IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 001282

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Naomi Charmaine MAHON

Delivered On:	28 May 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	7-9 October and 5 December 2013
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr J. SNOWDON, Corporate Counsel, appeared on behalf of Monash Medical Centre/ Monash Health (formerly Southern Health)
Police Coronial Support Unit	Sergeant D. DIMSEY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of NAOMI CHARMAINE MAHON
and having held an inquest in relation to this death at Melbourne
on 7-9 October and 5 December 2013:

find that the identity of the deceased was NAOMI CHARMAINE MAHON
born on 21 October 1977
and that the death occurred on 8 April 2011
at railway tracks adjacent to the Thompson Street/Carnish Road intersection, Clayton, Victoria 3168

from:

I (a) MULTIPLE INJURIES SUSTAINED WHEN STRUCK BY A TRAIN

Contributing factors

II PSYCHIATRIC ILLNESS, EFFECTS OF CANNABIS USE

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Naomi Charmaine Mahon was the 33-year old daughter of Glenn Mahon and Rosemary Robb. Her parents separated when she was about seven years of age and she lived with each of them at different periods throughout her childhood.

2. When Ms Mahon was 18 years old, she met Sajid Nazeer and they subsequently commenced an intimate relationship, having a daughter together in 1998. Their relationship has been described as 'on again, off again'[2] and 'tumultuous'[3], and appears to have involved periods of cohabitation and periods when Ms Mahon and Mr Nazeer lived apart.[4] Mr Nazeer

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

[2] Coronial Brief of Evidence (Statement of Glenn Mahon).

[3] Exhibit M, see in particular, Southern Health Triage Mobilisation report 30 November 2010.

[4] Coronial Brief of Evidence (Statement of Glenn Mahon) and Exhibit G.

characterised their relationship, throughout, as being a committed one[5] Immediately before her death, Ms Mahon appears to have been living with Mr Nazeer and their daughter.

PSYCHIATRIC AND SUBSTANCE USE HISTORY

3. Ms Mahon reportedly began misusing her mother's medication, when she was about 18 years of age.[6] In her early to mid-20s, Ms Mahon used heroin intravenously but had ceased using the drug several years before her death and, at the time of her death, was prescribed buprenorphine as opioid replacement therapy.[7] Also, Ms Mahon reportedly had a long history of heavy cannabis use, but had some success in reducing her use in the year before she died.[8]

4. Ms Mahon's first contact with public psychiatric services occurred in 1993 following an overdose. In 1996, she was psychiatrically assessed at Monash Medical Centre [MMC] following an attempt to jump from a bridge when reportedly feeling depressed, suicidal and trapped in an abusive relationship. She was diagnosed and treated for depression in 1997, 2008-9, and 2010 but discontinued her use of prescribed antidepressants. In 2004, Ms Mahon was diagnosed as probably suffering from Bipolar Affective Disorder but it is unclear what, if any, treatment she received at the time.[9]

5. In October 2010, Ms Mahon was living with her daughter in St Kilda when, reportedly, her mental health started to deteriorate. According to her father, she called him between 20 and 30 times a day, told him that she had stopped using cannabis and could not fall asleep.[10] Ms Mahon went missing with her daughter, for 'days at a time' and presented as extremely agitated, pacing, unable to sit still or maintain concentration and was quick to anger.[11] Mr Mahon advised his daughter to see her general practitioner. When she failed to do so, he called the Crisis Assessment Treatment Team [CATT] to report his concerns about her mental state.[12]

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[5] Exhibit G.

[6] Exhibit G.

[7] Exhibit F and Transcript page 53. Ms Mahon was first prescribed

[8] Exhibit M, see in particular, Southern Health Triage Mobilisation Report dated 30 November 2010.

[9] Monash Health Medical Records.

[10] Coronial Brief of Evidence (Statement of Glenn Mahon).

[11] Coronial Brief of Evidence (Statement of Glenn Mahon).

[12] Coronial Brief of Evidence (Statement of Glenn Mahon).

6. On 11 November 2010, CATT attended Ms Mahon's home, in company with police, to perform a psychiatric assessment and were initially refused entry. Ms Mahon was observed to be agitated, disorganised and unable to answer questions. She expressed grandiose and persecutory delusions and appeared to be responding to internal stimuli. She was aggressive and police ultimately deployed 'capsicum spray' to subdue her.[13]

7. Ms Mahon was admitted to the Psychiatric Unit of The Alfred Hospital; as an involuntary patient pursuant to the provisions of the *Mental Health Act* 1986 [MHA]. She spent the first 12 days of her admission in the High Dependency Unit and in seclusion due to her manic presentation and ongoing paranoid and persecutory beliefs. Ms Mahon was diagnosed with mania with psychotic features, likely Bipolar Affective Disorder.[14] Over the course of a five-week admission, she was trialled on sodium valproate (an anticonvulsant and mood stabiliser) but experienced significant side effects[15], and so another medication, the antipsychotic risperidone, was trialled. Ms Mahon's mental state improved gradually.

8. On 20 December 2010, Ms Mahon was discharged from The Alfred Hospital to live at her father's home with her daughter. At discharge, she was 'feeling a lot better' but with a slightly elevated mood, and reported good sleep and appetite.[16] Ms Mahon denied perceptual disturbances and suicidal ideation. She was referred, as a voluntary patient, for ongoing psychiatric case management and treatment by the Clayton Continuing Care Team [CCCT]. Noted on the discharge summary and referral documents was a risk of relapse, should Ms Mahon become noncompliant with medication.[17]

PSYCHIATRIC TREATMENT IN THE COMMUNITY - CCCT

9. Ms Mahon's CCCT consisted of consultant psychiatrist, Dr Leela Baswa, psychiatric registrar, Dr Keping Xu and Case Manager, Reyna Anderson. At her first review was on 29 December 2010, she was distressed about her recent psychiatric admission and presented as anxious, but not psychotic or suicidal. She reported cessation of risperidone shortly after her discharge due

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[13] Exhibit M, see in particular, Southern Health Triage Mobilisation Report dated 30 November 2010.

[14] Exhibit M, see in particular, Southern Health Triage Mobilisation Report dated 30 November 2010.

[15] Side effects included a rash, pitting oedema and abnormal liver function. See Exhibit K.

[16] Exhibit M, see in particular, Southern Health Triage Mobilisation Report dated 30 November 2010.

[17] Exhibit M, see in particular, Southern Health Triage Mobilisation Report dated 30 November 2010. I note, pursuant to Exhibit F, that Ms Mahon's general practitioner, Dr Drake, did not receive a copy of The Alfred Hospital's discharge summary.

to its side effects, but agreed to recommence it with a plan for ongoing monitoring and the trial of an alternate mood stabiliser if her mental state did not improve.[18]

10. When reviewed by Dr Baswa on 5 January 2011, Ms Mahon's mental state had improved. She reported taking risperidone without side effects, and that she was planning to return to her own home in St Kilda with her daughter. She denied substance use.[19] However, on further review on 19 January 2011, Dr Xu was concerned that Ms Mahon's mental state was deteriorating due to her report of some depressive symptoms in the context of cannabis use.[20] Ms Mahon was commenced on quetiapine at this time.

11. Mr Mahon was concerned about his daughter's mental state and called her Case Manager. Ms Anderson telephoned Ms Mahon who confirmed that she had been feeling restless for about a week. She was reminded to contact the Psychiatric Triage Service [PTS] if she required support, and accepted an earlier than scheduled appointment for review by Dr Xu.[21]

12. Ms Mahon was reviewed by Dr Xu on 8, 14 and 22 February 2011 and on each occasion she presented as anxious but not psychotic or suicidal, but with limited insight into her illness.[22] Her mental state was noted to be influenced by her level of substance use. Dr Xu observed that she had developed 'significant akathisia'[23] and could not sit still and was pacing during their meeting. Quietapine was ceased and diazepam was prescribed instead. By the middle of the month, Ms Mahon's akathisia had improved somewhat but her symptoms were moderately severe again by the end of the month.[24] Ms Mahon reported compliance with her prescribed medications due to her father's reminders and supervision.[25]

13. Ms Mahon attended her CCCT appointment on 18 March 2011 accompanied by Mr Nazeer. She complained of restlessness over the past six weeks and that she was feeling 'low'.[26] She

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[18] Exhibit K.

[19] Clayton Continuing Care Team progress notes dated 5 January 2011.

[20] Clayton Continuing Care Team progress notes dated 4 February 2011.

[21] Clayton Continuing Care Team progress notes dated 4 February 2011.

[22] See generally Clayton Continuing Care Team progress notes made in February 2011.

[23] Clayton Continuing Care Team progress notes dated 8 February 2011. Akathisia is a frequent and common adverse effect of treatment with antipsychotic (neuroleptic) drugs. The syndrome consists of subjective feelings of inner restlessness and the urge to move, as well as objective components such as rocking while standing or sitting. It is usually very distressing for the patient.

[24] Compare Clayton Continuing Care Team progress notes dated 14 and 28 February 2011.

[25] Clayton Continuing Care Team progress notes dated 8 and 14 February 2011.

[26] Clayton Continuing Care Team progress notes dated 18 March 2011.

denied depressive cognition but admitted occasional suicidal thoughts without any plan or intent. Ms Mahon reported variable compliance with risperidone and her akathisa remained prominent despite ceasing quetiapine.[27] Dr Baswa recommended a hospital admission for investigation of akathisia, monitoring of her mental state and commencement of medication as necessary in a supervised environment.[28] Ms Mahon refused an inpatient admission because she did not want to be away from her daughter, a decision supported by Mr Nazeer.[29]

14. Although presenting as 'significantly unwell'[30] on 18 March 2011, Ms Mahon did not meet the MH Act criteria for involuntary treatment[31] and so CCCT planned to work with her 'collaboratively'[32] in the community, with Ms Mahon agreeing to attend the Clayton Clinic frequently and her general practitioner for a physical examination and neurological investigations. Given the absence of psychotic symptoms and her presentation with marked akathisia, all antipsychotic medications were ceased and her diazepam dosage was increased.[33] Mr Nazeer and Mr Mahon were advised to contact the Psychiatric Traige Service (PTS) if Ms Mahon's mental state deteriorated. Mr Mahon was informed of Ms Mahon's ongoing management plan.

15. During reviews conducted by Dr Xu on 21 and 28 March 2011[34], Ms Mahon reported that her mood and her sleep had improved and she was feeling less anxious. Mrs Nazeer, Mr Nazeer's mother who attended the last March 2011 appointment with Ms Mahon, confirmed that she

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[27] Ibid.

[28] Exhibit L.

[29] Clayton Continuing Care Team progress notes dated 18 March 2011 and Exhibits K and L. I note that in his statement [Exhibit G], Mr Nazeer stated that he attended a CCCT appointment with Ms Mahon on 21 March 2011 during which she said words to the effect that she was suicidal and wanted to kill herself because CCCT were not assisting her. During her evidence at inquest, Dr Baswa testified that if a patient is accompanied to an appointment it is recorded in progress notes (according to the notes, Mr Nazeer accompanied Ms Mahon on 18/3/2011) and that any disclosure of the type Mr Nazeer attributes to Ms Mahon would, similarly, be noted (no such disclosure is recorded in the notes). See generally Transcript pages 117-8 and 133, and pages 129 and 132, as well as the Clayton Continuing Care Team progress notes. Ms Anderson confirmed progress noting practices in her evidence at inquest [Transcript page 169-170].

[30] Exhibit L.

[31] In her evidence at inquest, Dr Baswa confirmed that at no time during CCCT's involvement with Ms Mahon did she present as acutely psychotic or otherwise in a state that would warrant her recommendation for involuntary treatment under the MH Act [see Transcript 134]. Dr Baswa and Ms Anderson both gave evidence at inquest that a *voluntary* admission to investigate akathisia had been canvassed for some time [see, for instance, Transcript pages 171-2].

[32] Exhibit L.

[33] Exhibit K. Ms Mahon's 18/3/2011 diazepam script, if used as directed, would last until 26 March 2011.

[34] No formal Mental State Examination or Risk Assessment was conducted on 28 March 2011

was 'doing well'.[35] On examination, there was no evidence of disordered thought, delusions, or perceptual disturbance. Ms Mahon denied any suicidal ideation. She continued to exhibit symptoms of akathisia and frustration with them, but did not want an admission due to concerns about her daughter and fear that Child Protection Services may become involved if she were hospitalised again.[36] Ms Mahon reported cessation of cannabis use without withdrawal symptoms. Dr Xu's impression was that her mental state was improving and that she should return for review in one-to-two weeks' time.[37]

16. Ms Mahon failed to attend an appointment with her Case Manager on 1 April 2011. When Ms Anderson called her, Ms Mahon said that she did not feel well enough to attend and another appointment for psychiatric review was scheduled for 8 April 2011. Ms Anderson reiterated the importance of Ms Mahon attending her general practitioner for investigation of akathisia.[38]

CIRCUMSTANCES PROXIMATE TO DEATH

17. At midday on 7 April 2011, Ms Mahon attended the Jasper Family Medical Practice, and saw Dr Peter Drake for a regular review of her progress on buprenorphine. Dr Drake observed no signs of ongoing drug use, but found that Ms Mahon appeared 'quiet and withdrawn' and had lost weight.[39] Ms Mahon advised that her father was in hospital following a knee operation but otherwise gave minimal responses to his questions.[40] As her general practitioner, Dr Drake had observed some lability in Ms Mahon's mood[41] but not excessive lability.[42] In his assessment, her presentation on 7 April 2011 was not 'extreme'[43] and there was 'no statement of suicidality'.[44] He gave Ms Mahon a new prescription for buprenorphine and she left.[45]

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[35] Clayton Continuing Care Team progress notes dated 28 March 2011.

[36] See generally Exhibit Q. I note that Dr Baswa observed in evidence that CCCT was perplexed by Ms Mahon's continuing akathisia, particularly given her variable compliance with antipsychotic medications, that such medications had been ceased on 18/3/2011. Although known to be a side effect of antipsychotic medications, akathisia may have a medical/neurological cause, and Ms Mahon's treatment providers were unsure of the impact, if any, of her cannabis use on her condition. Accordingly, CCCT encouraged Ms Mahon consult her general practitioner for investigations. CCCT were concerned that akathisia may detrimentally effect Ms Mahon's mental state. See Transcript page 134-5.

[37] Clayton Continuing Care Team progress notes dated 28 February 2011.

[38] Clayton Continuing Care Team progress notes dated 1 April 2011

[39] Exhibit F and Transcript page 54.

[40] Transcript page 54.

[41] Transcript page 55.

[42] Transcript page 55.

[43] Exhibit F.

[44] Transcript page 54.

18. Mr Nazeer reported that when he went home between his morning and evening jobs on 7 April 2011, Ms Mahon was not at home as anticipated. He called her and she said that she was at her mother, Ms Robb's home, with her daughter, and would see him after he finished work at 11pm. When Mr Nazeer returned home, although their daughter was at home with her aunt, Ms Mahon was not there. Mr Nazeer called Ms Mahon who reportedly told him that she was in her car, parked across train tracks, waiting for a train to hit her because she had 'had enough of this life'.[46] Mr Nazeer directed Ms Mahon to drive away from the train tracks and park in the station car park. He remained on the telephone with her until he arrived at the station and found her parked safely with the ignition off. Ms Mahon was reportedly crying and apologetic. When they arrived home, she fell asleep[47] and Mr Nazeer did not call the PTS that night.

19. When she awoke at about 7am on 8 April 2011, Ms Mahon said to Mr Nazeer 'don't ever forget I love you'.[48] He thought this statement unusual and, given events the previous night, was concerned for her wellbeing. At about 8am, Mr Nazeer became aware that Ms Mahon had left home in her car without saying anything, and called emergency services.

20. Leading Senior Constable Bourchier and Constable Dorsey attended Mr Nazeer's home and found him on the telephone to Ms Anderson, Ms Mahon's Case Manager. L/S/C Bourchier spoke briefly to Ms Anderson and was in the process of hearing Mr Nazeer's account of Ms Mahon's threat to harm herself the night before when Ms Mahon returned. Ms Mahon went inside with the police and they discussed Mr Nazeer's concerns.

21. On the basis of Ms Mahon's presentation, and the information he had received, L/S/C Bourchier invoked his power to apprehend a person considered likely to harm themself pursuant to section 10 of the MHA. Ms Mahon packed a small black bag with personal effects and, accompanied by C/ Dorsey, was transported by ambulance to MMC Emergency Department [ED], arriving at about 10.30am.[49]

22. L/S/C Bourchier and C/ Dorsey remained with Ms Mahon in the ED while she was triaged and then moved from the waiting room to cubicle 6A to await an assessment by the

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[45] Exhibit F.

[46] Exhibit G.

[47] Exhibit G.

[48] Exhibit G.

[49] Exhibits C and E.

psychiatric team. L/S/C Bourchier completed a "Mental Disorder Transfer Form" while waiting.[50] At about 11.20am, psychiatry registrar, Dr Perera and Emergency Crisis Assessment and Treatment clinician, Emmanouil Karandinas, attended cubicle 6A and, after a brief conversation with the attending police members who were advised they could leave, commenced their assessment of Ms Mahon.[51]

23. As a result of her assessment, Dr Perera informed Ms Mahon that she intended to admit her to the MMC's psychiatric unit, "P Block". Dr Perera explained that before admission to P Block Ms Mahon was required to have blood tests and be medically cleared from the ED. Ms Mahon said that she had recently had blood tests done elsewhere. As Dr Perera turned to discuss whether further blood tests were required with the ED doctor, Dr Horn, she noticed Ms Mahon leave 6A and the ED.[52] MMC staff pursued Ms Mahon but lost sight of her. Given that she had absconded from the ED, Dr Perera recommended Ms Mahon for involuntary psychiatric treatment pursuant to section 8 of the MHA.[53]

24. MMC staff notified emergency services, Mr Nazeer and Ms Anderson that Ms Mahon had absconded from the ED. L/S/C Bourchier and Constable Dorsey were among the police members who joined the search for Ms Mahon.[54]

25. At about midday on 8 April 2011, the driver of the Southern Cross to Traralgon Vline Sprinter train was approaching Clayton Railway Station when he observed a person emerge from a treed area to his left, step onto the tracks and face the oncoming train, about 200 metres ahead. The driver immediately applied the train's emergency brakes and sounded a long blast of its whistle but could not stop the train in time to avoid impact.[55] The train stopped about 30 metres from the point of impact, about halfway between Huntingdale and Clayton Railway Stations.[56]

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[50] Exhibits C and E; the Form itself is Exhibit D.

[51] Exhibits C, E, H and O.

[52] Exhibit H.

[53] Exhibit H.

[54] Exhibits C and E.

[55] Coronial Brief of Evidence (Statement of Benjamin Egan).

[56] Coronial Brief of Evidence (Incident Report prepared by Alan Scott of Metro Trains).

26. Police and paramedics were summoned to the scene where they found a woman, later identified as Ms Mahon[57], with injuries incompatible with life. Ms Mahon was pronounced deceased shortly after paramedics arrived.[58]

27. Senior Forensic Pathologist Dr Shelley Robertson, from the Victorian Institute of Forensic Medicine [VIFM], performed a post-mortem examination of Ms Mahon's body. Dr Robertson reviewed the circumstances of Ms Mahon's death as reported by the police to the coroner and post-mortem CT scans of the whole body when preparing a written report of her findings. Dr Robertson advised that Ms Mahon had suffered significant traumatic injuries that would have caused death almost instantaneously.

28. Routine toxicological analysis of post-mortem samples detected oxazepam and tramadol, at levels consistent with therapeutic use and delta-9-tetrahydrocannabinol (THC, one of the main psychoactive ingredients of cannabis) at levels indicating recent use.[59]

29. Accordingly, Dr Robertson attributed Ms Mahon's death to multiple injuries sustained when struck by a train, and noted that psychiatric illness and the effects of cannabis contributed to her death.

INVESTIGATION – SOURCES OF EVIDENCE

30. This finding is based on the totality of the material the product of the coronial investigation of Ms Mahon's death. That is the brief of evidence compiled by Sergeant Daniel Petrou of Preston Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[60] 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.

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[57] Ms Mahon was identified through a combination of those personal effects, including a black bag containing identity documents, found at the scene and fingerprint analysis conducted hy the Fingerprint Branch of Victoria Police. See, for example, Coronial Brief of Evidence (Statements of S/C Bouchier and L/S/C Faul).

[58] Coronial brief of Evidence (Statement of Jodie Nyberg).

[59] Coronial Brief of Evidence (Medical Examiner's Report of Dr S. Robertson). Dr Noel Woodford reviewed, completed and signed the report on 4 October 2011following Dr Robertson's departure from VIFM.

[60] 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.

PURPOSE OF A CORONIAL INVESTIGATION

31. The purpose of a coronial investigation of a *reportable death* is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[61] 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 to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[62]

32. 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.[63] Coroners are also 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.[64] These are effectively the vehicles by which the prevention role may be advanced.[65]

33. 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 maybe, guilty of an offence.[66] However, a coroner may include a statement relating to a notification to the

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[61] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[62] 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.)

[63] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[64] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[65] 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.

[66] Section 69(1).

Director of Public Prosecutions if the coroner believes an indictable offence may have been committed in connection with the death.[67]

FINDINGS AS TO UNCONTENTIOUS MATTERS

34. In relation to Ms Mahon's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Naomi Charmaine Mahon born on 21 October 1977, late of 441 Highett Road in Highett, died on 8 April 2011, on railway tracks adjacent to the Thompson Street/Carnish Road intersection, Clayton, Victoria.

35. Ms Mahon's death was clearly reportable as she died directly from accident or injury and was, immediately before death, a patient within the meaning of the MHA 1986. I note in this regard that Dr Perera completed the relevant "recommendation" for the purposes of section 8 MHA immediately after Ms Mahon fled the ED.[68]

36. I find that Ms Mahon she died of multiple injuries sustained when struck by a train, and that psychiatric illness and the effects of cannabis, contributed to her death.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

37. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Ms Mahon's death was on the circumstances in which she died. Specifically, how Ms Mahon, who had been apprehended by police pursuant to their MHA powers and transported to MMC for assessment, managed to abscond from the ED and, shortly thereafter, take her life by stepping into the path of a train. For convenience and clarity, this overarching concern will be addressed by reference to the three distinct decision points and related issues, namely:

    a. Invocation of, and compliance with, section 10 of the MHA;
    b. Clinical assessment of Ms Mahon at MMC ED; and
    c. Ms Mahon's flight from the ED, and the response by MMC staff and police.

[67] Sections 69 (2) and 49(1).

[68] Sections 4(2)(a) and (d).

Before canvassing the evidence in relation to each of these decision points, it is appropriate to briefly outline the legislative framework that governs the apprehension of, and provision of treatment to, mentally ill people, namely, sections 4, 8 and 10 of the MHA.

KEY PROVISIONS OF THE *MENTAL HEALTH ACT* 1986

38. In Victoria, at the time of Ms Mahon's death in April 2011, the treatment and protection of people with mental illness, was regulated by the *Mental health Act* 1986. When enacted, the legislation sought, among other things[69], to reflect and formalise the emerging and existing practices of de-institutionalisation and compulsory community treatment of the mentally ill.[70] The crux of the "cultural shift" in the delivery of psychiatric treatment codified by the MHA is encapsulated in section 4 which states, in part, that people with mental illness are to be provided the best possible care and treatment appropriate to their needs in the least possible restrictive environment and least intrusive manner consistent with providing that treatment effectively. Further, that any interference with the rights, privacy, dignity and self-respect of the mentally ill are kept to the minimum necessary in the circumstances.[71]

39. In keeping with the MHA's objective of providing treatment to mentally ill individuals in a minimally intrusive and restrictive manner, the criteria for involuntary treatment are specific and cumulative. The salient features of the criteria in section 8 are that -

(a) the person appears to be mentally ill; and
(b) requires immediate treatment; and
(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety; and
(d) the person has refused or is unable to consent to necessary treatment; and
(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

40. If a registered medical practitioner, after having conducted a personal examination[72] of the purportedly mentally ill person, is satisfied that the section 8 criteria are satisfied and that an involuntary treatment order should be made, /he may make a recommendation in the

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[69] Arguably, one of the most significant changes affected by the MH Act was regular external review of involuntary psychiatric patients by the newly established Mental Health Review Board.

[70] Neil Rees, 'Learning from the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform?' presented at the Mental Health Review Board of Victoria's 20th Anniversary Conference, 6 December 2007: Melbourne.

[71] See section 4(2)(a) and (b) of the MH Act and section 4(1) more generally which contains the objectives of the legislation.

[72] Section 9(1)(b) of the MH Act.

prescribed form.[73] A recommendation for involuntary treatment remains in effect for 72 hours[74] and, within 24 hours, an authorised psychiatrist must review the individual subject to the recommendation, and must determine whether the section 8 criteria continue to apply.[75]

41. Section 10 of the MHA empowers a member of the police force to apprehend a person, who appears to be mentally ill, if the police member has reasonable grounds for believing that the person has recently attempted suicide or is likely to do so.[76] Police may exercise the powers conferred in this section by having regard to the behaviour and appearance of the person in question and are not (of course) expected to form a clinical judgment as to whether a person is mentally ill.[77] Having apprehended a person under section 10, police must arrange for an assessment by a mental health practitioner, or an examination by a registered medical practitioner as soon as practicable.[78] The purpose of an assessment is to determine if the person meets the criteria for involuntary treatment under section 8 of the MHA.

42. Importantly, pursuant to the provisions of the "Department of Health and Victoria Police Protocol for Mental Health" [the Protocol][79], the person apprehended by police pursuant to section 10 remains in police custody until -

- a mental health practitioner completes the psychiatric assessment and advises police to release the person, or completes an "Authority to Transport without Recommendation" for ambulance transport, or
- a registered medical practitioner formally accepts responsibility for the person in order to conduct a psychiatric examination, or
- any law enforcement matters are resolved.[80]

Police cannot delegate custody to a security guard, receptionist or nurse in a hospital ED. Nor can police leave a person who is still in police custody in a secured room within a hospital.[81]

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[73] Section 9 of the MH Act. There are two documents required to initiate involuntary treatment, a request and a recommendation.

[74] Section 9(4) of the MH Act.

[75] Section 12AC of the MH Act.

[76] Section 10 of the MH defines the police power to apprehend a mentally ill person slightly more broadly than this paraphrase of the section which is sufficient for the purposes of this Finding. See section 10 of the MH Act.

[77] Section 10 of the MH Act.

[78] Section 10(4) of the MH Act.

[79] Department of Health and Victoria Police Protocol for Mental Health (2010), available at http:health.vic.gov.au/mentalhealth/publications/index [accessed 12 May 2015].

[80] The Protocol page 7.

INVOCATION OF, AND COMPLIANCE WITH, SECTION 10 OF THE MHA

43. L/S/C Bourchier and C/ Dorsey both provided statements and gave evidence at inquest about their interactions with Ms Mahon on the day of her death.[82] They attended Mr Nazeer's home in response to his concern that she may harm herself given her unexpected departure that morning and the threat to harm herself the night before.[83] Police members were informed of Ms Mahon's distress over a dispute with her father over lost or removed property,[84] an apparently renewed threat to harm herself, and a threat to burn down her father's home, made that morning.[85]

44. C/ Dorsey's initial impression of Ms Mahon was that she did not appear 'emotionally stable'.[86] Both police members noted Ms Mahon's anxiety, distress, agitation and that she paced around continually and appeared unwilling or unable to remain still.[87] Ms Mahon attributed her pacing to anxiety.[88] Police spoke briefly to Ms Anderson from the CCCT and when they foreshadowed potential use of their MHA powers, were told that doing so may be 'for the best'.[89] On the basis of all of the above information, and their own observations of Ms Mahon, L/S/C Bourchier invoked his section 10 MHA powers. He gave evidence that he had 'genuine concerns' about Ms Mahon's safety.[90] C/ Dorsey testified that apprehending Ms Mahon pursuant to section 10 of the MHA was the 'appropriate' course of action in the circumstances.[91]

45. Police advised both Mr Nazeer and Ms Mahon that they intended to transport her to hospital for a psychiatric assessment. Ms Mahon was visibly distressed and said, 'I want to end it all

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[81] The Protocol.

[82] See generally Exhibits C, D and E and Transcript pages 6-51.

[83] Exhibits C & E. L/S/C Bourchier noted in his addendum to the "Mental Disorder Transport" form that Ms Mahon denied attempting or intending to harm herself the night before by parking her car across train tracks; see Exhibit D.

[84] Transcript page 35.

[85] Exhibit E. I note that Mr Nazeer does not refer to either of the new threats in his statement, but clearly this information either came from him and/or Ms Mahon. L/S/C Bourchier records in his addendum to the "Mental Order Transport" Form [Exhibit D] that Ms Mahon denied any attempt to harm herself on 7 April 2011.

[86] Exhibit E.

[87] Exhibits C & E and Transcript page 47.

[88] Transcript page 47.

[89] Exhibit E.

[90] Transcript page 13.

[91] Transcript page 41.

... I just can't take it anymore'.[92] In addition, when saying goodbye to her daughter, she said, 'Mum may not see you again'.[93] C/ Dorsey gave evidence that Ms Mahon 'didn't say a lot' while being transported to hospital by ambulance.[94]

46. C/ Dorsey recalled that Ms Mahon became even more anxious on arrival[95] at MMC, an observation corroborated by triage nurse, Ms Kesby, who felt that Ms Mahon required a 'certain amount of priority' given her presentation.[96] Both police members tried to calm Ms Mahon by talking with her.[97] She remained very agitated and it was 'fairly clear' to police that Ms Mahon did not wish to be psychiatrically assessed or return to hospital for treatment.[98] Ms Mahon was 'quite emotional ... she would cry and then get her emotions back in check'.[99]

47. Police were aware that a person in Ms Mahon's position may try to abscond and so kept a close eye on her throughout their wait in the triage area of the ED and after a psychiatric assessment "cubicle"[100] was made available.[101] However, Ms Mahon did not make any attempt to run away from police and was not uncooperative with them. They did not restrain her physically her but used their bodies to create a cordon of sorts and so contain her.[102] Both police stayed with Ms Mahon and were, in their own estimation, vigilant about ensuring she remained in their custody.[103]

48. Once moved to cubicle 6A, police continued to contain Ms Mahon: one of them would be in the room or at its entrance and the other outside it.[104] Ms Mahon continued to pace and would

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[92] Transcript page 36.

[93] Exhibit C.

[94] Transcript page 42.

[95] Transcript page 37.

[96] Exhibit N. Nurse Kesby noted, too, her awareness of police resourcing issues associated with section 10 MH Act attendances at the ED if handover to a medical practitioner or psychiatric team is delayed.

[97] Transcript page 44.

[98] Transcript pages 14-5.

[99] Transcript page 15.

[100] The term cubicle is a misnomer. The "cubicle" to which Ms Mahon was taken, 6A, was in fact a room, with a lockable door into which was set a glass observation panel.

[101] Transcript page 16.

[102] Transcript page 16.

[103] Transcript page 18.

[104] Transcript page 37.

'frequently wander out [of 6A and police] would have to convince her to wait inside again'.[105] At one point, prior to the arrival of the psychiatric team, Ms Mahon said, 'I should just run'.[106] L/S/C Bourchier observed that 'obviously [Ms Mahon] wasn't in a position to do that ... [and] patients say a lot of things [they don't do].[107] She did not make any attempt to run or leave the ED while police were present.[108]

49. L/S/C Bourchier testified at inquest that until police could complete an 'official handover' to a medical practitioner or the psychiatric team, Ms Mahon would remain in their care and was their responsibility, a responsibility he took 'very seriously'.[109] Indeed, police remained with Ms Mahon until Dr Perera and Mr Karandinas arrived. They then gave them the completed Mental Disorder Transport Form, including an additional sheet of paper on which L/S/C Bourchier had recorded background information and his observations of Ms Mahon[110]. They also performed a verbal handover.[111]

50. L/S/C Bourchier could not recall whether he specifically mentioned Ms Mahon's comment about running away during the handover.[112] Dr Perera made it clear to police that they could leave and so they wished Ms Mahon well and left to return to other duties.[113] L/S/C Bourchier stated that if he and C/ Dorsey had been asked to stay longer, they would have done so,[114] and, that at the time they left he had no concerns about Ms Mahon because she was in the company of at least three MMC staff in 6A.[115]

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[105] Transcript page 37.

[106] Exhibits C and E.

[107] Transcript page 26.

[108] Exhibit C.

[109] Transcript page 17.

[110] Exhibit D.

[111] Transcript page 26.

[112] Transcript page 26. I note Dr Perera's evidence that she did not read this document until after Ms Mahon absconded fro the ED [see Transcript page 81].

[113] Transcript page 24.

[114] Transcript page 25.

[115] Transcript page 29.

CLINICAL ASSESSMENT OF MS MAHON AT MMC

51. Dr Anthony Kambourakis, Director of Emergency Medicine at MMC, provided a statement, including copies of ED procedures relevant to the management of psychiatric patients, and gave evidence at inquest.[116] He observed that, pending assessment by a mental health clinician, ED staff will attempt to assess (and meet) a psychiatric patient's risk of absconding and consider the following patient groups (and others) to be at 'high risk' of doing so: those demonstrating extreme agitation and restlessness, those who threatened or actual self harm, those brought to the ED by police under the MH Act, any patient with a behavioural disturbance indicating they will not wait for treatment or individuals requiring involuntary treatment under the MH Act.[117]

52. Triage Nurse Kesby described Ms Mahon as being very unsettled, unable or unwilling to answer questions in full[118] and avoiding eye contact[119] but that she had allowed vital sign observations to be taken.[120] Given this presentation, Ms Kesby notified the Nurse-in-Charge to prioritise assignment of Ms Mahon to 6A but believed she was 'compliant enough' to stay in the triage area because she was being closely watched by paramedics and police.[121]

53. Cubicle 6A is the preferred location for patients arriving by police escort, or those assessed as at risk of ongoing self harm or absconding from the ED. The cubicle is located within the adult main care area of the ED, close to the doctors and nurses workstation and away from front exits of the ED. Its layout was designed specifically for the assessment and management of patients with acute behavioural disturbance to minimise the risk of self harm from standard equipment (which is locked behind a panel) and by eliminating hanging points. The comparatively spacious room has a door that can be closed and locked, rather than a curtain,

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[116] Exhibit V and Transcript pages 1-31 (day 4).

[117] Southern Health Clinical Protocol and Guidelines, 'Emergency Department Management of a Behaviourally Disturbed Patient,' 5 November 2008 (version 1.0) [ED Protocol]. This document lists other patient groups deemed to be at high risk of absconding but they are not relevant to Ms Mahon's presentation or circumstances.

I note that patients identified as "high risk mental health presentations", those recommended for involuntary treatment or those physically or chemically restrained are, by virtue of the Protocol, required to have 1:1 nursing which is defined as including (a) continuous visual observation conducted at arm's length [known as specialling], (b) continuous visual observation within the same room [close observation] and (c) within hearing distance [readily available]. No clinical staff considered Ms Mahon to require 1:1 nursing of any type.

[118] Exhibit N.

[119] Transcript page 140.

[120] Exhibit N.

[121] Transcript page 139.

and a panel of shatterproof glass to allow continuous observation of the patient when the door is closed.[122] Outside 6A, there is space for police, security and nursing staff to observe the patient. A small room is situated next to 6A where clinicians can write notes, access clinical records or mental health paperwork and interview relatives, police or paramedics.[123]

54. Ms Mahon was escorted to 6A, where attending paramedics performed a verbal handover with Cubicle Nurse Kwan. Mr Kwan appears to have had a short interaction with Ms Mahon. just long enough to observe/chart her vital signs, and at inquest reported that she made eye contact, appeared relaxed and calm, was not fidgeting[124], and when asked directly whether she had a plan to harm herself, responded that she had 'no plan yet'.[125]

55. At MMC, all psychiatric patients are assigned to an ED doctor and are managed jointly, and often simultaneously, with the Mental Health Team [MHT] whilst in the ED. However, medical issues must be treated and/or a patient medically "cleared" before s/he is transferred to a psychiatric ward. [126]

56. Before Dr Perera and Mr Karandinas assessed Ms Mahon psychiatrically, Mr Karandinas accessed Ms Mahon's medical records and had a brief discussion with her CCCT Case Manager. After a verbal handover from police, during which Mr Karandinas was informed that Ms Mahon had threatened suicide and threatened to burn down her father's house because she blamed him for her previous admission to The Alfred Hospital, police were relieved of Ms Mahon's care. Risk issues were assessed as low, given that Ms Mahon had been co-operative while in the presence of the police.[127]

57. Dr Perera observed that Ms Mahon appeared unkempt and had akathisia, or restless legs. She presented as agitated[128] but later was more settled, was cooperative and answered questions, albeit briefly. Her speech was relevant and coherent and Ms Mahon described her mood as

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[122] Employees of MMC uniformly gave evidence that the door of 6A would be closed/locked only in exceptional situations, it was not ED policy to lock a patient in a room alone.

[123] Exhibits V and A (plan of the MMC ED).

[124] Transcript page 163.

[125] Exhibit P.

[126] That is, ED clinicians perform a medical assessment of the patient (to identify and manage any organic causes that may have precipitated a behavioural disturbance or other medical issues) while the Mental Health Team (ECATT clinicians or psychiatry registrars) will perform psychiatric assessments. See Exhibit V and the ED Protocol.

[127] Exhibit O.

[128] Mr Karandinas referred to Ms Mahon appearing 'mildly agitated' Transcript page 158.

'stressed', referring to losing her home while a psychiatric inpatient and being evicted from her father's home. When questioned, she explained that her partner had called police because he was concerned when she had said, 'I wish I am dead'.[129] She denied current suicidal thoughts or plans, and mentioned her daughter as a protective factor.[130] There was no evidence of psychotic symptoms but her insight into her illness was assessed as poor and her judgement limited.[131]

58. Further information was sought from Ms Mahon's Case Manager who confirmed that her medications had been recently ceased, that she had failed to attend her last CCCT appointment and would benefit from inpatient treatment and monitoring.[132] Ms Anderson reported that Ms Mahon's presentations were almost always superficial and guarded and attributed this to her 'not being overly happy' about being involved with mental health services.[133] She confirmed that Ms Mahon had previously reported suicidal ideation but had not, to her knowledge, acted on her thoughts because she had a 13-year-old daughter to look after.

59. Given all the available information, [134] Dr Perera decided to admit Ms Mahon to the psychiatric ward for further observation and containment due to her stated suicidal threats, untreated akathisia, history of mental illness and for planned recommencement of her medication.[135] When Dr Perera conveyed this plan to Ms Mahon, she initially responded 'I have no choice' but was cooperative and agreed to a voluntary admission.[136] The admission process, including the need to be medically cleared by the ED, was also explained.

60. As Ms Mahon had agreed to be admitted to P Block, situated only some 150 feet from the ED, Dr Perera had not completed any paperwork in relation to the admission or her MHA status.[137] At inquest, Dr Perera testified that had she believed Ms Mahon was resistant to treatment, she

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[129] Exhibit H.

[130] Transcript page 101.

[131] Exhibit H. Mr Karandinas' assessment of Ms Mahon conforms to that of Dr Perera and appears in Exhibit O.

[132] Exhibit Q and Transcript pages 173ff.

[133] Exhibit O.

[134] Mr Karandinas, during evidence at inquest, provided a concise summary of all of the factors taken into account by the MHT when formulating the plan for Ms Mahon's management Transcript page 158.

[135] Exhibit H.

[136] Exhibit H.

[137] Transcript page 75

would have asked a nurse to sit on the chair outside 6A, while she liaised with the ED doctor.[138]

MS MAHON'S FLIGHT FROM THE ED & RESPONSE OF MMC STAFF AND THE POLICE

61. The MHT left Ms Mahon (apparently) settled and seated in[139] cubicle 6A, and walked over to the ED doctor in the adjacent corridor to request blood tests. When they returned to cubicle 6A, Ms Mahon told Dr Perera that she had recently had blood tests performed and the results were satisfactory. Standing, Ms Mahon then gestured in a way that suggested that she and the MHT should proceed to P Block.[140]

62. Dr Perera and Mr Karadinas approached the ED doctor again to establish whether or not blood tests were required immediately. As they did so, they were no longer facing Ms Mahon, when Dr Perera 'just felt something behind [her] back'[141] and turned to see Ms Mahon run past her in the direction of the ambulance bays.[142] The MHT pursued Ms Mahon. En route nursing staff advised that she had left through the doors to the ambulance bay that were operated by an exit button. No one knew whether Ms Mahon had turned left or right on exiting, and by the time the MHT reached the ambulance bay, there was no sign of her.[143]

63. At inquest, Mr Karandinas recalled that Ms Mahon had absconded in the 'split second' that he and Dr Perera had turned away from her to speak to their ED colleague[144] Until that point, his belief was that Ms Mahon's words and deeds had been consistent with her cooperating with the plan to admit her to the ward, [145] a view with which Dr Perera concurred.[146]

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[138] Transcript page 86. I note Dr Kambourakis' evidence at inquest that 'what might've happened is that ... the concern sort of went down a level ... because they though that [Ms Mahon] was going to be compliant' [Transcript page 13 (day 4)].

[139] The evidence is unclear as to Ms Mahon's position just before she absconded from the ED. Dr Perera's recollection was that Ms Mahon was inside 6A [Transcript pages 77-8] while Mr Karandinas remembers her being seated outside 6A [Transcript page 151].

[140] Exhibits H and O.

[141] Transcript page 81.

[142] Transcript page 149.

[143] Transcript pages 149-150.

[144] Transcript page 154

[145] Transcript page 147.

[146] Transcript page 97.

64. MMC security staff and the emergency services were contacted to report that Ms Mahon had absconded from MMC. Two of the three security staff on duty conducted a foot search of the ED and environs while another reviewed the available CCTV camera footage.[147] Ms Mahon was not found during the foot search and, although an individual likely to be Ms Mahon was depicted in CCTV footage leaving through the ambulance bays, her direction of travel could not be determined.[148]

65. Mr Karadinas telephoned Mr Nazeer to inform him that Ms Mahon had absconded and advised him to contact police and then the hospital, if he saw Ms Mahon.[149] On the basis that Ms Mahon's flight from MMC represented a refusal of necessary inpatient treatment, Dr Perera completed the required paperwork to recommend her for involuntary treatment.[150]

66. At about 11.40am, L/S/C Bourchier and C/ Dorsey were tasked via Integraph to join the search for Ms Mahon. Based on their conversations with Ms Mahon earlier that day, they formed the view that the railway station (whether to enable her to return home to Highett or to her father's home) was a likely destination for Ms Mahon, and so prioritised a search of nearby railway stations.[151] They patrolled the route from their present location back towards MMC, including the Clayton Railway Station (on foot), searched the MMC grounds adjacent to the ED and then attended Ms Mahon's father's home and spoke with neighbours, but there was no sighting of Ms Mahon.

67. Prior to leaving Mr Mahon's address they heard the prolonged sound of a train's whistle and, at 11.55am, received information that a woman had been struck by a Vline train on the railway line adjacent to Carnish Road in Clayton South. L/S/C Bourchier and C/ Dorsey

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[147] MMC Security Operations Co-ordinator, Peter Linden, provided a statement [Exhibit T] and gave evidence at inquest [Transcript pages 201-212]. He stated that MMC protocols relating to the presence of security officers in the ED are directed towards the prevention of violence (including protecting staff) and patient safety. In Mr Linden's view here is unlikely to be a practical benefit if continuous security presence were introduced in the ED. Security staff involvement in patient management at close quarters is lead by MMC clinicians. There are 32 entry/exit points at MMC [Clayton], most of which are accessible by staff and members of the public. At present, a limited number of these points of entry/exit [that is, the main points of entry, including the ambulance bay] are monitored by CCTV cameras. By design, the ambulance bay doors are readily accessible to the ED and provide easy access to the MMC grounds and Clayton Road.

[148] Coronial Brief of Evidence (Statement of Gary Quinn).

[149] Exhibit O.

[150] Exhibit H and Transcript page 76.

[151] Exhibits C and E and Transcript page 48.

attended the collision scene and the former presumptively identified the deceased woman as Ms Mahon.[152]

68. At inquest I was informed that following Ms Mahon's flight from the ED, MMC conducted an internal review of the incident and that resultant recommendations relating to the timely conduct of risk assessments, identification of 'high risk' patients, the types of information to be used in risk assessments and the documentation of risk assessments, were implemented.[153]

CONCLUSIONS

69. 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 explication.[154] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

70. Having applied the applicable standard to the available evidence, I find that:

a. Ms Mahon had a psychiatric history that involved a probable diagnosis of Bipolar Affective Disorder and, following a period of involuntary treatment as an inpatient, her mental health had been managed in the community by CCCT.

b. Ms Mahon's behaviour in the 24 hours prior to her death caused her partner, Mr Nazeer, to be concerned that she may harm herself and he appropriately called emergency services for assistance.

c. Given Ms Mahon's presentation and the other information available to him at the time, L/S/C Bourchier's decision to exercise his powers under section 10 of the MHA, was reasonable and appropriate.

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[152] In addition to the deceased being in the vicinity of MMC shortly after Ms Mahon was seen there and wearing clothes similar to those Ms Mahon worn, L/S/C Bourchier located a small black bag near the collision site and was aware that a Driver Licence bearing Ms Mahon's details had been located.

[153] Transcript pages 21-23.

[154] *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..."

d. Both L/S/C Bourchier and C/ Dorsey complied with the substance (and spirit) of section 10 and the principles underpinning the MHA, by executing their duties with sensitivity, and in the least intrusive manner necessary in the circumstances.

e. An appropriate handover of Ms Mahon's care occurred between the Victoria Police members and the medical staff of MMC in the ED, and Ms Mahon's care was effectively transferred to MMC prior to L/S/C Bourchier and C/ Dorsey's departure from the ED.

f. The psychiatric assessment conducted by Dr Perera and her colleague, Mr Karandinas, was reasonable and appropriate.

g. In light of this psychiatric assessment and Ms Mahon's physical and verbal cues, Dr Perera's determination that Ms Mahon did not meet the MHA criteria for involuntary treatment was sound, and her decision to admit Ms Mahon to MMC's psychiatric ward as a voluntary patient, was a reasonable and appropriate clinical response.

h. The available evidence does not enable me to determine whether Ms Mahon's flight from the ED was premeditated, and if so from what point in time, or was an impulsive and opportunistic reaction to the circumstances in which she found herself.

i. Neither Dr Perera nor Mr Karandinas could or should have *predicted* that Ms Mahon would abscond. That said, it was perhaps naïve on their part to assume that Ms Mahon would remain compliant and take her at her word, given all of the circumstances, in particular the fact that only minutes earlier, the police had thought it necessary to use vigilance and a moving cordon to contain her.

j. The actions taken by MMC staff after Ms Mahon absconded from the ED, including Dr Perera's decision to recommend her for involuntary psychiatric treatment at that juncture, were reasonable and appropriate.

k. The efforts made by Victoria Police to locate Ms Mahon after they were alerted that she had absconded from the ED were similarly reasonable and appropriate.

l. Ms Mahon placed herself in the path of an oncoming train in circumstances where she knew and intended that the train could not stop in time.

m. The train driver made all possible efforts to stop the train in order to avoid impact with Ms Mahon but was simply unable to do so.

71. In conclusion, I find that Ms Mahon intentionally took her own life. I further find that the available evidence does not support a finding that there was any want of care on the part of Victoria Police, or any want of clinical management or care on the part of the staff of Monash Medical Centre, that caused or contributed to Ms Mahon's death.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment connected with the death:

1. The circumstances in which Ms Mahon died are, regrettably, all too familiar in the coronial jurisdiction, where a number of people take their own lives or die as a result of misadventure, after absconding from an emergency department to which they were taken by police pursuant to section 10 of the *Mental Health Act* 1986. While these deaths are generally considered preventable, without the benefit of hindsight, there is nothing in the available evidence to indicate deficiencies that could have improved the outcome for Ms Mahon or improved public safety at large.

2. A new *Mental Health Act* 2014 was enacted on 1 July 2014. Through a rights-based model of mental health service delivery, this Act seeks to minimise the use and duration of compulsory treatment and to ensure that the treatment is provided in the least restrictive and least intrusive manner possible. The 2014 Act introduces new criteria for involuntary or 'compulsory' treatment, and a revised assessment and treatment order process with greater oversight by the Mental Health Tribunal. The place of 'informed consent' appears significantly enhanced within this new framework.

3. Relevantly, Victoria Police retain a power to apprehend a person who appears to be mentally ill to prevent 'serious and imminent harm' to that person or another person. While it remains to be seen how the 2014 Act will operate in practice, it is hoped that the treatment and engagement of people such as Ms Mahon can be improved, and that the number of deaths in similar circumstances to those in which Ms Mahon died, can be reduced.

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

Mr Sajid Nazeer

Ms Mahon-Nazeer's legal representative, Slater and Gordon Lawyers

Monash Health (formerly Southern Health)

Chief Commissioner of Police

The Chief Psychiatrist

Michael Averkiou, Department of Transport

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 28 May 2015