JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	27 JUNE 2024
DELIVERED	**:**	13 AUGUST 2024
FILE NO/S	**:**	CORC 818 of 2022
DECEASED	**:**	DEANE-JOHNS, AMY REBECCA

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops appeared to assist the coroner.

Sergeant C Martin assisted the coroner.

Mr A Gibson appeared for the North Metropolitan Health Service and the Western Australian Police Force.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Amy Rebecca DEANE-JOHNS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 27 June 2024 find that the deceased was 48 years of age and that death occurred on or about 29 March 2022 at Unit 3, 84 Stanley Street, Scarborough, from combined drug toxicity (predominantly methadone) in the following circumstances:*

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INTRODUCTION

1. Amy Rebecca Deane-Johns (Ms Deane-Johns) was 48 years of age when she died on or about 29 March 2022 from combined drug toxicity (predominantly methadone).[1,2,3,4,5,6,7,8]

2. At the time of her death, Ms Deane-Johns was subject to a community treatment order (CTO)[9] made under the *Mental Health Act 2014* (WA) (the MHA).[10] Accordingly, Ms Deane-Johns was an "*involuntary patient*" and thereby a "*person held in care*", and her death was a "*reportable death*".[11]

3. Given the circumstances of Ms Deane-Johns' death, a coronial inquest was mandatory, and because she was a person held in care, I was required to comment on the quality of the supervision, treatment and care Ms Deane-Johns received while in that care.[12]

4. I held an inquest into Ms Deane-Johns' death on 27 June 2024, at which the following witnesses gave evidence:

a. Dr Mark McAndrew (Consultant psychiatrist);
b. Ms Jessica Butler (ICOT Case Manager); and
c. Det. Sen. Constable Nathan Dalton (Investigating Officer).

5. The Brief of evidence tendered at the inquest comprised two volumes, and included a report into Ms Deane-Johns' death by a coronial investigator,[13] as well as expert reports and medical notes. The inquest focused on the supervision, treatment and care Ms Deane-John received while subject to a CTO, as well as the circumstances of her death.

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[1] Exhibit 1, Vol. 1, Tab 1, P100: Report of Death (30.03.22)
[2] Exhibit 1, Vol. 1, Tab 2, P92: Identification of Deceased Person (30.03.22)
[3] Exhibit 1, Vol. 1, Tab 3, P98: Mortuary Admission Form (30.03.22)
[4] Exhibit 1, Vol. 1, Tab 5, Life Extinct Form (30.03.22)
[5] Exhibit 1, Vol. 1, Tab 4.2, Post Mortem Report (06.04.22)
[6] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (26.09.22)
[7] Exhibit 1, Vol. 1, Tab 6, Toxicology report (28.07.22)
[8] Exhibit 1, Vol. 1, Tab 7, Report - Coronial Investigator C Tassell (05.06.23), pp1-5
[9] An order made under the MHA that a person receive treatment on an involuntary basis in the community.
[10] Exhibit 1, Vol. 1, Tab 18.4, Form 5A: Community Treatment Order (14.03.22)
[11] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[12] Section 25(3) *Coroners Act 1996* (WA)
[13] Exhibit 1, Vol. 1, Tab 7, Report - Coronial Investigator C Tassell (05.06.23)

MS DEANE-JOHNS

Background[14,15]

6. Ms Deane-Johns was born on 27 July 1973 in Perth. She lived alone in Scarborough, and had three children from different partners. At the time of her death, Ms Deane-Johns was not in paid employment, and reportedly estranged from her family.

7. According to clinical notes, Ms Deane-Johns had a traumatic childhood, and she had disclosed she was the victim of sexual assaults by family members and their friends. Ms Deane-Johns said she attended school until Year 10, and had left school due to "*abuse by the nuns*".

Medical and mental health issues[16]

8. Ms Deane-Johns' interaction with mental health services began in 2013 when she was 39 years of age. Between 2016 and her death, she had 18 admissions to inpatient mental health units, as either a voluntary or an involuntary patient.

9. During her inpatient admissions Ms Deane-Johns disclosed her history polysubstance use including methamphetamine (which she had reportedly started using at the age of 14 years), benzodiazepines, and alcohol. She also occasionally used heroin, and had experienced a heroin overdose in 2016. Ms Deane-Johns was observed by staff on various occasions to be heavily intoxicated by alcohol and/or illicit drugs.

10. Ms Deane-Johns was managed by the Duke Community Treatment Team (the Team) from January 2018 until 18 February 2022. It had been determined that Ms Deane-Johns required a greater level of service, and she was eventually transferred to the Intensive Community Outreach Team (ICOT), having being referred to the service in about July 2021.

[14] Exhibit 1, Vol. 1, Tab 7, Report - Coronial Investigator C Tassell (05.06.23), pp1-5
[15] Exhibit 1, Vol. 1, Tab 8, Report - Constable K Bunton (30.03.22)
[16] Exhibit 1, Vol. 1, Tab 15, Report - Dr L Smith (02.05.22), pp1-2

Management by the ICOT Team[17,18,19]

11. In her statement, Ms Butler (a mental health nurse) explained that ICOT is a mental health team that works with people with "*persistent mental illness*" and manages their care in the community. Ms Butler said that clients are referred because they require additional support, and that ICOT clients:

> [A]re often experiencing functional decline, including difficulties with transport, managing their home, meals, social interactions, medical support, and behavioural issues. These clients' conditions are often at risk of deteriorating such that regular contact with the client is required.[20]

12. Ms Butler noted that whereas community mental health care teams can usually only provide case manager input every two to four weeks, ICOT case managers typically have only 12 clients and can therefore offer a more intensive service. Ms Butler said that most ICOT clients require weekly contact, and that this is possible because of this lower caseload.

13. Ms Deane-Johns was accepted by ICOT on 18 February 2022,[21] and she came under the care of Dr Main (consultant psychiatrist) and Ms Butler (who became her case manager). During a home visit Ms Butler conducted on 2 March 2022, Ms Deane-Johns complained of feeling unwell, and appeared intoxicated and responding to "*unseen stimuli*".

14. Ms Butler raised her concerns with Dr Main, and although they attempted to assess Ms Deane-Johns during a home visit on 8 March 2022, she was not home. Following further attempts to contact Ms Deane-Johns, she was eventually reviewed by Dr Main and Ms Butler during a home visit on 14 March 2022. During this review, Ms Deane-Johns appeared to be distracted by unseen stimuli, and it was noted that her compliance with oral medication had been intermittent.

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[17] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), paras 11-97 and ts 27.06.24 (Butler), pp20-33
[18] Exhibit 1, Vol. 1, Tab 15, Report - Dr L Smith (02.05.22), pp2-6 and ts 27.06.24 (McAndrew), pp5-20
[19] Exhibit 1, Vol. 1, Tab 18.1, ICOT Outpatient notes (25.01.22 - 06.05.22)
[20] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), para 15
[21] Exhibit 1, Vol. 1, Tab 18.3, Community Mental Health Referral Form (18.02.22)

15. In view of Ms Deane-Johns' presentation, and given her lack of insight into her need for treatment, and her poor compliance with medication, Dr Main decided to place Ms Deane-Johns on a CTO, and he prescribed a depot injection of the antipsychotic medication, aripiprazole.[22]

16. When the ICOT team visited Ms Deane-Johns on 15 March 2022 to administer her prescribed depot injection, she was not at home although she had previously said she would be. During a phone call with Ms Butler on 16 March 2022, Ms Deane-Johns expressed suicidal ideation, and asked to be admitted to Graylands Hospital (Graylands), which was not an unusual request for her to make.

17. Ms Butler completed some admission paperwork and made relevant enquiries, but there were no available beds at Graylands. At about 2.30 pm on 16 March 2022, Ms Butler and a colleague conducted a home visit to assess Ms Deane-Johns, but she was not at home. Ms Butler called Dr Main to advise him of the situation, and then tried calling Ms Deane-Johns, but there was no reply.

18. In view of the circumstances, Ms Butler referred her concerns to the after-hours service. When a clinician made contact with Ms Deane-Johns later that afternoon, Ms Deane-Johns said she was still having thoughts about "*slashing her throat*". Although Ms Deane-Johns said she was able to guarantee her safety in the short-term, she said she would still like a voluntary admission to Graylands.

19. When Ms Butler and a psychiatric registrar conducted a home visit on 17 March 2022, Ms Deane-Johns said she no longer felt she needed to be admitted to Graylands. She also disclosed using "*a little bit*" of heroin at around midnight the night before, before consenting to receive her depot injection, which she was given by Ms Butler. Ms Butler was concerned about Ms Deane-Johns' ongoing polysubstance use, but as she noted in her statement, it is generally very difficult for clients who are mentally unstable to engage with rehabilitation services.

[22] Exhibit 1, Vol. 1, Tab 18.4, Form 5A: Community Treatment Order (14.03.22)

20. When Dr Main and Ms Butler conducted a home visit on 28 March 2022, Ms Deane-Johns expressed some suicidal ideation, and also mentioned wanting to kill her ex-partner, who she described in disparaging terms. Although Dr Main and Ms Butler had some concerns about Ms Deane-Johns' level of psychosis, they assessed her as being at chronic, rather than acute risk.

21. In her statement, Ms Butler said she was aware from reviewing her history that Ms Deane-Johns had expressed similar distress in the past. Ms Butler also said that in her experience:

> [I]t is not uncommon for a client to express distress citing suicide to ensure people understand the distress they are experiencing, rather than necessarily indicating that the client is an acute suicide risk.[23]

22. It was determined that an inpatient admission was not necessary at that stage, and that Ms Deane-Johns could continue to be managed in the community. Dr Main assessed Ms Deane-Johns' level of self-harm as moderate, and expressed his care plan in these terms:

> To continue assertive (community mental health care). At this stage admission can be deferred, but more proximal risk indicators e.g. Active planning or access to her ex, may warrant admission. I will change the regular dose to ARI 400mg 4 weekly. Needs weekly medical appts.[24]

23. Ms Deane-Johns' care was transferred to a new consultant psychiatrist on 29 March 2022 because Dr Main was going on annual leave. However, the new consultant psychiatrist did have an opportunity to review Ms Deane-Johns before her death.

24. On 7 April 2022, Ms Butler telephoned Ms Deane-Johns to arrange a further home visit, but there was no response. Ms Butler and another case manager then conducted a home visit, and a neighbour advised them that Ms Deane-Johns' had died.

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[23] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), para 97
[24] Exhibit 1, Vol. 1, Tab 15, Report - Dr L Smith (02.05.22), p5

25. Ms Buter contacted local police to confirm what she had been told before contacting Ms Deane-Johns' sister. In her statement and at the inquest, Ms Butler confirmed that she had not been notified of Ms Deane-Johns death prior to the home visit she and a colleague conducted on 7 April 2022.[25]

26. In an email to Sergeant Martin on 6 August 2024, Mr Gibson[26] confirmed that there is currently no system in place that would ensure that services such as ICOT are advised when a person in their care has died.[27][28] Whilst it may be possible for services such as ICOT to advise local police of their involvement in the care of a person living in the district, there are obvious ethical and privacy concerns about doing so.

27. While I accept there may be benefits in local police advising support services when person receiving care has died, I am also mindful of the difficulties with implementing such a system. Therefore, after careful consideration, I have decided it would not be appropriate for me to make any recommendation about this issue.

Community treatment order[29,30]

28. The MHA provides that a person is not to be placed on a CTO unless: "*[T]he person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order*".[31]

29. In her statement, Ms Butler explained that ICOT clients are more likely to be managed on CTOs because they are "*often experiencing severe mental illness and chronic symptoms while having reduced capacity to make their own treatment decisions*".[32]

[25] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), para 97 and ts 27.06.24 (Butler), pp31-32
[26] Counsel for the North Metropolitan Health Service
[27] Email - Mr A Gibson to Sgt. C Martin (06.08.24)
[28] ts 18.06.24 (Dalton), pp40-41
[29] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), paras 30-36 and ts 27.06.24 (Butler), pp25-26
[30] ts 27.06.24 (McAndrew), pp10-12
[31] s25(2)(e), *Mental Health Act 2014* (WA)
[32] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), para 31

30. Ms Butler also noted that many ICOT clients are prescribed depot injections of antipsychotic medication, and that a CTO can assist with supporting medication compliance.[33]

31. Ms Butler observed that that CTOs are "*one of the most challenging aspects of ICOT's role*", and that before a client is placed on a CTO all other management options have been explored. Ms Butler also highlighted the important role that ICOT case managers can play in explaining to clients the reasons for them being placed on a CTO.[34]

32. In my view, Dr Main's decision to place Ms Deane-Johns on a CTO was justified. Ms Deane-Johns' mental illness required treatment, but she lacked insight into both her mental illness, and her need for treatment. Ms Deane-Johns was also non-compliant with her oral medication regime, meaning that prescribing monthly depot injections of antipsychotic medication was clinically appropriate.

33. A significant benefit of placing Ms Deane-Johns on a CTO was that if she became non-compliant with her medication, then breach action could be taken, and she could be required to attend an authorised hospital for assessment. Further, if it became necessary, the CTO could be revoked and Ms Deane-Johns could have been admitted to an authorised hospital on an involuntary basis.[35]

34. Having carefully reviewed the available evidence, I am satisfied that the decision to place Ms Deane-Johns on a CTO was justified on the basis that it was the least restrictive way to ensure that she was provided with appropriate treatment for her mental illness.

[33] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), paras 32-34
[34] Exhibit 1, Vol. 1, Tab 18, Statement - Ms J Butler (11.06.24), paras 35-36
[35] See: Division 4, Part 8, *Mental Health Act 2014* (WA)

EVENTS LEADING TO MS DEANE-JOHNS' DEATH[36,37,38,39]

35. At about 5.30 pm on 29 March 2022, Ms Deane-Johns' nephew (Mr Smith) dropped her home after they had spent the day time together, and had lunch in Perth. When they arrived at Ms Deane-Johns' home, there was an adult male at the premises who Mr Smith did not know.

36. Ms Deane-Johns told Mr Smith that the man (who seemed to be known to her) was homeless, and that she was assisting him by providing accommodation. Subsequent police inquiries have failed to determine the identity of this unknown male. When Mr Smith left to go home, he says Ms Deane-Johns was "*happy but slightly intoxicated from our afternoon drink*s", and he told her he would visit the next morning.

37. When Mr Smith arrived at Ms Deane-Johns' home at about 11.20 am on 30 March 2022, there was no response when he knocked on the front door. Mr Smith walked through the unlocked front door and found Ms Deane-Johns sitting, unresponsive, on the floor, apparently deceased. Mr Smith called emergency services, and ambulance officers arrived and confirmed that Ms Deane-Johns had died some time earlier.[40,41]

38. Police attended and found one empty bottle of methadone on the kitchen bench, and two full bottles of methadone in Ms Deane-Johns' handbag. Police enquiries determined that the bottles of methadone had been dispensed about 12-months earlier to one of Mr Smith's relatives.

39. Mr Smith told police that the bottles of methadone had been in the glovebox of his car, and that Ms Deane-Johns must have taken the bottles from the glovebox of his car without his knowledge.

[36] Exhibit 1, Vol. 1, Tab 7, Report - Coronial Investigator C Tassell (05.06.23), pp1-5
[37] Exhibit 1, Vol. 1, Tab 8, Report - Constable K Bunton (30.03.22)
[38] Exhibit 1, Vol. 1, Tab 9, Statement - Mr J Smith (30.03.22), paras 3-30
[39] Exhibit 1, Vol. 1, Tab 12, File Note - Det. Sgt. N Dalton and ts 18.06.24 (Dalton), pp34-43
[40] Exhibit 1, Vol. 1, Tab 16, SJA Patient Care Records SPK22D2 & SPK23D2 (30.03.22)
[41] Exhibit 1, Vol. 1, Tab 5, Life Extinct Form (30.03.22)

CAUSE AND MANNER OF DEATH[42,43]

40. A forensic pathologist (Dr R Junckerstorff), conducted a post mortem examination of on 6 April 2022, and noted Ms Deane-Johns' lungs were congested (a non-specific finding) and that there was possible scarring (fibrosis) of the liver.

41. Post mortem CT scans found no intracranial haemorrhage or skull fracture, and although PCR testing was positive for the COVID-19 virus, there was no viral infection of Ms Deane-Johns' heart or lungs. Biochemical testing found a slightly raised glucose level, and possibly impaired kidney function.

42. Toxicological analysis found therapeutic levels of amitriptyline, aripiprazole, diazepam, and tramadol in Ms Deane-Johns' system, along with raised levels of methadone, and methylamphetamine. Ms Deane-Johns also had a blood alcohol level of 0.073%, and a urine alcohol level of 0.103%.[44]

43. Dr Junckerstorff noted that opioids (such as methadone and tramadol) and benzodiazepines (such as diazepam) "*cause depression of the central nervous system with impairment of breathing and consciousness*".[45]

44. At the conclusion of his post mortem examination, Dr Junckerstorff expressed the opinion that the cause of Ms Deane-Johns' death was combined drug toxicity (predominantly methadone).[46]

45. I accept and adopt Dr Junckerstorff's opinion as my finding as to the cause of Ms Deane-Johns' death. Further, on the basis that there is no evidence that Ms Deane-Johns intended to end her life when she consumed her medication and the methadone, and I find her death occurred by way of accident.

[42] Exhibit 1, Vol. 1, Tab 4.2, Post Mortem Report (06.04.22)
[43] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (26.09.22)
[44] Exhibit 1, Vol. 1, Tab 6, Toxicology report (28.07.22)
[45] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (26.09.22), p1
[46] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (26.09.22), p1

QUALITY OF SUPERVISION, TREATMENT AND CARE

46. Ms Deane-Johns' mental health was managed by the Team from January 2017 until 18 February 2022, and by the ICOT for the six week period leading up to her death.

47. During the period Ms Deane-Johns was managed by ICOT, she was regularly reviewed by her consultant psychiatrist and her case manager, who was an experienced mental health nurse.

48. Ms Deane-Johns was placed on a CTO on 14 March 2022, and as I noted earlier, it is my view that this decision was appropriate given Ms Deane-Johns' lack of insight, and her history of non-compliance with medication.

49. During his evidence at the inquest, Dr McAndrew (an experienced consultant psychiatrist who had reviewed Ms Deane-Johns' care) said he could not identify anything in Ms Deane-Johns' management by ICOT that should have been done differently. Dr McAndrew also said that "*the treatment looked very solid from my perspective*".[47]

50. At the inquest, Ms Butler identified that in common with many of ICOT's clients, Ms Deane-Johns had ongoing polysubstance use issues, and this impacted negatively on her mental illness and its management. Ms Butler said that she felt ill-equipped to provide the level of alcohol and drug rehabilitation support that Ms Deane-Johns "*desperately needed*", although as I pointed out at the inquest, Ms Deane-Johns had regularly rebuffed attempts to refer her to rehabilitation services.[48]

51. Having carefully reviewed the available evidence, it is my view, that Ms Deane-Johns' management whilst she was the subject of a CTO was reasonable, and the supervision, treatment and care she received during that time was of a good standard.

[47] ts 27.06.24 (McAndrew), p18
[48] ts 27.06.24 (Butler), pp32-33

CONCLUSION

52. Ms Deane-Johns had a long-standing history of mental illness, and was 48-years of age when she died from combined drug toxicity on or about 29 March 2020.

53. As I did at the inquest, I wish to extend to Ms Deane-Johns' family and her loved ones, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
13 August 2024