JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA

ACT : CORONERS ACT 1996

CORONER : SARAH HELEN LINTON, DEPUTY STATE CORONER

HEARD : 8-10 September 2020

DELIVERED : 25 MARCH 2021

FILE NO/S : CORC 1430 of 2016

DECEASED : FJ

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

M N van Hattem (Sir Francis Burt Chambers) assisted the Coroner.
Mr E Cade (State Solicitor's Office) appeared on behalf of the East Metropolitan Health Services, the North Metropolitan Health Service and the DCP.
Ms N Naylor (Tottle Partners) appeared for Dr Samuel Febbo.
Mr A Willinge (AGS) appeared on behalf of the Department of Home Affairs.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of **FJ** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, from 8 September 2020 - 10 September 2020, find that the identity of the deceased person was **FJ** and that death occurred on 13 November 2016 at Unit 602/69 Leonard Street, Victoria Park, from multiple injuries in the following circumstances:*

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SUPPRESSION ORDER

The deceased's name is suppressed from publication. The deceased should be referred to as FJ and there should be no details published that might lead to the identification of FJ's child.

INTRODUCTION

1. FJ was born and raised in Iran. She obtained tertiary financial qualifications and later worked in finance. FJ was married in Iran but the marriage was troubled and eventually broke down. Coinciding with the end of her marriage, FJ suffered acute depression. While receiving treatment for depression, she was diagnosed with bipolar affective disorder and possibly schizophrenia. It seems that FJ continued to suffer from mental health issues from this time. Her family believed FJ's mental health was improving with medical treatment in Iran but she then decided to leave the country.[1]

2. In May 2012 FJ left Iran and travelled to Malaysia, ostensibly to study. The evidence indicates FJ left Malaysia and travelled to Indonesia without the knowledge of her family. From Indonesia, she made her way by boat to Australia and arrived in Australia as an unauthorised maritime arrival on 23 July 2012. FJ was held in immigration detention after her arrival in Australia, first on Christmas Island and then later in Perth.[2] FJ was originally in a relationship with a man who came to Australia with her, but the relationship was violent and she ended the relationship while still in detention.

3. Over the next few years, FJ had contact with various psychiatrists. In July 2014 FJ told her family back in Iran that she was pregnant, but she would not reveal the identity of the father.[3] FJ's mental health deteriorated significantly during her pregnancy. She was diagnosed with schizophrenia and became an involuntary patient at Bentley Hospital. In October 2014, FJ was transferred from Bentley Hospital to King Edward Memorial Hospital (KEMH), where she gave birth to a son. Concerns were raised about her ability to safely care for her baby. The Department for Child Protection and Family Support (as it then was)[4] became involved and eventually placed her son into foster care in late December 2014. FJ was released on a Community Treatment Order (CTO) with ongoing depot medication administered.

4. FJ's CTO was eventually revoked and she was reunited with her son in mid-2015. She remained living in community detention with her son until 31 May 2016, when they were both granted a Temporary Protection Visa. At the end of May 2016 FJ had a brief psychiatric admission to hospital and her son went into foster care again for a brief time, but this quickly resolved.

5. While in detention, FJ had been receiving psychiatric treatment from a private psychiatrist arranged through the Department of Immigration and Border Protection (DIBP)[5]. FJ had also been seeing a local general practitioner, Dr Max Bowater, since October 2015, who helped to coordinate her medical care. After FJ was granted a visa, her psychiatric care transferred from the Commonwealth to the State health system. FJ could not continue to see the same private psychiatrist as it was not funded. Dr Bowater made referrals for FJ to be seen by the local community mental

[1] Exhibit 1, Tab 11.
[2] Exhibit 1, Tab 11; Exhibit 2, Tab 14A.
[3] The father's identity has never been confirmed.
[4] Since 1 July 2017 the Department for Child Protection and Family Support has been part of the new DCP.
[5] The Department of Immigration and Border Protection was a department of the Government of Australia that was responsible for immigration, citizenship and border control. Since FJ's death this department has now been subsumed into the Department of Home Affairs.

health services instead, but there were issues with the referrals and FJ also indicated a reluctance to engage. As a result, FJ did not receive regular psychiatric treatment after May 2016.

6. FJ did have support from various agencies as she transitioned into the community, with support initially provided by the Australian Red Cross and then, from 8 June 2016, the support agency Life Without Barriers (LWB). LWB staff encouraged FJ to access other mental health and counselling services but she was resistant as she had been traumatised by her time as an involuntary patient.

7. Concerns were raised in late June 2016 about the safety of FJ's son while in her care. The Department of Child Protection and Family Support (DCP) for the purposes of this finding) investigated and a decision was made to take FJ's son into care at the end of June 2016. After her son was taken into care, FJ's mental health deteriorated and she eventually agreed to an admission to a psychiatric ward at RPH facilitated by a psychiatrist she had seen before, Dr Sam Febbo. FJ was admitted on 18 July 2016. However, it appears she was hoping that this admission would assist her to regain custody of her son. When it became apparent that the doctors would not write a letter supporting her custody application and she was told she could not see her son while in hospital, FJ discharged herself against medical advice. She was not referred to the Mirrabooka Clinic on discharge. An attempt was later made to refer her to the Clinic again but she declined to be referred. Therefore, FJ did not receive any specialist psychiatric care before her death.

8. FJ's community support agency changed from LWB to another agency, MAX Solutions, on 1 September 2016 as she was moving to complex case support since her immigration status had resolved. FJ initially had limited engagement with the staff from the new support agency although eventually it appears the case worker was able to establish some rapport. FJ continued to see her GP, Dr Bowater, with whom she had always had a supportive relationship. During her last consultation with Dr Bowater on 19 October 2016, FJ mentioned her distress at losing custody of her son. She indicated she was also experiencing financial distress. FJ was still taking her lithium medication at this time and she was given a repeat prescription before leaving. She did not see Dr Bowater again.

9. In October 2016 FJ indicated her intention to return to Iran and said she was willing to leave her son in Australia in the care of the DCP. Her family believe she loved her son and did not want to leave him, but she was frustrated by her treatment by the authorities and her mental health had deteriorated after her son was removed from her care for the second time, which affected her decision-making.[6] No final determination had been made about custody, as FJ had failed to attend the last court date, so it had been adjourned to 24 November 2016 to facilitate her attendance.

10. On 12 November 2016 FJ spent the day with her boyfriend. She was upset because of the problems she was experiencing with her son and with immigration. He attempted to support and reassure her. Her boyfriend left FJ at her unit at about

[6] Exhibit 1, Tab 11.

8.15 pm and he thought she was in a happier mood at that time. However, if she was, her mood changed soon after.

11. Just after midnight on 13 November 2016, FJ placed a chair against the wall of the balcony of her unit in Victoria Park, which was situated on the sixth floor of the building. FJ jumped from the balcony and landed on the ground below. She died from multiple injuries she sustained in the fall.

12. The circumstances of FJ's death were relatively clear in terms of the cause of death and the manner of death, although it was necessary to explore her psychiatric issues to ensure I was satisfied she had the capacity to form an intention to take her life.

13. An issue that arose in the coronial investigation was the difficulties faced in the transition of FJ's psychiatric care when she moved from community detention to a temporary protection visa. The change meant that FJ transitioned from being the responsibility of the Commonwealth into being an ordinary patient in the State health care system. FJ's General Practitioner, Dr Bowater, experienced great frustration as a medical practitioner trying to obtain psychiatric support for FJ once she left the federally funded private care.[7] Sadly, this is not uncommon for people suffering from mental health issues in Western Australia. Due to limited resources and increased demand, most public health psychiatric care is focussed on managing the acute cases, rather than providing ongoing psychiatric support to people with chronic mental health issues and prevent those people from deteriorating.

14. The issue of FJ's transition into the State health system was considered further at the inquest as to whether more could have been done to maintain continuity of her care. I noted at the conclusion of the inquest that the complexity of FJ's case was exacerbated by the involvement of so many different agencies, which hampered the ability of any one person to really connect with FJ and provide continuity in her care. The individuals involved were clearly well intentioned, but there were communication issues and also confusion as to the roles that people were expected to perform. FJ's GP, Dr Bowater, was her most constant caregiver, but he struggled to get the specialist support he required for FJ and lacked an understanding of who he should contact for assistance.

15. Just preparing for this inquest was a difficult exercise as it was necessary to try to ascertain which agencies had been involved with FJ and obtain reports from them individually. This put the various Departments and agencies, and their counsel, under considerable pressure to produce information at a late stage at the Court's request. I appreciate the efforts all involved made to produce what was requested in time for the inquest hearing. I understand through counsel that the DIBP, now Home Affairs, has on its own initiative indicated it will, in any future WA coronial investigations, provide a detailed report, setting out the chronology of the deceased person's journey through the immigration system, with input from the various support agencies. This will be of great assistance in helping the Court to understand what can be a complex system to those on the outside, and hopefully assist to narrow down the issues to be considered at inquest.

[7] Exhibit 1, Tab 17A.

16. The DCP has been of great assistance in providing what information it had access to in order to provide a more complete picture of FJ's case, although their focus was on the care of her son, who remains in Australia in the care of the DCP. I understand that FJ's son has remained in Australia and is doing well under the care of DCP.

17. Ultimately, I am satisfied that the various Commonwealth and State departments and their individual staff did their best to provide appropriate support to FJ in her transition into the Australian community. All agreed that her case was complex and challenging. Sadly, her complexities led to a decision to remove her son from her care for his safety. Although efforts were made to reassure FJ that there was a pathway back to being reunited with her son in the future, it appears she lost hope, resulting in her decision to take her life.

18. The evidence does reveal that there are ways the system could be improved to be of better support to people such as FJ, and I make some comments in that regard at the end of this finding.

RELEVANT BACKGROUND

19. As noted above, FJ had reportedly been diagnosed with bipolar affective disorder (BPAD) and possibly schizophrenia in Iran. She had been living separately from her husband for some time, although they were not formally divorced, and had felt isolated due to the stigma of being an 'unwanted' wife.[8] In May 2012, FJ left Iran and travelled to Malaysia. She told her family she intended to complete a three month study course there. FJ's family initially kept in contact with her by telephone and through the internet, but they then lost contact with her. The evidence indicates FJ left Malaysia around this time and travelled to Indonesia. From Indonesia, she made her way by boat to Australia and arrived in Australia as an unauthorised maritime arrival on 23 July 2012 on Christmas Island. She was detained under the *Migration Act* and was transferred to Perth Immigration Residential House on 21 August 2012.[9]

20. FJ had arrived in Australia with a male partner and initially they sought asylum as a couple. FJ made her first protection visa application as a dependent spouse of her partner on 12 November 2012 and they were granted a residence determination together to place them into community detention on 10 December 2012.[10] However, FJ's relationship ended following a domestic violence incident. On 12 January 2013 FJ presented to RPH after an alleged assault by her then partner.[11] FJ's mental health appeared to deteriorate thereafter in the context of being a victim of domestic violence.[12]

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[8] Exhibit 2, Tab 2, RPH Outpatient Case Notes, 6.3.2013, Transcultural MHC.
[9] Exhibit 2, Tab 14A.
[10] Exhibit 2, Tab 14A.
[11] Exhibit 2, Tab 2, RPH ED Case Notes.
[12] Exhibit 2, Tab 2, RPH Psychiatry Outpatient Case Notes, 6.3.2013, Transcultural MHS and Tab 14A.

21. FJ's Case Manager at the DIBP, Catherine Cheeseman, was notified by Red Cross of the domestic violence incident and assisted the Red Cross staff to find alternative accommodation for FJ so that she did not have to live with her abusive partner. This was the first time Ms Cheeseman met FJ, as her case had previously been managed by other case managers. Ms Cheeseman was a senior case manager and assistant manager in the WA Community Status Resolution Team, which provides a service for people whose immigration status is not yet resolved.[13] Ms Cheeseman remained FJ's case manager for the next few years and recalled it was a very complex case due to FJ's visa issues, her personal circumstances and her health issues.[14]

22. After separating from her partner, FJ had to withdraw her previous visa application and pursue an application for a protection visa on her own. Ms Cheeseman assisted her through this process, together with the help of a pro bono solicitor. They began the new visa process in April 2013. Ms Cheeseman recalled FJ was intelligent and knew what was happening, although she did need assistance.[15]

23. There is limited information about FJ's mental health in detention up until around the time of her pregnancy. FJ had contacted her family from detention and advised them she was in Perth, Western Australia. They have indicated they encouraged her to return to Iran.[16] It is clear that her family in Iran were concerned for her, given her known mental health issues.

24. Ms Cheeseman had a few meetings and telephone calls with FJ after she moved into her own accommodation and recalled FJ seemed quite settled despite the separation from her partner. Ms Cheeseman described FJ as an enthusiastic and happy person. However, she did later form some concerns that things were not quite right with her, given FJ seemed elevated or over-enthusiastic at times, so she asked the Red Cross staff if they could ensure her case worker kept an eye on her.[17]

25. FJ converted to Christianity in February 2013 and became a member of the Victory Life Church. Ms Cheeseman felt the church group was a good support network for her. FJ seemed happy and enjoyed attending church as she had made many friends there.[18]

26. FJ became a patient of the RPH Transcultural Mental Health Services from March 2013 for treatment of her ongoing mental health symptoms. She was referred to the service by the Red Cross and was noted to be an International Health and Medical Services (IHMS) client at the time, which is the medical service provider for the DIBP, as she was not eligible for Medicare while in detention.[19]

27. The association between FJ's recent deterioration at that time and the domestic violence was noted but there were concerns she was keen to associate the two and

[13] T 121.
[14] T 127.
[15] T 128; Exhibit 2, Tab 24.
[16] Exhibit 1, Tab 11; Exhibit 2, Tab 24.
[17] T 127; Exhibit 2, Tab 24.
[18] Exhibit 2, Tab 24.
[19] Exhibit 2, Tab 2, RPH Psychiatry Outpatient Case Notes, 6.3.2013, Transcultural MHS and Tab 24.

attribute her symptoms solely to the abusive relationship, which seems to have ended by April 2013.[20] FJ had expressed suicidal thoughts and unstable emotions and an impression of cluster B personality disorder (histrionic type) was formed by her treating psychiatrist, although the psychiatrist could not rule out BPAD, which remained one of the differential diagnoses. It was noted in a letter from her treating doctor, Dr Samani, to the DIBP that FJ's case worker at the Migration Support Program had raised concerns regarding FJ's safety if she was granted a bridging visa. They suggested that FJ was not a good candidate for such a visa due to her mental health vulnerabilities and FJ herself had expressed concern she was unlikely to get the higher levels of support she required on such a visa. Dr Samani believed that FJ was at chronic risk of self-harm, which could "exacerbate in acute stresses such as visa issues."[21] It appears FJ was requesting she be placed on a temporary protection visa, which did in fact later occur.[22]

28. In May/June 2013 FJ reported impulsive suicidal thoughts, including wanting to stab herself in the abdomen after her boyfriend had refused to marry her and broke up with her. She denied any active plan at the time of review.[23]

29. There had been ongoing issues with FJ refusing to take her prescribed lithium medication. She was commenced on another medication, quetiapine, on 9 July 2013[24] but reported at a psychiatric review on 27 August 2013 that she had not taken any as she did not believe in medications. She reported she had recently started psychotherapy with ASeTTS (Association for Services to Torture and Trauma Survivors).[25] FJ refused to start any regular medication but agreed to quetiapine being prescribed again, on an 'as needed' basis.[26]

30. FJ was reviewed again in October 2013 and reported she had stopped taking quetiapine. She was felt to be at low acute risk but her chronic risk, due to her underlying BPAD, was unchanged.[27]

31. FJ was discharged from the Transcultural Mental Health Service on 20 January 2014. Dr Samani, wrote to FJ's GP at the time, Dr Hany Ishak, to advise that he had reviewed FJ for six sessions from May 2013. She had not exhibited any evidence of manic symptoms during her reviews and although she reported fleeting suicidal ideation, she had no active plan. She had been commenced on quetiapine to control her anxiety, to which she responded well. She was referred back to her GP for ongoing management with advice that she could be transferred back to the service if she deteriorated.[28]

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[20] Exhibit 2, Tab 14A.
[21] Exhibit 2, Tab 2, Letter from Dr Samani to Dept of Immigration, 6.8.13.
[22] Exhibit 2, Tab 2, Letter from Dr Samani to Dept of Immigration, 6.8.13 and Psychiatry Outpatient Notes, Transcultural MHS and Tab 12.
[23] Exhibit 2, Tab 2, RPH Psychiatry Outpatient Case Notes, 24.5.13 & 24.6.13, Transcultural MHS.
[24] Appears to be wrongly dated as 9/7/16.
[25] Exhibit 2, Tab 2, Psychiatry Outpatient Notes, Transcultural MHS.
[26] Exhibit 2, Tab 2, Psychiatry Outpatient Notes, Transcultural MHS, 27.8.13.
[27] Exhibit 2, Tab 2, Psychiatry Outpatient Notes, Transcultural MHS, 15.10.13.
[28] Exhibit 2, Tab 2, Letter from Dr Samani to Dr Ishak, 20.1.14.

32. Around this time, at the beginning of January 2014, FJ fell pregnant. It doesn't seem the Transcultural Mental Health Service psychiatrist, Dr Samani, was aware of her pregnancy at the time of her discharge from the service. She had previously advised Dr Samani in October 2013 that she was not in a relationship.

33. On 22 July 2014 FJ was seen at Osborne Park Antenatal Clinic for her first antenatal appointment. She had previously failed to attend appointments on 25 June 2014 and 7 July 2014. FJ was quite far along in her pregnancy by this time, being approximately 25 weeks' pregnant.

34. On 28 July 2014 FJ was assessed at the RPH Emergency Department due to a manic episode. She was 26 weeks' pregnant at this time and did not disclose the identity of the father. She was reportedly facing ejection from Australia due to her failed refugee claim[29] and told doctors that she planned to return to Iran with her baby. Concerns had been raised by her Red Cross caseworker that FJ was exhibiting disinhibited behaviour (wearing increasingly revealing clothing and even walking around naked) screaming in public and other erratic behaviour that had led to complaints from her neighbours.[30] Her counsellor at the Association for Services to Torture and Trauma Survivors (ASeTTS) also confirmed FJ had been mildly inappropriate over the last six months and was using alcohol and neglecting herself and hoarding at home.[31]

35. FJ was medically cleared of any intracranial pathology and admitted as an involuntary psychiatric patient with the impression that she was experiencing a psychotic relapse. Notes were made of a possible intellectual impairment and cognitive difficulties related to alcohol use. FJ was referred on forms under the *Mental Health Act* to Bentley Hospital for further psychiatric review.[32]

INVOLUNTARY ADMISSION TO BENTLEY HOSPITAL

36. FJ was admitted to the locked ward at Bentley Hospital as an involuntary patient. She had referential thinking, mild thought disorder and a fatuous (childlike) affect. She was diagnosed with schizophrenia and commenced on the antipsychotic medication olanzapine.

37. For the last three months of her pregnancy FJ remained a psychiatric inpatient at Bentley Hospital and received antenatal care at King Edward Memorial Hospital (KEMH).

38. FJ reportedly absconded twice and required 'one to one' supervision on an open ward. Her dose of olanzapine was gradually increased in an effort to control her symptoms.

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[29] Her protection visa application had been refused on 13 December 2013 and the Refugee Review Tribunal affirmed the decision on 30 April 2014 – Exhibit 2, Tab 14A.
[30] Exhibit 1, Tab 6, p. 6.
[31] Exhibit 2, Tab 2, RPH ED Case Notes.
[32] Exhibit 2, Tab 2, RPH ED Case Notes.

39. Given FJ's known mental health issues, concerns had been raised during her pregnancy about her ability to care for a newborn child. Staff from KEMH notified the DCP of these concerns in August 2014. As FJ did not have a valid visa to stay in Australia, the DCP did not have full jurisdiction over the case, but they worked in cooperation with the DIBP. The DCP knew that FJ had complex mental health concerns and had been diagnosed with bipolar affective disorder. She demonstrated limited insight into her illness and this had an impact on her functioning. She had a history of not complying with her medication and refusing treatment, which raised concerns about her unborn baby's safety.[33]

40. Pre-birth planning was commenced in order to conduct an assessment of the future baby's safety and wellbeing so that a recommendation could be made to the DIBP for a care plan after the birth.[34]

41. On 14 August 2014 FJ was moved to an open ward and on 26 August 2014 FJ had a meeting with her DIBP caseworker, Ms Cheeseman. Prior to then, Ms Cheeseman had been kept informed of FJ's health issues through the Red Cross caseworker. At the meeting in August 2014 FJ told Ms Cheeseman she wanted to go back to Iran. This was the first time Ms Cheeseman could recall FJ ever mentioning wanting to return home.[35] Ms Cheeseman noted that FJ did not hold a visa for Australia at the time and she was within her rights to ask to go back to her home country, but FJ's medical practitioners raised concerns about her mental competency to make such a life changing decision at that time.[36] FJ had also contacted the International Organisation for Migration and had an understanding that it was a long process to return home, in any event.[37]

42. Ms Cheeseman met with FJ a few more times while she was at Bentley Hospital and FJ continued to express a desire to return to Iran. Ms Cheeseman attended some meetings with other DIBP officers to discuss the process of obtaining a passport for FJ to facilitate her return to Iran and the timeline in which that could occur, bearing in mind her pregnancy and fitness to travel. The Department also gave consideration to what travel documents might be required for her baby, in the event that she was unable to return home to Iran before the birth of her baby. In the end, the DIBP was told by FJ's doctors in September 2014 that she was not competent to make the decision to return to Iran and was not fit to travel due to the late stage of her pregnancy, so the matter did not progress.[38]

[33] Exhibit 1, Tab 7; Exhibit 2, Tab 12.
[34] Exhibit 1, Tab 7; Exhibit 2, Tab 12.
[35] T 129.
[36] T 129 – 130.
[37] T 130.
[38] Exhibit 2, Tab 14A and Tab 24.

BIRTH OF FJ'S SON

43. FJ was transferred to KEMH in preparation for the delivery of her baby on 27 October 2014. A form was completed on that day changing her status from an involuntary mental health patient to a voluntary mental health patient as it was felt she had improved sufficiently to trial voluntary management.[39]

44. The labour was complicated and FJ's son was eventually born via non-elective caesarean section on 30 October 2014. FJ's baby was classified as a non-citizen child pursuant to s 10 of the *Migration Act 1958* (Cth).[40] FJ and her baby were transferred to the Mother and Baby Unit (MBU) on 2 November 2014 for further monitoring and support. The MBU provides treatment for mothers with mental health issues in the late pregnancy and during the postnatal period.[41] FJ was referred to the unit as an involuntary patient due to a postpartum deterioration in her mental state

45. FJ showed a steady improvement in function and psychotic symptoms but continued to show no insight and maintained she was never unwell. She claimed her presentation was accounted for by the stress of being a refugee and the effect of her prolonged admission to Bentley Hospital. She also appeared opposed to the diagnosis of schizophrenia, partly due to the stigma of such a diagnosis in Iran. On 12 November 2014 FJ was commenced on depot antipsychotic medication due to concerns of non-compliance with her oral medications.[42]

46. In September/October 2014 the DIBP had undertaken an International Treaty Obligations Assessment to determine whether Australia owed her 'non-refoulement' obligations. At the time this process commenced her circumstances had changed, in particular due to the pregnancy and then birth of her son. It was relevant that FJ had given birth to an illegitimate child, which would have affected both their safety if they returned to Iran.[43] Accordingly, on 20 November 2014 the assessment found Australia did have non-refoulement obligations to FJ and her son, which meant that Australia could not involuntarily return FJ or her son to Iran without breaching its international obligations.[44]

47. Over time FJ's mental state continued to improve and she was reported to demonstrate reasonable care of her baby during a two week parenting assessment in early December. However, there were some issues with her compliance with safety directions. On 23 December 2014 she put her baby to bed in a manner contrary to SIDS safe sleeping policy and he overheated. This prompted MBU staff to move FJ's baby to sleep in the nursery, which caused her to become irritable. On 24 December 2014, the situation escalated and FJ initiated a serious incident, lasting more than 10 hours, in which she injured several members of staff and was consequently transferred to Graylands Hospital.[45]

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[39] Exhibit 2, Tab 19.
[40] Exhibit 2, Tab 12.
[41] Exhibit 1, Tab 7; Exhibit 2, Tab 19.
[42] Exhibit 2, Tab 19.
[43] T 130 – 131.
[44] Exhibit 2, Tab 14A and Tab 24, [32] – [33].
[45] Exhibit 2, Tab 20.

48. On presentation to Graylands FJ was teary, upset and uncooperative. She denied any thoughts of self-harm or harm to others but appeared insightless, with impaired judgment. She refused a physical examination. FJ was admitted to the secure ward and she gradually appeared more settled although she required persuading to take her oral medications as she did not believe she needed to take them. After eventually settling and showing no evidence of psychosis, FJ was transferred back to the MBU on 27 December 2014.[46]

49. As noted above, an assessment had found that FJ could not be involuntarily removed from Australia so Community Detention Operations had commenced planning for her discharge from hospital as she would require accommodation with space for herself and her baby.[47]

50. FJ's family have advised that on 6 January 2015 she requested a permanent stay visa from the Embassy of Iran so that she and her child could return to Iran but they believe FJ was not permitted to leave Australia.[48] She did also report to an IHMS psychiatrist that she wished to return to Iran to be supported by her family, but it appears she later changed her mind and indicated a desire to move with her baby to Sydney.[49] At that stage, as her son was not in her care, nothing could have progressed anyway.

51. On 7 January 2015 a large meeting took place with representatives from the hospital staff, medical staff, DCP staff and Ms Cheeseman from the DIBP. The MBU Psychiatric team were concerned that FJ was unable to give safe, ongoing care to her baby. The DCP shared their concerns. A decision was made at the end of the meeting that FJ's son would need to be removed from her care and placed in foster care upon discharge.

52. Ms Cheeseman was notified during the meeting that the Minister had intervened to revoke FJ's residence determination due to the prior incident at the hospital. This meant she would be discharged from hospital to a detention centre or facility rather than residential detention in the community.[50] Ms Cheeseman recalls that this decision "was one of the worst things I have ever had to tell someone,"[51] particularly as it followed FJ being told she would not be able to take her baby with her. Ms Cheeseman explained FJ had gone from thinking she was going home from hospital with her baby to her apartment, to having her child removed from her care and having to go into far more restrictive housing and give up her apartment. After Ms Cheeseman told FJ she was going back to the Perth Immigration Residential Housing (PIRH), where she had been before. Ms Cheeseman then left the room so FJ could say goodbye to her son.[52]

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[46] Exhibit 2, Tab 23A.
[47] Exhibit 2, Tab 24.
[48] Exhibit 1, Tab 11.
[49] Exhibit 2, Tab 18.
[50] T 132; Exhibit 2, Tab 24.
[51] Exhibit 2, Tab 24, [44].
[52] T 134; Exhibit 2, Tab 24.

53. FJ's baby son was subsequently transferred into foster care, with supervised visits coordinated by the Save the Children organisation for a period of nine months in total.[53]

54. FJ was discharged from the MBU on 8 January 2015 and was returned to detention in PIRH, where she had been housed not long after she first arrived in Australia.[54] Ms Cheeseman visited FJ after she had settled back in to PIRH. She was aware FJ was being supported by a mental health nurse attached to PIRH since her arrival and Serco officers provided general support.[55] In addition, Ms Cheeseman visited FJ several times and also spoke to her on the telephone. Ms Cheeseman recalls one conversation when FJ made a comment "that she was never going to get out of here and would leave in a box."[56] She then said she didn't mean it and just wanted to get her baby back. Ms Cheeseman contacted Serco and told them about the conversation and asked them to make sure they keep an eye on her, although she had been surprised by the conversation as FJ had appeared settled.[57]

55. Ms Cheeseman also kept in regular contact with MercyCare, the service provider for the foster arrangements for FJ's son, to arrange for FJ to have regular contact visits. FJ had supervised visits with her son three days a week for a couple of hours.[58] Ms Cheeseman attended a few of these visits, once in order to supervise the visit as no one else was available, even though it was not her designated role. Ms Cheeseman recalled FJ would be understandably upset when she had to return her son at the end of each visit. FJ's visits with her son were gradually increased and IHMS helped to arrange some parenting training sessions to help improve her parenting skills.[59]

56. During this time FJ was still telling the DIBP that she wanted to return home so Ms Cheeseman and other staff were looking at what was involved in getting FJ and her son back to Iran. One complication was that her son's birth certificate did not list his father's name and the paperwork for returning to Iran required information about the paternity of the child and details of the father's line. This problem was discussed with FJ. Conversations were also had with FJ's family in Iran to ascertain what help they could provide to assist her with getting the relevant documents and what support they could provide if she returned home. Unfortunately, FJ's family were said by the Department staff to not be very supportive of assisting her to return home. FJ had also spoken to family members back home and she told Ms Cheeseman she was upset that they were not supportive of her returning home.[60]

57. FJ was on a CTO under the care of Consultant Psychiatrist Dr James Baker at the Bentley Mental Health Clinic with ongoing depot medication. FJ's depot dose had to be decreased on 21 January 2015 due to Parkinsonian side effects.

[53] Exhibit 1, Tab 7.
[54] Exhibit 2, Tab 14A.
[55] Exhibit 2, Tab 24.
[56] Exhibit 2, Tab 24, [50].
[57] T 135; Exhibit 2, Tab 24.
[58] Exhibit 2, Tab 18.
[59] Exhibit 2, Tab 24.
[60] T 137; Exhibit 2, Tab 24.

58. FJ was reviewed by IHMS Psychiatrist Dr Christine McDonald on 23 January 2015 and was diagnosed with schizophrenia (undifferentiated) with a differential diagnosis of BPAD. Dr McDonald recommended ongoing reunification with her son, continuation of her CTO at Bentley and that consideration be given to allowing FJ to return to Iran.[61]

59. On 30 January 2015 the DCP informed the DIBP that it had investigated and substantiated that it was more likely than not that FJ's son would have been physically harmed and neglected if he remained in her care. FJ's son remained in foster care arranged by MercyCare. FJ was allowed supervised contact with her son. FJ did not have a visa and was being held in immigration detention, residing in immigration residential housing. She continued to receive healthcare through IHMS.[62]

60. FJ was regularly seen by Dr Baker at the Bentley Mental Health Clinic and continued on depot medication. On 25 March 2015 Dr Baker wrote a report in relation to the upcoming Mental Health Review Board hearing for FJ. Dr Baker noted there was strong support from her Bentley admission for the diagnosis of schizophrenia. FJ did not display any insight into her illness but despite this he had revoked the CTO in an effort to treat her on a voluntary basis as he perceived that "the distress of her involuntary status (together with her ongoing detention) was a risk factor for an early relapse."[63] Unfortunately, FJ refused to accept treatment, so Dr Baker had no option but to resort again to involuntary treatment on a CTO, although he was concerned this might result in the continuation of her detention and delay in any decisions by the DCP about future access and care of her baby. Dr Baker planned to revoke the CTO as soon as there appeared to be a reasonable prospect of FJ adhering to her medication regime.[64]

61. On 7 April 2015 Dr Baker received a report from an IHMS staff member that FJ had made verbal threats to Serco staff and refused to get out of bed when her baby arrived, which was obviously very concerning. She was also resistant to taking her medications. Dr Baker felt FJ's behaviour indicated her frustration with her situation rather than a relapse into psychosis. Dr Baker suggested starting FJ on lithium.[65]

62. In May 2015 Dr Baker reviewed FJ again and found no hint of relapse of psychosis or signs she was clinically depressed. He noted she was intolerant of the antipsychotic medications aripiprazole and olanzapine and changed her antipsychotic medication to zuclopenthixol, which she would take in addition to her quetiapine and lithium. Her CTO and associated depot medications were ceased as she appeared to be cooperative with her medication regime.[66] FJ indicated to Dr Baker she did not want to return to Iran but was keen to move to Sydney, where she had more support. FJ's lawyer later advised that her refugee status had been accepted, she was awaiting a visa and there was a plan to reunite FJ with her baby son.

[61] Exhibit 2, Tab 18.
[62] Exhibit 2, Tab 12.
[63] Exhibit 2, Tab 17B.
[64] Exhibit 2, Tab 17B.
[65] Exhibit 2, Tab 17C.
[66] Exhibit 2, Tab 17D.

63. On 1 July 2015 the Minister intervened and signed a residence determination for FJ and on 2 July 2015 she was released into community detention again. Ms Cheeseman met with FJ and assisted with her transfer to the community detention property. She went back to being managed by the Australian Red Cross because she knew them well and Ms Cheeseman believed it was a smooth transition. Ms Cheeseman saw FJ a few times at her unit and phoned her as well, and it appeared to her that FJ was happy and managing well although she still had a few things to do with her visa. FJ appeared to have some good friends who helped her and looked after her. Her main aim remained to get her son back in her care and she continued working with Ms Katherine Webster, a very experienced Family Nurse Practitioner at Webster's Health Care Services (Webster Kids), on her mothercrafting and parenting skills to move towards this goal.[67]

64. On 24 July 2015 FJ withdrew her request to be removed from Australia. Ms Cheeseman recalled that FJ was aware at the time that there was a possibility she would be granted a protection visa.[68]

65. FJ was discharged from the Bentley Mental Health Clinic on 27 July 2015 after remaining stable with no signs of relapse. A letter was sent to her GP at DR7 Medical Centre in Yokine for follow up. In the letter, Dr Baker, noted that the,[69]

> *extreme stresses of detention, pregnancy and single parenthood together with isolation from her family and supports in a strange country with an unfamiliar language and lack of resolution of visa issues appeared to have precipitated her illness.*

66. It was noted by Dr Baker that FJ had become much more settled following transfer to community accommodation and she seemed to be coping well and was stable on lithium treatment. Dr Baker did not consider FJ needed to transfer to another specialist service at that time.[70]

67. Ms Katherine Webster had been helping FJ with learning parenting skills and she conducted an assessment of FJ's mental health, development of parenting capacity and attachment building with her baby in late September and early October 2015 to develop a management plan. This assessment appears to have taken place over a two week period. It was noted that at the time of the assessment FJ had no psychiatric input as she had been discharged from Bentley and comment was made that monitoring her mental state, due to her being a sole parent for her baby, was imperative. It was recommended that IHMS complete a referral to a psychiatrist for three monthly sessions. Ms Webster suggested the involvement of MercyCare Home visiting and child care services to monitor FJ's son's wellbeing when her visa status changed. Ms Webster also recommended that FJ see the same GP as her son, namely Dr Max Bowater at the Victoria Medical Group.[71]

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[67] T 138; Exhibit 2, Tab 14A and Tab 24.
[68] T 138; Exhibit 2, Tab 14A and Tab 24, [64].
[69] Exhibit 2, Tab 17A.
[70] Exhibit 2, Tab 17.
[71] Exhibit 1, Tab 19B.

68. Dr Bowater had recently returned to general practice part-time at the Victoria Medical Group in East Victoria Park and had been approached earlier in the year by Ms Webster to ask him to consider looking after the needs of FJ's son, DJ, who was in foster care at the time. He had reviewed the documentation and case history and agreed to look after DJ's medical care. Dr Bowater saw DJ for the first time in the company of his foster mother on 28 April 2015.[72]

CARE IN LATE 2015 AND EARLY 2016

69. FJ and her son both came under the care of Dr Bowater on 21 October 2015.[73] A Signs of Safety Plan for mother and son identified Dr Bowater's role as including assessing FJ's son for signs of neglect, monitoring his weight, monitoring FJ's mental health status, particularly for signs of elevation or depression and assisting her with contraception as she was at high risk of relapse of her bipolar disorder if pregnant.[74] An Australian Red Cross Support Worker and a psychiatrist, Dr Julia Feutrill, were also part of the 'signs of safety' support network.

70. During 21 October 2015 Dr Bowater recalls FJ being concerned about her weight gain following the birth of her son, so they discussed weight reduction options. Following that appointment, Dr Bowater referred FJ to Consultant Psychiatrist Dr Sam Febbo for an opinion and management of her psychiatric disorder, as she had seen him previously at the Transcultural Mental Health Service in 2013. Dr Bowater explained at the inquest that he knew "nothing about the politics of community detention"[75] and had been given no information about what community detention involved. He only found out the relevant processes as he cared for FJ and DJ and said he felt he was working largely outside the system, particularly at the start, and attributed that to the fact that he had become involved in an unusual way. As he was not a doctor who regularly worked with IHMS at that time, Dr Bowater was unaware initially of the types of supports available, so he said he simply approached a specialist he knew FJ had seen before, being Dr Febbo. Dr Febbo reports he did not receive the referral as it was addressed to his old rooms.[76]

71. After this attempted referral to Dr Febbo, Dr Bowater had an email discussion with FJ's Red Cross case worker and he then wrote to the Red Cross case worker and IHMS and requested that IHMS negotiate with Dr Febbo so that he could continue follow up with FJ and stabilise her psychiatric condition.[77] Ms Webster had emailed Dr Bowater on 5 November 2015 to indicate that FJ would be managed by a private practitioner at the Elizabeth Clinic, a private clinic, and then, if she required hospitalisation, it would be facilitated by Dr Febbo at RPH.[78]

[72] T 12.
[73] Exhibit 1, Tab 17A, Letter dated 19 August 2016.
[74] Exhibit 1, Tab 17B, Signs of Safety Plan, unsigned copy, 19.11.15.
[75] T 13.
[76] T 13, 27; Exhibit 2, Tab 16.
[77] Exhibit 1, Tab 17, Letter from Dr Bowater to Red Cross and IHMS, 27.10.15.
[78] Exhibit 4.

72. Dr Bowater's request was declined and he was told he must refer to a different psychiatrist.[79] On 12 November 2015 Dr Bowater referred FJ to another psychiatrist, Dr Aleksandar Janca at the Elizabeth Clinic for an opinion and management. This was on the instruction of IHMS.[80] There is no record FJ was ever seen by Dr Janca.

73. In the end, on 11 February 2016 Dr Feutrill, who is a Perinatal and Infant Mental Health Specialist based at the Elizabeth Clinic in Perth, met with FJ after being requested by IHMS to provide regular psychiatric care for FJ while she was in detention on a three monthly basis. I note Ms Webster had actually suggested Dr Feutrill as an appropriate referral back in November 2015.[81] At the time Dr Feutrill reviewed her, FJ denied any episodes of hospitalisation or periods of risky behaviour, although Dr Feutrill was aware FJ had already had two periods of hospitalisation in Australia. When asked to explain the reason for these admissions, FJ was unable to do so although she did talk of distress she experienced during them. Dr Feutrill believed FJ was quite traumatised by her hospital admissions and had some symptoms suggestive of Post-Traumatic Stress Disorder, although she did not fully meet the criteria.[82]

74. During the assessment on 11 February 2016 FJ had no active symptoms of mood disturbances or psychosis but she did have some paranoid ideas about police and mental health services, which reflected her recent traumatic experiences. Her insight into her illness was poor and it appeared she complied with her treatment only to avoid further conflict with police. Dr Feutrill felt FJ enjoyed her son but did sometimes find the responsibility exhausting. He was in day care five days a week and FJ spent a lot of her time at the gym. It was noted she was in a relationship with a fellow Iranian man who had a job and residency, and also had one or two other friends.

75. Dr Feutrill's mental health plan for FJ at that stage, as communicated to Dr Bowater, was for her to continue her lithium on her current dosage, consider medical and psychological management of her trauma related anxiety and arrange ongoing support and monitoring of the parenting relationship between FJ and her son. Dr Feutrill recommended there should be a rapid response to relapse, with immediate referral to the community mental health services or an emergency department. Dr Feutrill proposed three or six monthly psychiatric reviews and suggested she could facilitate parenting support through the Elizabeth Clinic, if required.[83] Dr Bowater described Dr Feutrill as "fantastically supportive,"[84] and he was very happy with her plan.

76. On 24 February 2016 Dr Bowater referred FJ to the Osborne Park Older Adult Mental Health Services via a letter, which was received by fax on 25 February 2016. Dr Bowater sought an opinion and management of FJ's ongoing mental health needs, and the referral included a letter from Dr Feutrill.

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[79] T 14,
[80] Exhibit 1, Tab 17, Letter from Dr Bowater to Dr Aleksander Janca, 12.11.15.
[81] Exhibit 4.
[82] Exhibit 1, Tab 19A, Letter from Dr Feutrill to Dr Bowater, 11.2.16.
[83] Exhibit 1, Tab 19A, Letter from Dr Feutrill to Dr Bowater, 11.2.16.
[84] T 14.

77. The referral was reviewed by the Triage Officer of the service on the day the fax was received, namely 25 February 2016. A decision was apparently made not to progress the referral by the service at that time as FJ's mental state was currently stable and she was said to have several established support systems already in place, including through:

- International Health and Medical Services (IHMS), the medical contractor for the DIBP, with the understanding that Dr Feutrill had been asked to provide regular psychiatric care on a three monthly basis,
- the DIBP,
- her Case Manager from Red Cross,
- Life Without Barriers, and
- Dr Bowater.[85]

78. The Triage Officer telephoned Dr Bowater on 25 February 2016 and advised him of the outcome of the referral (namely that it would not progress) and that if FJ's mental state deteriorated in the future, then she should be referred to the Mirrabooka Clinic.[86]

79. On 3 May 2016 Dr Bowater and Dr Feutrill participated in a teleconference meeting with DIBP staff, Department of Social Services staff, Australian Red Cross staff, IHMS staff, the manager of the Child Care Centre providing care to FJ's son and the local child health nurse who looked after FJ's son. The meeting was held to address the concerns raised by a Red Cross worker about the care of FJ's son and to ensure that appropriate supports were put in place for FJ's planned transition on to a visa. Dr Bowater noted there were approximately 20 people involved in the teleconference, which he considered best illustrated how complicated the coordination of FJ's care was at the time.[87]

80. At the conclusion of the meeting it was noted that overall FJ and her son were doing well, although Red Cross staff still held concerns. It was clear that "ongoing specialised support and a thorough transition plan would be essential to the family's future wellbeing."[88] A planned referral to the Community Mental Health Team was discussed as an action item at the time but evidence was given at the inquest by the then head of the service of the relevant clinic, Dr Samir Heble, that he would have attended such a planning conference if he was invited.[89] It is unclear why this was not considered at the time. In hindsight it may have assisted.

81. Dr Feutrill wrote to Dr Bowater on 13 May 2016 with an update on her recent contact with FJ. She had been previously asked by IHMS to review FJ with regards to her medication after her discharge from Bentley Mental Health Service in August 2015. On her review on 12 May 2016, FJ appeared psychiatrically well but was complaining about diarrhoea that she attributed to her lithium, although Dr Feutrill

[85] Exhibit 1, Tab 8 [3] and Attachment 1.
[86] Exhibit 1, Tab 8 [3] and Attachment 1.
[87] T 13.
[88] Exhibit 1, Tab 17C, Jahani Family Teleconference, 3.5.16.
[89] T 92.

believed it was more likely related to gastroenteritis. Dr Feutrill expressed some concern that FJ denied having BPAD, which demonstrated a lack of insight into her illness, although she did indicate she would continue to comply with her lithium. She requested a reduction in her lithium dose, which Dr Feutrill felt was reasonable given her stability and the wisdom in keeping her dose as low as necessary. Dr Feutrill arranged for a pathology request, with the result to be sent to Dr Bowater.[90]

82. Dr Feutrill flagged with Dr Bowater in her letter the likelihood that FJ would be moving out of detention soon and would then no longer have access to Red Cross or IHMS funding and Dr Feutrill would no longer be able to see her. Dr Feutrill indicated she had thought that the community mental health services would be most helpful but then noted that it was unlikely they would take FJ without a relapse in her illness. Dr Feutrill stated she was unsure what would happen next for FJ, but indicated she was happy to assist in making referrals to services or to see her again, if necessary.[91]

83. On 23 May 2016 Dr Feutrill provided a report to the DIBP in anticipation of FJ leaving Federal care. Dr Feutrill advised that she had seen FJ on two occasions, for an hour each time, without an interpreter. Dr Feutrill also had access to two Mental Health Review Board Reports dated 25 March 2015 and 14 April 2015, correspondence from Consultant Psychiatrist Dr James Baker, Reports from Webster Kids and a Report from Consultant Psychiatrist Dr Mojdeh Bassiri.[92]

84. Based upon her own clinical assessment and the additional information available to her, Dr Feutrill expressed the opinion that FJ’s likely diagnosis was one of BPAD with a differential of schizoaffective disorder. Her condition had appeared in the past to respond well to lithium therapy. FJ’s relapse in the context of her pregnancy was severe but since her discharge from hospital she had made steady progress to recovery and in her current state she appeared to be without abnormal mood or psychotic symptoms. She did, however, exhibit significant anxiety symptoms secondary to traumatic experiences related to her psychotic episode.[93]

85. As noted to Dr Bowater, Dr Feutrill’s most significant concern remained FJ’s lack of insight into her illness. FJ was adamant that she no longer needed the lithium and could explain away all her behaviours and experiences in a way that negated any diagnosis of BPAD. She reported that she took the lithium ‘only to keep herself out of trouble’. Dr Feutrill stated it was difficult to assess FJ’s parenting of her son but she seemed to have an adequate understanding of his basic needs, including the emotional and developmental needs of a young child. Dr Feutrill sensed an “undercurrent of ambivalence” towards her son, given the unplanned nature of the pregnancy and the apparent negative relationship with the father of her son, but Dr Feutrill also noted FJ appeared to delight in her son and was invested in his wellbeing.[94]

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[90] Exhibit 1, Tab 19A, Letter of Dr Feutrill, 13.5.16.
[91] Exhibit 1, Tab 19A, Letter of Dr Feutrill, 13.5.16.
[92] Exhibit 1, Tab 19A, Letter of Dr Feutrill, 23.5.16.
[93] Exhibit 1, Tab 19A, Letter of Dr Feutrill, 23.5.16.
[94] Exhibit 1, Tab 19A, Letter of Dr Feutrill, 23.5.16.

86. Dr Feutrill summarised the position at that time as being that FJ had a serious mental illness that would almost certainly relapse without medication, which would present significant risk to her wellbeing and her parenting, and could happen suddenly. Interestingly, Dr Feutrill noted that unfortunately, "public mental health services are increasingly crisis driven"[95] and FJ was discharged from a community mental health service over a year ago and it was unlikely she would have access to such care while she remained well. A rapid referral to the acute services would, therefore, be necessary in the case of a relapse. Dr Feutrill suggested that FJ would need good community supports, who would need to be aware of the possible early warning signs for her illness, and she would need to have her blood levels checked by a GP. The main difficulty predicted was FJ's lack of insight and possible resistance to the need for ongoing medication.[96]

TRANSITION TO STATE HEALTH SYSTEM

87. On 31 May 2016 the Minister intervened under the *Migration Act 1958* to grant FJ and her son a Temporary Protection visa. FJ was released from community detention on the temporary protection visa. Once FJ's visa was granted, her medical care transferred from IHMS to Medicare and her care by Dr Feutrill came to an end.[97]

88. Also on 31 May 2016, the DCP received concerns from Red Cross staff pertaining to alleged physical abuse of FJ's now 18 month old son. Child Care Centre staff had raised concerns about bruises and scratch marks.[98] Red Cross staff advised that they had seen FJ screaming at her son, telling him she did not think he was her child. It appeared she could no longer safely care for her son and there were concerns she may harm him. WA Police were contacted about the safety concerns for the child and FJ was taken by ambulance to Sir Charles Gairdner Hospital for psychiatric assessment. Ms Cheeseman sat with FJ until the police arrived then drove the Red Cross case worker to SCGH at the same time FJ was taken to SCGH by police. Ms Cheeseman also called a friend of FJ, Ali, and asked him to come to the hospital to support FJ.[99]

89. FJ was seen at 2.26 pm on 31 May 2016 by a Psychiatric Liaison Nurse (PLN). She was noted to be suicidal and homicidal towards her baby and others. She had allegedly stated she wanted everyone dead and to be allowed to kill herself. It was noted she was a refugee from Iran and was at risk of deportation from Australia. Unexplained bruises had allegedly been seen on FJ's son approximately one week prior. Red Cross staff and DIBP staff were present during the assessment and had FJ's son in their care. A note was made that FJ had been experiencing abdominal issues, including diarrhoea, which may have affected her lithium levels. She had last had her levels checked the week prior by her GP Dr Bowater.[100]

[95] Exhibit 1, Tab 19A, Letter of Dr Feutrill, 23.5.16.
[96] Exhibit 1, Tab 19A, Letter of Dr Feutrill, 23.5.16.
[97] Exhibit 2, Tab 14A and Tab 24.
[98] Exhibit 1, Tab 7; Exhibit 2, Tab 3, Mental Health Triage Form.
[99] T 140.
[100] Exhibit 2, Tab 3, ED Continuation Notes, 31.5.2016.

90. The PLN recorded that FJ had no insight (underscored) at the time of review. She was tearful and asking to be allowed to die or kill herself. The impression was that she was acutely suicidal and homicidal. A plan was formulated to take bloods to check her lithium level and it was noted she might need to be considered for involuntary admission as she was not eager to stay in the hospital. She was placed on forms for psychiatric review.

91. She was reviewed by a Psychiatric Registrar, Dr Harprabhdeep, who noted that FJ was very distressed about the scrutiny by police and immigration authorities. She indicated she wanted to go back to Iran and to give her son away to anyone/the DCP. She reported that she had never felt happy and wished she was dead. FJ admitted feeling angry and upset all the time, particularly in relation to the fact she believed she did not have a visa (although it had in fact been granted at this time). FJ was unable to guarantee her safety and reported she hated hospitals and resented being psychiatrically reviewed. The Registrar completed a hospital transport order form for FJ to be taken to Graylands Hospital for psychiatric review on the recommendation of the on call Consultant Psychiatrist Dr Sewell.[101] A 'nurse special' was initiated, so that she was supervised by a nurse one to one prior to her transfer.[102]

92. The next notation is by a Senior Social Worker, Ms Joanne Willox, who recorded that FJ's son had been taken into care by the DCP, but this had then been revoked as he was under the guardianship of the DIBP. FJ's son was initially placed in foster care organised by the hospital. The DIBP supported the DCP assessment that FJ's son was unsafe and they funded his placement with Wanslea Family Services carers. FJ's son was taken to Wanslea for a temporary foster placement.[103]

93. The Transport Order was revoked by Consultant Psychiatrist Dr Ann Solar at 10.50 am on 1 June 2016. Dr Solar interviewed FJ at Graylands Hospital and believed she was a reliable historian and she was making a reasoned choice to return to Tehran to be with her family. FJ also admitted she had experienced difficulties bonding with her son and apparently seemed accepting of her son being in the care of authorities. They discussed her medication and the fact that she had a good relationship with a supportive GP. Dr Solar noted FJ was pleasant and appropriate and she did not exhibit any suicidal or homicidal ideation. Contrary to the PLN's assessment, Dr Solar believed FJ had insight and judgment and the capacity to make a choice as to her treatment. Therefore, Dr Solar revoked the forms signed by Dr Harprabhdeep and indicated FJ could be discharged.[104]

94. FJ was discharged from hospital at 10.30 am and was collected by a Red Cross case worker. A fax was sent to Dr Bowater in relation to the hospital presentation, although I note the contents of the form are not very illuminating about what led to the presentation and what occurred at the hospital.[105]

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[101] Exhibit 2, Tab 3, Form 4A, 31.5.2016 and Mental Health Triage Form.
[102] Exhibit 2, Tab 3, ED Continuation Notes, 31.5.2016.
[103] Exhibit 1, Tab 7.
[104] Exhibit 2, Tab 3, ED Continuation Notes, 1.6.2016.
[105] Exhibit 2, Tab 3, SCGH ED Discharge Summary, 1.6.16.

95. Dr Solar informed Ms Willox, the hospital social worker, that FJ was 'off forms' and it was felt that her BPAD was relatively well controlled with medication. She was cleared for discharge. Ms Willox made a note that FJ was well supported by the Red Cross and the DIBP in relation to her son and there was no further role for the hospital's social work department.[106]

96. On 3 June 2016, Dr Feutrill advised the DCP that FJ would need to transition to community mental health care given she was no longer eligible for DIBP funding. Dr Feutrill advised she could complete a referral for a community mental health service. This had already been done by Dr Bowater at Dr Feutrill's suggestion,[107] and Mirrabooka Clinic had apparently accepted the referral. The DCP has noted in its report that there is no record that the referral resulted in engagement with the service.[108] Dr Feutrill also noted that FJ had recorded high levels of lithium.[109]

97. Dr Feutrill emailed Dr Bowater the same day and referred to FJ's assessment at Sir Charles Gairdner Hospital. Dr Feutrill noted that it seemed FJ's BPAD remained stable and her alleged behaviour was more likely related to her personality style and the traumatic experiences she had had over the last couple of years. Dr Feutrill noted that FJ's lithium level recorded on 24 May 2016 was very high and, at that level, universally toxic, so further investigation needed to be carried out.[110] Dr Bowater later reduced the doses as FJ had stated that she felt sick from taking too much lithium and her blood levels confirmed this was the case. After reducing the dose, she said she felt much better.[111]

98. FJ had been living at a property funded by the DIBP and was being supported by the Australian Red Cross until she and her son were granted temporary protection visas. This change in status led to changes in the supports she was offered as well as her medical care, as a visa holder lives freely in the community and accesses services in the same way an ordinary citizen would.[112]

99. Transitional support services are offered by DIBP in certain cases to meet the short-term needs of recipients as they exit held detention to integrate into the Australian community when they have never previously lived in the Australian community. FJ was placed on Band 4 of the DIBP Status Resolution Support Services (SRSS) Programme to assist her with establishing various linkages as she transitioned into the community. She was granted the maximum of 12 weeks SRSS, commencing on 10 June 2016. On 8 June 2016 FJ transferred from Australian Red Cross to Life LWB to receive the SRSS.[113]

100. LWB is a national provider of social services, including SRSS to refugees and asylum seekers who are living in the Australian community while their immigration status is resolved. The services provided by LWB depend on each individual contract

[106] Exhibit 2, Tab 3, ED Continuation Notes, 31.5.2016.
[107] T 15.
[108] Exhibit 1, Tab 7.
[109] Exhibit 1, Tab 7.
[110] Exhibit 1, Tab 17B, Email of Dr Feutrill to Dr Bowater, 3.6.16.
[111] Exhibit 1, Tab 17A, 1st referral 14.6.16.
[112] Exhibit 2, Tab 12 and Tab 14A.
[113] Exhibit 1, Tab 18D, SRSS Support Recommendation.

with the Department and can include providing support and assistance with managing money, setting up a bank account, finding a job, learning English, housing, health and medical services, legal support and community engagement amongst other things.[114] In Perth at that particular time LWB were not part of the SRSS contract but they had been contracted by the Department before to provide this kind of service and it was felt in this case that they would be a good service provider as they were involved in fostering services, which were possibly necessary for FJ's son.[115]

101. As the SRSS grant was for 12 weeks, LWB involvement with FJ would end on 1 September 2016. An LWB worker noted that FJ's service support was for a relatively short period of time and was for the purpose of assisting and preparing her for transition into independent living, including providing information and assisting her to find accommodation.[116]

102. FJ was also reunited with her son on 9 June 2016. A LWB case worker/nurse was to live with FJ to ensure there were no concerns about her care for her son. FJ remained good friends with Ali and her plan was to look for a 2 bedroom apartment to live in with Ali, which would provide her with extra support.[117]

103. Dr Bowater sent through a referral to the Mirrabooka Community Mental Health Clinic on 14 June 2016. Dr Bowater requested an opinion and management with regard to FJ's bipolar disorder and her recent stress relating to the care of her son and the involvement of DCP. Her reduction in doses of lithium were noted and a copy of Dr Feutrill's letter recommending that her care be transferred to Mirrabooka Clinic was attached, along with blood results.[118]

104. The Head of Clinical Services at the Mirrabooka Clinic, Dr Samir Heble, advised in a report that this referral was not received by the Mirrabooka Clinic.[119] It is not clear why it was not received. There is apparently a routine procedure for dealing with the receipt of faxed referrals at the service, so it was suggested that it may not have been transmitted through properly.[120] Dr Bowater accepted this was possible although he believed he had sent it through and noted it was handled in the same way as any other referral from his clinic, including the one that the service accepted it had received in July.[121]

105. On 21 June 2016 the LWB Program Manager, Christine Kelly, and LWB Cultural Support Coordinator, Abdul Azizi, met the Australian Red Cross case worker and team leader who had been supporting FJ. The Red Cross staff provided the LWB staff with a handover. During the handover meeting the Red Cross case worker advised of FJ's mental health issues and explained that during her pregnancy she had presented with psychosis and been scheduled under the *Mental Health Act* for a period of four months until the birth. After the birth the baby was taken into care and

[114] Exhibit 1, Tab 8.
[115] T 122.
[116] T 41; Exhibit 1, Tab 8.
[117] T 141; Exhibit 1, Tab 18C, Case Plan, p. 6; Exhibit 2, Tab 24, [69].
[118] Exhibit 1, Tab 17A, 1st referral 14.6.16.
[119] Exhibit 1, Tab 8 [4].
[120] Exhibit 2, Tab 4.
[121] T 16 – 17, 30.

on discharge, FJ had been placed on a CTO with significant in-home support. At the time of the handover, FJ had been reunited with her son, although this was to change shortly afterwards.[122]

106. When FJ transitioned to LWB, Mr Azizi's role was to ensure that her short-term needs were met and she was able to integrate into the Australian community and had access to all the relevant mainstream services that she required. Mr Azizi was able to communicate with FJ in Farsi, as were most of the LWB support workers, and he recalled that FJ was delighted that LWB staff could speak to her in her native language. Mr Azizi felt that this enabled the LWB workers to build a positive and professional rapport with her and they were able to explain things in simple terminology in her own language.[123]

107. Mr Azizi recalled their main focus was on helping her with accommodation, health and wellbeing, child welfare and personal health, with her mental health support being critical.[124] Due to the complexity of her care, and the need to ensure her safety and wellbeing and that of her son, FJ was provided initially with 24/7 care by LWB cultural support workers, with Mr Azizi responsible for overseeing the services provided to her by the support workers. At a later stage, the level of support was scaled back to '9 to 5' day support after FJ's son was taken back into care, but for the early period there was a support worker with FJ night and day.[125]

108. Mr Azizi described a large part of his role in supporting FJ was to provide her with information that would empower FJ to care for herself but she found this difficult. Mr Azizi recalled that FJ seemed quite suspicious and untrusting of any authority figure, which he believed was because of her experience of being held as an involuntary patient in Bentley. She seemed from his discussions with her to have a very negative perception toward mental health practitioners and authority figures, other than Dr Bowater. FJ told Mr Azizi that she believed the "system was trying to prove her being crazy."[126] FJ told Mr Azizi that she felt it was shameful and it also made her feel hopeless and powerless.[127]

109. On 22 June 2016 Mr Azizi prepared an 'Initial Needs Assessment' for FJ and her son and identified that FJ had risks and needs relating to health, child welfare, social isolation, accommodation and finance. He then helped FJ to set short-term goals in those areas, with the plan that they could try to achieve the goals of stabilising her mental health and finding somewhere safe to live as a priority.[128]

110. Mr Azizi referred FJ for counselling at ISHAR Multicultural Women's Healthcare Centre and an appointment was booked with an ISHAR counsellor for 24 June 2016. However, FJ advised Mr Azizi she did not want to attend counselling as she did not feel the counselling would assist her to manage her mental health issues. She told

[122] Exhibit 2, Tab 8.
[123] T 43; Exhibit 2, Tab 8.
[124] T 42.
[125] T 43; Exhibit 2, Tab 8.
[126] T 44.
[127] T 44; Exhibit 2, Tab 8.
[128] T 45; Exhibit 2, Tab 8.

him that having to talk about her past brought back bad memories and she felt it would actually adversely affect her mental health. FJ told Mr Azizi that she was sick of repeating her story to different people again and again.[129]

111. On 23 June 2016 Mr Azizi prepared a Client Risk Assessment & Management Plan. He identified two risk behaviours in relation to FJ:[130]

    i. mental health issues, in particular threats to self-harm and suicidal ideation; and
    ii. challenging behaviour including non-compliance with treatment, budgeting/finance issues, erratic and odd behaviour, defiance, inappropriate responses and obsessive-compulsive behaviours.

112. Mr Azizi explained that he formed the impression very quickly that FJ was happy when she got what she wanted, but things would change very quickly if she did not get her way and she could be extremely volatile in those circumstances. The volatility included threats to harm herself, and she appeared quite paranoid about others motives and was prone to blaming other people for her misfortune.[131]

113. On 28 June 2016 a LWB Support Worker reported that FJ's behaviour had become unpredictable and the previous night FJ was overheard threatening her son, saying "bastard go to sleep, I want to kill you"[132] while shaking and pushing him. The Support Worker removed FJ's son from the room and took him to another room where she calmed him down. She noted there was a small scratch on his chest area but it did not require first aid.[133]

114. On 28 June 2016 a Signs of Safety Meeting was held by DCP staff and FJ attended with two support people. The DCP staff recorded that FJ "did not show any insight into her behaviour and denied the allegations."[134] The support people with FJ also did not agree that there were valid concerns. An appointment was booked with Dr Bowater to check on FJ's son's health and wellbeing but FJ declined to take him.[135]

115. On 30 June 2016 at approximately 9.00 pm a LWB Cultural Support Worker saw FJ become angry after receiving a phone call. FJ reportedly was yelling, swearing and throwing things in the kitchen in the presence of her son. The focus of FJ's agitation was reportedly the DCP, LWB and the DIBP. The LWB worker removed FJ's son to a bedroom for a period before FJ appeared to settle and came and got her son from the LWB worker. The LWB worker reported the incident to her superiors, who came and collected her from FJ's home.[136]

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[129] T 44; Exhibit 1, Tab 18C, Case Plan, p. 6.
[130] T 47; Exhibit 2, Tab 8.
[131] T 47.
[132] Exhibit 1, Tab 7, p. 3 and Tab 18, Email from Abdul Azizi 29.6.16, 8.39 am and Tab 18B, SRSS Incident Report 27.6.16..
[133] Exhibit 1, Tab 7, p. 3 and Tab 18, Email from Abdul Azizi 29.6.16, 8.39 am and Tab 18B, SRSS Incident Report 27.6.16.
[134] Exhibit 1, Tab 7, p. 3.
[135] Exhibit 1, Tab 18, email from Abdul Azizi 29.6.16, 2.13 pm.
[136] Exhibit 1, Tab 18C, Case Plan p 5.

116. FJ's son was taken into provisional care by the DCP the following day, being 1 July 2016, as it was concluded that there was an immediate and substantial risk to his wellbeing if he remained in FJ's care.[137] Senior Child Protection Worker Tariq Kerbelker was allocated FJ's son's case by the DCP. Mr Kerbelker understood that FJ's son had been removed from, and returned to, his mother a number of times by the DIBP in the past and at the time he took on the case, FJ's son had been taken into care by the DCP due to safety concerns. He also understood that FJ and her son's situation was complicated as they had only recently been issued with temporary visas to reside in Australia and FJ had a history of mental illness.[138]

117. Mr Kerbelker described FJ's son's case as "the most complex I have ever dealt with in the 7 years that I have been with the Department."[139] Mr Kerbelker explained that the case was unusual as there was a lot of speculation about what FJ had been through in the past and a lot of concerns about her parental capacity, so there were a lot of conversations happening on a consistent basis for FJ as well as her son. Mr Kerbelker recalled he was frequently trying to speak to FJ, her support workers and DIBP staff to get an understanding of the complexities of the case.[140]

118. Mr Kerbelker met FJ for the first time not long after he became her son's case manager and he facilitated the meeting with a Farsi interpreter to aid in their communication, which he tried to do thereafter whenever possible. Mr Kerbelker recalled throughout his meetings with FJ that she stood out because she appeared disengaged from the process and he had to make extra efforts to try to build a working relationship with her. He believed it was clear that FJ loved her son but he questioned her ability to "be there and put her son's needs first."[141] The complexities of her mental health were felt to be a part of that.

119. Due to her sporadic disengagement and peculiar behaviour, Mr Kerbelker consulted with their DCP's Clinical Psychologist extensively. He indicated he was aware of her trauma history and was concerned to ensure that the DCP staff did not exacerbate her condition. He also sought the psychologist's input as to whether it was in FJ's son's best interests to continue contact with his mother as her behaviour towards him fluctuated during supervised meetings.[142]

120. At the time her son was removed from her care again, FJ had rung Mr Azizi to advise that the DCP's child protection staff and police had arrived at her property and her son was being taken into care. FJ was understandably very distressed and Mr Azizi reassured her that LWB would assist her.[143] Mr Azizi then spoke to the DCP Team Leader, Ms Leah Jennings, who confirmed FJ's son had been taken into care and she was unsure if FJ and her son would be reunited but confirmed the DCP would conduct a Signs of Safety meeting within 30 days.[144] Mr Azizi telephoned FJ again to

[137] Exhibit 2, Tab 12.
[138] Exhibit 2, Tab 15.
[139] Exhibit 2, Tab 15 [9].
[140] T 99.
[141] T 99.
[142] Exhibit 2, Tab 15.
[143] Exhibit 1, Tab 18B, SRSS Incident Report 1.7.16; Exhibit 2, Tab 8.
[144] Exhibit 1, Tab 18B, SRSS Incident Report 1.7.16.

check on her and she advised that, although distressed, she didn't need medical assistance and her friend Mr Shehrabi was supporting her, which he confirmed.[145]

121. Mr Azizi commented that from his perspective, the Department's case worker, Mr Kerbelker, was very accommodating and provided help and information about the step by step process that would help FJ reunite with her son, but FJ refused to engage and did not wish to work within the system. Similarly, Mr Kerbelker gave evidence that LWB "was absolutely fantastic"[146] in terms of their involvement with FJ and the attempts to help her engage in the process. He also indicated that Ms Cheeseman and other staff from the DIBP were always available to provide whatever information they could at the time. However, although they worked well together, all of the service providers struggled to assist FJ to become engaged in the process.[147]

122. Mr Kerbelker expanded on his own concerns regarding FJ's behaviour, based upon his personal observations of her with her son. He noted that when she came into contact with her son, she would be very emotional, which was understandable, but her emotions would not subside during the visit. FJ would go through periods of extreme upset, crying to the point of wailing at times, then she would change to being very withdrawn. He described FJ as almost smothering her son at times, trying to hold and rock him as if he were still a baby. However, he was now an active, bubbly toddler who wanted to play with her. FJ's son would sometimes push her away, so that he could play, and she would then sob and rock herself in the corner, not speaking to anyone, rather than trying to engage with him in play. Mr Kerbelker also recalled that FJ would never speak in an ordinary tone and her body language was often unusual.[148]

123. The DCP staff also spent a lot of time explaining to FJ that she could not leave with her son. She would become very elevated and try to bargain with the staff to convince them to let her take him home. FJ was also quite fixated on the shame she felt, from a cultural perspective, of losing her child and this in part seemed to drive her need to have him back immediately. Mr Kerbelker said he was concerned that she did not fully understand the process, regardless of how many times it was explained to her, or by whom. Mr Kerbelker, indicated that the DCP's initial application was for a two year protection order with the objective of reunification of FJ and her son.[149] FJ became very fixated on timeframes and was insistent that she should have her son returned to her within two months instead of two years. When she was told the process could be lengthy, she would completely disengage from the reunification process and suggest that she might leave Australia without him.[150] She would sometimes say, 'I'm young. I can start a new family."[151] However, it was still clear to Mr Kerbelker that FJ loved her son and wanted him back in her care.

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[145] Exhibit 1, Tab 18B, SRSS Incident Report 1.7.16; Exhibit 2, Tab 8.
[146] T 100.
[147] T 100 - 101.
[148] T 101 – 102, 108.
[149] Exhibit 2, Tab 15.
[150] T 101 – 104.
[151] T 103.

124. LWB attempted to support FJ in her attempts to regain custody of her son but unfortunately, she refused to attend the first supervised meeting with her son and the DCP psychologist at the DCP office.[152] Mr Azizi then made some GP appointments for FJ, including one with Dr Bowater on 29 June 2016. Mr Azizi was hopeful if FJ saw Dr Bowater she could be referred to a community mental health service as he was worried about what he perceived to be her deteriorating mental health. FJ declined to attend and told Mr Azizi she did not have faith in the Australian healthcare system, although he was aware she did have faith in Dr Bowater personally. Mr Azizi tried to encourage her to change her mind but she remained adamant that she did not need to see the GP or any other health professionals. She seemed particularly reluctant to see psychologists, psychiatrists or counsellors as she was worried it might result in her being declared 'crazy'.[153]

125. On 7 July 2016 Mr Azizi received an email from FJ's former caseworker at Red Cross advising that FJ had expressed suicidal ideation to her via text message. Mr Azizi gave evidence that this information did not come as a surprise to him, given her situation at that time.[154] Based on that new information, on 8 July 2016 Mr Azizi created a new Safety Plan for FJ with the assistance of the clinical team. The purpose of the Safety Plan was to assess the potential risks in regard to FJ's care and outline safeguards and support strategies to address them. The LWB support staff were given a copy of the Safety Plan, which Mr Azizi described as very detailed and clinically tailored for FJ.[155]

126. On 11 July 2016 Mr Azizi and his Program Manager, Christine Kelly, went to FJ's house to try to assess her safety and wellbeing, clarify the role of LWB and offer her medical assistance. They explained to FJ that they had serious concerns about her mental health and that she needed to work with health professionals to stabilise her mental state. She refused their help and stated she did not need any medical assistance and the only thing she needed was to be reunited with her son. They reminded FJ she needed to contact the DCP case worker to discuss this issue.[156]

127. Mr Azizi and Ms Kelly returned to FJ's house on 13 July 2016 to check on her and again attempt to emphasise to her how important it was for her to engage with the services being offered. They took her out for coffee, with the hope that this different strategy might help by providing a change of scene and different context for their discussion. They discussed again with FJ that it was in her best interests to attend medical appointments with her GP and other health professionals. This time she agreed she would engage with health professionals to ensure she managed her health better, with the hope this would help her be reunited with her son.[157]

128. Mr Azizi gave evidence that the LWB workers and DIBP workers tried to change FJ's attitude toward the DCP and the reunification process. They encouraged her to provide all the relevant information, explaining that these were the rules in Australia

[152] T 48; Exhibit 2, Tab 8.
[153] T 48 - 49; Exhibit 2, Tab 8.
[154] T 49.
[155] T 49; Exhibit 2, Tab 8.
[156] Exhibit 2, Tab 8.
[157] T 51; Exhibit 2, Tab 8.

and she needed to comply with those rules in order to get her son back into her care, but he felt she wasn't interested in following their advice. Mr Azizi was not concerned that she did not understand the advice, as the information was communicated in Farsi by him and with the help of an interpreter, but felt she still chose not to engage as she did not like the advice she was given.[158] Mr Azizi felt FJ was very stubborn if things did not go her way and indicated her response was quite childlike and immature.[159] Mr Azizi had noticed a particular deterioration in FJ's mental health after her son was removed into care again by the DCP.

129. On 14 July 2016, a month after his first referral was sent, and having received no response, Dr Bowater sent a second referral to Mirrabooka Clinic. He sent it together with his first referral from 14 June 2016 to draw attention to it. Dr Bowater gave evidence that he sent this second referral letter after waiting for 20 minutes on the telephone to try to get someone at the service to answer, then taking the name of the person he spoke to so that he could direct it to a particular person to ensure it was received. He said he was "acting in complete frustration"[160] at this time. The second referral was dated, and received on, 14 July 2016. The first part of the second referral was typed in bold capital letters, done deliberately by Dr Bowater to gain the attention of the reader at the Clinic. Part of his referral is replicated below and was clearly identified as a second referral:

> **14/07/2016 UPDATE: UNFORTUNATELY [FJ] SITUATION HAS DETERIORATED WITH HER SON BEING REMOVED FROM HER AND IS NOW IN THE CARE OF DCP.**
>
> **[FJ] HAS PRESENTED TO THE SCGH THREATENING TO KILL HERSELF IF HER SON IS NOT RETURNED AND I AM VERY KEEN THAT SHE IS ASSESSED BY A PSYCHIATRIST TO GIVE ME FURTHER DIRECTION.**
>
> **I WOULD ALSO APPRECIATE ANY COMMUNITY SUPPORT THAT YOU CAN OFFER IN THIS MOST UNFORTUNATE SITUATION.**

130. Dr Bowater explained that he does a lot of referrals to the public health service and he has found that you need to try to get someone's attention, and using bold text and bigger text can help achieve that purpose. In this case, he said it was his "desperate attempt"[161] to get someone's attention at the service.

131. Dr Bowater explained at the inquest that, at this time, FJ's BPAD was stable on lithium treatment, which had been initiated by Dr Febbo and maintained by Dr Feutrill, but he was very concerned about her major depression and associated risk of suicide.[162]

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[158] T 47.
[159] T 48.
[160] T 17.
[161] T 18.
[162] T 35 – 36.

132. Dr Bowater later made a note in his medical records on 2 December 2016 that FJ was never seen by the Public Psychiatric Team "despite many phone calls and these two written requests."[163]

133. Dr Bowater's July referral letter was received and then discussed within the Multi-Disciplinary Team at the Mirrabooka Clinic. FJ was allocated a case manager, Senior Social Worker Andrew Barclay. Mr Barclay was informed that FJ's son had recently been removed by the DCP and "she was making suicidal and homicidal threats"[164] He tried to telephone FJ on 14 July 2016, the day he received the referral, and left a message when the call was not answered. He called FJ again the next day, being 15 July 2016, but again there was no response and this time he was unable to leave a message. Mr Barclay tried unsuccessfully to call FJ for a third time the following week on the morning of 19 July 2016, and shortly after he went to FJ's residential address but she was not at home.[165]

134. Mr Barclay gave evidence that the inability to contact FJ was not unusual for patients attending the Mirrabooka Clinic as it is a culturally diverse and economically diverse area and a lot of people move around a lot and are also reluctant to answer a private number because they are afraid it is a bill collector.[166]

135. Having been unable to contact FJ directly, Mr Barclay then telephoned FJ's Case Manager at the DCP, Mr Kerbelker, as he was concerned that it was a reasonably urgent referral and he wanted to action it.[167] Mr Kerbelker indicated he did not know FJ's whereabouts. Mr Kerbelker then contacted Mr Azizi at LWB to find out if he could assist. Mr Azizi advised that FJ had been admitted to Royal Perth Hospital the previous night (18 July 2016).[168] This was confirmed with RPH and the information was passed back to the Mirrabooka Clinic case manager, Mr Barclay.[169] Mr Barclay tried to call the nurse manager at the RPH ward where FJ was housed, but he was not able to speak to the nurse manager, so he left a message asking for his call to be returned. Mr Barclay did not receive a call back from the nurse manager so he called Mr Kerbelker again, who commented that FJ's case was complex, where there were a lot of different agencies trying to communicate. Mr Kerbelker advised Mr Barclay that he understood FJ would remain in hospital until at least 27 July 2016.[170]

136. Once he was aware that FJ was in hospital, Mr Barclay advised that his task became less urgent, as the Clinic would wait until FJ was discharged from hospital and then expect to be advised of "where she is; how she is; whether the treatment has changed; have the medications been altered; what is the new regime"[171] and then they could formulate a plan as to how they could assist. However, their assistance relied upon FJ being referred back to the service, which did not eventuate. As there was no referral back from RPH, after a reasonable period of time the file was closed

[163] Exhibit 1, Tab 17A.
[164] Exhibit 1, Tab 5 [19].
[165] Exhibit 1, Tab 8 [4].
[166] T 72.
[167] T 73.
[168] Exhibit 1, Tab 8 [5] – [6].
[169] Exhibit 1, Tab 18B, SRSS Incident Report 19.7.2016.
[170] T 74, 81.
[171] T 74.

to await any future referral. The closure of the file generated a letter to Dr Bowater, which was in about September 2016.[172]

137. Mr Barclay indicated that more recently, there is a trend of efforts towards improving communication with GP's. The practice at the Clinic is to write to the GP on receipt of the referral, so that the GP knows the referral has been received, and if they have difficulty contacting the client they will call the GP to see if they can assist. Once the patient begins treatment, regular letters are then sent to the GP to explain the care plan and the longer term goals.[173]

138. As to how FJ came to be admitted, there was evidence that on 18 July 2016 FJ had been in crisis. Dr Bowater phoned Dr Febbo and asked for his help. Dr Bowater said FJ was desperate at this time and he was desperate to try and find her support. Dr Bowater explained at the inquest that he was hopeful if FJ was admitted they could use the hospital's services and, in particular, the community social worker to help construct a plan with FJ. He did not consider her to be psychotic or particularly unwell from a psychiatric point of view, but considered her to be in crisis and she needed more help than he could provide.[174]

139. Dr Febbo was working half time as a consultant psychiatrist at RPH at that time. He worked mornings in Ward 2K and saw private patients in the afternoon. He also provided some emergency cover to the RPH ED and was on call at times, which would then decrease the time he had available on the ward.[175]

140. Dr Febbo did not recall his first contact being from Dr Bowater that day, although he accepted he would have spoken to Dr Bowater sometime that day. Dr Febbo recalled that he became aware of FJ's need for psychiatric admission on 18 July 2016 through his wife, Katherine Webster, who had previously been involved in FJ's case and happened to see FJ that day. Ms Webster saw FJ by chance when she was shopping and FJ told her about her son being removed into care and her concerns that she was going to lose her accommodation. After the chance meeting Ms Webster spoke to her husband, Dr Febbo, about FJ and told him that FJ was significantly distressed, vulnerable and in situational crisis. Ms Webster also said she had made suggestions to FJ about how she might access mental health treatment, but FJ was ambivalent about any mental health admission and had indicated she would only be prepared to accept an admission under Dr Febbo's care.[176]

141. Dr Febbo already knew FJ through his previous care of her at the Transcultural Mental Health Centre. Dr Febbo stated that he was very conscious of impediments to access to mental health services for people of transcultural backgrounds and on the basis of what his wife told him, he decided to facilitate a voluntary admission to Ward 2K at RPH for FJ. Dr Febbo reasoned that admission would allow FJ to have her mental state and medication assessed and provide her with access to support to

[172] T 74.
[173] T 76.
[174] T 33 – 34.
[175] T 228 – 229.
[176] Exhibit 2, Tab 16.

help her deal with her psychosocial stressors she was facing[177] and "just give her a bit of time out."[178]

142. There was some issue in finding an available bed, but in the end Dr Febbo facilitated FJ's direct admission, under his name as her Consultant Psychiatrist, to RPH that day.[179] Dr Febbo gave evidence that without his intervention he did not believe it would have been possible to get FJ admitted to Ward 2K that day and he also did not believe FJ would have accepted treatment from another psychiatrist as he felt she was very ambivalent even about seeing him, despite the fact Dr Bowater believed FJ placed a lot of trust in Dr Febbo and FJ also had a good relationship with Katherine Webster, which improved her level of trust in Dr Febbo.[180] Dr Bowater described Dr Febbo's conduct at the time as his "salvation"[181] and described Dr Febbo's achievement of getting FJ admitted that afternoon as "unbelievable"[182] given Dr Bowater's usual experience with the State public mental health service.

143. FJ had rung Mr Azizi that day and told him she might voluntarily admit herself to the RPH Psychiatric Ward.[183] He rang RPH later that day to confirm she had been voluntarily admitted. Mr Azizi said he was delighted to hear this, as he felt she was in safe hands. He sent her a text offering to provide any support she might require, but she declined his assistance.[184]

144. Overall, it is clear that all of the people involved in FJ's case at the time felt it was a positive step that she was willing to accept treatment from Dr Febbo and were hopeful her admission to RPH would help her.

ADMISSION AT RPH UNDER CARE OF DR FEBBO

145. Dr Febbo had first treated FJ in April 2013 when she was a patient at the Transcultural Mental Health Service. She was referred to him as she had stopped taking her lithium. He saw her twice only and then she was seen by other psychiatrists at the service thereafter.[185] He had not treated her since that time and did not have much information about her current mental state, other than what his wife and Dr Bowater had told him, which included information about her admission to Bentley Hospital during her pregnancy. He anticipated once she was admitted he would be able to establish whether she was in a depressive or manic phase of her bipolar disorder and if her medication needed further adjustment.[186]

146. Dr Rosemary Allen was the on call doctor in Ward 2K that evening. Dr Allen was a registrar and an unaccredited trainee in psychiatry at the time, completing a non-

[177] Exhibit 2, Tab 16.
[178] T 229 - 230.
[179] T 230; Exhibit 1, Tab 7, p. 3 and Exhibit 2, Tab 2.
[180] T 231.
[181] T 15.
[182] T 15.
[183] Exhibit 2, Tab 8.
[184] T 52.
[185] T 228.
[186] T 229 – 232.

training rotation in psychiatry in ward 2K at RPH. The ward was a 20 bed general adult open unit for voluntary acute patients. Dr Allen worked on the ward under the direction of Dr Febbo. Dr Allen would discuss each patient with Dr Febbo when he attended the ward in the morning on weekdays. Dr Allen had approximately nine months' experience in psychiatry at the time of FJ's admission.[187] Dr Allen described the role she was performing at that time as "very stretched"[188] with only half a resident supporting her and limited supervision while she was still quite a novice in psychiatry.[189]

147. Dr Allen recalled that Dr Febbo informed her during their patient review on Monday, 18 July 2016, that FJ would be admitted for in-patient treatment in Ward 2K that day. She initially thought FJ was a current private patient of Dr Febbo, but later came to understand FJ was actually a patient whom Dr Febbo previously treated at the Transcultural Mental Health Service in 2013. Dr Febbo had not made a note of what he discussed with Dr Allen, but he believed he would have told her FJ was a patient who was experiencing quite considerable stress and required admission to review her mental state and optimise her lithium treatment. Dr Febbo felt it was clear what was required and was hopeful the hospital would be a safe place for FJ.[190]

148. Dr Allen recalled Dr Febbo advised her that FJ was to be directly admitted to Ward 2K, which was unusual and the first time she had been involved in such a case. He also advised FJ had BPAD and had stopped taking her lithium medication twice daily, so she needed to be reintroduced to the medication and commenced on hourly observations. Dr Febbo indicated FJ could have leave from the ward during her admission.[191] Dr Febbo explained he gave that instruction as he knew FJ was ambivalent about being admitted so he tried to make it as flexible as possible to encourage her to stay.[192]

149. Dr Allen recalled that FJ arrived unusually late on the ward that evening at 7.30 pm, which was much later than Dr Allen had expected. In the end, FJ was admitted just before 9.00 pm. FJ attended with a man who she said was her friend but the way they interacted suggested he was her boyfriend. Dr Febbo did not see FJ on the day she was admitted to the ward given the time she was admitted.[193] Dr Allen was aware from her discussion with Dr Febbo that FJ was a refugee and a single mother with mental health issues and had been involved with child protection authorities. She understood it was a crisis admission to contain some level of risk for the patient.[194] Dr Allen already had instructions from Dr Febbo, so Dr Allen did not conduct her usual lengthy admission interview with FJ before she was admitted. Dr Allen recalled she took only a very brief history from FJ, which included mention of the DCP, and conducted a brief risk assessment to assess any risk of suicide. Dr Allen

[187] T 193; Exhibit 2, Tab 6.
[188] T 195.
[189] T 195 – 196.
[190] T 232.
[191] T 194 - 195; Exhibit 2, Tab 6.
[192] T 237.
[193] Exhibit 2, Tab 16.
[194] T 197 – 198.

then began the treatment plan discussed with Dr Febbo, which was to commence FJ on lithium and with regular observations to be conducted.[195]

150. Dr Allen recalled in her evidence that the circumstances were so different from what she was used to, in terms of being a direct admission of what she understood to be a private patient on the instructions of Dr Febbo rather than a public patient admitted through the ED, that she did not follow her usual protocols and simply followed the treatment instructions she had been given. She was also on duty in the ED, so she had limited time to spend admitting a patient on the ward.[196]

151. Dr Allen had an opportunity to have a longer consultation with FJ and take a history on Tuesday, 19 July 2016, Dr Allen conducted the assessment with two medical students, and then prepared a detailed typed set of notes. Dr Allen still recalled FJ many years later when she was giving evidence at the inquest, as she remembered it was a very sad story. However, Dr Allen also recalled she had some concerns as FJ's story appeared to change over time and there were also inconsistencies in her behaviour, which raised some red flags. During this first proper assessment Dr Allen also recalled FJ presented with quite idiosyncratic make-up, which also concerned her.[197]

152. Dr Allen noted that FJ had been diagnosed with BPAD in Iran and had a lengthy admission to Bentley and was diagnosed with schizophrenia when she was pregnant. FJ was noted to be appropriately dressed and cooperative on assessment. She denied any suicidal ideation or plans. One of her main themes of discussion was the removal of her son by the DCP and she was noted to have limited insight into her bipolar symptoms and the causative factors behind the decision to take her son into care. She believed the removal of her son was a form of punishment and was permanent. It was felt that FJ believed that by admitting herself for assessment one of the RPH doctors might write a letter on her behalf to the Perth Children's Court in support of her son being returned to her care.[198]

153. An Inpatient Management Plan prepared for FJ on 19 July 2016 indicated she had been feeling suicidal in the community and nurses should monitor her mental state each shift and engage in one on one time with her to offer FJ an opportunity to express any concerns.[199]

154. After this consultation Dr Allen discussed FJ with Dr Febbo and the medical students. Each of them was of the view that FJ presented with significant personality disorder traits.[200]

155. On 19 July 2016 a note was made by Mr Barclay of some of his phone conversations with Mr Kerbelker at the DCP, who was very keen for FJ to have a mental health assessment. Mr Barclay recorded that Mr Kerbelker told him that the DCP was very

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[195] T 197 - 200; Exhibit 2, Tab 6.
[196] T 200 – 201, 212.
[197] T 198.
[198] Exhibit 2, Tab 2, Inpatient Case Notes Review by Dr Allen and 2 Med Students
[199] Exhibit 2, Tab 2, Inpatient Case Notes, Client Management Plan 19.7.16.
[200] Exhibit 2, Tab 6 [39].

concerned that FJ's situation was "very complex and many agencies were involved who [were] not speaking to each other."[201] The Department's staff were unsure if FJ had the capacity to understand her court obligations or visiting rights with her son, or even why he had been taken into care.[202]

156. Dr Allen discussed FJ's case at the multidisciplinary meeting on 20 July 2016, which included Dr Febbo, and it was decided that FJ would require social worker involvement, GP contact as FJ was worried about missing an appointment and occupational therapy intervention, which would to be to decide on her level of independence and ability to function on her own at home. An attempt was made by Dr Allen to contact FJ's GP, Dr Bowater, but Dr Bowater was unavailable.[203] Dr Allen recalled FJ had expressed concern that she had an appointment with Dr Bowater that she would miss.[204] Dr Bowater rang back later and spoke to a medical student who recorded that Dr Bowater indicated he was happy with FJ continuing to be managed in Ward 2K and he could see her after she was discharged. Dr Bowater was apparently added in as FJ's GP by Dr Allen after this conversation in the hospital records, but for some reason the updated information was not saved.[205]

157. Dr Allen reviewed FJ later on 20 July 2016, after the multidisciplinary team meeting. FJ described some symptoms of depression, such as poor concentration and disrupted sleep, but denied suicidal ideation. She again requested a letter of support from Dr Allen for use in her court proceedings but Dr Allen declined and told FJ she did not believe the letter would be beneficial to her.[206] Dr Allen noted in her statement that it was apparent to her that Tariq Kerbelker was sincerely concerned with both FJ's welfare and her son's welfare and it appeared he was doing his best to make sure FJ got the best outcome possible.[207] Dr Allen indicated her observation of Mr Kerbelker made her question some of FJ's statements, as FJ had told her that the DCP' staff were out to get her and take her child. Initially Dr Allen had taken these statements at face value, but her dealings with Mr Kerbelker made her question the truth of FJ's beliefs and wonder if FJ was a person who perhaps did not know how to receive help.[208]

158. Dr Allen recalled that FJ was quite persistent in asking her to provide a letter of support for the Children's Court proceedings from an early stage, as FJ very much wanted to get her child back, but Dr Allen declined as she did not feel she could provide sufficient information at that stage.[209] Dr Allen also recalled FJ talked a bit about getting stable accommodation, so she and the RPH social worker assisted in terms of writing letters of support.

159. The RPH social worker, Viju Baby, saw FJ with an interpreter on 20 July 2016 and he noted she was quite distressed in relation to her son being taken from her care and

[201] Exhibit 2, Tab 1, Service Event Note 19.7.16.
[202] Exhibit 2, Tab 1, Service Event Note 19.7.16 and Tab 5.
[203] Exhibit 2, Tab 6.
[204] T 202.
[205] T 202 - 203; Exhibit 2, Tab 2, RPH Inpatient Case Notes 21.7.2016 and Tab 6.
[206] Exhibit 2, Tab 6.
[207] Exhibit 2, Tab 6.
[208] T 202, 210.
[209] T 203.

her upcoming child custody proceedings. Her main focus was that she wanted her child back. Mr Baby liaised with a DCP' staff member to find out more about the situation. The DCP provided historical information on FJ's mental health, historical contact with the DCP and the current status of the Department's involvement. The DCP staff indicated FJ's son had been removed as there were concerns FJ did not have the capacity to care for him and there had been concerns about her behaving inappropriately towards her son. The DCP was trying to arrange twice weekly contact between FJ and her son, but they advised this could not be done while she was a patient in the mental health ward as it was felt to be an unsuitable environment for a small child.[210]

160. On 20 July 2016 the DCP received an update from Dr Feutrill at the Elizabeth Clinic. Dr Feutrill noted that FJ had seen over five psychiatrists in Perth by this time and she had a diagnosis of a serious mental illness – possibly bipolar disorder or schizoaffective disorder – both of which are "enduring, relapsing and remitting serious mental illnesses, that are treated identically."[211] She also showed evidence of post-traumatic stress disorder. Her lack of insight into her psychiatric illness and likely poor compliance with medication were noted concerns. It was indicated that FJ had some personality pathology that limited her capacity to cope maturely in times of conflict, leading her to make extreme statements about intention to harm herself or her son. Dr Feutrill advised that FJ's emotional dysregulation was a concern regarding her ability to keep her son safe.[212] Dr Feutrill emphasised at this time that it was important for FJ to be referred to community mental health services again.[213] Of note, Dr Feutrill commented at the end that the "number of services involved with her in the last few years has been huge and the case management somewhat compromised by this – it has been difficult to be clear what my role was meant to be and how to provide comprehensive follow up"[214] and now she was stepping out of her role as FJ could not fund further treatment herself.

161. A DCP staff member spoke to Dr Allen. Dr Allen's primary concern was recorded as FJ's lack of insight into her mental health issues that had led to her son being taken into care.[215] FJ seemed preoccupied that RPH staff write a letter on her behalf to the Perth Children's Court advising that she was capable of caring for her son, but this was unlikely to be forthcoming.

162. On 20 July 2016 FJ was also reviewed by an occupational therapist during a cooking session. It was noted that she was difficult to assess as during the session FJ behaved in a way that appeared to be attention seeking rather than genuine. It was recommended that further observation be undertaken. A note was made by Dr Allen the following day that FJ expressed that she felt 'judged' by the occupational therapist.[216]

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[210] T 115 – 117; Exhibit 1, Tab 7, p. 4 and Tab 21.
[211] Exhibit 1, Tb 19A, Email from Dr Feutrill to Dept of Communities 20.7.16.
[212] Exhibit 1, Tab 7, p. 3.
[213] Exhibit 1, Tab 19A, Email from Dr Feutrill to Dept of Communities 20.7.16.
[214] Exhibit 1, Tab 19A, Email from Dr Feutrill to Dept of Communities 20.7.16.
[215] Exhibit 1, Tab 7, p. 4 and Tab 20, Email from Tariq Kerbelker 22.7.16.
[216] Exhibit 2, Tab 2, RPH Inpatient Case Notes, July 2016.

163. On 21 July 2016 FJ was reviewed again by Dr Allen and FJ reported she had a meeting with a lawyer. Dr Allen felt FJ was significantly less warm towards her because of her refusal to provide a letter of support. FJ also mentioned a plan to move to Sydney in the future. Dr Allen discussed her review with Dr Febbo afterwards.[217] Mr Azizi sent FJ a text message that day to offer support by LWB staff during her time in hospital. FJ replied that she was good and would let him know if she needed help.[218]

164. On 22 July 2016 Dr Allen conducted a progressive risk assessment and indicated that FJ's risk to herself and others at that time was felt to be low.[219] Various nursing notes indicated FJ continued to be distressed about the removal of her son.[220] The social worker, Mr Baby, was told by nursing staff that FJ was very distressed and wanted to see him. He met with her and noted her focus remained on wanting to see her child. She was crying and he tried to console her with the thought that the DCP usually decides the best place for a child to grow up is with their parent. He encouraged her to work with the Department and cooperate with them to make that happen. Following this discussion, Mr Baby spoke to DCP' staff and they indicated they would arrange a meeting with all relevant parties on 25 July 2016.[221]

165. On 22 July 2016 Mr Barclay, from the Mirrabooka Clinic, called Tariq Kerbelker again as he had not received a return call from the Nurse Manager at RPH about FJ. Mr Barclay was told by Mr Kerbelker that FJ was expected to remain as an in-patient at RPH until 27 July 2016. Mr Barclay advised that, as FJ was an inpatient at RPH her referral to Mirrabooka Clinic was to be closed, according with usual procedure. He noted that RPH staff could have referred FJ back to the service following her discharged, should it have been considered necessary, although this was not done. Mr Barclay then wrote a letter to FJ's GP, Dr Bowater, on 23 July 2016 advising of the outcome of the referral.[222]

166. Dr Febbo had indicated to Dr Allen and the other ward staff that FJ should be allowed leave from the ward. He explained in his statement that he understood that FJ would only remain on the ward if she was allowed leave and had a degree of flexibility as to when this leave was taken. Dr Febbo had formed the opinion that FJ was not suffering from a personality disorder; rather, he felt her presentation was affected by her personality, vulnerability and her difficult circumstances (such as needing new accommodation, wanting to maintain her relationship and concern about her custody court case). He was keen to maintain her admission for as long as possible, partly to ensure her lithium levels were stabilised before she was discharged, so he granted her leave to ensure her cooperation.[223]

167. FJ spent some time off the ward on day leave on 23 and 24 July 2016 and on 24 July 2016 she asked to be discharged against medical advice as she was not allowed to see

[217] Exhibit 2, Tab 2, RPH Inpatient Case Notes, July 2016.
[218] Exhibit 2, Tab 8.
[219] Exhibit 2, Tab 2, RPH Inpatient Case Notes, July 2016.
[220] Exhibit 2, Tab 2, RPH Inpatient Case Notes, July 2016.
[221] T 117.
[222] Exhibit 2, Tab 5.
[223] Exhibit 2, Tab 16.

her son whilst in hospital. She was told that she would then miss a scheduled meeting on 25 July 2016 with DCP' staff, so instead she took overnight leave and returned to the ward the following morning before the planned meeting. There was no note made of this being approved by Dr Febbo, but it was in keeping with his general instructions and Dr Allen indicated she would not have made such a decision without consulting Dr Febbo, given her limited experience in psychiatry at that time.[224] Dr Allen gave evidence she had been struggling to see FJ over those days as FJ was often off the ward. Dr Allen had felt anxious that she might not return after taking overnight leave on the Sunday night, but in the end she did return for the meeting.[225]

168. Also attending the meeting were Dr Allen and other RPH staff including the social worker Mr Baby, DCP and LWB staff to discuss contact arrangements and further define the processes for moving forward. FJ was assisted by an interpreter.[226]

169. During the meeting FJ appeared to have difficulty understanding why her son had been taken into care. She repeatedly requested a timeframe for when he would be returned and Department staff explained it would depend upon the decision of the Court, with the next court date set for 29 July 2016. FJ's boyfriend joined the meeting at some stage to support her. FJ was told during the meeting she would not be able to see her son until she had been discharged from the ward. Mr Kerbelker explained that he had spoken to his team leader and the Department's Clinical Psychologist and they had determined it was not in FJ's son's best interests to have visits on an adult mental health ward.[227] It was suggested FJ could meet with the psychologist later that day.[228]

170. Mr Kerbelker gave evidence that FJ made it clear in the meeting that she wanted to have contact with her son in hospital and he believed she may have felt that this would provide evidence to support her having increased contact with her son. He recalled FJ was very elevated in the meeting. She was standing throughout the meeting and demanded contact with her son and to have him returned to her care. It appeared to Mr Kerbelker that FJ was not willing to acknowledge any of the Department's concerns and was either unwilling to provide additional information that they sought or provided inconsistent accounts. For example, FJ was inconsistent in relation to her son's paternity. It appeared to Mr Kerbelker that FJ was only willing to provide as much information as she believed was necessary to regain custody of her son, and that information was not always reliable.[229]

171. The meeting lasted approximately 105 minutes and concluded just before midday.[230] It became clear during the meeting that FJ wanted to discharge herself from hospital and following the meeting, FJ discharged herself against medical advice.[231] She indicated her decision to leave was due to the fact that the Department would not let

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[224] T 204 - 205.
[225] T 205 – 206.
[226] Exhibit 1, Tab 21; Exhibit 2, Tab 6.
[227] Exhibit 2, Tab 15.
[228] T 118.
[229] T 104 – 107.
[230] Exhibit 1, Tab 7, p. 4 and Tab 8, Attachment 3, RPH Discharge Summary 25 July 2016 and Tab 18, Email from Tariq Kerbelker, 25.7.16; Exhibit 2, Tab 2, RPH Inpatient Case Notes, 25.7.16, 1.45 pm.
[231] Exhibit 1, Tab 7, p. 3; Exhibit 2, Tab 2, RPH Mental Health Care Transfer Summary.

her meet with her son whilst she was in hospital and she needed to get in contact with Legal Aid for the upcoming court appearance on 29 July 2016. Dr Allen considered FJ did not meet the criteria for being made an involuntary patient and she could not be persuaded to stay voluntarily, although Dr Allen did not know how hard she tried to persuade her as FJ had already been spending a lot of time off the ward.[232] FJ signed a 'Discharge Against Medical Advice' form and was discharged that day. The Department and LWB were informed that FJ had discharged herself about an hour after the meeting.[233]

172. Mr Baby made it clear in his evidence that he understood FJ's primary reason for discharging herself was to see her son. He had not seen any change in her attitude or demeanour from the time he first met her on the ward, and he believed she had remained a bit depressed throughout her admission. Mr Baby did not attempt to connect FJ with any services as she left as he was aware she was engaged with LWB, but he did send a letter supporting her application for Department of Housing accommodation at the request of LWB.[234]

173. Dr Febbo has indicated that he has no clear recollection of FJ's discharge but comments that "given her mental state it would not have been possible to prevent her doing so"[235] as she did not warrant an involuntary admission. Dr Febbo considered her to be relatively stable[236] and he did not believe she exhibited any risk that she might harm herself or others. He felt she would have benefited from more time in hospital but he also considered her well enough to return to the community if that was her choice. Although Dr Febbo acknowledged that patients with BPAD are at a higher than average risk of suicide because of their condition, he did not consider FJ was at a heightened risk of suicide during her admission or at the time of discharge.[237]

174. Dr Allen appeared to believe at the time that Dr Febbo would be following FJ up in the community, as at that time she still thought FJ was his private patient, and she also recalled hearing Dr Febbo say that he would ensure she was followed up. Dr Allen recalled that she was worried about FJ so she believed it was an important piece of information for her at the time.[238]

175. Dr Febbo did not have a plan to follow up FJ in the community but did say he had expected she would be referred back to Mirrabooka Clinic if she had been discharged in the ordinary way, rather than discharging against medical advice. However, he indicated FJ may have not engaged with the service, even if she had been referred back on discharge, or alternatively they may not have accepted her as she was quite stable at the time.[239]

[232] T 206; Exhibit 2, Tab 6.
[233] Exhibit 1, Tab 7, p. 4 and Tab 8, Attachment 3, RPH Discharge Summary 25 July 2016 and Tab 18, Email from Tariq Kerbelker, 25.7.16 and Tab 21.
[234] T 118 - 119.
[235] Exhibit 2, Tab 16 [78].
[236] T 263.
[237] Exhibit 2, Tab 16.
[238] T 207 - 208.
[239] T 267.

EVENTS AFTER DISCHARGE FROM RPH

176. It appears that FJ was not referred back to the Mirrabooka Clinic for follow up care after discharge, but instead was referred by the hospital to her previous GP, who was listed as Dr Hany Ishak at the Stirling Central Medical Group, and not Dr Bowater at the Victoria Medical Group. This was despite the details apparently being updated and Dr Bowater having been contacted by telephone by medical staff during her admission.[240] Dr Ishak was a doctor who FJ had attended in the past but was not her current GP, so there was little purpose in sending him the referral. I note it was not the fault of either Dr Allen or Dr Febbo, but appears to have been an administrative error. Dr Bowater was aware of the hospital admission, as he had received the phone call, but as he had not received the discharge summary, he was not immediately aware she had been discharged.

177. Records indicate FJ did not attend the Family Court hearing on 29 July 2016 although it seems she had obtained legal representation through Legal Aid.

178. Dr Bowater saw FJ on 5 August 2016, at which time he became aware she had been discharged. He received more information from FJ about the hospital admission and the situation with access to her son. She told Dr Bowater she couldn't understand any mechanism by which she might demonstrate to the Department her resolve to get her son back and he felt no real strategies had been put in place to help her. As a result, he expressed his opinion that it was a "No win situation"[241] as he felt they were back in exactly the same situation they had been in previously. He recalled FJ spoke of wanting to take her son home to Iran but she did not have a passport and was stuck in the immigration system. She was also unable to demonstrate to the authorities that she would be better off with her parents in Iran. Dr Bowater said he could only accept FJ's word as to her predicament, as he was not receiving any communication from the Department.[242]

179. Dr Bowater recalls during this consultation on 5 August 2016 FJ was animated, upset, crying at times and generally appeared highly frustrated. However, she did not appear to be psychotic, despite the stress she was experiencing, and he assessed her as psychiatrically stable. He felt she was still focussed on the task of getting her son back.[243]

180. Dr Bowater prepared a letter dated 19 August 2016 in support of FJ's upcoming court proceedings. Dr Bowater indicated in the letter that he had been caring for FJ since October 2015 and her son from his birth in April 2015 until June 2016. He stated he had never witnessed anything untoward with regards to FJ's care of her son and he observed FJ to be a loving and caring mother who, in his opinion, had been doing "a great job to date."[244] Dr Bowater explained at the inquest that he had seen FJ 13 times and DJ 15 times by then, and he based his comments on his observations of their interactions. He noted DJ was engaging, chatting to his mother and following

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[240] Exhibit 1, Tab 8 [8] and Tab 8, Attachment 3, RPH Discharge Summary 25 July 2016.
[241] T 18 – 19; Exhibit 1, Tab 17C, Medical Records, Victoria Medical Group, 5.8.2016.
[242] T 18 – 19.
[243] T 19 – 20, 33.
[244] Exhibit 1, Tab 17A, Letter dated 19 August 2016.

conversations and he had no concerns for him while he was in FJ's care. After DJ went back into foster care, Dr Bowater did not see him again, so his comments related to the earlier period.[245]

181. FJ had expressed some frustration at receiving differing advice about how to care for her son, particularly from the Cultural Support Worker employed by LWB, and Dr Bowater believed there was a personality conflict between this worker and FJ. Dr Bowater noted that FJ had been going through a stressful time transitioning from community detention to temporary protection visa status, which had forced her to lose the supervision of her regular private psychiatrist, Dr Feutrill, and his attempts to arrange for FJ to see a regular psychiatrist in the WA health system had not yet resulted in a face to face consultation with a psychiatrist.

182. Dr Bowater had also made phone calls to the DCP and the supervisor of LWB, but these calls had not assisted in indicating a pathway that would allow him to assist FJ to regain access to, and custody of, her son. He expressed the view that the process seemed "completely unreasonable to an outside observer."[246] Dr Bowater had consulted with FJ that day, being 19 August 2016, and on consultation she was psychologically stable and settled and her medications were well stabilised. He could see no reason why FJ should not be progressively reunited with her son, based upon her presentation.[247]

183. On 28 July 2016 LWB had sought an extension of the funding to continue their support of FJ, as the staff felt her transition into the community was not complete. Information was provided to the DIBP that FJ had been given support for longer than usual due to her multiple vulnerabilities, which had limited her from transitioning independently into the mainstream community. It was noted her vulnerabilities had been "impacted by her movement between service providers and the complex nature of issues which have arisen involving child protection and the removal of her child."[248] The removal of her child had 'had a negative impact on FJ's mental health."[249] LWB staff noted FJ was resistant to initiating any independence and relied on support to access all services and needed more time and support to build her life-skills. She had no family support as all her family were in Iran.[250] It was submitted an additional 12 weeks' support would allow LWB staff to further support FJ to engage in appropriate services for her mental health and social wellbeing and build her basic life skills.

184. The DIBP was unable to provide an additional 12 weeks extension of the contract for LWB. It was believed the appropriate linkages had been established with mainstream services such as Medicare, Centrelink, etc and it would only have been in a very exceptional case that such transitional services would have been extended for someone with a visa. No such exceptional circumstances were seen to exist in this

[245] T 21 – 22.
[246] Exhibit 1, Tab 17A, Letter dated 19 August 2016, p. 2.
[247] T 34; Exhibit 1, Tab 17A, Letter dated 19 August 2016, p. 2.
[248] Exhibit 1, Tab 18D, SRSS Support Recommendation, p. 2.
[249] Exhibit 1, Tab 18D, SRSS Support Recommendation, p. 2.
[250] Exhibit 1, Tab 20.

case that would justify such a decision.[251] Instead, FJ was approved for a different programme, known as Complex Case Support, which was available to her.

185. This complex case support was administered at that time by the Department of Social Services (DSS), not the DIBP. The complex case support had been approved on the basis FJ had a number of complex needs, including mental health issues and behavioural concerns, child welfare concerns, and she had limited social supports and life skills.[252] Initially, the DSS allocated FJ's complex case support to ASeTTS, as it was one of the then CCS providers in Western Australia and FJ had previously received counselling from ASeTTS when in community detention.[253] LWB was not a complex case support provider so they were unable to perform this role.[254]

186. ASeTTS staff undertook an initial needs assessment with FJ and concluded that they were unable to assist her as, from their perspective, FJ had proven challenging to engage with. FJ also advised DSS staff that she did not wish to be supported by ASeTTS.[255]

187. I note the initial needs assessment document, which records FJ's responses to various topics, indicates she wished for ASeTTS psychiatric staff to provide a letter regarding her mental health and indicate she has fully recovered. She was recorded as having said she did not believe Dr Feutrill and ISHAR were helpful in supporting her legal case regarding her son. She stated that once her son was given back to her, all her stresses and hardships would be settled.[256]

188. As ASeTTS was not a viable option, a different service provided had to be found, and ultimately FJ's case was allocated to Maximus (MAX) Solutions. They were contracted to provide complex case support for FJ for a further period of four months and one week.[257]

189. The MAX Solutions Initial Needs Assessment was completed with FJ and it shows a detailed assessment was conducted and they had a good understanding of FJ's current needs at that time.[258] The goals for MAX Solutions were to assist FJ, generally through linkages with appropriate services, with:[259]

- child welfare issues;
- obtaining accommodation;
- management of finances;
- addressing her unemployment; and
- management of her mental health concerns.

[251] T 248 – 249; Exhibit 1, Tab 18, email from Abdul Azizi, 1.9.16 and email from Linda Bone, 31.8.16.
[252] Exhibit 3A.
[253] Exhibit 3A.
[254] T 248 - 250.
[255] Exhibit 3A.
[256] Exhibit 3B – Complex Case Support – Initial Needs Assessment - ASeTTS.
[257] T 251.
[258] Exhibit 3B - Complex Case Support – Initial Needs Assessment – MAX Solutions.
[259] Exhibit 3A.

190. A worker from MAX Solutions contacted Mr Azizi on about 20 July 2016 to advise him they would be taking over FJ's support.[260] A further conversation with Mr Azizi on 3 August 2016 allowed information on the current service delivery by LWB to be explained. It was made clear to MAX Solutions staff that FJ had previously resisted engagement with health services, so that was factored into the future planning.[261]

191. On 30 August 2016 Mr Azizi attended a handover meeting at FJ's accommodation with the DIBP Case Manager, Catherine Cheeseman, Tariq Kerbelker from the DCP, a MAX Solutions psychologist, Anita Kazmierczak, and FJ. Mr Azizi had arranged the meeting. The purpose of the meeting was to make sure that FJ knew her new case manager and understood what to expect following the transition of her care from LWB to MAX Solutions. Mr Azizi gave evidence that he hoped the meeting would ensure that FJ was well supported after the transition.[262]

192. During the visit, FJ was informed that the LWB contract would cease the following day and MAX Solutions would then provide support to her for 17 weeks.[263] They discussed each person's responsibilities and that MAX Solutions staff would tell her what they could do in terms of supporting her to achieve her goals that she had set with LWB. Mr Azizi recalled that FJ was not happy with the change in support provider but they explained that it had to occur. Mr Azizi also recalled that FJ seemed very upset in the meeting, and fixated on getting her son back into her care, so she was distracted and it was unclear how much she understood. However, it was clear that she was unhappy about changing providers again and having to retell her story to more people, which she understandably found traumatic.[264] She asked why she had to keep going through this "cycle of repetitiveness."[265]

193. It had been noted by a DIBP case manager at the time that MAX Solutions would be FJ's only support in the community once LWB disengaged.[266] FJ was also referred by LWB to Partners in Recovery (as part of Black Swan Health in WA) for support and the referral was accepted, but FJ declined to access the services. Ms Cheeseman was also no longer to be involved in FJ's management, given her new visa status, and she believed they completed a satisfactory handover to MAX Solutions at the time and FJ was well-linked with the community.[267]

194. Significant concerns had been expressed by LWB' staff about FJ's ability to afford private rental on her Special Benefit from Centrelink. She apparently had unrealistic expectations about what she could afford, given her financial position. Shared housing options were suggested but she did not wish to live with others as she felt it adversely affected her mental health. She was not content with the options offered by LWB. FJ was assisted to apply for priority public housing with the support of LWB, the DCP, RPH staff and Dr Bowater in July 2016 but due to the lengthy waiting period it was felt possible she might end up homeless. LWB staff requested FJ's

[260] T 64.
[261] Exhibit 3B – Complex Case Support – Initial Needs Assessment – MAX Solutions.
[262] T 54.
[263] Exhibit 1, Tab 18C, Case Plan, p. 7; Exhibit 2, Tab 8.
[264] T 54 55.
[265] T 55.
[266] Exhibit 1, Tab 18, email from Catherine Cheeseman 29.8.16.
[267] T 123 - 125.

accommodation be extended for another 12 weeks but this did not occur and she was required to move out of the government assisted transitional accommodation given the extension had not been granted.

195. In the end, FJ moved into a private new unit in Leonard Street, Victoria Park in September 2016.[268] She had contacted Mr Azizi the day before to ask him to help her view a rental property and he had reminded her that her request needed to be redirected to her new MAX Solutions case worker, Ms Kazmierczak.[269] Mr Azizi recalled FJ seemed disappointed but he felt he had no choice given the handover between service providers had occurred.[270] Ms Cheeseman recalls her last contact with MAX Solutions was to be advised that FJ had found a unit and was moving into the property. At the time, it sounded like FJ was happy and excited to be moving into her own home.[271] Ms Cheeseman did not have any further contact with FJ or MAX Solutions prior to FJ's death.

196. The Mirrabooka Clinic Case Manager, Mr Barclay, wrote to Dr Bowater on 23 September 2016 and advised that the referral to the Clinic was now closed as the service had been unable to make contact with FJ, although Dr Bowater gave evidence he did not receive this letter.[272] FJ's new unit was in a suburb that was under the catchment for Bentley Mental Health Services, not the Mirrabooka Clinic, so if a further referral had been made, it would have been to Bentley in any event.

197. The evidence indicates FJ did not always engage with her new support provider, MAX Solutions, after the transfer of her care from LWB on 1 September 2016. FJ did not attend scheduled face-to-face appointments with her case worker, Ms Kazmierczak, on 6, 13 and 30 September 2016 and 9 November 2016. However, Ms Kazmierczak was able to make phone contact with FJ on a number of occasions in September. Ms Kazmierczak had provided FJ with details of a community law service for financial counselling but FJ did not engage with that service and FJ also declined to engage with community mental health services.[273]

198. FJ was assisted by MAX Solutions staff to find new accommodation and she moved into a one bedroom unit in Victoria Park sometime around 13 September 2016. Ms Kazmierczak suggested affordable removal services but FJ indicated she would arrange it with her friends to reduce costs. Ms Kazmierczak helped her to problem solve some low cost furniture and kitchen appliance options to furnish her new home and also gave her some education in relation to her rights and responsibility in regards to rent, the bond process and the importance of communicating with other parties if unable to complete tasks on agreed deadlines.[274]

199. Mr Azizi, from LWB, gave evidence FJ was difficult to engage and had needed intensive support in order to build a relationship with her and gain her trust. He said

[268] Exhibit 1, Tab 17C and Tab 18C -18D.
[269] Exhibit 2, Tab 8.
[270] T 57.
[271] T 126; Exhibit 2, Tab 24.
[272] T 30; Exhibit 1, Tab 8 [9], p. 3; Exhibit 2, Tab 4 [23].
[273] Exhibit 2, Tab 10.
[274] Exhibit 3B – Complex Case Support – Milestone/Exit Report.

they had a very tailor made approach to ensure she was well supported and safe and had tried their level best to reunite her with her son in a safe manner that also ensured the wellbeing of her child.[275] It appears that the MAX Solutions staff member dealing with FJ did not have the LWB workers advantage of speaking FJ's language of Farsi,[276] which would have hampered the building of trust, and FJ had indicated she was unhappy with having to start again, which would also have made establishing a new support relationship more difficult.

200. The DCP staff were still trying to work with FJ around this time to facilitate contact between FJ and her son. It was planned for their contact to be observed by the Department's psychologist but this was unable to be arranged due to difficulties making appointments with FJ. Instead, the case manager Mr Kerbelker supervised the visits.[277]

201. On 25 September 2016 the DCP used its legislative powers to request relevant information from RPH in order to assess the safety and wellbeing of FJ's son.[278]

202. Sometime between August and October 2016 FJ suggested to Mr Kerbelker that she might return to Iran alone, or alternatively move to New South Wales.[279] Mr Kerbelker indicated FJ fluctuated with her plans as to where she might go and her accounts of whether her family were supportive of her returning home. She again mentioned the possibility of starting another family, in the context that she could not cope with waiting a lengthy period of time to regain custody of her son.[280]

203. A new DCP case worker took over FJ's son's case in late September/early October 2016 as Mr Kerbelker had resigned. On 7 October 2016 FJ attended a meeting with two DCP' staff members, facilitated by an interpreter. They explained that the purpose of the meeting was to discuss with FJ her plans. FJ indicated that she had not been feeling well and felt terrified and unsatisfied. She could only see her son twice a week and felt she was "being treated worse than an animal; a cockroach has more rights."[281] She said she did not want anything more to do with the DCP and did not want to continue in this manner. As a result, she appeared to have decided that she would sign over any custody rights to her son, stating she did not "want to be insulted any more"[282] and intended to return to Iran. It was explained to FJ that if she left Australia she might not be able to return and she appeared to understand this would be the case. It's evident FJ had taken this position out of frustration with the process, rather than a lack of love for her son. The DCP staff encouraged FJ to reconsider and suggested that permanent separation from his mother might not be good for her son. They also suggested she could go away and think about it more, but FJ indicated she did not want to continue engaging with the court process. During the meeting FJ wrote a letter with the assistance of her translator.[283]

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[275] T 54 – 55.
[276] T 54.
[277] Exhibit 2, Tab 15.
[278] Exhibit 1, Tab 7, p. 3.
[279] Exhibit 2, Tab 15.
[280] T 109 - 110.
[281] Exhibit 2, Tab 22A.
[282] Exhibit 2, Tab 22A.
[283] Exhibit 2, Tab 22A.

204. FJ's letter stated she wished to return to Iran and requested her son be left in the care of the DCP. It is clear from the content of the letter that she was unhappy with the authorities in Australia and she also suggested she was afraid she would experience other problems if she took her son home to Iran. Following the meeting all contact between FJ and her son was cancelled, as per her request.[284]

205. The new DCP case worker, Ms Anna Hendry, spoke to Ms Kazmierczak from MAX Solutions and advised FJ had indicated she wished to return to Iran without her son and she had been counselled by the DCP's cultural consultant about the risk associated with returning to Iran.[285]

206. I understand on 18 October 2016 Legal Aid requested she confirm her wishes. She did not respond and, after failing to appear in court for the custody hearing, Legal Aid withdrew their services.[286]

207. On 19 October 2016 FJ saw Dr Bowater for her last appointment. It was noted that her frequency of appointments had reduced, which he attributed to the fact she was living a significant distance away from his practice with no direct public transport available. However, at the time of this appointment she had moved to Victoria Park, just down the road from the surgery.[287]

208. FJ indicated during the consultation that she was struggling to keep up with her rent and bills and she thought she might have to go back and live in a detention centre again as it was the only way she could see her financial situation easing. She also still spoke of wanting to return home to Iran.[288] Dr Bowater commented that FJ had demonstrated her commitment by how many hurdles she had jumped by that stage to try to get her son back, but she was "just not coping"[289] by this stage.

209. She was given a repeat prescription for her lithium, noting her last lithium level taken the day before was within a normal therapeutic range. That was the last time FJ saw a doctor.[290] FJ had not seen a psychiatrist since she discharged herself from RPH at the end of July 2016. Dr Bowater gave evidence that he was still concerned about FJ's risk of suicide at this time, which he saw as a reaction to the situational crisis she was in, rather than due to any biological depression.[291]

210. On 1 November 2016 Ms Hendry advised Ms Kazmierczak that she had not had contact with FJ since 10 October 2016 and the court hearing on 24 October 2016 had been adjourned as FJ had not attended. The court hearing was now listed for 24 November 2016.[292]

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[284] Exhibit 2, Tab 22B and Tab 22C.
[285] Exhibit 3B – Complex Case Support – Milestone/Exit Report.
[286] Exhibit 2, Tab 22D.
[287] T 24.
[288] T 25 – 26.
[289] T 26.
[290] Exhibit 1, Tab 17C, Medical Records, Victoria Medical Group, 19.10.16.
[291] T 36.
[292] Exhibit 3B – Complex Case Support – Milestone/Exit Report.

211. There is an undated file note from a DSS staff member that Ms Kazmierczak spoke to them on an unknown date and indicated FJ was disengaging from CSS service and no longer wanted their support. Ms Kazmierczak had arranged an appointment for the following day to try to get FJ's agreement to engage with support. It appears Ms Kazmierczak was successful, as FJ did continue to engage with MAX Solutions until shortly before her death.[293]

212. Ms Kazmierczak last spoke to FJ on 3 November 2016 and FJ reported her unit was good and she was enjoying having a view of Perth City. She stated she would sit on the balcony with a tea or coffee to relax and doing this made her "feel happy."[294] She reported she was clear on her responsibilities regarding rent payments and had not had any tenancy issues. FJ had applied for over 200 jobs without success but had not yet received a response to any of her applications, so she was still managing on Centrelink. She explained that her job hunting had been the reason for failing to answer Ms Kazmierczak's calls in the previous days. They discussed ways FJ might be able to access work experience while looking for employment. FJ commented to Ms Kazmierczak that "everything is expensive" [295] but had been able to pay her bills so far and she was aware she could contact a financial counsellor if she began to struggle.

213. FJ was supposed to attend a face to face appointment with Ms Kazmierczak on 9 November 2016, arranged during the phone conversation on 3 November 2016, but FJ did not attend and did not make contact to explain why. Ms Kazmierczak made further calls to FJ on 9 November 2016 and 11 November 2016 but she was unsuccessful in making contact with her.[296]

214. In the final exit report prepared by Ms Kazmierczak, she notes that she had tried to refer FJ to Mirrabooka Clinic but FJ had declined to engage and still appeared to lack insight into her mental health condition. She had reported to Ms Kazmierczak in their last phone conversation on 3 November 2016 that she was compliant with her medication under Dr Bowater's supervision and she remained consistent in her view that she did not want to engage with mental health services.[297] Ms Kazmierczak believed she had managed to develop some rapport with FJ, despite her unreliability in attending face to face appointments or even answering calls on occasion, and she felt that MAX Solutions had largely achieved its goal of assisting FJ to become independent.[298]

[293] Exhibit 3B – File note of Donna Jenkins, undated.
[294] Exhibit 3B – Complex Case Support – Milestone/Exit Report.
[295] Exhibit 3B – Complex Case Support – Milestone/Exit Report.
[296] Exhibit 2, Tab 9 and Tab 10; Exhibit 3B – Complex Case Support – Milestone/Exit Report.
[297] Exhibit 3B – Complex Case Support – Milestone/Exit Report.
[298] Exhibit 3B – Complex Case Support – Milestone/Exit Report.

EVENTS LEADING UP TO HER DEATH

215. FJ had been in a relationship approximately two years prior to her death with Mr Ali Shehrabi, who lived and worked in Perth. They had travelled on holidays to Albany and Sydney and generally got on well together.[299]

216. On 12 November 2016 Mr Shehrabi telephoned FJ and they arranged to meet in the city. They met as arranged and Mr Shehrabi then drove them to Morley. Mr Shehrabi recalled FJ was upset because of the problems she was experiencing with her son and with immigration. They discussed her problems and he then tried to take her mind off them. Later in the afternoon they returned to Mr Shehrabi's home, where they shared a meal. He then drove FJ home and he stayed with her at her unit until he left at about 8.15 pm. FJ hugged him as he left and he thought she was in a happy mood at that time.[300]

217. A neighbour was reading a book at about 12.30 am the next morning when she heard a loud bang outside the apartment. She mentioned it to her husband, who went outside to check whether a car had hit something in the unit car park. He saw what he believed could be a body in the car park, so they made a report to police.[301]

218. At 12.38 am on Sunday, 13 November 2016, two police officers attended at 69 Leonard Street, Victoria Park, in response. They were met by the partner of the neighbour, who directed them to the location of FJ's body. The police officers observed FJ lying face down on her stomach on the bitumen of the unit block car park. She was fully clothed. It was apparent that she had multiple fractures to her head and body and she was lying in a pool of blood. There was no signs of a disturbance around her body and the unit complex was in darkness. St John Ambulance officers attended and deemed her injuries were incompatible with life. They certified FJ's death at the scene.[302]

219. Police officers forced entry to FJ's unit and found no persons present inside. The back door and flyscreen door were slightly ajar and a chair was positioned on the back porch next to the balcony edge, suggesting FJ had stood on the chair before jumping from the balcony. Neighbours were spoken to, who indicated they had not seen any other persons visiting FJ's unit. There were no signs of a struggle inside and police located various documents and FJ's watch and rings on a table inside her unit.[303]

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[299] Exhibit 1, Tab 12.
[300] Exhibit 1, Tab 12.
[301] Exhibit 1, Tab 13.
[302] Exhibit 1, Tab 9.
[303] Exhibit 1, Tab 9.

CAUSE AND MANNER OF DEATH

220. Forensic pathologist, Dr Daniel Moss, made a post-mortem examination of FJ on 22 November 2016. It revealed severe injuries to her head, neck, chest, abdomen and pelvis. There was no evidence of significant pre-existing natural disease. Toxicological analysis showed a low therapeutic level of the antidepressant amitriptyline. There was also a positive result for benzodiazepines. No alcohol or other common drugs were detected.[304]

221. Post mortem toxicology results also confirmed the presence of lithium at therapeutic levels, supporting the fact FJ had been compliant with her prescribed lithium medication, which was important for maintaining her mental state, and supported Dr Bowater's belief that her BPAD was well controlled.

222. Dr Moss formed the opinion the cause of death was multiple injuries.[305] I accept and adopt the opinion of Dr Moss as to the cause of death.

223. I am satisfied based upon the evidence obtained in the police investigation that no other person was involved in FJ's death and her death occurred by way of suicide. I note that Dr Bowater, who had perhaps one of the closest professional relationships with FJ over this time, gave evidence that when he heard about her death as a possible suicide he was not surprised, although he had hoped "we could have avoided it."[306]

COMMENTS ON PUBLIC HEALTH, SAFETY AND ADMINISTRATION OF JUSTICE

DCP

224. I do not propose to make many any comments about the management of FJ's son, other than to note it was a very difficult situation and the priority of those involved in considering his care were required to put his best interests first, irrespective of the impact this might have on FJ's mental health. Information was provided that women with schizophrenia are at significant risk of loss of their role as primary carer of their children, with either temporary or permanent custody loss occurring in an estimated 50% of mothers, so sadly FJ's loss of custody of her son was not uncommon for a person suffering from her particular mental illness.[307]

225. Mr Azizi, who had significant contact with FJ and was involved in trying to arrange care to support FJ and her son, accepted that there were valid concerns that FJ might harm her son prior to him being removed from her care the second time around the end of June 2016. He noted that LWB assisted her to get in contact with Legal Aid

[304] Exhibit 1, Tab 4 and Tab 5.
[305] Exhibit 1, Tab 5.
[306] T 36.
[307] Exhibit 2, Tab 19.

and she initially received a grant of Legal Aid, but it was withdrawn due to the way she interacted with her lawyer.[308]

226. Mr Azizi had regular contact with the DCP and accepted that the case worker, Mr Kerbelker, appeared to be genuinely attempting to reunite FJ with her son.[309]

227. Mr Kerbelker gave evidence that FJ had often behaved in a peculiar manner and he had sought guidance and expert assessment from the DCP' psychologist, but at no stage had FJ ever said anything to him about self-harm. When he found out about her death he was greatly saddened for both FJ and her son. He reflected on the fact that FJ had come to Australia in search of safety and a better life on a background of trauma and violence but the trauma had not stopped for her in Australia. Mr Kerbelker's focus throughout these events was on the immediate safety and ongoing safety of FJ's son and he was aware that FJ's son is now in very good care and apparently happy, but Mr Kerbelker acknowledged a very big part of him will be forever missing due to the loss of his mother. Nevertheless, Mr Kerbelker confirmed that at no time while he was involved in their case for those last few months did he consider FJ to be a safe person to care for him due to her mental state.[310]

228. I accept that DCP staff had to put the safety of FJ's son first and they did their best to try to help FJ through the process of reunification.

July RPH Admission

229. Some concerns had been expressed in the papers about the processes around FJ's non-standard direct admission to Ward 2K at RPH in July 2016. Dr Nigel Armstrong, a Consultant Psychiatrist and Head of the Department of RPH Psychiatry, suggested that there was an absence of documentation that made it difficult to fully understand why FJ had been admitted and what was her treatment plan while in hospital, as there was no referral letter from Dr Febbo and no accompanying risk assessment when she was admitted. Dr Armstrong did not have any personal involvement in FJ's case and worked off the medical notes and statements/reports of witnesses to provide his opinion.[311] Dr Armstrong, in effect, commented on the absence of record keeping as a problem in this case, as it made it difficult to decipher what had, and had not, been done during FJ's admission.[312]

230. It was accepted by Dr Febbo that since FJ's death, there has been a change in policy and an increased focus on Consultant Psychiatrist's completing their own documentation. He indicated in a similar case now, he would be completing a written risk assessment and documenting his own entries in the medical notes. Dr Armstrong stated that he, personally, finds it is beneficial to make his own notes as it gives clarity to his expectations of care for the patient.[313]

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[308] T 59.
[309] T 59.
[310] T 111 - 112.
[311] T 158 – 159; Exhibit 2, Tab 7.
[312] T 169.
[313] T 172.

231. As for the admission itself, it was clear to me from Dr Febbo's evidence that, while FJ's admission may have been slightly unorthodox, he facilitated it as he was aware that there was little prospect FJ would have cooperated with the usual admission process through the ED and he strongly believed she needed to be reviewed and supported as she was in crisis. Dr Armstrong agreed that Dr Febbo had a basis for concluding that FJ would find the ordinary admission via the ED traumatic so she would 'fit that mould'"[314] for an extremely rare non-standard entry to Ward 2K. The admission was arranged urgently and she did not actually arrive until the evening, when Dr Febbo was not on duty. Dr Allen had instructions to facilitate the admission and I am satisfied she carried out those instructions appropriately.

232. While FJ was in hospital, all efforts were made to try to make her admission flexible, to keep her in hospital as long as possible. Dr Allen managed to keep her engaged enough to return to hospital after overnight leave for the Monday meeting, but when it became clear to FJ that she would not be able to see her son while she was in hospital, she was not going to be able to be persuaded to stay. Neither Dr Febbo, nor Dr Allen, appears to have had any concern that FJ was unstable or unwell to the level that she might warrant being made an involuntary patient, so there were no options available to keep her there against her will.

233. Dr Bowater indicated at the inquest that FJ had great faith in Dr Febbo and he noted that Dr Febbo was the only person who Dr Bowater felt had helped him when he sought assistance in caring for FJ, once she left Commonwealth care.[315] He was very complimentary of the assistance he received from Dr Febbo and the input of Ms Webster in FJ's medical care.

234. There is a criticism that FJ was not referred to any Community Mental Health Service on discharge,[316] and it does appear that there was some confusion around who would be following her up in the community and who should initiate such a referral. I note Mr Barclay from Mirrabooka Clinic had tried to maintain communication with the hospital at an early stage, without much success, and he had anticipated that if FJ required follow up by them, they would have been advised by hospital staff. I accept the fact that FJ discharged against medical advice probably affected consideration of the community mental health service referral process, and I also note that when attempts were made to convince FJ to be referred later by her support provider, she declined to engage. However, it is an example of an area where better communication between individuals and agencies is needed.

235. There was also an error when the discharge summary was sent to the GP after FJ left the hospital. Although the current GP was correctly recorded as Dr Bowater by Dr Allen in the interim discharge summary and the medical students were aware of his involvement, a clerical error was made at the bottom of the discharge summary, which resulted in the discharge summary being sent to the wrong GP.[317] Dr Armstrong commented that it also would have been useful for RPH staff to have a

[314] T 185.
[315] T 34.
[316] T 168; Exhibit 2, Tab 7.
[317] T 166 – 167.

discussion with Dr Bowater about his expectations of care while FJ was in hospital and then to include him in the discharge planning.[318]

236. Dr Armstrong mentioned in his report that RPH has been emphasising to junior staff since this time that “transfer of care is an important part of ensuring ongoing safe medical care for patients discharged from their Team.”[319]

FJ’S Transition into State Health Care

237. Dr Bowater was asked to provide a report as part of the investigation into FJ’s death. Dr Bowater helpfully provided some documentation he had prepared to assist FJ in her court proceedings. He noted in his correspondence that when FJ was in community detention she had access to a private psychiatrist paid for by the Federal government, but when she was transitioned on to a temporary protection visa, this private service was withdrawn and her care was moved to the Western Australia public health system. Dr Bowater indicated he made two written referrals and several phone calls to the local Mirrabooka Community Health Service but as far as he was aware they did not arrange an appointment for her. Dr Bowater expressed his frustration as he felt as a practitioner he “was not being supported by the State funded Health Dept of WA (Psychiatric Section).”[320]

238. Dr Bowater commented that once she had left community detention and moved onto a visa, this was when “all the love had stopped. And now you’ve got no money. Look after yourself. Do the best you can. And the State health system will look after you … And this is when her stress levels dramatically increased.”[321] At the same time, FJ’s child was removed from her care again, so it was a very stressful time, with both her child and all the money removed.

239. As I have outlined earlier in this finding, there was an issue with the initial referral to community mental health services not being received by the Mirrabooka Clinic, and her inpatient admission at RPH threw out the second, successful, referral process. Dr Bowater gave evidence that he was unaware that FJ had not been accepted by the service due to her hospital admission and said the Mirrabooka service had communicated nothing to him. It was only through these court proceedings that he had become aware of what had occurred.[322]

240. It was accepted by Mr Barclay in his evidence that communication with the GP, in such instances, is important and he advised that there is more done to facilitate that kind of communication currently. However, Mr Barclay has been working at the Mirrabooka Clinic as a caseworker since 2004. He commented that the “workload pressure has been increasing steadily since 2004, with probably a brief respite during the COVID period.”[323] The caseload numbers have increased over time, as well as the complexity of cases and the acuity of cases. His view, which is echoed by almost

[318] T 168.
[319] Exhibit 2, Tab 7 [5].
[320] Exhibit 1, Tab 17A, Letter dated 2 December 2016.
[321] T 16.
[322] T 24.
[323] T 77.

every mental health practitioner who has appeared before me in an inquest, is that the staff are not well resourced enough to do the job that they would like to be doing and provide the care patients deserve, given the expanding population and increasing demand. He stated that he believes the service "is doing as well as it can under the circumstances, but it is still tragically the case that … at times the processes are not followed 100 per cent of the time."[324]

241. Dr Heble, who was the head of clinical services at Mirrabooka Clinic at the time of FJ's referral, and who is currently the Medical Co-Director of the Acute Mental Health Stream, overseeing inpatient mental health admissions to hospitals including Graylands Hospital and SCGH, agreed with Mr Barclay's comments that there is a greater use of and demand for the mental health service now.[325]

242. Dr Armstrong who is also well positioned to know about the current demand on mental health services, agreed with these comments. He noted the comments about services being stretched in 2016 and indicated "the trend is continuing in that direction"[326] particularly with unacceptably long wait times in the ED until a mental health bed becomes available.[327]

243. These comments do reinforce the correctness of Dr Bowater's opinion that FJ's move from Commonwealth detention, where her psychiatric care was well-funded, to life as a free citizen in a chronically underfunded State mental health system, was ironically not to her benefit. I have no doubt FJ benefitted from being able to live independently and make her own decisions about her life, but certainly her mental health care suffered.

244. I acknowledge that there was an indication in the LWB records that FJ had declined to access the Mirrabooka Clinic services. She had also declined to see a counsellor at the ISHAR Multicultural Women's Health Centre and a service called Partner in Recovery.[328] MAX Solutions staff also were unable to convince FJ to engage with community mental health services. Further, she chose to discharge herself from the mental health ward of RPH against medical advice, so it was clear she was reluctant to engage with the mental health services that were on offer to her. Nevertheless, it is relevant that from the time of her discharge on 25 July 2016 until her death on 13 November 2016, it does not appear that FJ was seen by any psychiatrist or mental health practitioner. Her only medical reviews were performed by Dr Bowater, who had been asking for help and received none.

Transcultural Mental Health Service

245. FJ had been a patient of the Transcultural Mental Health Service (TMHS) that was previously run at RPH, earlier when in detention, and this was where she first met Dr Febbo. Dr Febbo explained that until it closed down, the TMHS provided a

[324] T 77.
[325] T 86.
[326] T 170.
[327] T 170.
[328] Exhibit 1, Tab 18C.

service for transcultural patients who found it difficult to access mainstream health services. He understood the purpose of the service was to capture patients who might otherwise slip through the cracks because of their cultural background.[329]

246. The TMHS included two psychiatrists, a social worker and a psychologist. The patients were primarily people from non-English speaking backgrounds, In Dr Febbo's experience, the issues that patients from those backgrounds often face include:[330]

- Mental health literacy deficits (which can include a lack of both awareness of where treatment or assistance might be found, and awareness of the need for assistance and treatment);
- Cultural stigma attached to mental health disorders and issues, which may affect access to treatment; and
- Concerns that having mental health issues, or treatment for mental health issues, may exacerbate existing disadvantages or issues for the patient.

247. Dr Febbo suggested that FJ's tragic case "highlights the vulnerability of people from transcultural backgrounds to mental health issues and the need for a specialised mental health service like the TMHS."[331]

248. Dr Armstrong was asked about the TMHS during his evidence and he indicated the service had previously come under his governance when he was head of service. Dr Armstrong acknowledged the TMHS provided a valuable service, but advised that at a later stage the referrals reduced, so it was ultimately disbanded and the patients were diverted to the care of the various community mental health clinics. Dr Armstrong noted there are still some culturally appropriate services in the community.[332]

249. In submissions, further information was provided by Dr Armstrong, indicated that transcultural services are provided by all Mental Health Services as part of their core clinical work, and to his knowledge, the closing of the Transcultural Mental Health Services did not leave a gap in service and there are no clinical indicators that there is a need to re-establish the Transcultural Mental Health Services. Dr Aleksandra Jaworska, Medical Co-Director of the Mental Health Division, Royal Perth Bentley Group, reportedly agrees with Dr Armstrong's opinion.

250. I am somewhat surprised by this submission, given the evidence of Dr Febbo, a very experienced Consultant Psychiatrist who has worked in the service and considered it to be a very good service for people like FJ. It is quite clear that the current system did not afford FJ the level of care she required, did not assist Dr Bowater to help her, and the only person who was able to help him was Dr Febbo, who knew her from that very same service.

[329] Exhibit 2, Tab 16.
[330] Exhibit 2, Tab 16 [13].
[331] Exhibit 2, Tab 16 [100].
[332] T 169.

251. However, given the limited information available to me, and the fact that two very senior Consultant Psychiatrists in the Department of Health do not support the reinstation of this service, I do not make a recommendation to that effect, even though I could see how referral to a service such as this would have been a very simple solution for some of the problems that were faced in FJ's case.

252. I do, however, urge both the relevant decision-makers in the Department of Home Affairs and the Western Australian Department of Health to have a discussion about how they can ensure that there is a better method for complex cases like FJ to be psychiatrically supported when they transition out of detention and into the community. In my view, there needs to be a senior representative from the relevant State Mental Health Service that the person will come within as a patient included in any meeting that takes place as the transition occurs, so that they can make suggestions about how the client can be referred in a way that ensures there is an understanding of the background and ensure that the client will not slip through the cracks in the way it appears FJ did. It is entirely unfair to put that responsibility on a GP such as Dr Bowater, and then expect him to spend lengthy periods of time waiting on hold on the telephone to get through to someone in the service when he has sent a referral.

253. In making these comments, I entirely accept that mental health resources are stretched in Western Australia and the staff and clinicians do their best to provide an adequate level of care at a time when demand regularly outstrips beds and staff numbers. The fact that a community mental health service will generally decline to take on a patient with chronic mental illness when they are 'stable,' because they really only have capacity to deal with those people acutely unwell, is indicative of a lack of resources and government funding for community mental health services in general. Surely a better system would be to have sufficient resources to allow staff to manage chronically ill patient, and establish rapport with them over time, so when they become acutely unwell they are willing to receive help? It is an area of ongoing concern that I am hopeful the State Government will focus more attention on as a new term of government is imminent and the problem is not going away.

254. However, my current comments are limited to the smaller number of mental health patients who can be identified as at increased risk and particular vulnerability, knowing their background. The DIBP staff rightly considered FJ to be a complex case, requiring more support than the usual case, but there needs to be a mechanism for bringing such people into the sphere of the decision makers within State psychiatric services. Dr Heble gave evidence of how that could be done, in the sense that he would have attended the meeting on 3 May 2016 if he had been invited, and that would appear to be a very simple solution in a future case.

Continuity of Care

255. A recurring theme in the notes of various people dealing with FJ from the different agencies was the complexity of her case and the difficulties presented by so many agencies being involved in supporting her. This is a list of the main organisations/practitioners involved in FJ's life in the period prior to her death, due to her immigration, mental health and child custody issues:

- Australian Red Cross
- ASeTTS
- Bentley Hospital
- DIBP
- Department of Social Services
- DCP
- GP – Dr Max Bowater
- Graylands Hospital
- IHMS – in particular via the Elizabeth Clinic
- KEMH
- Legal Aid
- LWB
- MAX Solutions
- Mirrabooka Clinic
- Mulberry Tree Child Care Centre
- RPH
- SCGH
- Transcultural Mental Health Centre
- Webster Kids.

The sheer volume of this list gives some indication of the complexity of FJ's case.

256. The general evidence was that all of the individual staff from the different agencies made substantial efforts to communicate with each other and they worked well together. Counsel for the DIBP submitted that there was a great deal of respect between the organisations and a real acknowledgment of the hard work and care that had gone in to trying to help FJ, and I agree with his submission.[333] All of the staff should be commended for their efforts. However, the reality is that FJ was required to move between a number of support agencies and speak to many different people for all number of reasons, which she understandably found frustrating and a violation of her privacy at times. Even though she was by all accounts bright and well-educated, for an Iranian woman who did not speak English as a first language and who had suffered trauma and was continuing to live under stress, it must have been extremely difficult for FJ to develop rapport and trust with others and the constant change of people appeared to make that even harder.

257. The DIBP has explained why it was not possible for FJ to continue to have support from LWB after her SRSS ended. I accept that the DIBP, in conjunction with the staff from MAX Solutions worked hard to help FJ through the transition to a new support agency. Nevertheless, in my opinion, the large number of organisations/specialists involved in FJ's management led to some fragmented care and difficulties with FJ forming meaningful, therapeutic relationships, particularly at this difficult time. FJ also lost access to her private psychiatrist at Elizabeth Clinic, lost her accommodation and Ms Cheeseman, who had clearly been a support at

[333] T 281.

times, no longer needed to be involved in her case. She then lost the support of Mr Azizi and LWB.

258. Mr Azizi gave evidence he was very upset and disappointed when he was informed of FJ's death as he felt her death could have been averted.[334] It was apparent he had tried very hard to help FJ accept mental health care and engage with DCP without success.

259. Ms Cheeseman said she was "shocked and devastated"[335] to learn of FJ's death. She described FJ as a "lovely person, friendly, trusting, exuberant and happy"[336] who had loved her son and had found it very distressing not to be able to care for him.

260. Dr Bowater's obvious distress at FJ's death, and what he perceived as his failure to help her, was also a sign of how much people had tried to help FJ receive the care she needed. Dr Bowater commented in his evidence that he knew FJ had put a lot of faith in him to solve her problems, but he had not been successful.[337] It was certainly not through lack of trying on his part. Dr Armstrong expressed his opinion that "Dr Bowater is to be commended for driving this inquest"[338] and I agree.

261. What this inquest has shown is that, irrespective of the best intentions of individuals, there are some inherent problems in the system, and people like FJ can struggle to transition into the community and may require a different support system. There needs to be some more flexibility available to bend the rules in complex cases such as hers.

262. Ms Lauren Richardson, who currently holds the position of Director of Global Talent and Regional Outreach in the Immigration Programs Division of the Department of Home Affairs, but who has previously held the role of Director of the Status Resolution Support Services program management,[339] gave evidence about the current SRSS and CSS programs run by the Department. Both services are now administered by the Department of Home Affairs, as well as an additional program called Specialist and Intensive Services (SIS), which provides similar services to CSS.[340] Ms Richardson advised that there are currently four providers registered with the Department that are to provide services across these programmes, although currently none of them are in Western Australia.[341] Ms Richardson accepted that there would be benefits from using the same provider, to ensure continuity of care, but noted that where that cannot be achieved, efforts are made to brief the project management team for CSS or SIS early in complex cases, to ensure that services are ready for the client when the visa is granted. However, this does not solve the issue that FJ faced, of reaching a high level of fatigue having to tell her story to multiple people and establish a rapport with new staff members repeatedly.

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334 T 58 – 59.
335 Exhibit 2, Tab 24, [76].
336 Exhibit 2, Tab 24, [75].
337 T 24.
338 T 170.
339 T 242 – 243.
340 T 250.
341 T 251.

263. I encourage those who set the policies for the Department of Home Affairs, and who are involved in engaging service providers, to consider the importance of continuity of care in these cases and make efforts to ensure that, where possible, there is the option of a client having the same support agency assisting them throughout the process.

CONCLUSION

264. FJ was an Iranian woman who had a history of mental health issues, which began before she came to Australia and then continued after her arrival and detention in Australia. She had suffered several relapses while in Australia that required hospitalisation, including a particularly lengthy admission while she was pregnant with, and immediately after the birth of, her son. Her ability to care for her son was affected by her mental health issues, but the removal of her son from her care also detrimentally affected her mental health as she loved him and wanted him with her.

265. FJ was clearly vulnerable to the effects of stress. The stress caused by the uncertainty of her visa situation and whether she would return home, cultural differences, past traumas and recent domestic violence, financial insecurity and insecurity about care and custody of her son all appear to have played a role in her deteriorating mental state during her final years in Australia.

266. Although there were good intentions by all those involved in her case, there were an excessive number of services involved in FJ’s management, which caused confusion and fragmented care, particularly as she transitioned from detention and into the community on a visa.

267. At the time of her death, it is apparent that FJ had lost faith in the child protection system and felt hopeless about the prospect of regaining custody of her son. She had declined to receive psychiatric treatment and discharged herself from hospital against medical advice a few months before and there had been no follow up by any outpatient service and she had declined to be referred again by her support provider. She appears to have lost trust in the mental health system, and so her mental state was not able to be regularly monitored, other than by her GP. He last saw her a few weeks before her death, and was concerned about her mental state but felt he had little avenues to refer her for more specialised assistance, given his previous efforts had not been successful.

268. On the night of her death it appears FJ made an impulsive decision to end her pain and suffering and jump from the balcony of her unit. I have found her death occurred by way of suicide as, although she was clearly in a depressed mental state, there is no evidence to suggest she did not have the capacity to understand the nature of what she was doing.

269. This is a very sad case that has clearly affected many of the people involved. I hope that we can learn some lessons from FJ’s needless death and find a better way to

support people like her when we are welcoming them into our community. Better communication and continuity of care must be the goal.

S H Linton
Coroner
25 March 2021