IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 4727

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Samuel Carl JOHANSEN
Delivered on:	28 February 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	Directions Hearing on 13 September 2016 Inquest at Wangaratta on 13- 14 October 2016
Findings of:	Coroner Paresa Antoniadis SPANOS
Counsel assisting the Coroner:	Leading Senior Constable Stuart HASTINGS from the Police Coronial Support Unit
Representation	Mr Paul HALLEY of Counsel appeared on behalf of Dr Jennifer Nan ELLIX Ms Naomi HODGSON of Counsel appeared on behalf of NORTHEAST HEALTH and ALBURY-WODONGA HEALTH
Catchwords	Psychotic illness, recent inpatient admission, voluntary patient, drug related death, multi-organ failure complicating injecting drug use

TABLE OF CONTENTS

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of SAMUEL CARL JOHANSEN

and having held an inquest in relation to this death at Wangaratta 13 and 14 October 2016:

find that the identity of the deceased was SAMUEL CARL JOHANSEN

born on 7 February 1976, aged 36

and that the death occurred on 6 November 2012

at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065

from:

I (a) MULTIORGAN FAILURE COMPLICATING INJECTING DRUG USE

in the following circumstances:

INTRODUCTION[1]

1. Mr Johansen was born in Melbourne and raised and educated largely in Wangaratta. Mr Johansen was survived by his parents Dan and Sylvia Johansen and his siblings. He was a valued member of his family remembered as a loving person. In her statement in the coronial brief, Mrs Johansen reproduced a note that her son had placed on the wall by his bed under the title of epitaph – "Work hard Sam. Be smart. Always forgive. Help others."

2. Mr Johansen started exhibiting difficult behaviours in the later years of his secondary education. He left school at 16 and started working in the family business. When Mr Johansen began using drugs, his behaviour became even more problematic. In his early 20s, he became very involved in body building and started using steroids. At about this time it became apparent to his family that he was also using heroin.

3. Mr Johansen had an involved and supportive family who maintained a relationship with him through all his difficulties over many years. His mother, in particular, remained involved in his life, saw him regularly (virtually daily) and provided him with ongoing support. Mrs Johansen was her son's strongest advocate.

EARLY PSYCHIATRIC HISTORY

4. When Mr Johansen was a teenager and following a plane crash, he was diagnosed with post-traumatic stress disorder, but his first known contact with an *adult* public mental health service was in 1999 at the age of 23 years. At this time Mr Johansen was admitted to the

[1] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances that were contentious and will be discussed in some detail below.

Kerferd Psychiatric Unit, Wangaratta, part of the Northeast Health Service [the Kerferd Unit], as an involuntary patient under the ***Mental Health Act 1986*** (the MHA) after threatening his mother and members of Victoria Police. His actions were seen to be in the context of depression and cannabis use and he was ultimately discharged to seek help with his substance abuse. Later that year, despite referring himself to Wangaratta Community Psychiatry Services, he did not engage with the case management offered by that service.

5. Matters came to a head again in 2002, when Mr Johansen was assessed following a siege involving Victoria Police. He was believed to have been substance affected at the time of the siege and ultimately assessed as not requiring psychiatric care. Later that year, Mr Johansen was transferred to the Kerferd Unit via Bendigo Psychiatric Inpatient Unit and a drug rehabilitation program he had been bailed to. During this admission, Mr Johansen was treated for psychotic depression and advised to decrease or preferably cease his substance use altogether in the interests of his mental health. On this occasion, he was referred to community psychiatry for follow-up after discharge but did not really engage and was discharged from that service after only attending two appointments.

6. Also in 2002, Mr Johansen commenced on opiate replacement pharmacotherapy with methadone and was admitted to private psychiatric hospitals in Melbourne and ultimately discharged to the care of his local general practitioner [GP] Dr Bruce Wakefield for follow-up. Mr Johansen remained relatively stable in the community for almost the next ten years. He was treated and supported by Dr Wakefield and living independently in his own premises facilitated by his family and supported by them.[2]

DETERIORATING MENTAL HEALTH IN 2012

7. In January/February 2012, Mr Johansen started exhibiting increasing paranoia with security doors, window mesh and CCTV cameras being installed at his home which his mother described as being 'like a fortress'.[3]

8. From 22 August 2012, and following referral by his sister, Mr Johansen was assessed as suffering an exacerbation of psychosis and received intensive treatment and support from Wangaratta Community Psychiatry [community psychiatry]. Mr Johansen was sleeping poorly and had possession of medications that were unaccounted for. He was experiencing auditory hallucinations, expressing paranoid thoughts and was difficult to engage. His mother expressed a number of concerns to community psychiatry clinicians, including (relevantly) a

[2] It is fair to say that Mr Johansen was not entirely symptom free during this time. See Exhibit B where A/Prof Newton makes the assessment that – *"Between his imprisonment in 2002 and 2012, his family describes ongoing disability with difficulty in maintain his functions of daily living but maintained some reasonable stability of his mental state."*
[3] Statement of Ms Sylvia Johansen dated 15 March 2013, Exhibit A, at page 29 of the coronial brief.

concern that he might continue to self-medicate until the voices were gone and inadvertently harm himself in the process. She was rightly concerned for his welfare and safety.[4]

9. The management plan developed by community psychiatry at this time involved support from his family, medication adjustments and intensive community management. From 22 August until mid-September 2012, Mr Johansen was reviewed either by telephone or home visit on twelve occasions including a psychiatric review during a home visit on 11 September 2012.[5]

10. After some initial improvement in his mental state with community psychiatry management, Mr Johansen's condition deteriorated. He was poorly compliant with his medication regime, floridly psychotic and making plans to travel to Melbourne without accommodation in place, when on 15 September 2012, he was made an involuntary patient and admitted to the Kerferd Unit.

FINAL ADMISSION – 15 SEPTEMBER – 23 OCTOBER 2012

11. The adequacy of the clinical management and care provided to Mr Johansen during his last admission to a psychiatric facility was the primary focus of the coronial investigation and inquest into Mr Johansen's death and will be discussed in some detail below.[6]

12. Suffice for present purposes to say that Mr Johansen was treated in the Kerferd Unit as an involuntary patient until 15 October 2012 when his mental state had sufficiently improved for him to be discharged from his involuntary status. Thereafter he remained in the unit as a voluntary patient until 23 October 2012 when, after an incident involving a perceived interference with his night vision goggles and a threat to a staff member, Mr Johansen elected to take his own discharge.

EVENTS FOLLOWING DISCHARGE

13. Mr Johansen's movements and state of mind in the days immediately following his discharge will be discussed below as they are relevant to his state of mind and to the issue of "intent".

14. Suffice for present purposes to say that while the evidence of friends and family suggests there was nothing overt in his behaviour to indicate he was acutely unwell or to raise concerns for his welfare at the time, CCTV footage (obtained by police after his death) from the system

[4] See Exhibit E Discharge Summary for a description of the incident that preceded increased support from WCP "increased support…following minor overdose of prescribed medication (7x200mg quetiapine) in an effort to either "get rid of the voices" or end his life."
[5] Statement of Dr Jennifer Nan Ellix dated 29 November 2012, Exhibit C.
[6] See discussion at paragraphs 36 and following below.

installed by Mr Johansen at his home, suggests that by 1 November 2012, he became quite unwell and as suffering from the paranoia and delusions that were a feature of his illness.[7]

15. Mr Johansen was last seen alive by his family on the evening of 31 October 2012 and by the family's gardener the following morning. From the afternoon of 1 November 2012, Mrs Johansen could not contact her son and started to become concerned for his welfare. Mrs Johansen, her husband and others tried to make contact with Mr Johansen but were unsuccessful. The CCTV footage affords a rare insight into Mr Johansen's last hours and captures what appears to be his last movement, a collapse onto the floor, at about 12.16pm on 1 November 2012.

16. When the police responded to a request for a welfare check and gained entry into Mr Johansen's home at 5.10pm on 2 November 2012, some 29 hours later, they found him unconscious but still breathing on the kitchen floor and called for an ambulance. They also found empty tablet bottles, evidence of injecting drug use and methylated spirits at the scene.

WANGARATTA AND ST VINCENT'S HOSPITALS – 2 TO 6 NOVEMBER 2012

17. Ambulance paramedics assessed Mr Johansen as having a Glasgow Coma Score of 7 [GCS][8] and stabilised him before transporting him to Wangaratta Hospital. There he was diagnosed with left upper limb compartment syndrome[9], presumed to be due to a recent intravenous injection and underwent a fasciotomy.[10] Thereafter Mr Johansen went into acute renal failure secondary to rhabdomyolysis,[11] was commenced on noradrenalin infusion for haemodynamic instability and transferred to St Vincent's Hospital.

18. On the morning of 3 November 2012, Mr Johansen was admitted to the Intensive Care Unit [ICU] at St Vincent's Hospital for further management. He remained intubated, was in acute renal failure with metabolic/respiratory acidosis and was commenced on a heparin infusion.

19. Mr Johansen's clinical course was complicated by ongoing haemodynamic instability requiring noradrenalin and vasopressin, and ongoing difficulty maintaining adequate

[7] A summary of the events depicted on CCTV footage between 26 October 2012 and entry by police shortly after 5.00pm on 2 November 2012 and discovery of Mr Johansen after his collapse some 28 hours earlier.
[8] A standardised system for assessing response to stimuli in a neurologically impaired patient; reactions are given a numerical value in three categories (eye opening, verbal responsiveness, and motor responsiveness), and the three scores are then added together. The maximum score is 15 and the lowest values are the worst clinical scores.
[9] A condition in which increased tissue pressure in a confined anatomical space causes decreased blood flow leading to ischaemia and dysfunction of contained myoneural elements, marked by pain, muscle weakness, sensory loss and palpable tenseness in the involved compartment. Ischaemia can lead to necrosis resulting in permanent impairment of function.
[10] Fascia – a sheet or band of fibrous tissue such as lies deep to the skin or forms an investment for muscles and various other organs of the body. Fasciotomy – surgical incision or transection of fascia, often performed to release pressure in compartment syndrome, as in this case.
[11] Disintegration or dissolutions of muscle (associated with excretion of myoglobin in the urine).

ventilation and oxygenation, despite ventilatory support. He was diagnosed with acute respiratory distress syndrome secondary to rhabdomyolysis.

20. Mr Johansen's family were kept informed of his prognosis during the course of his admission and a decision made by treating clinicians in conjunction with the family to limit treatment such that he would not be resuscitated in the event of a cardiac arrest. On 6 November 2012, Mr Johansen had a rapid loss of cardiac output and subsequently passed away.[12]

INVESTIGATION AND SOURCES OF EVIDENCE

21. This finding is based on the totality of the material the product of the coronial investigation of Mr Johansen's death. That is, the brief of evidence compiled by First Constable Ashley Coysh from the Wangaratta Police, additional material obtained by my assistant Leading Senior Constable Stuart Hastings, from the Police Coronial Support Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel.

22. All of this material, together with the inquest transcript, will remain on the coronial file.[13] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

23. The purpose of a coronial investigation of a *reportable death*[14] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[15] It is self-evident that Mr Johansen's death falls within the definition of a reportable death.

24. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined

---

[12] Mr Johansen's clinical course is summarised in the Medical Deposition provided by St Vincent's Hospital clinicians when his death was reported to the coroner and this is replicated in the autopsy report of Dr Heinrich Bouwer at page13 of the coronial brief. In his statement dated 19 July 2013 at pages 51-57 of the coronial brief, Dr Harn-Ying Ong, ICU Specialist (Consultant Intensivist) from St Vincent's Hospital provided a more detailed outline of Mr Johansen's clinical course from 3-6 November 2012.

[13] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[14] The term is exhaustively defined in section 4. Apart from a jurisdictional nexus with the State of Victoria (see section 4(1)), reportable death includes *"a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury"* (see section 4(2)(a) of the Act).

[15] Section 67(1).

to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[16]

25. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[17] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[18] These are effectively the vehicles by which the coroner's prevention role can be advanced.[19]

26. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[20]

FINDINGS AS TO UNCONTENTIOUS MATTERS

27. There were no contentious issues surrounding Mr Johansen's identity, nor about the date and place of his death. I accordingly find, as a matter of formality, that Samuel Carl Johansen, born on 7 February 1976 and aged 36, late of 15 Green Street, Wangaratta, died at St Vincent's Hospital, Victoria Parade, Fitzroy, on 6 November 2012.

MEDICAL CAUSE OF DEATH

28. There is some lack of clarity about the medical cause of Mr Johansen's death, arising in the main from the length of time between his apparent collapse at about 12.16pm on 1 November 2012 and his discovery by Victoria Police at about 5.10pm on 2 November 2012, over 28 hours later.[21] During this time, it is likely that any substances ingested by Mr Johansen,

---

[16] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)
[17] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.
[18] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[19] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[20] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).
[21] A detailed chronology of events inside Mr Johansen's home as depicted in the CCTV footage is provided by the Coronial Investigator at pages 78-83 of the coronial brief (Exhibit H).

continued to metabolise, so that the levels detected in ante-mortem samples taken on admission to St Vincent's Hospital on the morning of 3 November 2012 are likely to be much lower than at the time of his original collapse, almost two days earlier.[22]

29. Forensic pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine [VIFM] reviewed the circumstances as reported by the police to the coroner, the medical records and medical deposition from St Vincent's Hospital and post-mortem CT scanning undertaken at VIFM and performed an autopsy. Dr Bouwer provided a detailed written report of his findings at autopsy and comments pertaining to the cause of Mr Johansen's death.[23]

30. Dr Bouwer's anatomical findings included status post left arm fasciotomy for compartment syndrome; cellulitis left arm; necrotic skin ulcers left arm and possible needle track marks in the cubital fossa; cardiac disease in the form of marked cardiomegaly (asymmetrical left ventricular hypertrophy, marked septal thickening up to 2.5cm, focal fibrotic plaque in the left ventricle outflow tract, moderate double vessel coronary artery atherosclerosis); marked generalised oedema as well as marked lung oedema, bilateral pneumonia, marked bilateral pleural effusions (left 500ml, right 300ml), ascites (300ml) and a congested liver.

31. Dr Bouwer commented that Mr Johansen had marked cardiomegaly with his heart weighing almost double the average expected for a man of his height and weight. He advised that the most common cause of cardiomegaly is hypertension but that cardiomegaly may also be associated with ischaemic heart disease, valvular disease, cardiomyopathy and the use of some stimulant drugs.[24]

32. Dr Bouwer observed that toxicological analysis of ante-mortem samples received from St Vincent's Hospital, as well as post-mortem samples collected at autopsy, detected methadone, EDDP/a methadone metabolite, morphine, codeine,[25] quetiapine, fluoxetine, midazolam, lignocaine and ranitidine, some of which may have been administered in the therapeutic setting. He also noted that possibility that drugs that may have been injected (or ingested) by Mr Johansen prior to his collapse, may have been completely metabolised and may therefore not have been detected during toxicological. Relying on the results of toxicological analysis, Dr Bouwer advised that Mr Johansen's cause of death is best formulated as *multi-organ failure complicating injecting drug use*.

---

[22] See the toxicologist's report at page 15 of the coronial brief (Exhibit H). The ante-mortem blood sample subject to routine toxicological analysis at the Victorian Institute of Forensic Medicine was taken at St Vincent's Hospital at 0750 hours on 3 November 2012. Post-mortem blood and urine were also tested.
[23] Dr Bouwer's report outlining his formal qualifications/experience is at pages 1-14 of the coronial brief (Exhibit H).
[24] Although the presence of cardiomyopathy was not confirmed, as cardiomyopathy may be inherited, Dr Bouwer strongly recommended that Mr Johansen's first degree relatives undergo review by a cardiologist.
[25] Morphine and codeine are available as drugs in their own right but they were detected at the levels consistent with the recent use of heroin of which morphine is a metabolite and codeine a common contaminant.

33. The toxicologist's report[26] advised that records from the Department of Health showed that Mr Johansen was being dosed with methadone at a dose of 6mg daily with evidence that he took supervised doses on 25 and 26 October, was supplied with three takeaway doses on the latter date for unsupervised consumption on 27, 28 and 29 October, and that he was again dosed under supervision on 30 and 31 October 2012. This was his final attendance for supervised dosing and no further takeaway doses were provided to him. Mr Johansen was due for regular supervised dosing the following day 1 November 2012.

34. The toxicologist further advised that the drugs detected are consistent with the use of methadone, morphine/heroin/codeine, fluoxetine and quetiapine and noted that other drugs such as midazolam and lignocaine may have been administered therapeutically by hospital staff. This is consistent with Mr Johansen's known clinical course as documented in the medical deposition and medical records provided by St Vincent's Hospital.

35. The available evidence supports a finding that the cause of Mr Johansen's death is multi-organ failure complicating injecting drug use.

THE FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

36. The primary focus of the coronial investigation of Mr Johansen's death was on the adequacy of the psychiatric management and care provided to him in the period immediately preceding his death. While it could be said that Mr Johansen's last engagement with public psychiatric services commenced with the referral made on 22 August 2012 to the Wangaratta Community Psychiatry [WCP], there was no serious suggestion of deficiencies in his management by this service.[27] Nor was there any serious suggestion that Mr Johansen's admission to the Kerferd Unit, facilitated by the WCP was other than appropriate.

37. Ultimately, the primary focus was on the adequacy of the psychiatric management and care provided to Mr Johansen during his last inpatient admission, in particular, as the context for evaluation of his discharge and follow-up in the community.[28]

---

[26] The report of toxicologist Dr Mark Chu is an addendum to the autopsy report at pages15-23 of the coronial brief.
[27] I note the comments made by Associate Professor Richard Newton about Mr Johansen's presentation to Wangaratta Hospital ED after an overdose on quetiapine on 7 September 2012 and the apparent disconnect between the ED doctor's assessment and that of the mental health clinician. *"…he was identified as being unable to control his auditory hallucinations hearing voices telling him to "waste himself". He said, "I would rather be dead than have them". He reported taking 1.4gms of quetiapine in order to make the voices go away or for him to die…referred to the mental health service…The person who assessed him at this time, believed that the overdose was in the context of wanting to get rid of the voices and stated that there was 'nil deliberate self-harm'…This assessment specified that his hallucinations were not command hallucinations or violent…the difference between the emergency physician's assessment that he had significant command hallucinations telling him to "waste himself", that he could not control and the assessment that he did not have command hallucinations on the same day was not explored."*
[28] Transcript of Directions Hearing at page 6.

38. Another focus of the coronial investigation was Mr Johansen's state of mind at the time that he ingested the substances that led to his collapse on or about 1 November 2012 and his subsequent death on 6 November 2012, and whether he intended to self-harm and/or to cause his own death.

ADEQUACY OF PSYCHIATRIC MANAGEMENT AND CARE

39. The clinical management and care provided to Mr Johansen is to be gleaned from the relevant medical records and the statements and evidence of Consultant Psychiatrist Dr Ellix, the statements and evidence of Ms Sally Anfruns, Registered Psychiatric Nurse and Discharge Coordinator at the Kerferd Unit and the statement of Mr Casey Fahey, Registered Psychiatric Nurse and Mr Johansen's Case Manager in the Community.

40. On admission to the Kerferd Unit on 15 September 2012, Mr Johansen appeared polite but with underlying irritability. He reported poor sleep and poor appetite. He seemed preoccupied and distracted, was experiencing auditory hallucinations and expressing litigious themes and paranoid themes about people attempting to gain entry to his home. He described high level security devices installed in his home.[29]

41. On 17 September 2012, Mr Johansen was reviewed for statutory purposes by Consultant Psychiatrist Dr Jennifer Ellix. According to her statement, Mr Johnsen's compliance with medication was poor (he was thought to be taking less than half his prescribed dose of the antipsychotic quetiapine[30]), he was floridly psychotic at the time of admission and making plans to travel to Melbourne although he had no accommodation.

42. A more fulsome description appears in the progress notes and discharge summary where Mr Johansen is described as uncooperative, irritable, threatening and expressing litigious themes about suing staff. He had a restricted affect, was cognitively alert, with slightly increased speech tempo, normal thought form but content that was grandiose, entitled and threatening. Mr Johansen lacked insight and was seeking a private hospital admission but assessed as too unwell for private hospital management.[31]

---

[29] Documented in the progress notes but conveniently summarised in Exhibit E. See also Exhibit B, statement of A/Professor Richard Newton at page 69 of the coronial brief *"On the 15th September, it was decided to admit him to hospital in the context of poor compliance with medication, irritability with parents and persecutory beliefs leading him to want to leave the area. During the admission process, it was further identified that adherence to prescribed medication being an ongoing problem and that he was probably taking half or less of his usual dose of Quetiapine."*

[30] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia, available in Australia as Seroquel and Seroquel XR (modified release tablets).

[31] Exhibit E.

43. Mr Johansen's diagnosis was of Acute Schizophrenic Episode which was treated with major tranquilisers, and his other medications were reviewed.[32] An improvement in Mr Johansen's mental state was seen during the involuntary stage of his admission such that by 15 October 2012, Dr Ellix's assessed that his mental state had sufficiently improved for him to be discharged from the Involuntary Treatment Order.[33] He was offered and accepted an informal or voluntary admission and remained at the Kerferd Unit.

44. According to Dr Ellix's statement, Mr Johansen improved considerably becoming more appropriate in his interactions, more coherent and less grandiose and paranoid. However, he remained disorganised and had major difficulties structuring his time and engaging in meaningful activities. The progress notes and discharge summary do not convey quite as clear a picture of clinical improvement but they do document that he continued to *settle* in terms of his behaviour in the unit but also remained distracted and difficult to engage.[34]

45. As part of discharge planning, rehabilitation options were discussed with Mr Johansen and his mother, and he accepted a referral to Benambra Community Care Unit [Benambra][35], effectively as a transitional or step-down facility.

46. On 23 October 2012, Mr Johansen was reviewed by Dr Ellix and presented as pleasant and cooperative. His affect was restricted and cognition normal and he was not obviously hallucinating. His speech rate and thought form were normal and content appropriate to the topic under discussion. He displayed partial insight. The plan at that juncture was for Mr Johansen to continue as an inpatient and await the outcome of the Benambra referral.[36]

47. At inquest, Dr Ellix maintained that while the matter was not entirely within her control, it would have been optimal for Mr Johansen to remain an inpatient and transition smoothly to Benambra *if* he was accepted by that service and as soon as a *bed became available*. She conceded however that the reality that it may not have ultimately been feasible as the time before a bed would be available was very variable and Mr Johansen's admission to a public psychiatric facility like the Kerferd Unit could not be extended indefinitely.[37]

AN UNPLANNED DISCHARGE

48. However, events took a turn for the worse later on 23 October 2012 when Mr Johansen returned to the Kerferd Unit after what appeared to have been a successful visit to Benambra

[32] Exhibit C, at page 49 of the coronial brief.
[33] Exhibit C.
[34] Exhibits E and B especially at page 70 of the coronial brief.
[35] Ibid.
[36] Exhibit E.
[37] Transcript pages 87, 98-99, 106-108.

with his case manager and threatened one of the nurses who he believed had damaged or "prostituted out" his night goggles. He said they were no longer working and threatened to organize a very nasty person to do harm to the nurse. Mr Johansen was also seen to be brandishing a knife in the dining room (apparently a butter knife).[38]

49. As a result, Dr Ellix and one of the psychiatric nurses reviewed Mr Johansen again, accompanied by one of the psychiatric nurses.[39] According to Dr Ellix's statement, Mr Johansen became angry and threatened to kill a staff member. When he was informed this behaviour was inappropriate he elected to discharge himself. Dr Ellix found no grounds to recommend him and he was (discharged and) referred for community management with a view to continuing with the Benambra referral for rehabilitation.[40]

50. At inquest, Dr Ellix was questioned at some length about the decision to allow Mr Johansen to leave the unit and about notations made by her in the medical records in respect of this incident.[41] Dr Ellix maintained that it was her decision to allow Mr Johansen to leave the unit as he did not fulfil the criteria for involuntary treatment at the time. She did not assess him as psychotic at the time but rather as angry about the perceived interference with his night vision goggles.[42] Nor was the incident sufficiently concerning to be reported to police.[43]

51. As this was an unplanned discharge and in accordance with her usual practice, Dr Ellix held a bed for Mr Johansen, in case he deteriorated overnight so that his return to the unit could be facilitated. In light of her stated practice of holding a bed for patients like Mr Johansen whose discharge was unplanned, Dr Ellix's notation in the medical records was problematic and this was highlighted by cross-examination during the inquest.[44] Relevantly, the notation was to the effect that 'a bed would be held for Mr Johansen in case he deteriorated overnight and/but he would only be accepted back if recommended with police escort'.[45] Dr Ellix conceded that the notation was internally inconsistent and could not explain why she expressed herself in this way as it did not represent her intention.[46]

---

[38] The progress note is conveniently summarised in A/Professor Newton's statement, Exhibit B.
[39] Exhibit D.
[40] Exhibit C and transcript pages 107 and following.
[41] Transcript pages pages 84 and following.
[42] Transcript pages 85-86, 100, 105.
[43] Transcript page 84.
[44] Transcript pages 84 and following.
[45] Exhibit D is a photocopy of one page of Total Care progress Notes for 23-24 October 2012, part of the medical records held by the health service.
[46] Transcript pages 89-90 for Dr Ellix's evidence and transcript pages 136-137 for RN Anfruns' evidence which illustrates the confusion around Dr Ellix's plan to hold a bed for Mr Johansen. See also transcript page 104 for the practical constraints of "voluntary" treatment.

52. Internal inconsistency aside, the plan to hold a bed for Mr Johansen for 24 hours or so was pointless unless his family or carers were aware that his return to the Kerferd Unit could be facilitated, and this was not the case.[47] Such a plan would rely on their monitoring of Mr Johansen, a perception of a deterioration in his mental state and their ability to encourage or cajole him to return.

53. Consistent with best practice in the public mental health system, discharge planning for Mr Johansen had commenced early in his admission, when he was still an involuntary patient. Sally Anfruns is a Registered Nurse and, at all material times, was the Discharge Coordinator for the Kerferd Unit [RN Anfruns]. This was her primary role, and in her statements, RN Anfuns sets out what the role involves in general and her involvement in planning for Mr Johansen's discharge in particular.[48]

54. Discharge planning involves supporting primary nurses and allied health staff to identify resources required for effective discharge, engaging in regular discharge planning meetings with the community mental health team and liaising with community based psychiatric support organisations, where appropriate, such as MIND, drug and alcohol support services or housing support services. The discharge coordinator's level of involvement with a patient both during and after an admission depended on the patient and their circumstances.[49]

55. It is apparent from the medical records and RN Anfruns' statements that the discharge planning for Mr Johansen involved Mr Johansen himself, Mrs Johansen, the inpatient care team, Dr Ellix and community psychiatry, and that a significant focus was the need for psycho-social rehabilitation and exploration of possible organisations that could provide, effectively, a step-down or transitional placement in the hopes of broadening Mr Johansen's social networks and support base and improving his ability to live independently.[50]

56. Consistent with the evidence of Dr Ellix, RN Anfruns' evidence was that the agreed discharge plan for Mr Johansen was for admission to Benambra. In the event that Mr Johansen was not accepted by Benambra, or he decided not to take up the referral, they would explore other community based psycho-social programs and outreach support programs such as those offered by MIND, Australia, again with Mr Johansen's agreement. In any event, the discharge plan envisaged that Mr Johansen would remain case managed by

[47] Exhibit A and transcript page 34.
[48] Supplementary Statement of Sally Anfruns dated 11 October 2016, Exhibit F, provided by Lander & Rogers Lawyers and an earlier undated statement (at pages 64-65 of the coronial brief) provided directly to the court, Exhibit G.
[49] Exhibit F and transcript page
[50] Ibid. According to RN Anfruns the *"program offered by Benambra would have provided education regarding illness management, the benefits of medication adherence and training around cooking, financial budgeting and other day-to-day living skills intended to assist patients with improving and enhancing their ability to live independently."* See also transcript page 133, 147 and following.

community psychiatry as he had been immediately before his admission and this would be the case whether he was in Benambra or another public or private rehabilitation facility or simply in the community.[51]

POST-DISCHARGE MANAGEMENT – INFORMATION SHARING

57. Other aspects of post discharge management explored at inquest was post-discharge communication with Mr Johansen's GP Dr Wakefield who was to resume responsibility for his primary care in the community, and the timeliness and level of engagement between community psychiatry and Mr Johansen. As a matter of logic, these two aspects were not confounded by the unplanned nature of Mr Johansen's discharge, but rather by his refusal to allow the sharing of his health information or to provide a direct telephone number (whether landline or mobile) so that community psychiatry could contact him directly without using his mother as an intermediary.

58. According to RN Anfruns, she had several discussions with Mr Johansen during his admission, about his willingness to sign the "Consumer Consent to Share Information" form to allow the sharing of information with Dr Wakefield, community psychiatry and Benambra. In these discussions (some of which were documented in the medical records and others which were not but were still within her recall), RN Anfruns also explained to Mr Johansen the importance of those services being aware of any changes to his medication regime and plans for rehabilitation, and attempted to explain to him the obligations imposed on health care professionals to maintain the confidentiality of health information they receive. Mr Johansen refused to sign the form, telling her that he would see his GP after discharge and advise him of changes to his medication regime and also refused to provide her with his telephone number. [52]

59. Both in her statement and in evidence at inquest, RN Anfruns' stated that she was conflicted by Mr Johansen's refusal to allow the sharing of information and found herself in a difficult position, straining between the need to ensure continuity and safety in the transition of care and her perceived need to respect his wishes.[53] Indeed, RN Anfruns consulted her unit manager RN Betty Payne and they came to a join decision to continue to seek Mr Johansen's consent through his community psychiatry case manager, in order to respect his wishes, but to provide the information to the GP Dr Wakefield regardless. Ultimately, while she made the decision to provide a discharge summary to Dr Wakefield on 1 November 2012, when she confirmed that Mr Johansen had seen him post-discharge, RN Anfruns was unsure

[51] Ibid.
[52] Ibid and transcript pages 134, 138 and following.
[53] Ibid and transcript pages 132, 142 and following.

whether she in fact sent Dr Wakefield the discharge summary before becoming aware that Mr Johansen had been found unconscious and was in hospital.[54]

60. At the time, the giving of such information was governed by section 120A of ***Mental Health Act 1986*** [MHA 1986] which limited disclosure except in certain stipulated circumstances. Relevantly, apart from the giving of information with the prior consent of the patient[55] and disclosure to a guardian, family member or primary carer that is reasonably required for the ongoing care of the patient,[56] information could be given if required in connection with the further treatment of the patient.[57] The latter would have supported provision of the discharge summary to Mr Johansen's GP Dr Wakefield, by RN Anfruns or any other staff member of the Kerferd Unit. RN Anfruns conceded this at inquest and Dr Ellix and A/Professor Newton also testified to this effect.[58]

61. RN Anfruns' evidence was that her approach to the disclosure of information to Dr Wakefield was influenced by training in anticipation of the commencement of the ***Mental Health 2014*** [MHA 2014] with its paradigm shift to a "recovery model"[59] and that she felt that the decision to disclose would have been easier for her to make under its provisions. While I accept that this was a bona fide belief on her part, the disclosure provisions under the MHA 2014 are not materially different from those under the MHA 1986[60] in any relevant respect and both Acts would have supported provision of the discharge summary to Dr Wakefield (at least).

CONTACT BY COMMUNITY PSYCHIATRY

62. With encouragement from his mother, Mr Johansen called the Kerferd Unit later on the 23 October 2012 to apologise for his behaviour.[61] This was his last known direct contact with

---

[54] Exhibit F and transcript pages 130 and 137 and following.
[55] Section 120A(3)(a) MHA 1986.
[56] Section 120A(3)(ca) of the MHA 1986. Note that disclosure to this class of person was only permissible if they were to be involved in providing care to the patient and not otherwise, simply because of their connection with the patient.
[57] The provision is couched in terms of 'the giving of information required in connection with the further treatment of a person with a mental disorder.' Section 120A(3)(e) of the MHA 1986.
[58] Transcript pages xx and following; pages 64 and following, especially page 73 and following for A/Professor Newton's evidence in this regard and pages 94 and following for Dr Ellix's.
[59] The MHA 2014 establishes a supported decision-making model that will enable and support compulsory patients to make or participate in decisions about their treatment and determine their individual path to recovery. Legal mechanisms in the Act that enable supported decision making include a presumption of capacity, advance statements, nominated persons and the right to seek a second psychiatric opinion. These mechanisms will promote best practice and facilitate optimal communication between practitioners and people with mental illness and their families and carers, leading to improved treatment outcomes and recovery. The Act also provides a legislative framework that supports the ongoing development of recovery-oriented practice in the public mental health service system. Recovery refers to a unique personal experience, process or journey that is defined and led by each person with a mental illness. It is owned by, and unique to, the person. The role of mental health services is to create an environment that supports and does not impede people's recovery efforts.
[60] Section 346 of the MHA 2014.
[61] Exhibits A and C.

the Kerferd Unit staff. As events transpired, after his discharge, there was no direct contact between community psychiatry and Mr Johansen.

63. Having physically left the Kerferd Unit on 23 October, Mr Johansen was formally discharged on 24 October and RN Anfruns prepared the discharge summary on 25 October 2012. The fact of Mr Johansen's discharge would have been handed over to community psychiatry on the morning of 24 October and his case manager was notified by email of the availability of the discharge summary on Orion, the software used by Northeast Health Wangaratta and accessible to Kerferd Unit staff and community psychiatry alike.[62]

64. Registered Nurse Casey Fahey from community psychiatry was Mr Johansen's case manager and had established a rapport with him since his pre-admission engagement with community psychiatry.[63] RN Fahey was not available to attend the inquest as he had moved overseas but did provide a statement. He cited Mr Johansen's refusal to consent to a discharge summary being sent to Dr Wakefield as raising some uncertainty as to whether or not Mr Johansen would cooperate with follow-up from community psychiatry as he had been discharged as a voluntary patient.[64]

65. RN Fahey spoke to Mrs Johansen on 26 October 2012 and identified no immediate concerns. He ascertained that Mrs Johansen was having regular contact with her son, that she had crisis numbers to call if there were any concerns over the weekend and planned to see Mr Johansen the following week at the family home (where all previous contact had taken place). RN Fahey was involved with crisis assessments of other patients on both Monday 29 and Tuesday 30 October 2012 and made no attempt to contact Mr Johansen, comforted by the belief that he was having regular contact with the family.[65]

66. This level of contact between community psychiatry and Mr Johansen/his mother is to be contrasted with Dr Ellix's expectations following the unplanned discharge.[66] Dr Ellix expected that the fact that Mr Johansen had left the unit would have been handed over to community psychiatry on the morning of 24 October 2012 and that there would be face to face contact by Friday 26 October or by the following Monday 29 October at the absolute latest. Dr Ellix agreed with A/Professor Newton that assertive case management was

[62] Exhibit F and transcript pages xx, 109 and following.
[63] Exhibit A, page 30 of the coronial brief.
[64] Page 66 in the coronial brief.
[65] Ibid. I note that RN Fahey was contacted by Benambra staff and arranged to confirm Mr Johansen's interest in the placement on 31 October 2012 or when he was next on duty after days off on 5 November 2012.
[66] Transcript page 99. I note that Dr Ellix was under the misapprehension that Mr Johansen would living in the family home after discharge and was unaware as guests were staying due to a family wedding, Mr Johansen might be spending the days with his family he would be sleeping at this own home. Transcript page 96.

warranted and that earlier contact with Mr Johansen, perhaps on 24 or 25 October would have been better, ideal.[67]

INDEPENDENT EXPERT

67. Associate Professor John Richard Newton [A/Prof Newton] was asked to provide an independent expert report to the court in relation to the clinical management and care provided to Mr Johansen, with particular emphasis on his last admission, the discharge process and provision of community follow-up prior to his death. A/Prof Newton has been working in Australia as a consultant psychiatrist since 1992 and has been the Medical Director of Mental Health at Austin Health since 2009.[68]

68. At first instance, A/Prof Newton's evaluation was based on a perusal of the relevant medical records and other documents. In his appraisal, he found that Mr Johansen was correctly identified as having a relapse of a significant psychotic illness and was admitted to the Kerferd Unit after an appropriate trial of community care. He noted that Mr Johansen was seen at least weekly by a consultant psychiatrist and that he gradually became more behaviourally settled during the admission.[69]

69. In terms of Mr Johansen's admission, A/Prof Newton felt the medical records had significant gaps, stating that in terms of developing a sophisticated understanding of his psychotic experiences and other psychiatric problems, there is no detailed exploration of the content of Mr Johansen's delusions, the impact that they may have had on him that would have assisted the treating team to better understand Mr Johansen's experience of his illness. Significantly in this regard, although it is clearly documented that he had ongoing hallucinations, the content of these hallucinations is not elicited or at least not documented.[70]

70. A/Prof Newton concluded that a sophisticated understanding of Mr Johansen's complex range of risks is not clearly contained within the file. While Mr Johansen was vulnerable to put himself at risk, and the small overdose that led to his initial presentation appeared to be in response to command hallucinations to "waste himself", his risk of harm to himself and risk

[67] Transcript pages 110-111.
[68] In his statement dated 27 January 2016, Exhibit B, A/Prof Newton details his professional qualifications and affiliations as follows – *"I am Honorary Clinical Associate Professor at the University of Melbourne, Department of Psychiatry and an Adjunct Clinical Associate Professor at Monash University, Department of Psychiatry, Psychology and Psychological Medicine. I received my Fellowship of the Royal Australian and New Zealand College of Psychiatrists in 1995, my Membership at the Royal College of Psychiatrists in 1989 and my basis medical degree from the University of Edinburgh in 1985."*
[69] Exhibit B, paragraph 37.
[70] Exhibit B, paragraph 39. The notable exception is the ED doctor who did document that the command hallucinations were telling Mr Johansen to "waste himself".

of harm to others is not regularly assessed or documented. This is particularly important given that a threat to staff triggered his discharge from hospital.[71]

71. Also absent from the medical records, in A/Prof Newton's appraisal, was consideration of Mr Johansen's poor compliance to his medication regime in the period leading up to his admission and the implications of this for his ongoing care.[72]

72. At inquest, A/Prof Newton expanded on his views and was also cross-examined about aspects of the evidence given at the inquest and about to be given, especially the evidence of Dr Ellix who had yet to testify. Mr Halley, Counsel representing Dr Ellix "put" the evidence he expected she would give when called.

73. A/Prof Newton agreed that in order to prevent Mr Johansen from taking his own discharge, all the criteria in section 8 of the MHA 1986 had to be met and that Dr Ellix had no power to detain him on 23 October 2012 unless she assessed him as meeting each and every criteria. A/Prof Newton conceded that Dr Ellix was best placed to make this assessment of Mr Johansen, and that if she undertook a full mental state examination as was suggested and asked probing questions about whether or not Mr Johansen was experiencing hallucinations, that was the appropriate way to do so.[73]

74. At inquest, A/Prof Newton maintained the need for Mr Johansen to receive assertive follow-up by community psychiatry. His evidence was that optimal management would have seen contact being made with Mr Johansen within 24 hours of his departure from the Kerferd Unit, so on Wednesday 24 October 2012. A/Prof Newton accepted that contact by community psychiatry within 24-48 hours, so on or by Thursday 25 October 2012, would have constituted reasonable management of a patient such as Mr Johansen, given all the circumstances that prevailed.[74] While A/Prof Newton was aware of some contact between RN Anfruns and Mrs Johansen and RN Fahey and Mrs Johansen, he maintained that the clinical requirement for assertive follow-up could only be met by direct, face-to-face contact between community psychiatry clinicians and Mr Johansen.[75]

[71] Exhibit B, paragraphs
[72] Exhibit B, paragraphs 40-41.
[73] Transcript pages 52-54.
[74] Transcript pages 58-61.
[75] Transcript pages 75 and following, especially page 79. I note that A/Prof Newton wa also critical of the consideration given to Mr Johansen's compliance with his medication regime and its implications for his ongoing care and risk, although Dr Ellix expressed the view that he was only non-compliant when unwell. Exhibit B, paragraphs 40-41 and transcript pages 94 and following.

STATE OF MIND/INTENT

75. Despite the unplanned nature of the discharge and any possible deficiencies in community follow-up, there is a body of evidence that suggests that Mr Johansen did not appear unwell to his family in the first few days after discharge. There was a family wedding to attend and a number of friends and relatives of the Johansen family were in Wangaratta for the wedding, including guests that were to stay at the family home. Mr Johansen spent the days largely in the company of his family returning to his own home each evening. At the time, there were no reported concerns about his mental state, although, since her son's death, some concerns were brought to Mrs Johansen's attention. Mrs Johansen herself testified that she did not notice anything unusual in her son's behaviour, although she described herself as a little distracted by her responsibilities to other family members at the time.[76]

76. As mentioned above, CCTV footage was obtained by police from Mr Johansen's home after his death. The stored footage commences on 26 October 2012, is derived from a number of cameras located in and around the house[77] and is generally of average quality so that some smaller items are not recognisable. Nevertheless it provides a rare insight into how Mr Johansen spent his time at home from 26 October until 2 November 2012 when he was located by police and transported by ambulance to hospital.

77. In particular, from about 7.00am until about 11.00am on 1 November 2012 the CCTV footage shows Mr Johansen handling a firearm and appearing to attempt to discharge it with his head in the firing line. During the same morning, he is shown handling medication, using a kitchen blender and handling a syringe before disappearing from view at about 11.28am. Thereafter while he can be heard breathing heavily and/or snoring loudly, he cannot be seen. At 12.16pm, the kitchen table which is in view is jolted and moves about 30cms, consistent with Mr Johansen collapsing into the position in which he was found by police some 29 hours later.[78]

78. A number of handwritten notes were found by police on the kitchen bench, apparently on display consistent with an intention that they be found by first responders. While it is not possible to say when the notes were written, the content would suggest that at the time they were written, Mr Johansen was acutely unwell and suffering from the symptoms of his mental illness.

[76] Exhibit A and transcript pages 17 and following.
[77] See pages 78 of the coronial brief and following where the coronial investigator sets out a summary of matters observed on the footage. Sections of the interior are not captured by the cameras, significantly, the fridge and sink area of the kitchen, the deceased's bedroom and the rear of the house.
[78] Pages 82-83 of the coronial brief.

CONCLUSIONS

79. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [79]

80. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession, and in so doing caused or contributed to the death under investigation.

81. Having applied the applicable standard of proof to the available evidence, I find that:

    a. After some ten years relative stability under the care of his GP Dr Wakefield with the support of his family, by early 2012, Mr Johansen started exhibiting the signs and symptoms of a deterioration in his mental state, in particular evidenced by increasing paranoia.

    b. From 22 August 2012 and following referral by his sister, Mr Johansen received intensive treatment and support including case management from Wangaratta Community Psychiatry.

    c. The clinical management and care provided to Mr Johansen by community psychiatry was reasonable and appropriate, including the decision to seek an inpatient admission for Mr Johansen to the Kerferd Unit of Wangaratta Hospital on 15 September 2012.

    d. Mr Johansen was admitted to the Kerferd Unit as an involuntary patient until 15 October when Dr Ellix assessed him as sufficiently improved to be discharged from his involuntary status and offered a voluntary admission which he accepted.

    e. Mr Johansen remained relatively stable in the Kerferd Unit thereafter with a plan for referral to the Benambra Community Care Unit as a transition or step-down placement before discharge home.

    f. The clinical management and care provided to Mr Johansen whilst an inpatient was reasonable and appropriate.

[79] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

g. Documentation of Mr Johansen's clinical course during his inpatient admission was sub-optimal in terms of providing an understanding of his illness and formal documentation of his risks.

h. In accordance with best practice, discharge planning commenced early in the admission, appropriately involved both Mr Johansen and his mother, and the discharge plan for placement at Benambra was appropriate for his ongoing needs.

i. Dr Ellix was best placed to assess Mr Johansen following the incident on 23 October 2012 and she formed the view that he did not fulfil the criteria for involuntary treatment and therefore could not be prevented from taking his (albeit unplanned) discharge.

j. Mr Johansen's clinical needs were such that he required assertive follow-up by Wangaratta Community Psychiatry, optimally face-to-face contact within 24 hours of his departure from the Kerferd Unit. Contact within 48 hours would have been reasonable in the circumstances.

k. The contact between Kerferd Unit and community psychiatry staff and Mrs Johansen while entirely appropriate was insufficient and could not satisfy a requirement for assertive follow-up of Mr Johansen following the unplanned discharge.

l. Mr Johansen was well enough during the period immediately following discharge as evidenced by his known interactions with family members and the CCTV footage showing the interior of his home and graphically depicting his ongoing paranoia.

m. The lack of any face-to-face contact with community psychiatry in the post-discharge period, while not causative of death, was a lost opportunity for clinical assessment of Mr Johansen and the potential for any deterioration in his mental state to be addressed.

n. On or by 1 November 2012, Mr Johansen became acutely unwell, his judgement was likely impaired and he was *possibly* responding to hallucinations when he first tried unsuccessfully to set up a firearm to shoot himself, before injecting himself and collapsing.

o. While Mr Johansen's actions were deliberate in the sense that they were not accidental and that he intended to inject himself, the evidence does not support a finding that, at the time that he did so, he formed the intent or was able to form the intent to take his own life.

p. Nevertheless, Mr Johansen died as a result of the unintended complications of injecting drug use.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008,*** I make the following comment/s in connection with the death:

1. As foreshadowed during the inquest, Northeast Health Wangaratta and Albury Wodonga Health submitted information regarding the initiatives and improvements implemented across the Northeast and Border Mental Health Service since Mr Johansen's death, recognising that the tragic loss of his life provides an opportunity to review their practices and systems to improve the safe and appropriate treatment of patients with mental illness.
2. Those initiatives and improvements were outlined in a letter dated 19 December 2016 from Michael Nuck, Director Mental Health, Albury Wodonga Health and include:
    a. A review of inpatient care discharge planning processes, including development of a standard for responding to "unplanned discharge" that is intended to link unplanned discharges to escalation processes to ensure that senior management and acute response teams are aware than an unplanned discharge has occurred. The patient will be automatically placed on daily review until he service is satisfied that appropriate follow-up and engagement is occurring.
    b. Revision of policies and procedures for follow-up of patients after inpatient unit discharge, with the aim of improving the quality of the 7 day post discharge follow-up and the identification of patient and social risk factors. Following the inquest, psychiatrists have already commenced a more prescriptive discharge management plan which clearly outlines the patient's current mental state, level of risk and timeline for community follow-up, including whether follow-up must be fact-to-face (linked to the level of assessed risk) and recognises that appropriate follow-up may need to be within 24 hours, particularly in an unplanned discharge.
    c. The creation of a peer workforce which will provide practical support for individuals and their families at discharge and for up to three weeks, a state-wide initiative in its design phase at the time.
3. Appropriate reflective professional practice is encouraged in this jurisdiction and the health services are to be commended for their endeavours which are, at least in part, in response to Mr Johansen's death and which should improve outcomes for mental health patients in the future.

I direct that a copy of this finding be provided to:

The family of Mr Johansen

Dr J. N. Ellix c/o Moray & Agnew

Albury Wodonga Health and Northeast Health Wangaratta c/o Lander & Rogers

Dr Brue Wakefield, General Practitioner

Professor John Richard Newton c/o Austin Health

The Office of the Chief Psychiatrist

First Constable Ashley Coysh (# 37943) c/o O.I.C. Wangaratta Police

Signature:

_____

PARESA ANTONIADIS SPANOS
Coroner
Date: 28 February 2018

Cc: Manager, Coroners Prevention Unit/Mental Health Investigators