IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 003966

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of TAYLAH GEORDON MAHON

without holding an inquest:
find that the identity of the deceased was TAYLAH GEORDON MAHON
born on 17 October 1994
and the death occurred on 14 August 2009

from:

1(a) HANGING.

Pursuant to section 67(2) of the ***Coroners Act 2008***, I make findings with respect to **the following circumstances:**

INTRODUCTION AND PURPOSE

1. This investigation examined the circumstances and contributing factors relating to the death of Taylah Mahon. Before I make my findings on these circumstances and factors, I wish to convey my sincere condolences to Taylah's parents, Mr James and Ms Wendy Mahon and her family and friends. The unexpected death of a young person is devastating for parents, family and friends, and my purpose in conducting this investigation was to explore whether any lessons can be learnt which might prevent similar deaths in the future.
2. This prevention role is one of two parallel functions of the modern coronial system. The first involves the findings that I must make under the *Coroners Act 2008* (Vic), which requires, if possible, that I find the:
   - identity of the person who has died

- cause of death (and for our purposes this usually refers to the medical cause of the death); and
- circumstances surrounding the death.

3. It is the investigation I am permitted to conduct surrounding the circumstances of a death that gives rise to my ability to consider broader issues of public health and safety. These considerations form the second parallel purpose of a coronial investigation into a death. This purpose has been enshrined in the Preamble of the *Coroners Act 2008* (Vic), which sets out that the role of the coroner should be:
   - to contribute to the reduction of the number of preventable deaths; and
   - promote public health and safety and the administration of justice.

RELEVANT HISTORICAL FACTS

4. The circumstances surrounding Taylah Mahon's death were fully investigated by Victoria Police.
5. Taylah Mahon was a 14-year-old female who lived in the family home at the above address with her parents, James and Wendy Mahon, and younger brother.
6. Taylah was a student at the Geelong College. She had begun to struggle academically, but otherwise enjoyed school, had many friends and was a creative student who had a talent for art. Taylah had been in a relationship with a boy her own age for about six months before her death, and the relationship appeared to be happy.
7. Ms Mahon had taken Taylah to see a dermatologist, Dr Timothy O'Brien, for treatment of acne that had not responded to antibiotics or topical agents. Dr O'Brien prescribed Roacutane (isotretinoin), which was, in his view, the only treatment that works reliably for the condition. The medication was effective, and at her last visit with Dr O'Brien in December 2008, it was intended that Taylah would continue the medication for the next few months.
8. Taylah did not have any other significant medical or mental health history. However, her family noted that she had become increasingly tired in the months before her death, and Ms Mahon stated that her daughter had fainted at home about six weeks before her death.

CIRCUMSTANCES OF THE INCIDENT

9. On Friday 14 August 2009, Mr Mahon picked up Taylah and her brother from school. He stated that Taylah appeared to be tired when she entered the car, but was in good spirits. She arrived home, and Mr Mahon did not notice any changes in her behaviour.

10. At around 5.30pm, Mr and Ms Mahon left the house with their son to take him to his football game. Taylah stated that she wanted to stay home alone to complete some homework. Ms Mahon telephoned Taylah at around 6.13pm, and they had a short conversation about feeding their dog. Ms Mahon called again at around 7.40pm after the football game had finished, but Taylah did not answer the home or mobile phones.

11. The family returned home shortly afterwards, and Ms Mahon went upstairs to find Taylah. The lights were switched off, and Ms Mahon found Taylah in her bedroom. She was in a kneeling position over her bed, and the belt from her dressing gown was tied around her neck, with the other end attached to a rail at the top of her four-poster bed.

12. Ms Mahon immediately called for Mr Mahon and her son. They cut the belt and called 000, and Mr Mahon performed CPR with the assistance of the telephone operator.

13. Paramedics arrived a short time later and continued CPR and resuscitative efforts, but they were unable to revive Taylah and confirmed that she was deceased.

THE MEDICAL CAUSE OF DEATH

14. No autopsy was performed. However, an external examination of Taylah's body and post mortem CT scanning (PMCT) were performed, which revealed the cause of her death to be *hanging*. The external examination was consistent with the reported circumstances.[1] Post mortem toxicology testing did not reveal the presence of ethanol (alcohol) or any other common drugs or poisons.

15. I find that Taylah acted with the intention of taking her own life, and that there were no suspicious circumstances surrounding her death.

FURTHER INVESTIGATION

Prescribing of isotretinoin

16. The Court obtained an expert opinion from Dr Anne Howard of the Royal Australasian College of Dermatologists on the prescribing of isotretinoin and its side effects, including possible depression and suicidal thoughts.

17. Dr Howard's report addressed the major adverse side effects of isotretinoin, which included teratogenicity (serious foetal abnormalities), mucocutaneous effects (dry lips, eyes, nose and

[1] Medical investigation report of Forensic Pathologist Dr Melissa Baker, dated 1 September 2009.

skin), photosensitivity, lipid abnormalities, liver effects (especially in patients with other liver problems), ocular effects, mood changes and musculoskeletal pain.

18. Dr Howard cited a recent formal epidemiological study that compared oral isotretinoin with other oral acne treatments, and found no increase in the risk of depression or suicide attributable to isotretinoin. However, Dr Howard noted that it is clear that clinically significant depression may occur in patients treated with isotretinoin and that, if the depression is severe, it may be accompanied by suicidal ideation and attempts. However, Dr Howard also stated that it is possible that depression in this context is caused by the severe acne and its impact on self esteem and social function in patients who may be at an emotionally vulnerable stage of development.

19. Dr Howard stated that, despite the lack of any established causal link between isotretinoin and depression, any patient with acne severe enough to require treatment with the drug must also be considered at risk for clinical depression and its consequences including possible suicide attempts. The patient should therefore be alerted to the possibility and to the need for urgent reassessment if signs of depression emerge. Further, Dr Howard noted that the consumer medicine information accompanying the drug advises those experiencing depressive symptoms to stop taking isotretinoin and see their doctor.

20. Dr Howard commented on the usefulness of isotretinoin and stated that most practitioners in Australia prescribe the drug in a safe and informed way, whilst emphasising that patients and their relatives must be informed of the side effects and that depressive symptoms should be actively assessed, with appropriate referral or discontinuation of the drug if necessary.

21. Dr Howard's expert evidence makes clear that it is important to watch for suicidal behaviour in patients with severe acne. In Taylah's case, her dermatologist and general practitioner regularly reviewed her, and her family, who clearly had a close relationship with her and were very involved and supportive, state that they noticed no signs of depressive symptoms or any concerning behaviours.

22. The evidence before me clearly demonstrates that Taylah was well supported by her loving parents, family and friends, and that they could not have reasonably foreseen that she was contemplating taking her own life.

Findings pursuant to section 67 of the *Coroners Act 2008*

23. I find that:

    a. the identity of the deceased was Taylah Geordon Mahon; and

b. Taylah died of hanging, on 14 August 2009, at her home, in the circumstances described above.

COMMENTS

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

24. During the investigation of Taylah's death, it came to the attention of the Coroners Court of Victoria that seven persons[2] aged 18 years and under residing in the City of Greater Geelong had suicided during 2009, five prior to Taylah's death and one after. This was compared to one in 2008 and one in 2007. It is also significant to note that there were no suicides amongst usual residents of the City of Greater Geelong aged 18 years and under in 2010, one in 2011, one in 2012 and two in 2013.[3] This retrospective examination of suicides amongst persons aged 18 years and under showed that during 2009, the City of Greater Geelong experienced a suicide cluster,[4] as defined by the Centres for Disease Control and Prevention. On this basis, assistance was sought from the Coroners Prevention Unit (CPU)[5] to review the evidence provided by Victoria Police to identify and examine the presence and patterns of contributing factors to these deaths to inform recommendations for prevention.

25. In November 2013, an inquest was held into three Geelong deaths of secondary school students at different campuses of the same school (and not Taylah's school). The inquest examined evidence about the various factors that can contribute to suicides among young people. The CPU review identified four factors that warranted further examination and / or input from external organisations:

    a. the presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.

    b. media treatment of youth suicide, including:

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[2] Court Reference Numbers: 20090405; 20090665; 20091426; 20091767; 20093500; 20093966; 20094922.

[3] During this seven-year period, the City of Greater Geelong experienced the highest frequency of suicides of young people aged 13-18 years in the State of Victoria. When the population of 13-18 year olds was accounted for, the City of Greater Geelong ranked sixth in the state for females (8.3 suicides per 100,000 population) and equal eighteenth in the state for males (6.7 suicides per 100,000 population).

[4] *A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

[5] The Coroners Prevention Unit is a specialist service for coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

i. the potential for media coverage of youth suicides to trigger further suicides among vulnerable and impulsive young people; and

ii. the potentially intrusive and distressing nature of reporters' behaviour towards a grieving family whose child has suicided.

c. the presence and role of bullying and cyber-bullying on youth suicide.

d. the local post-vention response by:

i. the Department of Education and Early Childhood Development (DEECD), including Western Heights Secondary College; and

ii. Barwon Health.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

26. In light of the information I received and have considered, I believe there is an opportunity to reinvigorate suicide prevention activity in Victoria. To that end, I restate the recommendation made in the deaths of Zac Harvey, Taylor Janssen and Chanelle Rae that the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.

I direct that a copy of this finding be provided to the following for their information:

Ms Wendy and Mr James Mahon, Senior Next of Kin
Department of Education and Early Childhood Development, c/o Ms E Gardner
The Hon. David Davis MLC, Victorian Minister for Health
The Hon. Kim Wells, MP, Victorian Minister for Police and Emergency Services
The Hon. Mary Wooldridge, Victorian Minister for Mental Health
Mr Tim Bull, MP, Victorian Minister for Local Government
Dr Kevin Freele, Executive Director, Barwon Health
Mr Leigh Bartlett, Barwon Adolescent Task Force
Dr Jaelea Skehan, Director, Hunter Institute of Mental Health
Ms Sandra Craig, National Centre Against Bullying, Alannah and Madeline Foundation
LSC Gregory Kitchen, Victoria Police, Coroner's Investigator.

I direct that a copy of this finding be provided to the following for their response:

Dr Pradeep Philip, Secretary, Department of Health

Chief Commissioner Ken Lay APM, Chief Commissioner of Victoria Police

Dr Mark Oakley Browne, Chief Psychiatrist

Mr Rob Spence, Chief Executive Officer, Municipal Association of Victoria

Associate Professor Morton Rawlin, Chair Victoria Faculty, Royal Australian College of General Practitioners.

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: **28 November 2014**