. 1, Tab 24-WC.1, Mental Health Triage form (09.12.20), p3
[92] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), para 15

Community assessment and admission

53. Clinicians from the Adult Mental Health Trauma Team at BHS (the Team) conducted a home visit on 9 December 2020 to assess Petya's mental state. The Triage form completed by the Team describes Mr Cizek as "*extremely supportive*", and notes he had taken time off work to monitor his wife and to attempt "*to placate Petya's increasing concern regarding her documents and her identity*". Petya disclosed she had lost 10kg in the previous six weeks, and was described as being "*extremely suspicious*" of clinicians, and as repeatedly asking why she needed to answer their questions.[94]

54. Petya disclosed feeling that people were monitoring her when she went out, and she said she was concerned for her husband's safety and her own. She told clinicians there was "*some form of conspiracy*" and believed she had "*done something heinous*" and would be "*interrogated and detained by the Federal Police, never to see her family again*". As to suicidal ideation, the Triage form notes:

> **(Petya) tearfully expressed that she did not want to "*be here anymore*". Clarified she did not want to be alive**. Sees no way out. States she could not see any way that could help her. Avoidant ++ of clarifying her thoughts further, becoming increasingly distressed and deferring to the support of her husband without clarifying plan or intent. On discussing plan of admission (to BHS) became increasingly more suspicious and reluctant to engage further regarding treatment regime.[95] [Emphasis added]

55. After Petya agreed to be admitted to BHS Mr Cizek drove her there. Mr Cizek says this about his wife's admission:

> I was obviously very concerned about Petya and what her diagnosis was. Throughout her admission to Bentley Hospital I was asking about her diagnosis and what her treatment plan was. I was told by nursing staff on several occasions that an appointment would be made for me to speak with doctors about Petya but this never materialised.[96]

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[93] Exhibit 1, Vol. 1, Tab 22.1, Report - Dr D Stevens (01.02.21), p1
[94] Exhibit 1, Vol. 1, Tab 24-WC.1, Mental Health Triage form (09.12.20), p3
[95] Exhibit 1, Vol. 1, Tab 24-WC.1, Mental Health Triage form (09.12.20), p3
[96] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), paras 18-20

56. At 10.15 am on 9 December 2020, Petya was reviewed by Dr Ayyar (who was a senior medical officer with the Adult Community Mental Health Services Team at BHS)[97] in the presence of Mr Cizek, and a community mental health nurse. The reason for the assessment was stated as "(patient) *acutely psychotic*", and Dr Ayyar was asked to see Petya as none of the doctors from the Team were available.[98]

57. Petya told Dr Ayyar she had taken time off work and was having problems with her memory. She also said she had applied for an Australian passport "*some months ago*" but had provided "*wrong information*" and now thinks "*they are causing harm to her and her family*". Petya said she was worried about "*the documents*" and thinks it is "*all part of a big conspiracy*" which her mother in Bulgaria "*may be connected to*". Petya also said she "*may not be real*", that people were watching her and her husband when they go to the park, and that she did not feel safe at home and that her husband was not safe.[99]

58. Dr Ayyar conducted a mental state assessment, noting that Petya's mood was "*low*", her affect was "*anxious*", and she was teary at times. Petya was also "*extremely paranoid*" and "*expressed thoughts of not wanting to be here*". Although she denied auditory hallucinations, Petya did refer to hearing "*helicopters flying past*", and alluded to possible ideas of reference "*from the TV when watching the news*". Dr Ayyar assessed Petya's insight as "*poor*", and her judgement as "*impaired*".[100]

59. Dr Ayyar's "*formulation*" of Petya was as follows:

> 41 year old lady referred by family/friend with history of depressive symptoms and increasing paranoid ideation for the past few weeks in the context of stress relating to documents submitted for Australian passport and possible complex family & financial issues. Denies other stressors, has a supportive husband and denies any work related issues. Impression: emerging depression with psychotic features. ?Psychotic episode. ?Stress reaction.[101]

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[97] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para41
[98] Exhibit 1, Vol. 1, Tab 24-WC.3, Mental Health Assessment (10.15 am, 09.12.20), p2
[99] Exhibit 1, Vol. 1, Tab 24-WC.3, Mental Health Assessment (10.15 am, 09.12.20), p2
[100] Exhibit 1, Vol. 1, Tab 24-WC.3, Mental Health Assessment (10.15 am, 09.12.20), p7
[101] Exhibit 1, Vol. 1, Tab 24-WC.3, Mental Health Assessment (10.15 am, 09.12.20), p8

60. It was noted that a "*Form 1A - Referral for Examination by Psychiatrist*" (Form 1A) had been completed (requiring Petya to be transported to an authorised hospital and be examined by a psychiatrist)[102] and that Petya was to be admitted to Ward 6 for further assessment. Petya's initial management plan was recorded as:

> Observations on Ward 6 as per ward protocol. Watch for increasing anxiety/suicidal behaviour. Medication was charted by treating team. Will require routine organic screening. GP to be contacted by team to get collateral information and recent MRI report. Will require physical examination as per ward routine.[103]

Admission to BHS - 9 December 2020[104]

61. When Petya was admitted to Ward 6 at BHS at 1.50 pm, she declined a physical examination "*due to paranoid delusions*".[105] Petya also declined to complete some of the standard admission paperwork (i.e.: mental health "*self-report*" documents, mental health safety plan, and skin assessment) saying she was "*being held illegally*" and her allocated nurse (Ms King) had "*illegally obtained her personal information*".[106] Nevertheless, Ms King was able to partially complete an inpatient admission form, malnutrition screening tool, catering request, falls risk assessment, and a pressure injury risk assessment.[107,108]

62. At the inquest, Ms King said it was not unusual for newly admitted patients to refuse to cooperate with admission procedures, and that outstanding paperwork was usually completed in the first few days of the patient's admission.[109] Ms King completed a Brief Risk Assessment (BRA) and assessed Petya's suicide risk as "*moderate*",[110] and Petya was orientated to the ward (with Mr Cizek). Ms King, who also gave Petya information about the Mental Health Advocacy Service (MHAS) and her rights under the MHA.[111,112,113]

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[102] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 40
[103] Exhibit 1, Vol. 1, Tab 24-WC.3, Mental Health Assessment (10.15 am, 09.12.20), p8
[104] ts 06.02.24 (Paul), pp49-61
[105] Exhibit 1, Vol. 1, Tab 19.1, BHS Mental Health Physical Examination form (4.20 pm, 09.12.20)
[106] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (4.50 pm, 09.12.20)
[107] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 29-50 & 61-74
[108] Exhibit 1, Vol. 1, Tab 14.2-LK-2 & LK-4-9, BHS admission documents
[109] ts 06.02.24 (King), pp152-153
[110] Exhibit 1, Vol. 1, Tab 14.2-LK-10, Brief Risk Assessment (5.10 pm, 09.12.20)
[111] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 51-60 & 75-86
[112] ts 06.02.24 (King), p153

MANAGEMENT AT BHS[114]

Dr Paul's assessment - 9 December 2020[115,116]

63. Dr Paul assessed Petya at BHS and his review is recorded in the inpatient notes in an entry scribed by Dr Thomas at 3.45 pm. During Dr Paul's assessment (which was attended by Ms King and Mr Cizek) Petya presented as "*anxious, paranoid,* (and) *fixated on the admission process*". She also reported feeling "*generally unwell*", having no appetite, not sleeping well, and having occasional difficulties with her memory. Petya also appeared guarded and suspicious and was reportedly "*refusing to be assessed without a legal right*".[117,118,119]

64. During the assessment, Petya disclosed an episode of depression in 2003, and expressed a present inability "*to cope with life in general*". She also requested a neurology assessment "*for memory loss*" and reported that her mood was "*very low all the time*". Under the heading MSE (mental state examination), the following entry was made in the inpatient notes:

> Caucasian female of stated age, wearing denim jacket + jeans, sitting in close proximity to her partner (John), good eye contact, superficial rapport, mood described as very low, flattened affect, appears anxious + paranoid, expressing concerns about the MHA + "*who put her on it*". **Thoughts about not coping (with) life at all, but no overt suicidality expressed**.[120] [Emphasis added]

65. Dr Paul's impression of Petya's mental state was: "(Major depressive disorder)*/severe depressive disorder* (with) *psychosis. Risk of harm to self at the time of* (review) *high, requires admission*".[121] At the time of his assessment, it appears that Dr Paul did not have access to the Triage form completed by the Team, and in my view, this is particularly unfortunate.[122]

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[113] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (4.50 pm, 09.12.20)
[114] Exhibit 1, Vol. 1, Tab 19.1, BHS Discharge summary (16.12.20)
[115] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 41-65 and ts 06.02.24 (Paul), pp49-61
[116] Exhibit 1, Vol. 1, Tab 22.1, Report - Dr D Stevens (01.02.21)
[117] Exhibit 1, Vol. 1, Tab 24-WC.5, BHS Integrated Progress Notes (3.45 pm, 09.12.20)
[118] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 48-52
[119] Exhibit 1, Vol. 1, Tab 25-JP.1, Email - Dr J Paul (21.12.20)
[120] Exhibit 1, Vol. 1, Tab 24-WC.5, BHS Integrated Progress Notes (3.45 pm, 09.12.20)
[121] Exhibit 1, Vol. 1, Tab 24-WC.5, BHS Integrated Progress Notes (3.45 pm, 09.12.20)
[122] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 55-59 and ts 06.02.24 (Paul), pp54, 57-58 & 95

66. The Triage form completed by the Team contained relevant information about Petya's mental state, and in particular recorded her clear disclosure of suicidal ideation.[123] At the inquest, Dr Paul pointed out the potential importance of such community assessments (as well as relevant outpatient records) and suggested that hospital clinicians should have access to both when making assessments about potential inpatient admissions. I completely agree with Dr Paul's views on this matter and I have made a recommendation about this issue.[124]

67. Dr Paul's interim treatment plan for Petya included prescribing escitalopram (an antidepressant) and olanzapine (an antipsychotic), both of which are commonly used in presentations like Petya's and regarded as reasonable choices given Petya's presentation.[125,126,127,128] The treatment plan also required that Petya be allocated a mental health advocate from the MHAS, and that she be given information about the Mental Health Legal Centre (MHLC).[129]

68. Petya was also scheduled for review by Dr Choy (the consultant psychiatrist for Ward 6) the following day. At the time of Dr Paul's review, Petya was the subject of a Form 1A which expired at 12.43 pm on 12 December 2020. The Form 1A detained Petya at BHS until she could be reviewed by a consultant psychiatrist and a decision made about whether to place her on an inpatient treatment order (Form 6A), thus making her an involuntary patient.[130,131,132]

Dr Choy's review - 10 December 2020[133,134]

69. Dr Choy says he saw Petya for about an hour on 10 December 2020, and his assessment is recorded in the inpatient notes in an entry scribed by Dr Thomas. Also present were a mental health nurse ("*Peter*") and a "*student*" ("*Georgia*"), and Mr Cizek joined the review a little later.

[123] Exhibit 1, Vol. 1, Tab 24-WC.1, Mental Health Triage form (09.12.20)
[124] ts 06.02.24 (Paul), p95
[125] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 63-65
[126] ts 06.02.24 (Paul), pp60-61 and ts 07.02.24 (Choy), pp175-176
[127] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p11 and ts 07.02.24 (Brett), p262
[128] Exhibit 1, Vol. 1, Tab 25-JP.7, BHS Medication Chart (09-10.12.20)
[129] Exhibit 1, Vol. 1, Tab 24-WC.5, BHS Integrated Progress Notes (3.45 pm, 09.12.20) and ts 06.02.24 (Paul), p57
[130] Exhibit 1, Vol. 1, Tab 24-WC.5, BHS Integrated Progress Notes (3.45 pm, 09.12.20)
[131] Exhibit 1, Vol. 1, Tab 24-WC.2, Form 1A - Referral for examination by psychiatrist (09.12.20)
[132] See: Exhibit 1, Vol. 1, Tab 24-WC.7, Form 6A - Inpatient treatment order in authorised hospital (10.12.20)
[133] Exhibit 1, Vol. 1, Tab 24-WC.6, BHS Integrated Progress Notes (9.30 am, 10.12.20)
[134] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 52-69 and ts 07.02.24 (Choy), pp173-177

70. Dr Choy noted Petya was fixated on "*how someone who doesn't know her can put her in hospital*". However, she disclosed feeling unwell for a "*long time*" and referred to memory issues that impacted on her daily life.[135] At the inquest, Dr Choy said he formed the impression that Petya was "*quite unwell*" based on "*her level of distress*" and the fact that "*she looked genuinely perplexed as to what the place was* (and) *why she was here*". Dr Choy also said he considered it was probably "*a plausible or even reasonable working hypothesis*" that Petya was experiencing a psychotic episode.[136]

71. At the inquest, Dr Choy said that at the time of his assessment he "*deferred making a specific diagnosis*" on the basis that "*there probably wasn't enough information available at that cross-section involvement to put a label on the patient*". However, Dr Choy also noted that "*the label is just the label*" and that it does not "*predetermine what the treatment or management would be*".[137]

72. In my view, it is concerning that the inpatient notes do not make reference to a mental state examination, and in his statement Dr Choy makes the following comments about this matter:

> Upon reviewing, for the purpose of preparing this statement, the entry in the Integrated Progress Notes for the assessment of (Petya) on 10 December 2020, I can see regretfully there is no mental state examination documented as being an element of the assessment. This oversight on my part may have been due to the fact I was leading up to a period of leave. In the usual course of things. I would review notes taken by a scribe to ensure their accuracy. As the mental state examination is not included in the notes. I am not able to say whether the notes were reviewed by me or not.[138]

73. In his statement, Dr Choy went on to note that had a mental state examination been documented in Petya's inpatient notes it: "*would clearly have captured matters required to be considered in connection with completing a Form 6A in respect of* (Petya)".[139]

[135] ts 07.02.24 (Choy), pp173-177
[136] ts 07.02.24 (Choy), p177
[137] ts 07.02.24 (Choy), p175
[138] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 62-64
[139] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 66 and ts 07.02.24 (Choy), pp174-178

74. Notwithstanding the deficiencies I have mentioned in the notes relating to his assessment, Dr Choy concluded that Petya met the criteria for an inpatient treatment order under the MHA.[140] In summary, those criteria are: that the person has a mental illness requiring treatment; that there is a significant risk of harm to the health and safety of that person (or another person); that the person lacks capacity to make treatment decisions; that treatment in the community "*cannot reasonably be provided to the person*"; and that there is no less restrictive alternative treatment available.[141,142]

75. Dr Choy says after reviewing the notes of his review, the Triage form completed by the Team, and Dr Ayyar's mental health assessment (all of which he had access to at the time of his review), he considered that Petya's admission to BHS on an inpatient treatment order: "*was justified under the Mental Health Act, having regard to the acute mental health illness she was suffering under*". Dr Choy therefore completed a Form 6A, confirming Petya's involuntary status.[143,144]

76. At the inquest, Dr Choy said that in his opinion Dr Paul's assessment and interim treatment plan for Petya were "*reasonable*".[145] Dr Choy's treatment plan was recorded in the inpatient notes as follows: "*1. Form 6A; 2. Advise* (patient) *of avenues to access MHAS/MHLC;*[146] *and 3.* (Continue) *current Rx* (medication)*, encourage Rx compliance*".[147]

77. I note that the entry about Dr Choy's review in the inpatient notes also referred to the fact that Petya had given permission for Mr Cizek to join the review, and that "*disgust*" had been expressed about Petya's living conditions. Mr Cizek was said to have "*appeared angry*" and to have pointed a finger at Dr Thomas as he "*mouthed*" the words "*I need to speak with you*". Despite this request, it was suggested to Mr Cizek that he first discuss any issues he had with Petya's mental health advocate.[148]

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[140] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 66 and ts 07.02.24 (Choy), pp174-178
[141] Section 25, *Mental Health Act 2014* (WA) and ts 06.02.24 (Paul), p61
[142] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 61
[143] Exhibit 1, Vol. 1, Tab 19.1, Form 6A - Inpatient treatment order in authorised hospital (10.12.20)
[144] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 65-66
[145] ts 07.02.24 (Choy), p173
[146] Mental Health Advocacy Service and Mental Health Law Centre
[147] Exhibit 1, Vol. 1, Tab 24-WC.6, BHS Integrated Progress Notes (9.30 am, 10.12.20)
[148] Exhibit 1, Vol. 1, Tab 24-WC.6, BHS Integrated Progress Notes (9.30 am, 10.12.20)

78. Mr Cizek says both he and Petya were surprised she had been made an involuntary patient and from his perspective, Mr Cizek considered that: "*Very little was shared with us about the reason for Petya's detention or the plan for her care*".[149]

79. In her first statement, Ms Janssen says that when she spoke with Petya and Mr Cizek on 10 December 2020, they discussed issues with Petya's room, Mr Cizek's request for a second opinion, the possibility of a review hearing in the Mental Health Tribunal (the Tribunal), and Petya's desire to have EGA, which would have allowed her to have supervised access to the hospital grounds.[150]

80. Although Petya had initially said she wanted to think about whether she wanted to get a second opinion, she confirmed this was her desire on 11 December 2020. After speaking with Petya and Mr Cizek, Ms Janssen says she raised the request for a second opinion with Dr Choy, and on 14 December 2020 (in accordance with the procedure at the time) she emailed a liaison officer at MHAS to progress the request.[151,152] In his statement, Dr Choy said he did not recall speaking with Ms Janssen, but that her recollection "*is probably correct*".[153]

81. Although requests for a second opinion were usually actioned within a few days, it could sometimes take time to arrange a review from an independent psychiatrist. In this case, although Dr Stevens made considerable efforts to organise a second opinion, these arrangements were not finalised before Petya's death.[154,155,156]

82. When Ms Janssen saw Petya on 15 December 2020, she told her that a Tribunal hearing had been arranged for 2.00 pm on 21 December 2020. However, despite the possibility that the Tribunal might review her involuntary status, and this was something Petya had previously expressed an interest in, Ms Janssen says when she told Petya about the scheduled hearing, Petya "*was not interested in this news*".[157]

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[149] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), para 21
[150] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), pp2-3 and ts 06.02.24 (Janssen), pp13-16 &
[151] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p4 and ts 06.02.24 (Janssen), pp46-47
[152] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p5 and ts 06.02.24 (Janssen), pp32-33
[153] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 95-97
[154] Exhibit 1, Vol. 1, Tabs 27-DS.1 & Tab 27-DS.1, Emails - Dr D Stevens (14.12.20 & 16.12.20)
[155] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 73-79 and ts 07.02.24 (Stevens), pp213-214 & 226
[156] ts 07.02.24 (Choy), pp191-194 and ts 07.02.24 (Stevens), pp213-214 & 226
[157] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p5 and ts 06.02.24 (Janssen), pp32-33

83. In his statement, Dr Paul says that in preparation for the Tribunal hearing, he was in the process of preparing a medical report "*with the intention to justify ongoing treatment under the* (MHA)". In his statement, Dr Paul pointed out that as the document had not been completed by the time of Petya's death and was still in draft, it should be regarded "*as an unfinished and unverified summary of her care*". Dr Paul also said that although he had made some amendments to the document on 16 December 2020, he "*did not believe the summary is correct or up to date as at that time*".[158]

84. Nevertheless, the draft report does provide an indication of Petya's presentation and clinical progress, and under the heading "*Treatment Support and Discharge Planning*", the draft report states:

> Petya remains in the acute phase of her illness and given her admission was only 1 week ago, we believe that the severity of her symptoms is consistent with her stage of recovery.
>
> Petya has gradually begun to provide a history of presenting illness with the team although she remains paranoid towards staff and guarded during reviews.
>
> She has been inconsistent with accepting treatment and we are in the process of reviewing her medical management and considering alternative forms of treatment, including the possibility of depot preparations.[159]

85. During her admission, Petya was never permitted to have EGA on the basis that her risk of absconding remained too great. Although Ms Janssen did raise the issue on 14 December 2020, Dr Stevens was unavailable, and it appears Dr Harding (a consultant psychiatrist who was providing cover for Dr Stevens that day) did not know Petya well enough to authorise the request. On 15 December 2020, after a "*Code Black*" incident I will describe later in this finding, the inpatient notes record that EGA was to be considered subject to Petya's compliance with her treatment.[160,161]

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[158] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 117-119
[159] Exhibit 1, Vol. 1, Tab 25-JP.10, Medical report to the Mental health tribunal (unfinished draft - 16.01.24), p6
[160] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p4 and ts 06.02.24 (Janssen), p39
[161] Exhibit 1, Vol. 1, Tab 25-JP.8, BHS Integrated Progress Notes (1.00 pm, 15.12.20)

Petya's presentation during her admission

86. From the time of her admission to BHS, Petya's inpatient notes record that she consistently expressed paranoid ideation, suspicion of clinical staff, and that she spent most of her time in her room. Petya also regularly stated that clinical staff were "*actors*", and that BHS was "*a prison*". Further, despite the persistent and determined efforts of nursing staff, Petya consistently declined to engage with staff, and she generally refused to engage in ward activities.[162]

87. In his statement, Dr Stevens says this about Petya's presentation:

> Petya was spending most of her time in her room, and there was no opportunity for me to have casual contact with her on the ward. A patient spending all of their time in their room can mean a lot of different things. Often, it can simply just be a symptom of depression. It can also be a way for patients to avoid the often noisy and chaotic environment in the common areas of the Ward. **In hindsight, the isolation may have been because (Petya) was suicidal, and because her paranoia had given her significant mistrust of nursing staff.**[163,164] [Emphasis added]

88. As noted, Petya was prescribed the antidepressant, escitalopram, and the antipsychotic, olanzapine, which Dr Choy and Dr Paul both confirmed were appropriate medications in Petya's case.[165] The evidence establishes that despite regular refusals, Petya usually agreed to take her prescribed medication eventually.[166,167]

89. The evidence before me is that although some of the positive effects of psychotropic medication[168] may manifest in a few days, it usually takes four to six weeks for the full effects of such medication to take effect.[169] I therefore accept that in some cases, part of a patient's treatment plan may be to simply allow sufficient time to elapse for the positive benefits of their prescribed medication (if any) to manifest.

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[162] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (09-16.12.20)
[163] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 63-66
[164] See also ts 07.02.24 (Brett), pp250-251 on the need to investigate why Petya was isolating in her room
[165] ts 07.02.24 (Choy), pp175-176 and ts 06.02.24 (Paul), pp60-61
[166] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (09-15.12.20)
[167] Exhibit 1, Vol. 1, Tab 19.2, Nursing Handover History (09-15.12.20)
[168] The term "*psychotropic*" refers to medication capable of affecting the mind, emotions, and behaviour
[169] ts 07.02.24 (Choy), p208 and ts 07.02.24 (Brett), pp261-262

90. Nevertheless, I am concerned that despite the fact that Petya's paranoia, suspicion, and isolation appear to have been persistent (and apparently intractable) features of her presentation during her admission, at no stage was her care ever escalated to a consultant psychiatrist. Further, after she was made an involuntary patient following Dr Choy's review on 10 December 2020, Petya did not receive any further assessments from a consultant psychiatrist.[170]

Aspects of Petya's care 11 - 15 December 2020[171,172]

91. As the following summaries of nursing observations make clear, Petya's presentation during her admission was characterised by persistent and ongoing paranoia, suspicion, and isolation:

a. *11 December 2020*:
Remains paranoid and fearful of others, delusional, believes staff are actors, teary++, pacing the ward and asking to go to the police station to confess, believes security on the ward is for her, increasingly agitated, throwing chairs, firm limits set, hovering around the air lock, visited by husband compliant with (night) medication;

b. *12 December 2020*:
Paranoid, hypervigilant, fearful, withdrawn, isolatory, avoidant, guarded, suspicious, hiding away in dark bedroom, staying in room for majority of time, requiring prompting +++ to take medications, visiting by husband, but later pushing him out, husband wants family meeting ASAP;[173]

c. *13 December 2020*:
Refused meals, refused medications, hypervigilant, suspicious, paranoid, visited by (Mr Cizek) who wants a family meeting ASAP, and believes hospital environment affects negatively (on Petya's mental state), extremely agitated (when Mr Cizek left the ward), crying loudly and constantly banging loudly on the door, resistive to counselling, finally settled around midnight;[174]

[170] Exhibit 1, Vol. 1, Tab 19.1, BHS Inpatient notes (9.30 am, 10.12.20)
[171] Exhibit 1, Vol. 1, Tab 19.1, BHS Inpatient notes (09-15.12.20)
[172] Exhibit 1, Vol. 1, Tab 19.2, Nursing Handover History (09-15.12.20) and See also: ts 06.02.24 (Finney), pp99-100
[173] Exhibit 1, Vol. 1, Tab 30, Statement - Mr P Nguyen (01.02.24), paras 79-88
[174] Exhibit 1, Vol. 1, Tab 30, Statement - Mr P Nguyen (01.02.24), paras 89-94

d. *14 December 2020*:
Low profile, most of her time in her room, refused breakfast, refused medications despite multiple attempts. Only ate when husband visited, believes hospital is fake, forms are fake, and there are restrictions on her. When attempting to explain, (Petya) shaking head stating: "*No*", isolates in room, remains paranoid ++, ate dinner/(medication) with (Mr Cizek) present, mood low, affect restricted, engaged in OT activities (PM); and

e. *15 December 2020*:
Mostly found isolating in her room, declined (medication) in the morning but later took (medication) and food in front of her husband, denied her bloods to be taken, denied to talk and meet two of her friends, lots of over involvement with friends saying contradictory stories, needs (social worker) involvement, delusional +++, worrying about husband's safety.

Multidisciplinary team meeting - 15 December 2020[175]

92. The evidence before me is that along with all of the other patients on Ward 6, Petya's mental state was discussed at a multidisciplinary team (MDT) meeting on the morning of 15 December 2020. Although the entry in the inpatient notes does not list the attendees, it is clear that the meeting was attended by Dr Stevens, Dr Paul, and Dr Thomas, as well as nursing staff. In his evidence, Dr Stevens said that the MDT meetings were usually also attended by the ward's social worker, occupational therapist, and "*a representative of the nursing staff*".[176,177]

93. In his evidence at the inquest, Dr Choy said that MDT meetings were "*a briefer meeting than many in the Court might imagine*". He said the meetings could take "*the better part of two hours*", but when Ward 6 was full, that would mean each patient would be discussed for only six or seven minutes. As Dr Choy noted this: "*is not a lot of time, especially if you are going around the room and people are chipping in with their various opinions*".[178,179]

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[175] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 80-96
[176] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), para 82
[177] See also: Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 73-76
[178] ts 07.02.24 (Choy), p197
[179] At the relevant time, patients did not attend MDT meetings, but at some facilities they now do: ts 06.02.24 (Paul), p64

94. Due to the pressure of his other duties, Dr Stevens had a limited understanding of the patients on Ward 6 at the time of the MDT meeting. In his statement, Dr Stevens said the only issue he could recall being discussed in relation to Petya, was the "*frequency of visits*" from Mr Cizek and that "*staff were worried he was complicating her care*". Dr Stevens also recalled there was discussion about whether there should be "*formal restrictions*" on Mr Cizek's visits under the MHA.[180]

95. However, Dr Stevens said no formal restrictions were in place in relation to Mr Cizek, and that the notation in the inpatient notes that staff were to: "(continue) *visitor restrictions as necessary*", was likely a reference to the "*more informal restrictions*" which Dr Stevens recalled staff had imposed. Under these restrictions, Mr Cizek had been asked to visit Petya for only one hour, twice daily, which he had agreed to do.[181,182]

96. As I will discuss later in this finding, allegations about Mr Cizek's interactions with Petya had been made by some of her friends, and were recorded in the inpatient notes on 12 December 2020.[183] However, notwithstanding the potential seriousness of these concerns, by the time of Petya's death the investigation into these allegations was: "*still in the early phase of obtaining collateral information about whether Mr Cizek was having a harmful influence*".[184] For reasons I will explain later in this finding, this state of affairs is entirely unsatisfactory.

97. At the MDT meeting entry in the notes describes Petya as "*insightless and paranoid*", and notes "*Suspicion of power/control behaviour ?(domestic violence). Ongoing (social worker) involvement*". Petya's medication was continued, and a Progressive Risk Assessment (PRA) recorded her risk of harm to self and others as "*low*", and her risk of impulsivity, absconding and psycho-social risk were all assessed as "*moderate*".[185]

[180] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 83-84 and ts 07.02.24 (Stevens), pp219-220
[181] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 83-84
[182] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 103-104
[183] Exhibit 1, Vol. 1, Tab 19.1, BHS Inpatient notes (12.12.20)
[184] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 138
[185] Exhibit 1, Vol. 1, Tab 24-WC.6, BHS Inpatient notes (10.00 am, 15.12.20)

98. In relation to the PRA (which is ticked as having been a "*team*" review), Dr Stevens says: "*I do not recall this being completed, and as I had not reviewed (Petya) I doubt I had a contribution in relation to it*". Dr Stevens also said that the fact that the "*level of observation required*" panel on the PRA had been left blank meant Petya's standard one hourly observations were to continue.[186]

99. In his statement, Dr Stevens noted that risk assessment was "*an inexact science*" and that:

> Practitioners can only undertake an assessment based on the information they have to hand in circumstances where risk factors are dynamic. Often, practitioners are guided by a patient's self-report, and whether they have voiced any suicidal or self-harm ideas.[187]

100. The PRA provides no justification for lowering of Petya's risk of self-harm, despite her continued paranoia, lack of insight, and ongoing isolation in her room.[188] Further, despite their ongoing efforts, Petya refused to engage with nurses, and Dr Paul conceded that the therapeutic rapport between Petya and clinical staff "*was not good*". At the inquest Dr Choy agreed that despite incidental contact with staff, any sort of therapeutic rapport with Petya had eluded them.[189]

101. In his statement, Dr Paul did not recall what had led to Petya's risk of self-harm being assessed as "*low*" and confirms the rationale "*is not expressly documented in the entry for this meeting*". Dr Paul noted Petya was compliant with her medication "*most of the time*" and "*at that time there had been no threats to others and I do not recall any self-harm threats or attempts*".[190]

102. Dr Paul also noted that expressions of self-harm do not necessarily mean a patient's risk level is high and such expressions "*are evident in many mental illnesses*". Instead, Dr Paul said the level of risk "*depends on the circumstances of the individual patient*".[191]

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[186] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 88-89
[187] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 90-91
[188] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), pp11-12
[189] ts 06.02.24 (Paul), p66 and ts 07.02.24 (Choy), p181
[190] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 77-80
[191] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 80

103. At the inquest, Dr Paul was asked about the rationale for lowering Petya's risk rating at the MDT meeting, in the following exchange:

> *Mr Stops (Counsel Assisting):* I'm just struggling to understand why, during the MDT meeting on (15 December 2020)…the impression by the team was that her harm to herself was now low. So it has gone from high/moderate to now low. Can you explain why that is the case?
>
> *Dr Paul:* I can't recall exactly the discussion that was had but based on my personal opinion, her lack of suicidal gestures, self-harm gestures or expressing suicidality to us during her reviews or nursing staff interactions, are evidence that her risk remained low.[192]

104. If this was the basis for the reassessment of Petya's risk of self-harm, it seems problematic. Precisely because Petya remained paranoid and suspicious of clinical staff, her interactions with them were usually perfunctory and superficial. Indeed, none of the witnesses at the inquest claimed to have developed any therapeutic relationship with Petya, although Ms Janssen appears to have made more headway in this regard than anyone else.[193]

105. At the inquest Dr Paul was also asked about the significance of Petya's ongoing practice of isolating herself in her room, and he said this behaviour may have "*many causes*" including Petya's paranoia belief that "*we were some sort of government officials and we were against her and that sort of thing*". However, Dr Paul[194] also agreed Dr Stevens' observation, namely:

> A patient spending all of their time in their room can mean a lot of different things. Often, it's just a symptom of depression. It can also be a way for patients to avoid the often noisy and chaotic environment in common areas of the ward. **In hindsight, the isolation may have been because (Petya) was suicidal and because her paranoia, had given her significant mistrust of nursing staff.**[195] [Emphasis added]

[192] ts 06.02.24 (Paul), p66
[193] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p11
[194] ts 06.02.24 (Paul), pp67-68
[195] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 64-66 and ts 07.02.24 (Stevens), pp25-216

106. On the basis of the available evidence, it appears that the justification for lowering Petya's self-harm risk assessment at the MDT meeting was most likely the fact that she had not made any expressions or gestures of suicide or self-harm ideation up to that point. With the benefit of hindsight this seems to have been an insufficient basis on which to lower Petya's self-harm risk assessment.

107. As I have noted, by the time of the MDT meeting, Petya's presentation had remained relatively consistent and there was no compelling evidence of any significant improvement in her mental state. Clinical staff had not managed to develop any real therapeutic rapport, and Petya continued to isolate herself in her room. In addition, no therapeutic alliance had been forged with her most significant support person, Mr Cizek, who was instead being viewed with some suspicion.

108. Petya's "*predicted date of discharge*" was 12 January 2021, meaning the resolution of her symptoms was expected to take at least another four weeks. With the benefit of hindsight, had Petya's ongoing paranoia, suspicion, and isolation been interpreted differently, it is at least possible that this may have prompted an escalation in her care and a comprehensive review of her mental state by Dr Stevens.[196,197]

109. It is impossible to know what would have happened in Petya's care had been escalated in this way, but I note with approval that since Petya's death, changes have been made to documentation relating to MDT meetings. In his statement, Dr Stevens noted that:

> [C]hanges have been made to the information that is entered in a patient's medical record relating to an MDT meeting. In particular, that record must now record how frequently the patient is to be reviewed, with any deviation from the default position of daily review to be documented.[198]

[196] Exhibit 1, Vol. 1, Tab 24-WC.9, BHS Inpatient notes (10.00 am, 15.12.20)
[197] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 92-95
[198] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), para 132

Code Black incident and Dr Paul's assessment[199,200,201,202,203]

110. On 15 December 2020, Petya refused her morning medication and declined to have her vital signs recorded, saying "*I don't take medication or breakfast*". Mr Cizek then visited the ward for about an hour and when he left, Petya became agitated and was "*teary and banging on the entrance door calling out for her husband*". Later, after initially refusing lunch, Petya changed her mind and went to the dining room, although she "*appeared suspicious+++ and sarcastic* (saying) *'this is not a hospital'*".[204]

111. While she was in the Ward 6 dining room, Petya "*threw her tray of food onto the floor*", and another patient (Patient A) began verbally abusing her and accused Petya of wasting food. Staff intervened and deescalated the situation, and Petya returned to her room, where she was offered (and accepted) a dose of clonazepam.[205]

112. At about 12.30 pm, Petya came out of her room and began verbally abusing Patient A, who was returning to their room which was opposite. Petya was observed "*taunting and posturing, calling* (Patient A) *'worthless', and many names and offering to fight*". Patient A responded with verbal abuse and Petya and Patient A then began pushing and shoving at each other until Patient A "*slowly fell to the floor*", breaking a necklace in the process.[206,207]

113. The verbal altercation between Petya and Patient A continued until security guards stepped in and separated them. Although Patient A sustained no injuries as a result of their fall, a "*Code Black*" patient emergency was initiated, and Petya was reviewed by Dr Paul in the presence of a nurse, and two security guards who had been involved in the earlier incident.[208,209]

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[199] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p5
[200] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (3.00 pm, 15.12.20)
[201] Exhibit 1, Vol. 1, Tab 25-JP.8, BHS Integrated Progress Notes (1.00 pm, 15.12.20)
[202] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 97-104
[203] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 34
[204] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (3.00 pm, 15.12.20)
[205] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (3.00 pm, 15.12.20)
[206] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (3.00 pm, 15.12.20)
[207] Exhibit 1, Vol. 1, Tab 25-JP.8, BHS Integrated Progress Notes (1.00 pm, 15.12.20)
[208] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (3.00 pm, 15.12.20)
[209] Exhibit 1, Vol. 1, Tab 25-JP.8, BHS Integrated Progress Notes (1.00 pm, 15.12.20)

114. In his statement, Dr Paul noted that after the MDT meeting Petya was involved in a "*Code Black*" incident in which she was "*observed to push a co-patient and throw her lunch on the ground*". Dr Paul says he was asked to review Petya following this incident, which in his view "*was not particularly serious, and only resulted in a broken necklace*".[210] As noted, the review was attended by a nurse and "*two security guards who had participated in the incident*". In his statement Dr Paul explained the rationale for the review in these terms:

> The purpose of the review was to verbally deescalate (Petya). I saw this as an opportunity for early intervention in an escalation of behaviour, to reduce her level of distress. After talking to (Petya), I understood that she was still frustrated about being at BHS.[211]

115. In his entry in the inpatient notes, Dr Paul says Petya told him she was "*frustrated at being kept in this facility*" which she was convinced was a prison, despite "*attempts at explanation*". Petya also strongly believed staff were "*actors from the government pretending to be staff*", and she expressed concern for Mr Cizek, alluding to the fact that "*he might be dead*". However, Petya also told Dr Paul: "*she may consider the possibility that her mind/brain is causing her to be paranoid should* (Mr Cizek) *return alive & well*".[212] In his statement, Dr Paul said he thought Petya's comment showed:

> [S]he had begun to develop some insight into her behaviour. This was the first time she seemed to accept the possibility that her mind/brain may have been causing her to be paranoid. I saw this as a sign of possible improvement in Petya's condition.[213,214]

116. However, at the inquest Dr Choy was asked whether he considered there was much about Petya's presentation following the Code Black incident that was "*positive*". Dr Choy's response was that after he had reviewed Petya's notes: "*It's hard to put a positive spin on that*".[215]

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[210] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 83-84
[211] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 85-88
[212] Exhibit 1, Vol. 1, Tab 25-JP.8, BHS Integrated Progress Notes (1.00 pm, 15.12.20) and ts 06.02.24 (Paul), p69
[213] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 89-90
[214] See also: Exhibit 1, Vol. 1, Tab 25-JP.1, Email - Dr J Paul (21.12.20)
[215] 07.02.24 (Choy), p198

117. With the benefit of hindsight, it may be that Petya's involvement in these physical and verbal altercations and her demonstrated emotional dysregulation, were signs that her mental state was deteriorating, even though her presentation deescalated after Dr Paul's review.

118. In any case, Dr Paul's entry about his review notes that Petya "*adamantly denied*" any concerns about her personal safety in relation to Mr Cizek, although she did not "*clearly elaborate on food restrictions or preferences*". Petya was also recorded as having said: "*I wonder what would happen if I stopped eating…I am only eating what* (Mr Cizek) *brings*".[216] Dr Paul's entry in the inpatient notes does not say whether a mental state examination was conducted, and at the inquest, Dr Paul confirmed that he did not complete a PRA.[217]

119. Nevertheless, in his entry in the inpatient notes, Dr Paul said Petya was: "*More settled post-review*", and had agreed to "*approach staff if frustrated*". Dr Paul said he regarded this as a positive indicator, but at the inquest I pointed out that up to that point, Petya had not demonstrated any willingness to approach staff and may have just been making that comment without any real intent. Dr Paul's response was: "*Yes, it's hard for me to say. Yes*".[218] In any case, Dr Paul's plan was recorded as: "*1. Continue current treatment; 2. Should compliance be good may look towards stepdown & EGA*".[219]

120. In his statement, Dr Paul noted that as patients show signs of improvement, their risk of absconding usually decreases and they will often be transferred to a less secure ward. In addition, EGA requests can be viewed more favourably. Dr Paul also said that in his opinion: "*It would be expected*" that Petya's treatment (i.e.: medication) would take four to six weeks "*to take full effect*", but that early signs of improvement can be seen in "*about one to two weeks*", even when compliance with medication "*is only partial*". Dr Paul also confirmed that his reference to "*stepdown*" in the inpatient notes meant moving Petya "*to a less secure ward*".[220]

[216] Exhibit 1, Vol. 1, Tab 25-JP.8, BHS Integrated Progress Notes (1.00 pm, 15.12.20)
[217] 06.02.24 (Paul), p71
[218] ts 06.02.24 (Paul), p70
[219] Exhibit 1, Vol. 1, Tab 25-JP.8, BHS Integrated Progress Notes (1.00 pm, 15.12.20)
[220] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 92-94

121. Dr Paul said Petya's risk of absconding was initially viewed as "*high*" because she remained psychotic, believing she was in a prison, and she would often bang on ward doors and look for exits. However, Dr Paul says that by 15 December 2020, it appeared to him that "*things were trending towards us being able to give (Petya) escorted ground access*".[221] As to Petya's risk level, Dr Paul said: "*as it appears there had been some improvement overall with her level of insight into her illness, I did not consider that her risk rating* (i.e.: low) *had changed since that morning*".[222]

122. In his statement, Dr Paul also said that in preparing his statement, he had become aware that Ms Janssen had formed the view that Petya was angry with him and felt she was "*in trouble*" because of her behaviour during the Code Black incident. Further, Ms Janssen was of the view that Petya was "*worse than she had been*". Dr Paul said although he could not comment on whether Petya was angry with him, after his review, his impression was that Petya "*was more settled*".[223]

123. Dr Paul also said that nursing notes following the Code Black incident "*do not suggest a clear deterioration in her mental state*". However, while this comment is accurate on its face, it does not tell the whole story. As I will explain, following the Code Black incident, Petya made clear expressions of suicidality to Ms Janssen, which were conveyed to her allocated nurse, but not recorded in the inpatient notes.[224,225,226]

124. In any case, notwithstanding the fact that the Code Black incident appears to have been the first occasion of verbal or physical violence involving Petya, Dr Paul did not inform Dr Stevens (the consultant psychiatrist on Ward 6 at the relevant time) about the circumstances of the incident or his subsequent review because: "*it was not standard practice to escalate all Code Blacks to the consultant psychiatrist and on this occasion the incident was de-escalated successfully*".[227]

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[221] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 95-100
[222] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 95-100
[223] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 101-102
[224] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), paras 46-48
[225] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p5
[226] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 102
[227] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 103

125. Dr Stevens agreed that while it was not standard practice for all Code Black incidents to be "*escalated*" to the consultant psychiatrist, it was his hope and expectation that "*junior medical staff*" felt able to "*escalate any concerns regarding a patient's change in mental state or change in risk*" following a Code Black incident.[228] At the inquest, Dr Stevens agreed that with the benefit of hindsight, Petya's care should have been escalated to him following the Code Black incident.[229]

126. Dr Stevens also said that "*in an ideal world*", an updated risk assessment would be completed after a Code Black incident, but that after reviewing Dr Paul's entry, he could see that Petya appeared more settled "*which may indicate that the assessing clinician believed her risks had not changed*". Dr Stevens also made the following observation about why the Code Black incident may not have been raised with him: "*While I am speculating, it may be I was not told of these events as the staff were conscious of the limits on my time. If there was more consultant psychiatrist time on the ward during this period, he (i.e.: Dr Paul) may have been able to raise these issues*".[230]

127. Given that a person's suicide risk can fluctuate wildly, it is impossible to know whether Petya's journey would have been different had the Code Black incident (or her subsequent expressions of suicidality) been escalated to Dr Stevens. However, it is at least possible that she might have been reviewed by Dr Stevens and that her mental state and current levels of risk would have been assessed. As such, with the obvious benefit of hindsight, it is my view that the failure to escalate the Code Black incident to Dr Stevens was a missed opportunity to have potentially provided a higher level of care to Petya.

128. Further, other than some apparently recent insight into her paranoia (noted by Dr Paul), Petya's presentation had not changed significantly since her admission, and she had expressed suicidal ideation. As Dr Stevens noted at the inquest: "*I don't think the evidence pointed to much in the way of significant improvement*".[231]

[228] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 101 and ts 07.02.24 (Stevens), p215
[229] ts 07.02.24 (Stevens), p214
[230] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 102
[231] ts 07.02.24 (Stevens), p212

129. In my view, all of those factors, when viewed with the benefit of hindsight, are capable of supporting the proposition that Petya's mental state would have benefitted from a more detailed assessment by Dr Stevens, and it is obviously unfortunate that this did not occur.

Advocate's report of suicidality - 15 December 2020[232]

130. When Ms Janssen arrived on Ward 6 on 15 December 2020, she saw Petya throwing her lunch and yelling before "*storming off*". Petya did not want Ms Janssen to attend Dr Paul's review, and so Ms Janssen spoke to Petya later near her room. When Ms Janssen asked Petya if she was "*okay*" Petya said she wasn't but was unsure "*if she wanted to talk*". Ms Janssen says Petya seemed "*quite angry*" with Dr Paul and was complaining about being "*told off*" for things other patients "*don't get told off for*".[233,234]

131. Ms Janssen said Petya declined her offer to spend some time with her, and in her first statement (dated 11 June 2021) Ms Janssen gave the following account of her conversation with Petya:

> Petya told me she finds Ward 6 disgusting, she doesn't eat or drink the food here (she eats whatever John, her husband brings in), and she stated she would be better off dead. I asked if she was serious about this statement, and Petya said: "*I may as well be*".[235]

132. In her second statement (signed on 16 January 2024), Ms Janssen gave the following account of Petya's expression of suicidal ideation:

> **(Petya) then said words to the effect "*I would be better off dead*" and advised that she had a plan and it was not just a threat.** While my initial statement, and the notes on ICMS do not refer to (Petya) saying she had a plan, I do recall that…(Petya) did not give any indication of what her plan was, and I wasn't sure how she would harm herself, given the ligature minimised environment. I told (Petya) that I had a duty of care to tell a nurse what she had told me.[236] [Emphasis added]

[232] See also: Exhibit 1, Vol. 1, Tab 26.2-MJ.2, MHAS Consumer History Report (15.12.20), p19
[233] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p5 and ts 06.02.24 (Janssen), pp23-26
[234] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), paras 42-44
[235] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p5 and ts 06.02.24 (Janssen), pp26-27
[236] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), paras 46-48 & 52 and ts 06.02.24 (Janssen), pp42-43

133. At the inquest, Ms Janssen said following the Code Black incident, Petya's seemed "*very agitated*",[237] and the information in her second statement about Petya saying she had a plan is clearly significant. An expression of suicidal ideation with a plan is more serious and calls for an urgent risk assessment and possible escalation in care.[238] Ms Janssen also said she was very concerned about Petya and felt "*she had been going backwards and that she was getting…more unwell*".[239]

134. Ms Janssen was clearly took what Petya had told her seriously, and although she could not recall the nurse she reported her concerns to, the evidence establishes this was Ms Finney (Petya's allocated nurse at the time).[240] Ms Janssen's account of what she told Ms Finney about Petya's expression of suicidality varies between her two statements as follows:

> *First statement:* Petya asked me to leave so she could rest on her bed. I complied with her wishes. I went and spoke to her nurse, and told her that Petya had expressed that she would be better off dead. Her nurse thanked me for letting her know and said she would check in with Petya. I also told her that Petya had expressed concern for (Mr Cizek's) safety on the ward when he comes to visit, and her nurse said she would have a chat with Petya.[241]
>
> *Second statement:* I can recall telling a nurse that (Petya) was going to harm herself, that she had a plan, and I was concerned for her safety. Unfortunately I do not recall the name of the nurse I spoke to, although I believe it was a female with blonde hair.[242]

135. At the inquest, the following exchange took place between Ms Lee (counsel for Ms Finney) and Ms Janssen:

> *Ms Lee*: Do you agree there's a possibility that Petya did not mention she had a plan to harm herself, to you?
>
> Ms Janssen: **It's possible. But as far as I can recall (Petya) did tell me that she had a plan.**[243] [Emphasis added]

[237] ts 06.02.24 (Janssen), pp41-42
[238] ts 07.02.24 (Brett), pp251-252
[239] ts 06.02.24 (Janssen), p30
[240] ts 06.02.24 (Finney), p106
[241] Exhibit 1, Vol. 1, Tab 12, Statement - Ms M Janssen (11.06.21), p5
[242] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), para 52
[243] ts 06.02.24 (Janssen), p45

136. At the inquest, Ms Janssen said she did not ask Petya for details of her plan because as a mental health advocate, that was not her role. Ms Janssen also said that after conveying her concerns to Petya's allocated nurse, it was her expectation that the nurse would "*check on* (Petya) *and increase observations of her*".[244,245]

137. At the inquest, Ms Finney confirmed that at about 2.00 pm on 15 December 2020, she had a conversation with Ms Janssen about Petya. Although there is no reference to this conversation in the inpatient notes (or in Ms Finney's statement), at the inquest Ms Finney said she had an independent recollection of the conversation, explaining that: "*when there has been such a significant incident…you're going to recall…a lot of the prior times you've nursed the patient the week prior…I think that's normal*".[246]

138. Ms Finney's account of what she was told by Ms Janssen is as follows:

> So I recall it was the mental health advocate (i.e.: Ms Janssen) had said to me that she was concerned because she had spoken to Petya and Petya said she didn't want to be here anymore and then I responded saying, "*That's not uncommon. She gets very distressed when her husband is not here*." He…definitely keeps her calm and I think he had left for the day and then she said she just wanted to raise it because she was concerned that…(Petya) was suicidal and I said I would go and speak to her…and check in with her.[247]

139. Ms Finney says she then had the following interaction with Petya:

> I said, you know, "*How are you feeling*?" (and she said) "*I'm fine. I just want to be left alone*." You know, and then I tried to kind of push it – like, engage (indistinct) "*Are you waiting on your husband*?" because she was in the visitor's room and she said, "*I'm fine. Just leave me alone*." And I said, "*Well, I'm here to check in on you. I'm here if you need anything*," and she just wanted to be – like, that was quite standard. She didn't often engage.[248]

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[244] ts 06.02.24 (Janssen), pp30-31
[245] Exhibit 1, Vol. 1, Tab 26, Statement - Ms M Janssen (16.01.24), para 53
[246] ts 06.02.24 (Finney), p106
[247] ts 06.02.24 (Finney), p107
[248] ts 06.02.24 (Finney), p107

140. At the inquest, Ms Finney was asked whether the addition of a plan to Petya's expression of suicidal ideation would have increased Petya's risk of self-harm. Ms Finney's response was: "***Yes. But I wasn't informed that she had a plan or intent***".[249] [Emphasis added]

141. In terms of how Ms Finney may have interpreted what she was being told by Ms Janssen, the following exchange at the inquest is instructive:

> *Coroner Jenkin*: So as far as the advocate is concerned, although she hasn't got a note of this at the time, she recalls telling you that Petya had told her that she had a plan?
>
> *Ms Finney*: No. I wasn't informed that she had a plan or intent.
>
> *Coroner Jenkin*: I noticed when you were giving your evidence about this you said that in terms of the…information that you received from the advocate about Petya saying she "*didn't want to be here anymore*", you seem to have interpreted that in the context of her missing her husband or…not wanting to be on the ward rather than not wanting to be alive anymore?
>
> *Ms Finney*: **That's right. She would often say she doesn't want to be here and would bang on the airlock.** [Emphasis added]
>
> *Coroner Jenkin*: So let's assume that for whatever reason the information from the advocate wasn't communicated in the way that it might have been, but the advocate is trying to tell you that Petya is saying to her that she has suicidal ideation?
>
> *Ms Finney*: She said she was concerned that it was - like, suicidal ideation and then I went and addressed it with Petya.[250]

142. Clearly, information about Petya having said she had a plan to self-harm would have been highly significant. Ms Finney agreed that if she had been advised Petya had said she had a plan to self-harm she would have informed the ward coordinator, contacted Petya's treating team (or the on-call doctor), and considered whether a "*nurse special*" (constant observation of the patient) should be initiated.[251]

[249] ts 06.02.24 (Finney), p121 and see also: ts 06.02.24 (Finney), p136
[250] ts 06.02.24 (Finney), p122
[251] ts 06.02.24 (Finney), p122

143. Had those actions been taken, Petya would almost certainly have been reviewed by Dr Paul (or an on-call doctor), and her risk assessment (which at the time was "*low*") would have been reviewed. Further, if a "*nurse special*" been initiated, it seems unlikely Petya would have had the opportunity to self-harm.

144. There is an obvious difficulty in determining exactly what Ms Janssen conveyed to Ms Finney after her conversation with Petya. Neither Ms Janssen's notes, nor her first statement contain any reference to Petya saying she had a plan to self-harm. Nevertheless, Ms Janssen's recollection is that this is what she is told. For her part, Ms Finney is adamant that Ms Janssen did not tell her that Petya had expressed a plan, but again there is no reference to their conversation, either in the inpatient notes or in Ms Finney's statement.

145. The lack of any contemporaneous reference to the conversation between Ms Janssen and Ms Finney is clearly regrettable. Further, it is a notorious fact that memories of an event, even one that is significant or traumatic, can vary widely and people's recollections of events have often been found to be wildly inaccurate.

146. Nevertheless, it does seem surprising that Ms Finney would say that she was not told Petya had a plan if in fact that is what she had been told by Ms Janssen. On the other hand, it would be surprising if Ms Janssen's memory of such an important fact was faulty. Notwithstanding the lack of any contemporaneous notes, Ms Janssen is a very experienced mental health advocate, and she had previously worked as a mental health nurse. She would obviously have been aware of the importance of a patient expressing suicidal ideation **and** a plan.

147. After carefully considering the available evidence, I have concluded that I cannot be satisfied, to the relevant standard, about exactly what was conveyed to Ms Finney by Ms Janssen. However, what is beyond doubt is that Petya told Ms Janssen she "*did not want to be here*" (or words to that effect) and that Ms Janssen conveyed her concerns about Petya's suicidality to Ms Finney. It is also clear that following this conversation, Ms Finney spoke to Petya, although Petya was dismissive of Ms Finney's enquiries about her mental state.

148. As I have noted, it may be that Ms Finney interpreted what she was being told by Ms Janssen in the context of Petya's previous (and consistent) expressions of displeasure at being at BHS, and of missing Mr Cizek. In that way, when Ms Finney was told that Petya had said "*I don't want to be here*", this may have seemed more like a repeat of Petya's previous concerns, rather than being a new and genuine expression of suicidal intent.

149. Either way, due to an apparent miscommunication, this incident represents (in my view) a missed opportunity to have carried out a more comprehensive assessment of Petya's mental state and risk of self-harm.

150. Following Petya's death, the MHAS reviewed Ms Janssen's notes about her interactions with Petya and Mr Cizek, and relevant protocols relating to the service provided to Petya by Ms Janssen. In a letter to the Court dated 25 January 2024, the Chief Mental Health Advocate advised that:

> As a result of our review of our practice in this case, the MHAS leadership team determined that in addition to existing requirements:
>
> 1. the Advocate would ask the Nurse Manager/Coordinator for the information to be documented in the consumer's file, and for the treating team to be informed; and
>
> 2. the Advocate would note down the full name of the Nurse Coordinator/Nurse Manager and details of the conversation in ICMS notes as soon as possible.[252]

151. Mental health advocates were advised of these changes in an email sent on 5 July 2021, and the relevant protocol document had been updated.[253] The changes have been reinforced at team meetings and training sessions, and are: "*taught in the induction program for new Advocates*".[254] In my view the changes MHAS has made to its procedures are sensible, and at the inquest Ms Janssen confirmed that mental health advocates now follow the new protocol.[255]

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[252] Exhibit 1, Vol. 1, Tab 29.1, Letter - Dr S Pollock to Mr W Stops (25.01.24), pp1-2
[253] Exhibit 1, Vol. 1, Tab 29.2, Responding to Suicide or Self-Harm Ideation or Threats to Harm Others Protocol (24.01.24)
[254] Exhibit 1, Vol. 1, Tab 29.1, Letter - Dr S Pollock to Mr W Stops (25.01.24), p2
[255] ts 06.02.24 (Janssen), p29

Reports of red marks - 16 December 2020

152. Mr Cizek says when he visited Petya to take her breakfast on the morning of 16 December 2020, he noticed "*a very well-defined mark*" across her neck. Mr Cizek said he was "*very concerned*" about the mark and when he asked Petya about it, she said it "*was from a strap*".[256]

153. In his statement, Mr Cizek also makes the following observations about the mark, and Petya's condition on the morning of 16 December 2020:

> The mark was very prominent and would have been obvious to all those treating Petya. I asked Petya if I could take pictures but she told me this was not allowed. Petya had a very pale complexion with bags under her eyes. She looked extremely unwell and I was concerned for her. I had never seen her look so bad, and was worried about her, especially since I could only stay for around one hour in the mornings.[257]

154. Mr Cizek says he raised his concerns about the mark on Petya's neck, and presentation with her allocated nurse and asked that Petya be monitored more frequently. Mr Cizek says that although the nurse "*nodded her head*", he did not think she was taking him seriously.[258] In any case, neither Mr Cizek's reported concerns, nor the red mark he says he saw on Petya's neck, are referred to in the inpatient notes.

155. Indeed, the only notation in the inpatient notes after Mr Cizek's visit that was made prior to Petya's death, is a nursing entry at 1.10 pm on 16 December 2020, which states:

> Paranoid, isolating in room, refused breakfast, refused (morning medication) despite ++ encouragement. Stating "*nothing can help me, no point in taking them*". Visited by (Mr Cizek) for 1 hour, (Petya) & (Mr Cizek) reluctant to leave, (Mr Cizek) brought in food that (Petya) did not eat. (Mr Cizek) requesting family meeting, advised to make appointment with (treating team).[259]

[256] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), para 25
[257] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), para 25
[258] Exhibit 1, Vol. 1, Tab 18, Statement - Mr J Cizek (30.03.21), para 26
[259] Exhibit 1, Vol. 1, Tab 19.1, BHS Mental Health Physical Examination form (1.10 pm, 16.12.20)

156. Clearly any mark on Petya's neck would have been of grave concern to clinical staff, as it may have indicated an attempt to self-harm. Although the evidence clearly establishes that Mr Cizek reported his concerns about a red mark on Petya's neck to nursing staff on the morning of 16 December 2020, there is no evidence of what (if anything) was done about his concerns at the time.[260,261]

157. Dr Paul says that towards the end of his shift on 16 December 2020, he had a brief conversation with Petya about her refusal to take her morning medication, and that intramuscular injections may have to be considered.[262] Petya seemed "*calm*" and "*engaged in the conversation* (about her medication) *meaningfully*".[263] Dr Paul did not recall Petya having a mark on her neck, but agreed that if he had seen such a mark, he would most likely have conducted a risk assessment, and "*would probably have spoken with the consultant as well*".[264]

158. In my view, it is gravely concerning that Ms Finney (who was Petya's allocated nurse during the afternoon shift on 16 December 2020) was not made aware of Mr Cizek's concerns until after Petya's death. At the inquest, Ms Finney said:

> I think after the incident the coordinator had said the morning nurse had raised that there were red marks on (Petya's) neck, but the coordinator didn't inform me of that until after the incident…so after the death…the coordinator had said that the morning nurse had raised that the husband was concerned that there were red marks on (Petya's) neck…though that wasn't handed over to myself.[265]

159. Dr Stevens said that "*in a perfect world*" reports of Mr Cizek's concerns about a red mark around Petya's neck should have been documented in the inpatient notes, and that: *It would certainly require further investigation*". In his report, Dr Brett said: "*it was essential that* (such reports) *be followed up as a matter of urgency*.[266,267]

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260 Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (16.12.20)
261 See also: ts 06.02.24 (Finney), p134
262 Exhibit 1, Vol. 1, Tab 25-JP.1, Email - Dr J Paul (21.12.20)
263 Exhibit 1, Vol. 1, Tab 25-JP.1, Email - Dr J Paul (21.12.20)
264 Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 104-107 and ts 06.02.24 (Paul), p90
265 ts 06.02.24 (Finney), p134
266 ts 07.02.24 (Stevens), p223 and ts 07.02.24 (Brett), p260
267 See also: Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p12

Concerns relating to Mr Cizek

160. In his statement, Dr Paul says he had "*numerous*" conversations with Mr Cizek during Petya's admission as he tried to obtain collateral information. Dr Paul says Mr Cizek appeared to believe that the cause of Petya's mental illness was her diet, and that her mental health issues "*could be treated that way*". Although Dr Paul said he agreed that diet was an important part of holistic care, clinical staff had formed the belief that Petya had a severe mental illness that required "*a variety of measures and treatment in addition to maintaining adequate nutrition*". Further, although Petya was initially diagnosed with "*depression exhibiting psychotic symptoms*", Dr Paul said that diagnosis could change once further information was obtained.[268]

161. In her second statement, Ms King (who was Petya's allocated nurse) refers to an incident involving Mr Cizek on 10 December 2020. Ms King says she recalled telling a colleague she "*couldn't build up a rapport with Petya or observe her*" because Mr Cizek was "*spending 10 hours on the ward each day*".[269]

162. Ms King says she and her colleague spent "*significant time*" speaking with Mr Cizek in the "*comfort room*" and he had said he was "*also in the medical field*" and that Petya was not going to improve "*without sunshine and Digestaid and flaxseed oil*". Ms King says she also explained to Mr Cizek that it was difficult for staff to build a "*rapport or therapeutic relationship*" with Petya whilst he was on the ward for several hours and that Petya would not engage with staff while he was present.[270]

163. Ms King says that Mr Cizek agreed with her comments, and was then asked to leave as he had been on Ward 6 for about five hours. Ms King says at the time, Mr Cizek was in Petya's room and when she tried to remind him that this was not permitted for safety reasons, he complained that the service provided by BHS was: "*inhumane and cruel as Petya's room is too cold*".[271,272]

[268] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 120-123
[269] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 103-104
[270] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 103-104
[271] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 103-104
[272] Exhibit 1, Vol. 1, Tab 14.2-LK15, BHS Integrated Progress Notes (8.30 pm, 10.12.20)

164. In her second statement, Ms King says that as Mr Cizek was leaving Ward 6 (in compliance with her request) Petya began "*banging on the airlock watching* (Mr Cizek) *walking out*". Ms King says Petya was "*screaming and yelling*", and then notes:

> I vividly remember (Mr Cizek) turned around and he stood there at reception for about 15 minutes with a smile on his face. I remember I asked another nurse to call reception and ask him to leave because he was inciting Petya's behaviour[273]…(*later in her statement in relation to the same incident, Ms King also says*):…I saw (Mr Cizek) turn around and stand there, smiling at Petya from the reception area, watching her bang and scream out for him.[274]

165. The inpatient notes also contain serious allegations about Mr Cizek, which were reportedly conveyed to nursing staff by some of Petya's friends. The unidentified complainants had reportedly visited Petya on 12 December 2020, and expressed concerns "*about ill effects on Petya's health that come from her husband*".[275,276] The entry in the inpatient states that Petya's friends had alleged:

> [T]hey had taped (phone calls) with (Mr Cizek) where he admits that he tells Petya not to drink water on the ward as it is medicated, not to eat on the ward as he's going to bring her own food, that there are cameras everywhere and she's not safe. Friends would like to have a word with psychiatrist to give more collateral information.[277]

166. Dr Paul said he was aware staff had received information from Petya's friends which: "*caused us to be concerned about Mr Cizek*", and that:

> I can recall that they provided information that they had seen Mr Cizek exhibiting controlling behaviour, including his strict control of (Petya's) diet. The friends alerted staff to the possibility that domestic abuse was at play. This abuse was not necessarily violence, but more controlling behaviour and emotional abuse.[278]

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[273] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 15-16
[274] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 109-111
[275] Exhibit 1, Vol. 1, Tab 19.1, BHS Inpatient notes (12.12.20)
[276] See also: ts 06.02.24 (King), pp145-146
[277] Exhibit 1, Vol. 1, Tab 19.1, BHS Inpatient notes (12.12.20)
[278] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 124-127

167. However, Dr Paul also noted that Petya responded better to treatment when Mr Cizek was on the ward, and that he "*was an important part of us establishing a rapport with* (Petya)". Dr Paul also said that at times Petya appeared "*very upset*" when Mr Cizek left the ward and would bang on the exit doors, whilst at other times she "*appeared eager for* (Mr Cizek) *to leave*". Dr Paul said it was difficult to know whether Petya's actions were "*illness related or whether it could have been related to domestic abuse*",[279] and also he noted that:

> Mr Cizek would often speak on behalf of (Petya), and would often be sitting very closely to her. These are things that someone may also do when they are concerned about a loved one. However, given the collateral information, I had some concerns regarding the possibility of domestic abuse.[280]

168. In any event, notwithstanding the extraordinary nature of allegations which had been made against Mr Cizek there is no evidence that these concerns were ever substantiated. In his statement, Dr Paul said that when staff had concerns about domestic abuse relating to a patient, they would speak to the social worker allocated to their ward. Dr Paul recalled "*the concerns about Mr Cizek were being investigated by a social worker*", but could not recall who the social worker was. Dr Paul also said that if a social worker spoke to a patient or "*made a finding in relation to a patient*" this would be recorded in the inpatient notes.[281] There is no such entry in Petya's inpatient notes.

169. After the allegations about Mr Cizek had been raised with nursing staff, an entry in the inpatient notes (following the MDT meeting) states:

> First admission to (Mental Health Service). (History) of depression. Suspicion of power/control behaviour. ?(domestic violence). Ongoing SW (social worker) involvement. Continue to (review) (medication). Insightless + paranoid. Plan: 1. (Social worker) involvement when well; 2. (Continue) visitor restrictions as necessary; and (Projected Discharge Date) 12/1/21.[282]

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[279] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 129-131
[280] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 132
[281] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 133-137 & 174€
[282] Exhibit 1, Vol. 1, Tab 24-WC.9, BHS Inpatient notes (10.00 am, 15.12.20)

170. In his statement, Dr Paul said he recalled that at the time of the MDT meeting, the investigation relating to the allegations against Mr Cizek: "*was still in the early phase of obtaining collateral information about whether Mr Cizek was having a harmful influence, and there was a concern about not wanting to jump to conclusions*".[283]

171. Nevertheless, precisely because the allegations against Mr Cizek were never substantiated or refuted, his presence on the ward whilst he was visiting Petya appears to have been viewed with some concern. This much is apparent from the fact shortly after Petya's admission, Mr Cizek was asked to limit the length of his visits to the ward so that staff could observe Petya in his absence and try and develop a rapport with her.[284]

172. As mentioned, Mr Cizek complied with the request to limit his visits, and thereafter visited Petya twice daily, bringing in meals for her when he did so.[285] I agree with Dr Brett's comment in his report that on the face of it Mr Cizek's conduct did "*not seem compatible*" with the concerns that had been raised about him.[286] In any case, in my view the serious allegations that had been made against Mr Cizek should have been investigated expeditiously so that the validity or otherwise of the allegations could be determined.

173. Had there been any truth in what Petya's friends were reportedly alleging about Mr Cizek this would obviously have been of significant concern. Behaviour of the kind alleged may have had the potential to impact on Petya's care, and to have impeded her recovery. If the allegations against Mr Cizek had been substantiated, he could have been counselled about the potential negative impact of his behaviour.

174. Alternatively, if the allegations were not substantiated, Mr Cizek could (and should) have been actively recruited as a key member of the therapeutic alliance that staff were clearly trying to establish for Petya's benefit.[287]

[283] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 138
[284] Exhibit 1, Vol. 1, Tab 19.1, BHS Inpatient notes (2.50 pm, 11.12.20)
[285] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 140-146
[286] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p13
[287] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p13 (paras 21 & 23)

175. In my view, the failure to promptly ascertain the validity of the concerns about Mr Cizek's alleged interactions with Petya is clearly unsatisfactory. Mr Cizek could (and should) have been recruited as an important member of Petya's therapeutic alliance, but in the absence of any determination about whether the allegations against him were true or false, this could not occur. In my view, this represents a missed opportunity to have potentially enhanced Petya's care.

Failure to convene a family meeting

176. The evidence establishes that both Petya and Mr Cizek made several requests for a family meeting, mainly it seems so that confusion about Petya's diagnosis and treatment plan could be explored.[288,289] However, despite these repeated requests a family meeting was never held, and in my view this is very unfortunate.

177. Apart from addressing any concerns that Petya and/or Mr Cizek may have had about her diagnosis and/or treatment plan, a family meeting may also have been able to elicit useful collateral information. Such a meeting may also have been an appropriate vehicle to explore ways in which Mr Cizek could more actively support Petya's treatment and care.

178. I accept that for logistical and staff availability reasons, requests for family meetings may not always be able to be accommodated immediately. Nevertheless, such meetings have been shown to be a useful way to obtain collateral information and to involve a patient's significant others in their care.

179. At the inquest, Dr Brett noted that the Chief Psychiatrist had published standards which clearly identified collaboration with a patient's significant others is an important aspect of involuntary care.[290,291] In my view the failure to convene a family meeting (despite repeated requests by Petya and Mr Cizek) was a missed opportunity to have potentially enhanced Petya's care and to have promoted her recovery.

[288] Exhibit 1, Vol. 1, Tab 19.1, BHS Inpatient notes (12.12.20)
[289] Exhibit 1, Vol. 1, Tab 24-WC.9, BHS Inpatient notes (10.00 am, 15.12.20)
[290] Exhibit 1, Vol. 1, Tab 32, Chief Psychiatrist's standards for Authorised Hospitals under the *Mental Health Act 2014* (WA)
[291] ts 07.02.24 (Brett), pp253-254

180. At the inquest, Ms King,[292] Dr Paul,[293] Dr Choy[294] and Dr Brett[295] all agreed that a family meeting should have been held.[296] Further in her submissions at the conclusion of the evidence, Ms Van Nellestijn (counsel for EMHS) confirmed that EMHS did not dispute that in Petya's case "*there should have been a family meeting*".[297]

[292] ts 06.02.24 (King), p146
[293] ts 06.02.24 (Paul), p83
[294] ts 07.02.24 (Choy), pp206-207
[295] ts 07.02.24 (Brett), pp256-257
[296] ts 07.02.24 (Choy), pp206-207 and ts 07.02.24 (Brett), pp256-257
[297] ts 07.02.24 (Van Nellestijn), p297

EVENTS LEADING TO PETYA'S DEATH

Rounding checks - 16 December 2020[298]

181. On 16 December 2020, Mr Maphumulo conducted the hourly "*ward safety checks*" (Roundings) at about 3.20 pm, 4.00 pm and 5.00 pm.[299] At the inquest, Mr Maphumulo said that during the 3.20 pm check, he went into Petya's room, and because it was dark he asked her for permission to turn on the room light but Petya's response was "*No*". Mr Maphumulo says Petya "*looked to me puzzled, like suspicious or scared in a way*", and as if he had disturbed her.[300]

182. In relation to his interactions with Petya during the 3.20 pm Rounding, Mr Maphumulo says:

> I remember that I asked her two times if she was alright, because the light was dark. I asked her if she was alright. She just looked at me with this suspicious way or some sort of…I don't know if I can say - angry that I've walked into her room. And I thought yes, I probably disturbed her when she is in her own private space. So after introducing myself, telling her that I'm just doing the roundings, and I'm one of the nurses that is (on) shift in the afternoon and her nurse is held up somewhere. I retreated and closed her room.[301]

183. During the 4.00 pm Rounding, Mr Maphumulo says he saw Petya standing in her room near where she had been during the 3.20 pm check. Petya's room was still dark, and Mr Maphumulo's observations were made through a glass panel in the room's closed door. Mr Maphumulo says Petya "*appeared to be standing as though she was changing her clothes*", and at the inquest he added that Petya appeared to have her arms above her head as if she was "*preparing to get into her gown to prepare to sleep*".[302] Mr Maphumulo also said "*I didn't speak with* (Petya). *Other staff have told me that she spent a lot of time in her room*".[303]

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[298] Exhibit 1, Vol. 1, Tab 19.3, Rounding Checks (16.12.20) and ts 07.02.24 (Maphumulo), pp163-171
[299] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Maphumulo (12.05.21), paras 4-8
[300] ts 07.02.24 (Maphumulo), p163
[301] ts 07.02.24 (Maphumulo), p163
[302] ts 07.02.24 (Maphumulo), p165
[303] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Maphumulo (12.05.21), paras 7-10

Petya is discovered[304,305,306]

184. During the 5.00 pm Rounding, Mr Maphumulo says that in addition to performing checks on patients, he was also asking them to come for dinner. As he approached Petya's room, Mr Maphumulo looked through the door's glass panel and noted the room "*was quite dark*" and was only illuminated by a light shining through the half-opened door of the bathroom.[307]

185. Mr Maphumulo says he could see: "*what looked like a tall figure which appeared to be standing near the right side of the toilet door (on the outside of the bathroom)*". Although he called out to Petya to "*come for the dinner activity*" there was no response. Mr Maphumulo went into Petya's room and found her hanging, about 15cm off the ground. Petya had what were later confirmed to be shoelaces around her neck, which she had tied to the bathroom door.[308]

Resuscitation efforts[309,310,311,312,313,314]

186. Petya was unresponsive and Mr Maphumulo initiated a "*Code Blue*" medical emergency, and yelled out to staff to bring something to cut the ligature around Petya's neck. Mr Maphumulo also activated his personal duress alarm and attempted to lift Petya's body up so as to remove her from the ligature.[315]

187. Moments after Mr Maphumulo called the "*Code Blue*", other staff arrived and Petya was cut down using a "*ligature cutter*", before CPR was commenced. A clinical nurse and a doctor arrived to assist a short time later, but despite the efforts of clinical staff, Petya could not be revived, and she was declared deceased at 6.27 pm.[316,317]

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[304] Exhibit 1, Vol. 1, Tab 8, Report - Det. Snr. Const. S Rogers (02.12.22), pp1-2 & 5-11
[305] Exhibit 1, Vol. 1, Tab 9, Memo - Snr. Const. P Smith (17.12.20)
[306] Exhibit 1, Vol. 1, Tab 10, WAPOL Incident Report 161220 1925 15679 (16.12.20)
[307] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Maphumulo (12.05.21), paras 11-14
[308] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Maphumulo (12.05.21), paras 15-17
[309] Exhibit 1, Vol. 1, Tab 14.1, Statement - Ms L King (29.03.21), paras 12-23
[310] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 124-127
[311] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Finney (27.04.21), paras 18-26
[312] Exhibit 1, Vol. 1, Tab 16, Statement - Mr B Hinks (11.05.21), paras 10-31
[313] Exhibit 1, Vol. 1, Tab 16, Statement - Mr B Attwood (20.05.21), paras 9-21
[314] Exhibit 1, Vol. 1, Tab 22.1, Report - Dr D Stevens (01.02.21), p3
[315] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Maphumulo (12.05.21), paras 17-20
[316] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Maphumulo (12.05.21), paras 21-32
[317] Exhibit 1, Vol. 1, Tab 4, Death in hospital form (16.12.20)

188. At the relevant time, Ward 6 did not have its own resuscitation trolley for use in emergency situations. Instead Ward 6 shared a resuscitation trolley with the adjacent ward (Ward 7). During the attempts to resuscitate Petya, staff fetched the trolley from Ward 7 and brought it to Room 9.[318]

189. Ms King (who was assisting with resuscitation efforts) says that when she went to grab a bag-valve mask device from the resuscitation trolley, it had "*no mask attached*". As a result, Ms King says she was forced to improvise by fetching a complete bag-valve mask device she had recalled seeing earlier in the Ward 6 treatment room.[319]

190. Although there is no evidence that any issue relating to the resuscitation trolleys contributed to Petya's death, I note with approval that all mental health wards at BHS (including Ward 6) now have their own resuscitation trolleys, and that these trolleys are checked for completeness on a weekly basis.[320,321]

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[318] Exhibit 1, Vol. 1, Tab 14.2, Statement - Ms L King (31.01.24), paras 125-126
[319] Exhibit 1, Vol. 1, Tab 14.1, Statement - Ms L King (29.03.21), paras 12-19 and ts 06.02.24 (King), pp146-147
[320] Exhibit 1, Vol. 1, Tab 31, Email - Ms D Van Nellestijn to Mr W Stops (05.02.24)
[321] ts 06.02.24 (King), pp147-150

CAUSE AND MANNER OF DEATH[322,323,324,325]

191. Dr Moss and Dr Junckerstorff (forensic pathologists) conducted a post mortem examination of Petya's body on 29 December 2020. The examination found ligature marks on Petya's neck which "*correspond to the supplied ligatures*". The examination did not identify any natural disease, but did note fractures of the superior horns of Petya's thyroid cartilage, and evidence of attempted resuscitation. Petya's lungs were also congested, "*a non-specific finding that may be seen in hanging*".[326]

192. Microscopic examination of tissues noted non-specific and post mortem changes, and specialist examination of Petya's brain showed no significant abnormality.

193. No viral infection of the heart, lungs or spinal fluid was detected, and toxicological analysis found diazepam (sedative) and olanzapine (antipsychotic) in Petya's system. Alcohol, cannabinoids and other common drugs were not detected.[327]

194. Notably, the toxicological analysis did not detect the antidepressant, escitalopram, which Petya had been prescribed, and which she was seen taking by Ms Finney (Petya's allocated nurse on 16 December 2020).[328] Whilst escitalopram should presumably have been detected in Petya's system, on the basis of the available evidence I have been unable to determine why this was not the case.

195. At the conclusion of the post mortem examination, Dr Moss and Dr Junckerstorff expressed the opinion that the cause of Petya's death was ligature compression of the neck (hanging). I respectfully adopt that opinion as my finding as to the cause of Petya's death. Further, on the basis of the available evidence, I find that the manner of Petya's death was suicide.

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[322] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (24.10.22)
[323] Exhibit 1, Vol. 1, Tab 5.2, Addendum Post Mortem Report (07.01.21)
[324] Exhibit 1, Vol. 1, Tab 5.3, Post Mortem Report (29.12.20)
[325] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (10.01.21)
[326] Exhibit 1, Vol. 1, Tab 5.2, Addendum Post Mortem Report (07.01.21), p7
[327] Exhibit 1, Vol. 1, Tab 6, Toxicology report (28.01.21)
[328] ts 06.02.20 (Finney), pp114-115 & 118

SAC1 REVIEW

Overview

196. On 10 February 2021, a clinical panel (the Panel) issued a report (SAC1 review) following its investigation into the circumstances of Petya's death. After conducting interviews with "*clinicians involved in accordance with the principle of root cause analysis*", the Panel identified a number of issues which I will now briefly summarise.[329]

Admission/intake process flawed

197. The Panel reviewed the relevant EMHS policy relating to the search of patient belongings, and noted that the policy provided that: "*following the search of belongings, staff should remove 'dangerous items'*". The Panel noted that the list of dangerous items in the policy included potential ligatures, but that:

> Interviews with a number of clinicians had confirmed that the local practice does not involve the removal of potential items including shoelaces and belts as part of a standard admission to the ward.[330]

198. Although the Panel noted: "*no personal items were removed*" when Petya was admitted to Ward 6, I note that at the inquest Ms King confirmed that Petya's handbag had been confiscated.[331] Significantly (given she used them to take her life) Petya's shoelaces were not removed on admission. After noting Petya was uncooperative with the admission process, the Panel found that:

> As a secure mental health unit, removal of any item that poses a risk to the consumer or to others should be removed, with particular reference to any item that could be used as a ligature (e.g. shoe lace, bed sheets and clothing) should be standard practice. The panel noted that this would make the unit consistent with policy requirements in other comparable units in WA. An immediate recommendation was made to implement an urgent practice change, including updating policy and completing observational audits to monitor compliance.[332]

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[329] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21)
[330] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p7
[331] ts 06.02.24 (King), p140
[332] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p7

199. At the inquest, Ms King confirmed that in the entirety of her graduate nurse program "*shoelaces were not removed*" from patients, and both she and Dr Choy confirmed that at the relevant time, it was not standard practice to remove a patient's shoelaces on Ward 6.[333] By way of contrast, in her evidence at the inquest Ms Finney said that when a patient was received "*any high risk items would be removed*", and when asked if Petya's shoelaces should have been removed, Ms Finney replied: "*I think all patients' shoelaces should be removed*".[334]

200. At the inquest Dr Paul said he was unfamiliar with the relevant policy, but agreed that it would have been a sensible idea to have removed Petya's shoelaces. Dr Paul also noted that most of the hospitals he had worked at whilst he was a registrar would have done so.[335]

201. These differing perspectives highlight the fact that over time local practices at different facilities can vary. However, in the context of Petya's death, it is unsurprising that Dr Choy, Dr Stevens, Dr Gupta, and Dr Brett all agreed that her shoelaces should have been removed, and Dr Stevens and Dr Gupta confirmed this is the current practice.[336,337,338]

202. In passing, I note that at the inquest, there was mention that removal of a patient's shoelaces may be seen as an affront to that person's dignity.[339] In fact, the same could be said for the process of placing a patient on an involuntary treatment order, but with respect none of this is relevant. The stark reality is that any concern about such "*affronts*" must give way to the serious risk of a patient harming themselves opportunistically using items such as shoelaces and belts.[340] However, whilst it is true that if Petya's shoelaces had been removed she would not have been able to use them to take her life, the imponderables in this case mean it is impossible to know whether her outcome would have been different had this occurred.

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[333] ts 06.02.24 (King), p140 and ts 07.02.24 (Choy), pp184-185; and see also: ts 07.02.24 (Stevens), p223-224
[334] ts 06.02.24 (Finney), pp104-105
[335] ts 06.02.24 (King), p140 and ts 06.02.24 (Paul), pp55 & 85-86
[336] ts 07.02.24 (Choy), pp185-186 and ts 07.02.24 (Stevens), pp217 & 222
[337] ts 07.02.24 (Gupta), p232 and ts 07.02.24 (Brett), pp248 & 255
[338] In submissions, EMHS conceded that Petya's shoelaces should have been removed: ts 07.02.24 (Van Nellestijn), p297
[339] ts 06.02.24 (Paul), p86; ts 07.02.24 (Choy), p185; and ts 07.02.24 (Stevens), pp222-223
[340] ts 07.02.24 (Brett), p255

Medical review inadequate

203. The Panel found that the "*locally accepted standard*" was that a patient would be reviewed weekly by their allocated consultant psychiatrist, and registrar for a total of two medical reviews per week. The Panel noted Petya's initial reviews by Dr Paul and Dr Choy, and her review by Dr Paul following the Code Black incident, but determined that: "*this medical review frequency is insufficient for consumers admitted to an involuntary inpatient unit*".[341]

204. In fairness, I note that at the inquest, Dr Paul referred to a review by Dr Harding (who was providing cover on 14 December 2020),[342] however, there is nothing in the inpatient notes to confirm that this review occurred.[343] The Panel also noted that during Petya's eight-day admission she had been under the care of four consultant psychiatrists, and that there was no formal process to handover patients (including patients of concern) between the in-hours and after-hours teams.[344]

205. The Panel said that as Petya was not identified as "*high risk*" it was unlikely she would have been included in any "*consumer-of-concern*" handover, and the Panel therefore deemed this factor as "*non-causal/contributory*". However, the Panel did recommend that a "*standardised medical clinical handover process across (the) mental health inpatient service*" be implemented.[345]

Observations

206. With reference to procedures in other mental health units, the Panel determined that the Rounding practice on Ward 6 at the relevant time "*was not in accordance with best practice*", explaining that:

> The experts on the panel indicated that visual observations present an opportunity to engage with and assess the consumer. By sighting the consumer only, this presents a missed opportunity to develop and strengthen the therapeutic relationship (one of the care goals outlined in the original care plan for this consumer)…

[341] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p8
[342] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), paras 25-26
[343] ts 06.02.24 (Paul), pp63-64
[344] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p8
[345] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p8

> In addition, the frequency and outcome of these observations should form part of the medical record. A recommendation to improve the standard of practice for routine visual observations has been made.[346]

207. Whilst I agree with the Panel's finding on this point, in fairness, I also acknowledge Dr Stevens' comment in his statement that: "*When a patient is paranoid, trying to force them to engage with others can cause them more distress*".[347] With the benefit of hindsight, it seems that the appropriate response to Petya's continued paranoia, suspicion and isolation in her room would have been to escalate her care to her consultant psychiatrist. However, as I have explained, this never happened at any time during Petya's admission.

Risk assessment/escalation of care

208. The Panel noted that although Petya was identified as a "*high suicide risk*" by Dr Paul during his assessment on 9 December 2020, care planning resulting from this review "*was limited*" and was not updated "*in any significant way*" during Petya's admission. The Panel also found Petya's "*high suicide risk*" should have initiated "*regular risk assessment and safety planning with an update in the care plan*".[348]

209. The Panel noted that throughout her admission Petya consistently demonstrated risk factors for "*injury to self*", including her inability to seek staff assistance or engage with staff, her lack of insight, and her ongoing isolation in he room. The Panel also considered that the Code Black incident: "*should have triggered an escalation in care for a review or discussion with the consultant psychiatrist*".[349]

210. The Panel noted that although Mr Cizek and some of Petya's friends had made requests for family meetings to provide collateral information, these requests "*did not result in timely action*". As the Panel noted, had these meetings occurred, the treating team may have been provided "*with additional information to inform the assessment of* (Petya's) *risk*".[350]

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[346] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p8
[347] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), para 134(e)
[348] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), pp9-10
[349] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p10
[350] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p10

211. The Panel also noted Petya had told Ms Janssen "*I would be better off dead*", and had said she was serious. Although Ms Janssen's case notes indicate she had "*escalated this to the consumer's nurse*", the Panel noted: "*the absence of documentation regarding this information or any actions taken as a result*".[351] The Panel also noted that: "*staff are not provided clear parameters to trigger escalations of care (including medical reviews and/or increased observation frequencies)*" and recommended that existing policies be reviewed and updated "*to address the lack of escalation processes in the inpatient setting*".[352]

212. At the inquest, Dr Choy and Dr Stevens both agreed that with the benefit of hindsight, Petya's care should have been escalated to a consultant psychiatrist given her persistent paranoia and suspicion, and her ongoing isolation in her room.[353]

Clinical supervision

213. The Panel found that systems for formal clinical supervision within the mental health workforce "*were not well-established, monitored or embedded*", even though the relevant policy required that staff providing "*direct clinical care*" were to receive one hour of "*formal clinical supervision*" per month. The Panel noted that had this policy been implemented as intended: "*this may have assisted in pro-actively identifying gaps in care such as those seen in this case*".[354]

Infrastructure/ward environment

214. The Panel identified issues with the anti-ligature audits conducted by EMHS, including the fact that in July 2018, the relevant standard (since superseded) did not include door hinges as a potential ligature risk. In this case, Petya used a door hinge in her room as a ligature anchor point, and the Panel made recommendations "*to mitigate the risk of existing doors and to implement an appropriate anti-ligature audit program*".[355]

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[351] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p10
[352] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p10
[353] ts 07.02.24 (Choy), p181 & pp199-200 and ts 07.02.24 (Stevens), p214
[354] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p11
[355] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p11

Patient flow and acuity

215. Although acknowledging that patient acuity on Ward 6 was heightened at the relevant time, the Panel determined that this issue "*did not contribute to the outcome in this incident*".[356] I note that in his report and at the inquest, Dr Brett disagreed with the Panel's conclusion,[357] and for reasons I have already identified, it is my respectful view that the Panel's conclusion on this issue is simply wrong.

Recommendations and summary of actions taken[358]

216. In addition to its findings the Panel made eight recommendations designed to improve the service offered by BHS to mental health consumers. In his report, Dr Gupta outlined progress on work to address these recommendations and in summary, the situation is as follows:

a. ***SAC1 Recommendation 1:*** *the Service will implement a practice change to ensure the removal of items that have the potential to cause harm on an involuntary ward. This practice change will be supported by implementation of a policy which specifies which items are appropriate. The policy implementation is to include education around these requirements. (Refer to AKG patient Property in Mental Health Wards policy). Change management principles will be applied to support the implementation of this practice change.*

Progress: Dr Gupta says the *Potentially Harmful Items Management for Mental Health Patients SOP* (the Policy)[359] has been revised, and "*is now embedded throughout RPBG Mental Health Division Inpatient ward/services*" and "*forms part of the treatment and management of every patient*".
Dr Gupta also said that amendments made to the Policy following a workshop conducted as part of "*a full review*" are predicted to be published in the first quarter of 2024.

[356] Exhibit 1, Vol. 1, Tab 22.2, SAC1 Clinical Investigation Incident Report (10.2.21), p11
[357] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p14 (para28) and ts 07.02.24 (Brett), p253
[358] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), pp4-8
[359] Exhibit 1, Vol. 1, Tab 28.5, Potentially Harmful Items Management for Mental Health Patients SOP

Progress: (continued) All new staff are required to attend training in relation to "*assessing and responding to suicidal persons*" and discussions are underway with Curtin University with a view to offering a Diploma in Mental Health to nursing and allied health staff in order to provide further training including in suicide risk assessment.[360] Of particular relevance to the present case, I note that the Policy now provides that "*laces/ribbons*" are "*Items deemed not appropriate*" for Ward 6, which is the ward Petya was admitted to.[361]

b. ***SAC1 Recommendation 2:*** *the Service will undertake facilities upgrades to ensure all room and ensuite doors in all mental health wards are fit-for-purpose and meet required anti-ligature standards.*

Progress: Dr Gupta says that the "*Anti-Ligature Door Replacement Program is still underway*" and that work to change "*all doors on Wards 6 and 7*" to anti-ligature doors is "*expected to be completed by 30 June 2024*".[362]

With great respect, this timeframe is completely unacceptable. Whilst I accept that work of this nature can be costly and is logistically difficult on an active closed mental health unit, I am **gravely concerned** that despite the fact that Petya's death occurred on 16 December 2020, remediation work to address the obvious ligature risks posed by doors on Wards 6 and 7 is only "*expected*" to be completed by 30 June 2024.

I am aware that mental health consumers can (and do) take their lives in environments which are regarded as "*ligature minimised*". Nevertheless, given that there is obvious merit in making mental health units as safe as possible, the slow pace of this remedial work is a matter of grave concern.[363] **In my view, the remediation work should be prioritised and completed as a matter of urgency.**

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[360] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), pp4-5
[361] Exhibit 1, Vol. 1, Tab 28.5, Potentially Harmful Items Management for Mental Health Patients SOP, p13
[362] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p5 and ts 07.02.24 (Gupta), pp235-236
[363] See also: ts 07.02.24 (Brett), p256

c. ***SAC1 Recommendation 3:*** *the Service will immediately undertake an anti-ligature audit across the site 's mental health units, and implement an anti-ligature program in line with the requirements of the Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014. The audits are to be undertaken by staff who are aware of ligature risk audit principles but do not work within the clinical areas they are auditing to prevent over-familiarity with the environment.*

Progress: Dr Gupta says that an "*internal ligature audit*" was completed by the RPBG Mental health Division shortly after Petya's death. Further, a comprehensive external audit of all EMHS mental health sites led to the development of an anti-ligature remediation program to address the identified risks.[364]

Dr Gupta says that funding was obtained to address "*the highest ligature risks within mental health units*", and this remedial work is expected to be completed by 30 June 2024. In relation to the medium and low risks identified by the external audit, Dr Gupta says that "*Further funding is being sought*".[365]

The fact that remedial work is underway to address the "*highest risks*" identified by the external audit is commendable. However, I remain gravely concerned about the timeframe for completion of this work. I am also concerned that there may be delays in obtaining the "*future funding*" referred to by Dr Gupta. In my view, work to remediate the medium and low risks identified by the external audit should be completed as a matter of the utmost urgency.

I therefore urge EMHS, in the strongest possible terms, to immediately allocate the necessary funding so that remediation work to all medium and low ligature risks identified by the external audit in its mental health facilities can be promptly undertaken and completed.

[364] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p5
[365] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p5

d. ***SAC1 Recommendation 4:*** *the RPBG (Royal Perth Bentley Group) Minimum Requirement for Medical Review of Patients Admitted to inpatient Wards/Community Mental Health Services Policy (Review Policy) is to be reviewed and updated to clearly articulate the required minimum frequency (in days) for medical review on an involuntary inpatient unit. This is to be operationalised and closely monitored until embedded as standard practice. Change management principles will be applied to support the implementation of this practice change.*

Progress: Dr Gupta says the Review Policy has been updated and patients admitted to acute wards (such as Ward 6) are now reviewed within 24 hours, with the patient's risk "*discussed at every multi-disciplinary team meeting and a determination made and clearly documented about how often each patient should be seen*".[366] A flowchart at Appendix 1 of the Review Policy says that during the treatment/maintenance phase, a patient is to receive "*In person daily medical review until the treating Psychiatrist/Duty Psychiatrist prescribes a reduced frequency.*[367]

e ***SAC1 Recommendation 5:*** *the expected standard of care for conducting routine safety observations was not articulated in policy. This may have led to inadequate observations for monitoring the consumer on the mental health unit and may have affected the staff's ability to establish a therapeutic rapport with the consumer. This may have contributed to an insufficient recognition and response to the consumer's mental state through the admission.*

Progress: Dr Gupta says that the observations policy in place at the time of Petya's death was reviewed and replaced by a new policy[368] which: "*more clearly outlines the expected standard of care for conducting routine safety observations*". The new policy applies to all observation regimes, and audits have been conducted to ensure compliance.

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[366] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p6
[367] Exhibit 1, Vol. 1, Tab 28.7, Minimum Requirement for Medical Review of Consumers, Appendix 1, p6
[368] Exhibit 1, Vol. 1, Tab 28.9, Special and Supportive Observations Policy (11/2018)

Progress: (continued) As noted earlier in this finding, "Rounding" observations are now completed by a patient's allocated nurse and entered into a separate sheet for each patient.[369]

f. ***SAC1 Recommendation 6:*** *develop and implement an escalation protocol for recognising and responding to mental health deterioration in mental health inpatient units, which includes: Clear thresholds for graded escalation of care; Designation of roles and responsibilities for members of the healthcare workforce; and Time frames for response. Change management principles will be applied to support the implementation of this practice change.*

Progress: a policy entitled "*Recognising and Responding to Acute Deterioration in Mental State, Cognition, and Behaviour SOP*" was published in May 2021.[370] The policy, which applies to all patients at BHS not just those on mental health wards, was reviewed in the last quarter of 2023, to "*ensure contemporary guidance*". Amendments suggested by the review committee are due to be published in the first quarter of 2024.[371]

g. ***SAC1 Recommendation 7:*** *operationalise the RPBG Clinical Handover policy within the Mental Health inpatient services to ensure shift-to-shift handover (in the iSoBAR format) processes are implemented and embedded. Change management principles will be applied to support the implementation of this practice change.*

Progress: a handover tool based on the iSoBAR[372] format has been developed for the BHS Mental Health Division. The tool enables the mental health registrar to provide an update on "*patients of concern*" in an MS Teams document that is available to the medical team, and the next registrar on call.

[369] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), pp6-7
[370] Exhibit 1, Vol. 1, Tab 28.10, Recognising and Responding to Acute Deterioration in Mental State, Cognition, and Behaviour SOP (02/2021)
[371] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p7
[372] The mnemonic "iSoBAR" is used to guide the structure and content of clinical handovers at BHS and includes the following components: Identify (i), Situation (S), Observations (o), Background (B), Agreed Plan (A), and Readback (R)

Progress: (continued) Three surveys have been conducted "*to address the effectiveness of the tool, and identify any improvements that could be made*".[373]

h. ***SAC1 Recommendation 8:*** *the service will implement EMHS (East Metropolitan Health Service) Clinical Supervision in Mental Health policy to ensure that all mental health practitioners providing direct clinical care participate in one hour of clinical supervision per month. A gap analysis will be undertaken to identify training requirements for clinical supervisors, with a training plan developed and implemented as part of the operationalisation of this policy. Change management principles will be applied to support the implementation of this practice change.*

Progress: Dr Gupta says that EMHS's clinical supervision policy[374] relevantly provides that all staff providing direct care to mental health patients "*will participate in one hour of formal clinical supervision per month*".

A register has now been designed to record supervision sessions and each staff member will complete a "*contract*" with their supervisor detailing when and where supervision sessions will occur. Dr Gupta also advised that an external provider was engaged to deliver a two-day clinical supervision training course to 20 mental health staff, and that "*Work is currently being undertaken to provide further supervision training to staff*".[375]

[373] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), pp7-8
[374] Exhibit 1, Vol. 1, Tab 28.11, Clinical Supervision in Mental Health (November 2019)
[375] Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p8

OTHER ISSUES IDENTIFIED BY DR GUPTA

Overview[376]

217. In addition to outlining the actions that have been taken (or which are underway) to address the recommendations made by the SAC1 review panel, Dr Gupta addressed two other issues in his report which I will now briefly summarise.

Medical review[377]

218. In his report, Dr Gupta said the policy relating to the medical review of patients admitted to mental health wards requires that patients are reviewed by a registrar or duty medical officer within two hours, and by a psychiatrist within 24 hours. In Petya's case, these requirements were met and as I have noted, she was reviewed by Dr Paul at 3.45 pm on 9 December 2020, and by Dr Choy at 9.30 am 10 December 2020.[378]

219. However, the medical review policy also requires that the frequency of subsequent medical reviews is to be determined "*based on presentation as discussed*". However, there is no evidence this occurred in Petya's case and this is clearly unsatisfactory. At the inquest, Dr Gupta (with whom Dr Choy and Dr Brett agreed)[379] said Petya should have been reviewed by a psychiatrist more frequently during her admission.[380] In my view Dr Gupta's concession is appropriate, especially given Petya's ongoing paranoia, her refusal to engage with clinical staff, and her persistent isolation in her room.

Risk assessment[381]

220. In his report, Dr Gupta noted that a PRA completed on the day of Petya's admission (9 December 2020), assessed her risk as "*high*". However, as Dr Gupta also noted, following the MDT meeting Petya's risk rating was reduced to "*low*" "*without any evident changes in* (Petya's) *mental state*".[382]

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376 Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), pp3-4
377 Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3
378 Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (3.45 pm, 09.12.20 & 9.30 pm, 10.12.20)
379 ts 07.02.24 (Gupta), pp232-233 & 186; ts 07.02.24 (Choy), pp182-183 & 186 and ts 07.02.24 (Brett), pp248-249
380 Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3
381 Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3
382 Exhibit 1, Vol. 1, Tab 28, Report - Dr V Gupta (25.01.24), p3

221. The updated PRA completed during the MDT meeting assesses Petya's risk of harm from others and her risk of harm to self and others as "*low*", with her impulsivity, risk of absconding, and "*psycho-social*" risk all assessed as "*moderate*".[383] However, there is nothing in the inpatient notes to justify the lowering of Petya's risk of harm to low, and it appears to have been largely based on the fact that during her admission, Petya had not expressed any suicidal ideation, nor had she made (or attempted) any act of self-harm.[384,385]

222. If this was the basis for the reassessment, it is problematic. Precisely because Petya remained paranoid and suspicious of clinical staff, her interactions with them were usually perfunctory and superficial. Indeed, none of the witnesses at the inquest claimed to have developed any therapeutic relationship with Petya, although Ms Janssen appears to have made more headway in this regard than anyone else.[386]

223. For reasons I have explained, Petya's most important support person (Mr Cizek) was not engaged in any meaningful way, and instead he remained the subject of unsubstantiated allegations about his interactions with his wife. Although Petya was reviewed by Dr Paul after the Code Black incident, she later had a verbal altercation with another patient, and these events may represent a deterioration in her mental state which was not fully appreciated at the time.[387]

224. In my view, given Petya's ongoing paranoia, suspiciousness, and isolation, it is surprising her risk rating was lowered without the benefit of a recent, comprehensive review by a psychiatrist. However, it is impossible to know whether Petya's clinical journey would have been any different had her risk rating been left at "*high*" and I note that she was subject to hourly "*observations*" during all her admission. Nevertheless, one possible impact of Petya's risk rating having been lowered to "*low*" may have been that she was viewed as less of a concern to staff and therefore received less attention in the context of a ward that was already full of high acuity patients.[388]

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[383] Exhibit 1, Vol. 1, Tab 19.1, BHS Integrated Progress Notes (3.45 pm, 09.12.20 & 9.30 pm, 10.12.20)
[384] ts 06.02.24 (Paul), p66
[385] At the inquest, Dr Brett said: "*Reading the file, it seemed if anything, (Petya's) risk had increased*": ts 07.02.24 (Brett), p251
[386] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p11
[387] ts 07.02.24 (Stevens), p214
[388] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p11

OBSERVATIONS BY DR BRETT

Overview[389]

225. Dr Adam Brett is an experienced consultant psychiatrist and at the Court's request, he conducted a review of the care provided to Petya while she was at BHS.[390] Dr Brett identified a number of issues related to Petya's care, many of which I have already referred to. However, I wanted to briefly touch on five issues raised by Dr Brett in his report.

Risk assessment[391]

226. In his report (and in his evidence at the inquest), Dr Brett identified issues with the Brief Risk Assessment tool (BRA), which was being used at the time of Petya's admission but which is no longer used at BHS, and the Progressive Risk Assessment tool (PRA), noting that:

> The…Brief Risk Assessment or the Progressive Risk Assessment is a very brief tick box which has no utility, no validity, and I think, really, services need to review how they're managing people's risk. So, again, I'm not blaming the clinicians. These are mandated tools which they've got to use, but it's the people who mandate them (that) need to review how we're managing people's risk.[392]

227. At the time Petya's self-harm risk was changed to "*low*" at the MDT meeting, her mental state had not altered significantly, and there is no evidence of the rationale for this change. Dr Brett made the following comment about risk management and therapeutic engagement:

> Maden[393] states that risk management begins not with checklists of risk factors and tables of statistics, but with a sense of caring about what happens to the patient when they walk out your door. He also states that risk assessment will never be an alternative to looking after the patient properly. Most risk assessment guides emphasise engagement as the key to risk management. There is limited evidence regarding the therapeutic engagement of (Petya).[394]

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[389] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23)
[390] Exhibit 1, Vol. 1, Tab 23.2, Letter of instruction - Counsel Assisting to Dr A Brett (02.06.23)
[391] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23)
[392] ts 07.02.24 (Brett), p269
[393] Professor Tony Maden, Emeritus Professor of Forensic Psychiatry, Imperial College London
[394] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p12 (para16)

228. In his statement, Dr Choy also expressed concerns about the BRA and the PRA, and said in his experience they were "*of limited clinical value*", and from a practical perspective, "*little turns on the outcome of these assessments*". Dr Choy said this was because: "*the capacity of a medical professional to assess risk, in a forward sense, is subject to multiple confounding factors*".[395,396]

229. I note that since Petya's death, the PRA sticker used at BHS has been amended and now includes "*more detail in the record of the assessment*".[397,398]

Medical reviews

230. Dr Brett found that during her admission Petya had not received an appropriate number of reviews by "*sufficiently senior psychiatric staff*". Dr Brett noted that only one consultant psychiatrist (Dr Choy) had made an entry in Petya's inpatient notes, and considered that Petya should have had daily reviews by the medical team, and at least thrice weekly reviews by her psychiatrist.[399] In his statement, Dr Choy said he agreed there had not been sufficient reviews by "*senior psychiatric staff*", and Dr Brett's observations about staffing levels on Ward 6 were "*reasonable*".[400,401]

Observations and engagement with staff

231. Dr Brett did not believe Petya had "*an appropriate level of observations during her admission*" and said this was "*less to do with the quantity but the quality*".[402] Dr Brett also noted that "*it appears (Petya) was seen for longer by the mental health advocate than by her medical team*", and Ms Janssen had "*collated a lot of useful information that would have been helpful for the treating team*" and had "*relayed her concerns to the treating team*" but these concerns do not appear to have "*been documented or acted upon*".[403]

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[395] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 100-102
[396] See also: Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), paras 168-169 & 174(d)
[397] Exhibit 1, Vol. 1, Tab 27, Statement - Dr D Stevens (16.01.24), para 131
[398] Exhibit 1, Vol. 1, Tab 27-DS.7, Progressive Risk Assessment sticker (amended)
[399] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p13 (para19)
[400] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), para 111
[401] Dr Paul also agreed with Dr Brett's comments, see: Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 174(f)
[402] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p12 (para18)
[403] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p11 (para 9)

232. As to Petya's engagement with staff, Dr Choy noted that on the day of her death, patients on Ward 6 were "*particularly acute*", and several needed nursing specials. Dr Choy also said: "*If a patient is more withdrawn and has minimal engagement by staff (as Petya did), it is expected that where staff are already stretched, engagement with that patient may reduce*".[404]

Ward acuity and staffing

233. Dr Brett considered that staffing levels on Ward 6 during Petya's admission were inadequate, and nursing staff: "*were busy with other patients due to acuity*". Dr Brett said Petya's care was impacted by the fact that she was managed by several consultant psychiatrists during her admission. As an example, Dr Brett noted when Ms Janssen approached Dr Harding on 14 December 2020 to convey Petya's EGA request, a decision was not made because Dr Harding did not know Petya.[405]

234. Dr Brett also said that allied health staff had minimal involvement in Petya's care. Although Dr Choy agreed he said: "*I suspect this is because (Petya) was simply not well enough to engage with them*". Although Petya had attended an occupational therapy session on 14 December 2020, Dr Choy noted she needed assistance with a simple craft task and this was "*abnormal for an adult person*".[406,407,408]

235. Dr Choy said: "*short of being a sympathetic ear*", he did not think it likely an occupational therapist or a social worker would have been able to assist Petya. Dr Choy said that in his experience, if an allied health worker had tried to engage with someone as unwell as Petya, "*the patient would have been distressed*". In any case, as Dr Choy noted, the capacity of allied health staff to engage with Petya "*at that level*" was minimal given that they were "*already over stretched*" seeing other patients on Ward 6.[409]

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[404] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 109
[405] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), pp13-14 (para 27)
[406] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), pp13-14 (para 27)
[407] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 82-83 & 87-88
[408] Exhibit 1, Vol. 1, Tab 24-WC8, BHS Integrated Progress Notes - Occupational Therapy (4.00 pm, 14.12.20)
[409] Exhibit 1, Vol. 1, Tab 24, Statement - Dr W Choy (16.01.24), paras 84-86

Failure to obtain collateral information

236. Dr Brett could find no comprehensive formulation about Petya in the inpatient notes, and said this should have included information about her childhood, how she came to Australia, things she enjoyed, and her "*pre-morbid functioning*". Dr Brett acknowledged Petya may have been too unwell to provide this information, but noted there was no evidence anyone had liaised with her GPs, and that engagement with Mr Cizek "*was inadequate*".[410]

237. Dr Brett also noted that: *"It seems that no-one obtained a comprehensive history from her husband, even though he regularly visited twice per day, bringing her food and requested a meeting with her treating team*".[411]

238. In his statement, Dr Paul referred to Dr Brett's comments about obtaining further information about Petya's background, and noted: "*I recall that we were still trying to obtain collateral information but that this had been difficult due to (Petya's) mental illness and* ***concerns of domestic abuse from her partner***".[412] [Emphasis added]

239. In my view, the difficulties Dr Paul identifies in obtaining collateral information from Mr Cizek, illustrate why the serious allegations that had been levelled against him should have been expeditiously investigated. The concerns about Mr Cizek had neither been substantiated nor refuted by the time of Petya's death, and this failure had the effect of limiting Mr Cizek's involvement in Petya's care. This is clearly very regrettable, and in my view it represents a missed opportunity to have potentially enhanced Petya's care.

[410] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p11 (para 8) & p13 (para 21)
[411] Exhibit 1, Vol. 1, Tab 23.1, Report - Dr A Brett (05.07.23), p11 (para 8)
[412] Exhibit 1, Vol. 1, Tab 25, Statement - Dr J Paul (16.01.24), para 174(b)

QUALITY OF SUPERVISION, TREATMENT AND CARE

240. I acknowledge the pressures which medical, nursing, and allied-health professionals working in mental health units in the public health system deal with on a daily basis. I also accept that too often inadequate facilities, insufficient staffing levels, and inflexibility in responding to increasing levels of patient acuity, hamper the efforts of these dedicated individuals to provide a quality service to mental health consumers.

241. I also acknowledge that many of these issues are systemic and of long-standing, and that resources (both human and financial) available to address the patently obvious deficiencies in the mental health system in Western Australia are often limited. I also accept that suicide is extremely difficult to predict, and that a person's suicidality (and therefore their risk of suicide) can fluctuate often on very short timeframes.

242. Nevertheless, for reasons I have outlined in this finding and after careful consideration of the available evidence, I have come to the conclusion that the supervision, treatment and care provided to Petya whilst she was an involuntary patient at BHS was inadequate. I have also identified a number of missed opportunities where, with the benefit of hindsight, Petya should have been provided with an enhanced level of care.

243. Given the imponderables in this case, I have been unable to make a finding, to the relevant standard, that Petya's clinical journey would necessarily have been different if her care had been escalated at any stage during her admission, and/or if she had been the subject of more frequent observations at any particular time.

244. Finally, I find the resuscitation efforts made by clinical staff after Petya was found hanging were appropriate. There is no evidence before me that the fact that Ward 6 did not have its own resuscitation trolley at the relevant time, and/or that a bag-valve mask device on that trolley was defective, had any significant impact on the efforts being made to revive Petya.

RECOMMENDATIONS

245. In light of the observations I have made in this finding, I make the following recommendations:

> **Recommendation No. 1**
>
> As a matter of the **utmost urgency** East Metropolitan Health Service should ensure that sufficient funding is made available so that remediation work to address all low, medium, and high ligature risks in its mental health facilities (identified during internal and external audits) is completed as **promptly** as possible.

> **Recommendation No. 2**
>
> East Metropolitan Health Service should take immediate steps to ensure that at all of its mental health facilities, clinicians assessing patients for possible admission have (at the time of that assessment) access to that patient's Mental Health Triage documentation, and any relevant outpatient notes, whether in hard copy or by way of an electronic medical record system.

> **Recommendation No. 3**
>
> East Metropolitan Health Service should review the current system of allocating two patients to each nurse working on Ward 6 at Bentley Hospital. The review should consider whether the current allocation is appropriate in all circumstances, and whether the available mechanisms to assess patient acuity are properly able to ensure that in each case, the nurse to patient allocations are correct.

246. At my request, Mr Stops (Counsel Assisting) sent a draft of my recommendations to all counsel by way of an email on 8 February 2024.[413] Feedback (if any) was requested no later than the close of business on 23 February 2024.

[413] Email - Mr W Stops to Ms J Lee, Mr I Murray, and Ms D Van Nellestijn (08.02.24)

247. By way of an email dated 13 February 2024, Ms Lee (counsel for Ms Finney and Ms King) advised that: "*The nurses are in complete agreement with the Coroner's draft recommendations and have no additional feedback to provide at this time*".[414]

248. By way of an email dated 14 February 2024, Mr Murray (counsel for Mr Cizek) advised that: "*Mr Cizek is very pleased with these proposed recommendations and has no suggested changes*".[415]

249. By way of an email dated 19 February 2024, Ms Van Nellestijn (counsel for EMHS and MHAS) sought an extension of one week within which to provide feedback because several key staff were on leave.[416,417] On that basis, I granted Ms Van Nellestijn's request and feedback was requested by close of business on 1 March 2024.

250. By way of an email dated 1 March 2024, Ms Van Nellestijn advised that MHAS did not have any feedback on the draft recommendations, but that EMHS's response was as follows:[418]

a. *Response to Recommendation 1:* Supported, subject to additional approved funding from Government.

EMHS advised that following Petya's death, funding had been obtained to replace doors in mental health units at BHS. A further request for funding in the 2022-2023 State Budget was made to address ligature risks identified in an independent risk audit. EMHS says that initially "*only partial funding*" was approved, and EMHS is focussing on "*the high risks in secure wards as the highest priority*".[419] Once this work is completed, EMHS says it "*will report back to Government seeking additional funding to address the remaining risks*".[420]

With great respect, for reasons I have explained, I remain of the view that the ligature risks identified by the audits conducted at BHS, should be remediated as a matter of urgency, and I repeat what I said earlier in this finding:

[414] Email - Ms J Lee to Mr W Stops (13.02.24)
[415] Email - Mr I Murray to Mr W Stops (14.02.24)
[416] Email - Ms D Van Nellestijn to Mr W Stops (19.02.24)
[417] Email - Mr W Stops to Ms D Van Nellestijn (19.02.24)
[418] Email - Ms D Van Nellestijn to Mr W Stops (01.03.24)
[419] EMHS response to draft recommendations (01.03.24)
[420] EMHS response to draft recommendations (01.03.24)

> **I therefore urge EMHS in the strongest possible terms, to immediately allocate the necessary funding so that all medium and low ligature risks identified by the external audit in its mental health facilities can be promptly undertaken and completed.**

b. *Response to Recommendation 2:* Not supported.

EMHS asserts that "*all patient information including mental health information is available in the patient medical record*" and that this includes the Mental Health Triage Form.

However, this assertion is contradicted by the evidence I heard from Dr Paul at the inquest,[421] and further, I note that the Digital Medical Record (which EMHS says enhances the "*visibility of the medical record*") is not currently "*live*" at all EMHS sites but "*will be rolled out to the remaining sites by end of 2024*".[422] For these reasons, despite EMHS's position, it remains my view that Recommendation 2 is appropriate.

c. *EMHS Response to Recommendation 3:* Supported.

EMHS noted that the allocation of two patients to each nurse on Ward 6 "*is the standard arrangement for the ward when all beds on the ward are occupied*". EMHS says that additional staff are allocated to Ward 6 when more than one patient is on 1:1 supervision, and further that:

> A state-wide review of nursing (and midwife) workloads, including patient ratios, is currently underway across the Department of Health".[423]

[421] ts 06.02.24 (Paul), p95
[422] EMHS response to draft recommendations (01.03.24)
[423] EMHS response to draft recommendations (01.03.24)

CONCLUSION

251. Petya was a much loved daughter, wife, sister, and friend who was 41-years of age when she died from ligature compression of the neck at BHS on 16 December 2020.

252. After carefully reviewing the available evidence, I concluded that aspects of Petya's supervision, treatment, and care whilst she was an involuntary patient at BHS were inadequate, and that with the benefit of hindsight, there were missed opportunities where Petya's care could potentially have been enhanced.

253. I arrived at these conclusions notwithstanding the unpredictability of suicide and the difficulties mental health staff face in managing the ever-changing risks of self-harm associated with some mental health illnesses.

254. I also determined that, in light of the imponderables in Petya's case, I was unable to conclude, to the relevant standard, that any particular action at any particular time would necessarily have prevented her death.

255. Nevertheless, I have made three recommendations which I hope will enhance the treatment provided to mental health consumers at BHS, and which I hope will be adopted. I remain gravely concerned with the slow progress being made to remediating the ligature risks identified in several audits, and I again implore EMHS to complete this work as a matter of the **utmost urgency**.

256. Finally, as I did at the conclusion of the inquest, I wish to again convey to Mr Cizek and Petya's family and loved ones, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
7 March 2024