FINDINGS and **COMMENTS** of Coroner McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Ross Alexander Johns

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Ross Alexander Johns with an inquest held at Hobart in Tasmania make the following findings:

Hearing Date

23 February 2023

Representation

Counsel Assisting the Coroner: K Siejka

Introduction

1. Ross Alexander Johns died between 14 and 15 June 2021, taking his own life by hanging after a history of mental health issues. This inquest focused particularly upon his mental health treatment prior to his death and whether there were any deficits in that treatment that may have prevented his death.

Background

2. Mr Johns was born on 10 June 1985 and was 36 years of age at his death. He was one of three children to Lesley Johns (Mrs Johns) and Gary Johns.

3. At the time of his death, Mr Johns had recently separated from his wife, Amelia Johns (Amelia), and lived alone in Nunamara. Mr Johns was a qualified chef, having worked in numerous high quality Tasmanian restaurants. However, for several months before his death, he worked for a friend who operated a tree service business. Mr Johns and Amelia maintained a positive relationship co-parenting their young son (born in 2018). Three months before his death, Mr Johns commenced a new relationship with Tracey Grosvenor.

4. Mr Johns had a long and complex medical history related to ongoing issues with his mental health. At 12 years of age, Mr Johns had his first significant mental health episode. Between the ages of 14 and 16 years, he was diagnosed with bipolar disorder.

He underwent hospital treatment on several occasions in South Australia, where he then resided with his family.

5. Mr Johns and his parents moved to Tasmania in 2002 where he completed year 11 and 12 at Newstead College. After arriving in Tasmania, Mr Johns came under the care of a psychiatrist in Launceston. Despite treatment from the age of 18 years, Mr Johns was hospitalised several times for suicide attempts and suicidal ideation. He continued to struggle with his mental health throughout his life, and was treated by a number of psychiatrists and general practitioners in the years before his death for his bipolar disorder and major depressive disorder. Mr Johns commenced consuming alcohol in his teenage years and suffered alcoholism.

6. His mother, Mrs Johns, was a continuous source of support for her son throughout his life.

Reasons for inquest

7. I have, for this investigation, categorised Mr Johns as a person "held in care" under the *Coroners Act 1995* on the basis that, at the time of his death, he was "liable to be detained" under a Mental Health Order pursuant to the *Mental Health Act* 2013. This is because the Mental Health Order, by its terms, authorized him to be admitted and, if necessary, detained in an approved mental health facility for the purpose of receiving treatment. The Mental Health Order was made on 8 April 2021 and was due to expire on 7 October 2021.

8. On the basis that he was "liable to be detained", I was required by section 24(1)(b) of the *Coroners Act* to hold a public inquest into Mr Johns' death and, in addition to my usual functions, to report on his care, supervision and treatment whilst he was a person held in care as required by section 28(5) of the *Coroners Act*.

9. Further, Mrs Johns and William Johns (Mr Johns' brother) raised several concerns with Mr Johns' treatment in the period before his death which they considered were responsible for his deterioration and decision to complete suicide. They considered that there were four points that triggered particular deterioration in his mental health. These may be summarised as follows;

(a) In March 2021, his psychiatrist, Dr Simon Barritt ended the patient relationship prematurely by email and in a way that was upsetting to Mr Johns and which continued to cause him distress.

(b) In May 2021, when Mr Johns attempted suicide by hanging, he finally initiated a visit to hospital and was taken there by ambulance. However, the treatment was brief, inadequate and he was discharged quickly, notwithstanding that he was subject to a treatment order. This event further exacerbated his sense of worthlessness and reinforced to him the pointlessness of treatment.

(c) He was discharged prematurely from his last inpatient admission to Northside on 9 June 2021. This discharge was prompted by the need to close the ward for renovations imminently. Secondly, Mr Johns had a poor relationship with the treating psychiatrist and this fact caused him to wish to discharge prematurely, which wish was acceded to. She said that the premature discharge meant that he did not stay for a further period of time to allow his new medication to properly take effect, with the consequences of this being that he resumed the consumption of alcohol.

(d) The CATT (Crisis Assessment and Treatment Team) follow-up for Mr Johns after discharge was by telephone and not in person.

Evidence at inquest

10. The documentary evidence at this inquest comprised exhibits C1 to C27. The exhibit list is annexed to this finding.

11. At inquest, oral evidence was received from:

- Dr Benison Elijah, Executive Director Medical Services for Statewide and Mental Health Services;
- Mrs Lesley Johns, mother of Mr Johns; and
- Mrs Amelia Johns, wife of Mr Johns.

Circumstances leading up to death

12. On 27 May 2021 Mr Johns presented to the Launceston General Hospital (LGH) emergency department after an attempted hanging whilst intoxicated. He was reviewed and discharged with an appointment booked the following day with Adult Community Mental Health Services (ACMHS).

13. On 31 May 2021 Mrs Johns found Mr Johns in bed, drowsy and vomiting, after she had fulfilled a script for him. An ambulance was called and he was taken to the LGH emergency department and treated for an overdose. He was then admitted to Northside Mental Health Unit of the LGH (Northside). During his admission to Northside, Mr Johns was compliant with his treatment regime, accepting of changes in his medication and successful in detoxification. Mr Johns reported that, at the time of his overdose on 31 May 2021, he thought his son would be better off without him and had taken all his tablets with his wine before going to sleep. Extensive psychoeducation was provided to Mr Johns about the effects of alcohol consumption and its relationship with depression, judgement and medication efficacy.

14. On 8 June 2021, whilst still an inpatient at Northside, Mr Johns was reviewed by consultant psychiatrist, Dr Franco Giarraputo, before his impending discharge. His discharge diagnosis was recorded as major depression and anxiety. Dr Giarraputo strongly encouraged Mr Johns to participate in counselling, talk to his case manager, attend his appointments, and follow the set safety plan upon his discharge. He was urged to pursue alcohol and drug support at Serenity House or Missiondale. Mr Johns expressed a desire to attempt alcohol detoxification at home rather than in the setting of a residential facility. Dr Giarraputo discussed the discharge care plan with Mr Johns and Mrs Johns. Mrs Johns was supportive and agreed to stay with Mr Johns in his home post-discharge. Mr Johns was recorded as being "discharged to the care of his mother" on 9 June 2021.

15. On Friday 11 June 2021, Mrs Johns was contacted by the CATT who were tasked to monitor her son's condition and provide any assistance required. Mrs Johns advised that Mr Johns was progressing well but she would like CATT to contact him over the long weekend (12 to 14 June 2021) as Mr Johns was looking after his young son. The CATT notes did not record that Mrs Johns expressed any specific concerns about risk to Mr Johns' safety at that time. I note that Mrs Johns was with Mr Johns on 9 June 2021, the day of his discharge. However, she had returned home to the south of the state for a medical appointment on Friday 11 June 2021. Although Mrs Johns intended to return to stay with Mr Johns over that weekend, they had a discussion in which Mr Johns indicated to her that it was not necessary, Mrs Johns therefore was not present with Mr Johns during this weekend but intended to visit again on Tuesday 15 June 2021.

16. On 12 June 2021 a CATT member attempted telephone contact with Mr Johns several times with no answer. A few hours after this attempted contact, a CATT member called Mr Johns for a further welfare check. The notes of this call recorded that Mr Johns was easily engaged, appropriate in conversation and appreciative of the call. It was noted that he had his two and a half year old son until Sunday and that he was looking forward to returning to work on Tuesday. It was noted that he had recommenced drinking alcohol that evening since his son went to bed and he had consumed four glasses of wine. It was noted that he did not have any future general practitioner appointments and that he declined any further follow up CATT calls over the weekend. Due to his recent admission to Northside, the CATT planned a follow-up call the following day, although contrary to the wishes of Mr Johns.

17. On 13 June 2021, a CATT member telephoned Mrs Johns to enquire if any family intended to visit him that day as there were concerns regarding the fact that he was consuming alcohol. Mrs Johns said she would telephone Mr Johns and asked if CATT could also follow up. The CATT made a call to Mr Johns and the notes of this call specified that he had not consumed any alcohol that day nor did he plan to. Mr Johns told the caller that he had no alcohol in the house, he was going to take his son out that day. He said that his son would be collected that evening at 6.00pm and he had no plans for the evening. He denied suicidal ideation but said but indicated that it occurred intermittently. He told the CATT member that he had no intention to act on his suicidal thoughts. Mr Johns was encouraged to telephone the Mental Health Helpline if he was feeling unsafe.

18. On Monday 14 June 2021 the CATT made a phone call to Mr Johns where it was noted that he was easy to engage in conversation; that his son had returned to his mother yesterday as planned; and that he had spoken to his mother that morning. He told the caller that he had been drinking that day, however he guaranteed his safety and had no suicide plan or intent. Mr Johns agreed to take a further call from the CATT that evening.

19. At 7.36pm on 14 June 2021, the CATT attempted to contact Mr Johns several times. There was no answer and the phone went to message bank. A message was left asking for Mr Johns to return the call via the Mental Health Helpline number, with the CATT to follow up the next day.

20. On 15 June 2021, Mr Johns' wife, Amelia, attended his home due to concerns regarding his welfare, particularly related to text messages she had received from Mr Johns the previous day which indicated that he was consuming alcohol and his mood was deteriorating. At about 10.30am Amelia located Mr Johns hanging in the shed, apparently deceased. Police officers and ambulance paramedics attended. Mr Johns was confirmed as being deceased and a full scene examination took place for the coronial investigation.

21. The evidence obtained in the coronial investigation indicates that between 14 and 15 June 2021, Mr Johns had been drinking alcohol inside his residence. At some point, he made his way to the rear shed where he tied a rope to one of the rafter beams, fashioned a noose from the other end and tied it around his neck. He then sat on a pre-positioned chair underneath the rope, placed his weight into the rope and asphyxiated.

22. A full autopsy was performed by State Forensic Pathologist, Dr Donald Ritchey, on 17 June 2021 at the Royal Hobart Hospital. He concluded that the cause of the death was hanging, with contributing factors of alcohol dependence and depression. Toxicology revealed that Mr Johns had an elevated blood alcohol concentration of 0.136 g/mL and therapeutic levels of several drugs, all prescribed to Mr Johns.

23. I am satisfied that Mr Johns took his final actions alone and with the specific intention of ending his life.

Comments and recommendations

24. Dr Benison Elijah, Executive Director Medical Services for Statewide and Mental Health Services, provided a comprehensive affidavit addressing the relevant issues in the investigation. In summary, his affidavit evidence was as follows:

- There were no deficits in the treatment or care of Mr Johns in the period prior to his death, with correct procedures and protocols being followed.
- Mr Johns was not discharged prematurely because of renovations occurring to Northside and, in fact, there was another nine days of inpatient treatment available to him in that facility, if required. Dr Elijah provided evidence that plans had been made for inpatients to be accommodated in alternative venues during the renovation period.
- Mr Johns was alcohol-dependent and particularly susceptible to the depressogenic effects of alcohol. His suicide risk fluctuated considerably, and he was liable to act impulsively, particularly after consuming alcohol.

Dr Elijah gave very helpful and knowledgeable evidence at inquest clarifying and expanding upon his affidavit evidence. He was firm in his view that, even if Mr Johns had remained in hospital for another few days, there would have unfortunately been no difference to the sad outcome. Dr Elijah referred to Mr Johns' long history of depression and alcohol dependence, and gave evidence that he was at moderate to high risk of alcohol relapse. Consistent with this opinion, Mr Johns told his aunt in a text message on 13 June 2021, just prior to his death that he was not "strong enough" and had resumed drinking.

Dr Elijah was questioned on whether Mr Johns did, in fact, lack decision-making capacity as that term is defined under the *Mental Health Act* 2013 such that the Mental Health Treatment Order to which he was subject was lawfully required.
He responded that a person's decision-making capacity can fluctuate and it was a question for Mr Johns' treating team as to whether such capacity was lacking. Nevertheless, Dr Elijah agreed that the Mental Health Treatment Order was a useful device for Mr Johns in order to keep him accountable and one which Mr Johns himself wanted to remain in place. I agree that the order served a useful purpose in this regard. In my view, however, Mr Johns likely did have decision-making capacity upon his discharge on 9 June 2021 and in the following days leading to his death. Specifically,

the action resulting in his suicide was conscious and deliberate, although it may have been impulsive and contributed to by an intoxicated state.

Dr Elijah endorsed the reasoning of the Root Cause Analysis prepared by the Tasmanian Health Service in respect of Mr Johns' death.

I accept the evidence and opinions given by Dr Elijah in full and agree that the Root Cause Analysis was sound in its conclusions.

Dr Elijah, both in his affidavit and evidence, detailed the very significant plans for a 30-bed mental health inpatient facility in Launceston and a consolidated co-located community service. This development, he said, will cater for mental health patients in varying categories. He gave evidence that the development is intended to be completed by 2027, following the replacement of the Spencer Clinic in Burnie with a new mental health precinct. I comment that these developments will provide much-needed assistance to patients in the North and North West of the state requiring treatment and care for mental health conditions.

25. Mrs Johns gave evidence that her son was a kind, caring and sensitive person, who felt a strong obligation to work to provide for his family. This fact was borne out by the evidence as a whole. She acknowledged that he had not engaged with many of the treatments offered (particularly the required inpatient rehabilitation) and thought that he did not wish to do so as this would mean taking time away from his work. She acknowledged that his mental health deteriorated in the months before death and accepted that the separation with Amelia and his alcoholism played some role in his decline.

26. I am satisfied that this investigation and inquest has thoroughly considered the issues raised by Mrs Johns and family members, even though I do not find that the matters raised were contributors to Mr Johns' death. Unfortunately, his very poor mental health, alcoholism and breakdown of his marriage were the predominant factors in his decision. He was fortunate to have the devotion of his mother and support from other family members. Unfortunately, his death could not have been prevented.

27. The circumstances of Mr Johns' death are not such as to require me to make any recommendations pursuant to section 28 of the *Coroners Act* 1995.

Formal Findings

28. I pursuant to section 28(1) of the *Coroners Act,* that:

    a) The identity of the deceased is Ross Alexander Johns;

    b) Mr Johns' died in the circumstances set out in this finding;

    c) Mr Johns' cause of death was hanging, an action taken by himself with the intention of ending his life; and

    d) Mr Johns' died between 14 and 15 June 2021 at Nunamara in Tasmania.

29. I further find, pursuant to section 28(5) of the *Coroners Act*, that the care, supervision and treatment of Mr Johns whilst subject to a Mental Health Treatment Order in the period leading up to his death, was of an appropriate standard.

Acknowledgements

30. I acknowledge the valuable assistance provided to me by counsel assisting, Ms Kirsten Siejka, in the preparation and hearing of this inquest.
31. I convey my sincere condolences to the family and loves ones of Mr Ross Alexander Johns.

Dated: 8 May 2023 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner