Court Reference: 732 / 2008

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Inquest into the Death of Marella JOHNSON

Delivered On:	8 May, 2013
Delivered At:	Bendigo
Hearing Dates:	19 November, 2011, 16 January 2012,and 3 February 2012
Findings of:	W.P. Gibb
Representation:	
Place of death:	Railway Place South. Goornong
SCAU	Senior Constable Mark Herman
Appearing for Family:	Ms Jill Prior

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

In the Coroners Court of Victoria at Bendigo

I, W.P. Gibb Coroner having investigated the death of:

Details of deceased:

Surname:	JOHNSON
First name:	Marella
Address:	23 Boothman Street, Echuca

AND having held an inquest in relation to this death on 19 November, 2011, 16 January 2012 and 3 February 2012

at Bendigo

find that the identity of the deceased was Marella JOHNSON

and the death occurred on 19 February 2008

at Railway Place South, Goornong

from 1. Bilateral haemothoraces with multiple rib fractures and fracture dislocation of thoracic spine, all consistent with a motor vehicle accident.

2. Liver: marked fatty change.

At the time of her death, Ms. Marella Johnson was a 32 year old Aboriginal woman and mother of three children aged 10, 7 & 6. She and her children lived in Echuca with Ms. Johnsons mother Mrs. Barbara Johnson.

It is the position of lawyers acting on behalf of Ms. Johnsons family, that

> "...Ms. Johnson's premature death was the result of a calamitous road accident, which was easily preventable, but for the negligence of Alexander Bayne Centre's (ABC) psychiatric facility"[1]

[1] See closing submissions by Victorian Aboriginal Legal Services (VALS) dated 16 March 2012 Page 1 para 2.

It must be understood at the outset, that it is not the role of a Coroner to attribute fault to any person or organization. A Coroner is required pursuant to S.67 of the Coroner's Act 2008 to find, if possible

a) the identity of the deceased; and

b) the cause of death and the circumstances in which death occurred.

A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.

Ms. Johnson had an extensive mental health history commencing in 1992 when she was first diagnosed as suffering from schizophrenia and schizoaffective disorder[2]. Between 1998 and 2000 she was admitted to psychiatric units on seven occasions suffering from depression and psychosis[3]. These multi psychotic episodes usually arose after excessive alcohol use and non-adherence to treatment regimes[4]. Ms. Johnson had engaged in binge drinking and cannabis use leading up to her presentation at Echuca Regional Health (ERH) on 16 February 2008[5].

Ms. Johnson was being treated with Zuclopenthixol depot medication (an injectable antipsychotic) that was to be administered fortnightly. Ms. Johnson received her last dose on 12 February 2008 which was nearly three weeks after it was due.

Ms. Johnson's treatment regime had been disrupted following the death of her father on 24 December 2007. Ms. Johnson and her family had travelled to Burke in the State of New South Wales to attend the funeral and had stayed on thereafter for some time missing two of her fortnightly injections[6].

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[2] See Retrospective Health Record Review Psychiatric Services 11 December 2008 page 1

[3] See Dr Eatons report dated 22 December 2008 page 1

[4] ibid

[5] See letter dated 9 June 2010 from Dr. Francis Acting Director of Medical Services, Echuca Regional Health para 2 and Dr Eatons report of 22 December 2008, Page 2, para 3

[6] VALS submissions Page 2, para 4

Chronological Events Leading to Ms Johnsons Death

14 February 2008

On 14 February 2008 Ms. Johnson presented to the emergency department of Echuca Regional Health intoxicated. She complained of auditory hallucinations and racing thoughts and expressed both homicidal and suicidal ideation[7].

She was treated with the addition of Quetiapine (a mood stabilizer and antipsychotic medication) assessed as a low suicide risk and allowed to return home. A follow up appointment was made for the next day which Ms. Johnson did not attend.

16 February 2008

At 5.00 a.m. on 16 February 2008, Ms. Johnson was brought into the Echuca Regional Health emergency department by ambulance in an intoxicated state. She expressed both suicidal and homicidal ideation. Bendigo psychiatric services were contacted by telephone and Echuca Regional Health was advised to keep Ms. Johnson in the Emergency Department until she was sober and then to contact the on call psychiatric worker to assess the patient[8].

At five minutes past 8.00 a.m., and before any such assessment could be made Ms. Johnson left the Emergency Department. Both psychiatric Services and police were notified. Thirty five minutes later police contacted the Emergency Department and advised them that Ms. Johnson was at her home in the care of her mother. Further, that she was conversing with them and did not want to return to Echuca Regional Health.

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[7] Retrospective Health Records Review, Page 1

[8] See Dr Greacen, Director Medical Services, Echuca Regional Health report dated 1 October 2010, Page 1, Dr. Zahedi's report dated 7 June 2011 Page 1

At about 9.00 am., police again contacted Echuca Regional Health and informed the Emergency Department that Mrs. Barbara Johnson had discovered two suicide notes which had been written by her daughter. She handed these to Police[9]. Police further advised that Ms. Johnson intended to return to the hospital.

At about 9.00 p.m. Ms. Johnson was brought to Echuca Regional Health in a private car. She was assessed as delusional and suffering from auditory hallucinations. Ms. Johnson again managed to leave Echuca Regional Health unnoticed. Police were notified to bring Ms. Johnson back to hospital "due to high risk and need for admission to Alexander Bayne Centre. Triage were notified"[10].

At ten minutes to midnight, police returned Ms. Johnson to Echuca Regional Health under Section 10 of the Mental Health Act 1986.

At this point in time Dr. Kahkami of Echuca Regional Health recommended that Ms. Johnson should receive treatment from an approved mental health service being Bendigo Health. Dr. Kahkami supported his recommendation by identifying "suicidal ideation, homicidal ideation, non compliance with treatment, responding to voices, racing thoughts, poor sleep, agitation, pacing, poor judgment, believes her mother is going to die"[11].

As Ms. Johnson was recommended for involuntary psychiatric treatment she was transferred by ambulance to the Alexander Bayne Centre for admission to the acute psychiatric unit arriving there at 2.20 a.m. on 17 February 2008[12].

Dr. Zahedi was the on-call psychiatric registrar responsible for Ms. Johnson's admission to the Centre. Admission took place at approximately 4.00 a.m.[13].

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[9] Dr. Greacens report 1 October 2010 and police Patrol Duty Sheet for 16 February 2008

[10] Dr. Greacens report 1 October 2010 Page 2

[11] Dr Eatons supplementary report dated 26 March 2010 Page 1

[12] See Leading Senior Constable Whitmans statement – 17 August 2010

[13] Dr. Zahedi's report – 7 June 2011 Page 1

At that time, Ms. Johnson "denied any psychotic, manic or depressive symptoms and denied any thought, plan or intent of suicide or homicide"[14]. Her mental state was described as settled.

As part of Dr. Zahedis provisional management plan, he directed (amongst other things) that Ms. Johnson be subject to regular sightings every fifteen minutes when awake and every thirty minutes when asleep[15].

This indicated a level of concern about Ms. Johnson which didn't apply to patients in general who were usually subject to half hourly or hourly sightings. Put another way, that a closer eye be kept on Ms. Johnson than other patients[16].

As Consultant Psychiatrist for Bendigo Health Care Group, Dr. Scott Eaton completed a review of Ms. Johnson at 11.05 a.m., and upheld her involuntary status. Whilst he thought her suicidality was low at that point in time, he increased her level of absconding to medium. He did this in the knowledge that Ms. Johnson had attempted to scale the unit's external perimeter fence earlier that morning[17].

This attempt was reported immediately by security personnel to nursing staff at about 9.30 a.m. Ms. Janice Tresize was Ms. Johnson' contact nurse at the time and whilst conceding in evidence that she had no specific memory of Ms. Johnson that day, agreed that she had made notes of the incident and says measures were then put in place to reduce her risk of absconding. As a general rule, these measures included close visual observations, medication to ease her anxiety and agitation and regular reassessments of her level of risk[18]. Again, Ms. Tresize had no specific memory of this

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[14] ibid Page 2

[15] ibid – see also the range of categories as set out in Bendigo Healths, "Inpatient Visual Observations" document, Page 2

[16] See Dr Eatons evidence at Inquest Page 66, para 1

[17] ibid Page 67 and 68. See also statement by Bendigo Health security supervisor, Mr. S. Houlden dated 13 May 2011. Note:- The external perimeter fence at that time was constructed in the style of a pool fence. This consisted of vertical metal tubing about 100mm apart to an approximate height of 1.5 metres. Along the top of the fence was a laser alarm system which activated an alarm in the staff base whenever the beam was broken. After Ms Johnson's death this particular fence has been replaced with a solid steel fence to a height of 2.4 metres. The laser alarm system has been removed. See Dr. Phiilip Tunes report dated 31 January 2011

[18] See statement by Janice Gaye Tresize

being done on the day[19]. Further, she had no memory of whether all access doors to the courtyard were locked by staff after this failed attempt to abscond, but acknowledged this could have been done as a form of punishment even though this would impact on all patients.

At the time Dr. Eaton conducted his review, it was open to him to recommend that Ms. Johnson be placed in the Alexander Bayne Centre's very restricted four bed capacity high needs area had he formed the view that this was necessary. He was loath to do this he says preferring instead to keep her in a more homely environment. This would not have been the case he says had Ms. Johnson expressed thoughts that life was not worth living and about ending her life[20].

18 February 2008

Ms. Claire Swanton was Ms. Johnson's nominated contact nurse on this day. Her first contact with her was at 8.00 a.m. when dispensing medication during her medication round. At that time, Nurse Swanton says Ms. Johnson showed no obvious signs of agitation or distress[21]. Mr. Peter Coleman, Nurse, stated his shift ended at 7.00 a.m. and can recall speaking to Ms. Johnson early in the morning, and like Nurse Swanton, says Ms. Johnson appeared to be fine[22].

Around mid morning however, under graduate student nurse, Ms Billie-Jo Bolch whose role included fifteen minute observations of Ms. Johnson, informed Nurse Coleman that she could not find Ms. Johnson. Mr. Coleman then assisted Ms. Bolch in searching for the whereabouts of Ms. Johnson but to no avail. When checking the court yard area, a patient (identity unknown) was heard to say, "if your looking for that Aboriginal girl she jumped the fence"[23].

Following a brief search of the court yard to ensure Ms. Johnson was not hiding anywhere, Nurse Coleman advised Mr. Martin Driscoll the Supervising Nurse that Ms. Johnson could not be found.

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[19] See evidence of Nurse Tresize at Inquest page 191

[20] Inquest transcript page 70, line 27

[21] See statement by Clarie Swanton dated 6 June 2011

[22] See statement by Peter Coleman dated 5 April 2011 page 2, para 3

[23] ibid

Nurse Coleman also checked the fence alarm and noted that it was on, but hadn't been activated. Being satisfied that Ms. Johnson was no longer at the Alexander Bayne Centre, Mr. Driscoll reported her absence to Bendigo Police at about 10.20 a.m.[24]. Senior Constable Hiatt confirms the time and content of that communication and compiled a missing person report which was listed on the police LEAP data base. He also contacted D24 and arranged for a description of Ms. Johnson to be broadcast to all units within the division and requested police at Echuca to attend Ms. Johnson's home address[25].

Having informed police that Ms. Johnson was missing, Mr. Driscoll then notified Ms. Johnson's mother, Mrs. Barbara Johnson. He asked her to let the Alexander Bayne Centre know if she was contacted by her daughter[26].

Subsequently, Mrs. B. Johnson received a telephone call (maybe two) from Ms. Johnson who asked her mother to come and pick her up. Mrs. B. Johnson "told her to call police and go back to hospital"[27].

Ms. Johnson responded to her mothers advice by telling her mother not to contact the police because if she did, she wouldn't see her again. On being told this, Mrs. B. Johnson told her daughter to wait where she was in White Hills, as she would organize some transport and come and pick her up. Mrs. Johnson was unsuccessful in her efforts to get a car and had no further contact with here daughter that day.

<u>19 February 2008</u>

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[24] See statement by Martin Driscoll dated 28 May 2010

[25] See statement by Senior Constable B. Hiatt, Bendigo Police dated 28 September 2010

[26] Inquest transcript (page 158 Lines 5-9) See also statement by Mrs. Barbara Johnson dated 1 February 2011, Page 2 para 2

[27] See statement by Mrs. Barbara Johnson dated 1 February 2011, Page 1 last para

Sometime prior to 3.00 p.m. on 19 February 2008, Mrs. Jenny Cooper was at her home located on the Midland Highway at Bagshot when she was approached by Ms. Johnson. Ms. Johnson sought directions to the nearest town which was Goornong about six kilometres away[28]. At Ms. Johnson's request, Ms. Cooper drove her to Goornong dropping her off at the park.

It is from Goornong that Ms. Johnson again telephoned her mother. When asked "if she needed her to do something", Ms. Johnson replied "no I'm alright I just want to come home to my kids and you". Mrs. B. Johnson then told her to wait where she could see her[29].

At about 3.15 p.m., Ms. Johnson was seen by several people sitting on a wooden bench outside the Goornong General Store[30]. Mr. John McNamara was one of these people. He entered the store for a very short time then returned to his vehicle which was parked about twenty metres east of the store. Almost immediately upon entering his vehicle he saw Ms. Johnson

> "jump up off the bench raise her arms in the air and ran straight out onto the Midland Highway as if she was attempting to wave a bus down".

At the same time he saw a semi trailer level with his vehicle travelling in a westerly direction towards Bendigo. This vehicle veered onto the incorrect side of the highway in an attempt to avoid Ms. Johnson[31]. Ms. Johnson continued to run towards the truck however coming into contact with the trailer which knocked her to the roadway.

Witnesses immediately went to Ms. Johnson's assistance and emergency services were contacted. Police and ambulance personnel attended shortly thereafter. Senior Constable Hockey of the Bendigo Traffic Management Unit was the first police member on the scene. He was unable to find any signs of life when he attended Ms. Johnson. Paramedic Mr. Lex Wynd examined Ms. Johnson immediately after Senior Constable Hockey and confirmed that Ms. Johnson was deceased.

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[28] See statement by Ms Jenny Cooper dated 23 February 2008 Page 1, para 2

[29] See statement by Mrs. Barbara Johnson (supra) page 2, para 1

[30] See statements by Ms. Lynette Perry dated 19 February 2008, page 1 para 1, Ms. Tania McKinstry, dated 19 February 2008 page 1 para 1 and Mr. John McNamara dated 20 February 2008 page 1 para 1.

[31] See statements by Mr. J. McNamara (supra) page 1 para 3, Ms Cheryle Cleaver dated 2 March 2008 page 1 para 2, Mr. Raymond Frappell dated 19 February 2008 page 1 last para and Ms. T McKinstry (supra) page 1 para 1.

After inquiry, Senior Constable Hockey established from Mr. Frappell, the truck driver, that Mr. Frappell had held a licence endorsed to drive heavy vehicles for the last thirty one years. That the truck he was driving on the day was a Kenworth semi trailer which was towing a forty-five foot trailer laden with about three tonne of plastic bins. Mr. Frappell had worked for the same haulage company that owned the truck for the previous six years. He was the only person who drove the truck and travelled the same route from Shepparton to Harcourt every day when at work. The vehicle was in a roadworthy condition. Mr. Frappell states that he had slowed to a speed of about 50 klm/h at the time he first sighted Ms. Johnson. His estimate of speed is consistent with the observations of eye witnesses. Mr. J. McNamara and Ms. C. Cleaver told investigating police member Senior Constable Whitman, Officer in Charge Goornong, that the truck driver had done all he could to avoid a collision with Ms. Johnson. Upon speaking to eye witnesses individually at the scene on the day Leading Senior Constable Hockey states that

> "the actions of the deceased at the time appeared to be deliberate...."[32]

This conclusion is rejected by the families lawyers who state several reasons for their position in their closing submissions dated 16 March 2012 (page 8-10).

These include as follows:-

1. Ms. Johnson was always at low risk of suicide.
2. Ms. Johnson only desired to see her family.
3. The semi trailer was travelling slower than the 60km speed limit.
4. Ms. Johnson was waving her arms in the air at the time of impact.
5. Impact occurred on the passenger side of the vehicle semi trailer.

Point 1

[32] See Leading Senior Constable Hockey's statement 21 March 2008 page 3 para

It is clear from the evidence that at the time of admission to the Alexander Bayne Centre on 17 February 2008, that on inquiry by Dr. Zahedi, Ms. Johnson "denied any thought, plan or intent of suicide…..[33]". Further, when subsequently reviewed by Dr. Eaton later that morning, she denied that she held any "suicidal wishes….[34]". As a result of this and the fact that Ms. Johnson was saying that things were getting better, Dr. Eaton "thought her suicidality was low….[35]".

It should be noted however that Ms. Johnson also denied any intent to abscond but eventually did so. This was in spite of the fact that her risk of absconding level had been upgraded to medium[36].

Point 2

On Sunday 17 February 2008, the first day Ms. Johnson was admitted to the Alexander Bayne Centre, she made it clear to nursing staff that she was keen to leave as she wanted to help her sister in Cherbourg[37]. The next day being Monday 18 February 2008 Ms. Johnson absconded from the Alexander Bayne Centre at about 9.40 a.m. It is not known what she did that day, save to say (as previously mentioned) that she telephoned her mother twice from the Bendigo suburb of White Hills asking her to come and pick her up. The next time Mrs. Johnson heard from her daughter was when Ms. Johnson called her from Goornong the following day. The time of this call is unknown but Ms. Johnson told her mother that she was alright and just wanted to return home to her and her children[38].

It is acknowledged, that by the time Ms. Johnson reached Goornong, she had travelled some thirty kilometres from Bendigo in the direction of her home in Echuca.

Point 3

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[33] See Dr. Zahedis report 1 October 2010 page 2 para 3.

[34] Dr. Eatons report 22 December 2008 page 3 para 1

[35] Inquest transcript page 67 lines 3-4

[36] See – Dr Eatons report 22 December 2008 page 3 para 7 and Inquest Transcript page 67 line 1 and 2

[37] Dr. Eatons report ibid page 3 para 5

[38] See Mrs. B. Johnson's statement dated 1 February 2011 page 2 para 1

Although Mr. Frappell had slowed to about 50 kilometres per hour after entering the township of Goornong[39], he was only about 20-30 metres away from Ms. Johnson when she ran onto the highway[40]. He was driving a laden semi trailer. He could see that Ms. Johnson was going to hit the trailer if she did not stop. He veered onto the incorrect side of the road in an attempt to miss her, but to no avail. He is not able to say where she hit the trailer, only that it was towards the rear[41]. He stopped the truck about two hundred metres on from the point of collision[42].

Point 4

In my view it is mere speculation to suggest that Ms. Johnson by waving her arms in the air as she ran onto the road was merely attempting to obtain Mr. Frappell's attention. The semi trailer was heading in the opposite direction to Echuca. She may even have stopped on the highway as the cabin of the semi passed her and veered away[43]. She then ran further towards the truck colliding with the trailer.

Point 5

According to Mr. McNamara, Ms. Johnson ran "into the trailer of the semi just above the drive wheels of the prime mover[44]. Mr. Frappell also says Ms. Johnson ran at the trailer he was towing. In my view, contact with such a large moving vehicle at the speed it was travelling, whether it be at the front or the side of the truck or trailer would in all probability result in serious injury or death.

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[39] See statement R. Frappell dated 19 February 2008 page 1 para 4

[40] See statement by M. McNamara dated 20 February 2008 page 1 para2 and page 1 para 3 – Mr. McNamara parked about twenty metres east of the store. At the time Ms. Johnson ran onto the highway, the semi trailer was level with his vehicle.

[41] See R. Frappell statement (supra) page 2 para 1

[42] Ibid page 2 para 2

[43] See J. McNamara statement (supra) page 1 para 3

[44] Ibid page 1 para 4

The point of impact with the semi trailer may simply come down to a question of timing. Ms. Johnson ran from a standing start on the footpath and onto the roadway when the truck was a mere 20 – 30 metres away from her.

A vehicle travelling at 50km/h will cover a distance of 27.78 metres in two seconds. Ms. Johnson may have intended to run in front of the semi but failed to take into account the closing speed of the vehicle over such a short distance.

It should also be remembered that Mr. Frapell swerved from his path onto the wrong side of the road in an attempt to avoid her.

Summary and conclusion

- Ms. Johnson had a long history of mental illness.
- Ms. Johnson's father had died only about eight weeks prior to the date of her death.
- Ms. Johnson's medication regime was interrupted during the time she attended her father's funeral in Broken Hill.
- Ms. Johnson had been using cannabis and drinking heavily shortly before her attendance at the Echuca Regional Health on 16 February, 2008.
- Ms. Johnson's mental health was so parlous at this time that she was admitted to the Alexander Bayne Centre as an involuntary patient.
- Dr. Eaton states that "her presentation was that of someone with a past history of schizoaffective disorder who recently relapsed with symptoms of psychosis and lowered mood with accompanying homicidal/suicidal ideas. Her condition appeared to have been fluctuant as the presence and strength of psychotic phenomena varied over time[45]".
- Ms. Johnson's ongoing treatment and medication regime was again interrupted when she left the Alexander Bayne Centre on 18 February, 2008.

[45] See Dr. Eatons report 22 December 2008 page 3, para 2

- Ms. Johnson's attitude to any further intervention by the authorities was made clear by her to her mother when she spoke to her over the phone from White Hills on 18 February, 2008.
- From the safety of the footpath in front of the Goornong store, Ms. Johnson ran onto the highway and into a moving semi trailer.

In my opinion, the evidence supports a finding that Ms. Johnson's actions were voluntary, conscious and deliberate. Further, that she had the capacity to form the intent to take her own life and did in fact form such an intention at the relevant time. In my view, the whole of the evidence does establish to the requisite standard of proof, that Ms. Johnson's death was one of suicide.

Comments –

Bendigo Health records reveal that it was not uncommon for patients to abscond from the Alexander Bayne Centre[46]. Ms. Johnson had demonstrated by her conduct at Echuca Regional Health on 16 February 2008 that she was a potential flight risk. This was known to staff at the time of her admission to the Alexander Bayne Centre on 17 February 2008[47]. Some hours after her admission, Ms. Johnson was seen by Security Guard Moulden attempting to climb over a perimeter fence[48]. He immediately informed nursing staff what he had seen[49]. Ms. Johnson remained in the open ward where observations were to be at fifteen minute intervals. Ms. Johnson absconded from the facility on the morning of 18 February, 2008.

Several changes have since been made to the security environment of the Alexander Bayne Centre. The perimeter pool type metal tubing fence with a height of about six feet has been replaced with a solid fence at a height of about ten feet. The unreliable laser alarm system has been removed. An additional set of secure doors have been installed in the corridor at the entrance of the patient area.

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[46] See undated statement by Wayne Daly, Nurse Business Manager, Alexander Bayne Centre page 1, para 5

[47] See report by Dr Jane Greacen, Director Medical Services, dated 1 October, 2010 Page 2, final para

[48] See statement by Stewart Moulden dated 13 May 2011 Page 2, para 1

[49] Ibid Page 2, para 4

This door can only be accessed via a staff proximity card[50]. Security personnel are now better resourced and have greater input into issues regarding security.

It is accepted and acknowledged that Aboriginal people, have a strong spiritual connection to 'country'. It is Mrs. B. Johnson's belief that her daughter should never have been taken from Echuca to Bendigo as she had no friends or family there. This problem could not be overcome by medical staff at Echuca however, for once a recommendation was made that Ms. Johnson be admitted as an "involuntary patient", the nearest facility equipped to deal with such patients was the Alexander Bayne Centre in Bendigo. Whilst necessary in the circumstances, this kind of transfer only serves to highlight the importance of the role of Aboriginal Liaison Officer at Mental Health facilities.

Ms. Debra Webster held this position at the time of Ms. Johnson's admission to the Alexander Bayne Centre. It was her role to provide assistance and support for Aboriginal people and their families who accessed Bendigo Health[51]. Ms. Webster's hours of duty were limited however. She was employed from 8.30 a.m. to 5.00 p.m. Monday to Friday. There was no specific after hour's notification procedure.

Bendigo Health now has a conjoint Aboriginal spiritual and emotional welfare worker. This appointment has been made in consultation with the Bendigo and District Aboriginal Co-op (BDAC). A similar role has been filled at Echuca. Whilst this may be seen as a positive outcome for the future at these hospitals, there is still no 'after hours' notification procedure in place[52].

Recommendations

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[50] See statement by Wayne Daly supra page 2, final para

[51] See inquest transcript page 194 line 17

[52] Ibid page 198 line 27-28

At the time of Ms. Johnson's death, Ms. Debra Webster was employed as Aboriginal Health Liaison Officer at Bendigo Health. Her hours of employment were 8.30 a.m. to 5.00 p.m. Monday to Friday.

1. It is recommended that this role be extended to include on call duties so that all times outside of the normal working week will also be covered. This would enable a 24 hour notification and support service for Aboriginal patients admitted to psychiatric hospitals.

When an Aboriginal person is taken into police custody, police are required to inform the Victorian Aboriginal Legal Service of that fact without delay in order to ensure that persons legal rights are protected.

2. It is recommended that whenever an Aboriginal person is admitted to a mental health facility, that as part of the process, the Aboriginal Liaison Officer (or any other person holding a similar role) be notified without delay so that all necessary services can be actioned.

Whilst satisfied that Ms. Johnson was taken to the nearest and most appropriate mental health facility given her involuntary patient status, the importance of 'country' to Aboriginal people must be acknowledged.

3. That being so, it is recommended that where circumstances permit, that Aboriginal involuntary patients always be located at a Mental Hospital as close to their country as possible.

At the time of Ms. Johnson's admission to the Alexander Bayne Centre as an involuntary patient, she was exhibiting homicidal/suicidal ideas. Ms. Johnson (and others before her) found it relatively easy to abscond from this facility.

4. Whilst accepting that Mental Hospitals are not prisons, it is recommended that regular audits be conducted into the security environment at these facilities with a view to minimizing the risk of patients (particularly involuntary patients) absconding.

Signature:

W.P. Gibb

Date: 8 May 2013

Coroners Court of Victoria