IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 004233

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Sidarthan Gajaharan

Delivered On:	27 February 2024
Delivered At:	Coroners Court of Victoria 65 Kavanagh St Southbank
Hearing Dates:	27 February 2024
Findings of:	Coroner Katherine Lorenz
Representation:	Jan Moffat, DTCH lawyers representing Melbourne Health (NorthWestern Mental Health)
Counsel Assisting the Coroner:	Dr Declan McGavin, Coroner's Solicitor
Keywords	Suicide, Inpatient Treatment Order, Mental Health, Schizophrenia, Ground Leave, Clozapine, Involuntary Treatment, *Mental Health Act 2014*, *Mental Health and Wellbeing Act 2022*

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INTRODUCTION

1. Sidarthan Gajaharan (**Sid**) was 26 years old when he died on 11 August 2019 from being struck by a train leaving Ginifer Railway Station after he absconded from hospital while on unescorted ground leave. At the time of his death, Sid was subject to an Inpatient Treatment Order (**ITO**)[1] at the Adult Mental Health Rehabilitation Unit (**AMHRU**), a Secure Extended Care Unit (**SECU**) located on the Sunshine Hospital Campus.

THE CORONIAL INVESTIGATION

2. Sid's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are 'in care', which includes Sid as the subject of a Treatment Order pursuant section 55 of the *Mental Health Act 2014* (**MHA**).[2]

3. The Act recognises that people 'in care' are vulnerable and affords them protection by requiring that the circumstances of their deaths are investigated by a coroner, irrespective of the medical cause of death, and by mandating that as part of that investigation there should be an inquest or formal public hearing unless it is a death from natural causes.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[1] Coronial Brief (**CB**), Treatment Order dated 12 June 2019, 227.
[2] On 1 September 2023, the MHA was replaced by the *Mental Health and Wellbeing Act 2022* (**MHWA**). The provisions governing Treatment Orders are unchanged and are duplicated in the new Act in section 192.

6. Coroner Audrey Jamieson initially held carriage of this investigation. I took carriage of the investigation in February 2021 upon my commencement at the Court.

7. This finding is based on the Coronial Brief and the submissions of counsel who appeared at inquest. The Coronial Brief includes material collected by the Coroner's Investigator – an officer assigned by Victoria Police who conducted initial inquiries on Coroner Jamieson's behalf – such as statements from witnesses including family, the forensic pathologist, treating clinicians, and investigating officers.

8. The Coronial Brief also includes additional materials obtained by Court at my direction including medical records, an independent expert opinion report, and other additional statements. It is unnecessary to summarise all the material; it will remain on the Court file, and I will refer only to so much of it as is relevant or necessary for narrative clarity.

9. In the coronial jurisdiction, facts must be established on the balance of probabilities.

BACKGROUND

10. Sid was admitted to AMHRU on 21 November 2018 with treatment-resistant schizophrenia in the context of poly-substance use for management of schizophrenia, monitoring of clozapine treatment, and further rehabilitation.[3]

11. Sid was diagnosed with schizophrenia in 2017. He also had prior diagnoses of possible childhood depression, substance use disorder, and adjustment disorder. Sid had been expressing suicidal ideation since 2011, and psychotic symptoms from 2015.[4]

12. Part of Sid's psychotic symptoms included delusions that made him believe that if he didn't sleep with particular women, then the world would get sick. This reportedly promoted him to physically and sexually assault women which led to his arrest and imprisonment for 18 months.[5]

[3] CB, Statement of Professor Christos Pantelis, 31.
[4] Ibid, 30.
[5] CB, Second Psychiatric Opinion Service, 269.

13. Sid required several admissions to mental health services in the context of substance abuse and psychotic symptoms. Throughout his treatment, he had a poor response to various medications and was commenced on clozapine[6] in 2017. This led to a significant improvement in his symptoms. The dose was reduced after Sid and his family reported side effects.[7]

14. In 2018, Sid relapsed after discontinuing clozapine altogether and was admitted to Werribee Mercy Psychiatric Unit before being transferred to AMHRU.[8]

15. Initially, clinicians and Sid's family reported difficulties adjusting to the inpatient setting. In late 2018, Sid had multiple episodes of self-harm including pouring hot water over different parts of his body and putting his head through a window. In early 2019, he also absconded on two occasions and was found on the railway tracks in circumstances suggesting that he intended to take his own life.[9]

16. On one of these occasions, Sid allegedly committed a further sexual offence. According to clinicians, Victoria Police placed Sid on their database on a Whereabouts Plan which would escalate the police response if he were reported absent without leave. Clinicians also referred Sid to a Forensic Specialist for assistance in discharge planning to minimise ongoing risks to the community relating to possible risk of further assaults. This was underway at the time of Sid's death and complicated by Sid not participating in any interviews with the forensic specialist.[10]

17. Sid's family echoed concerns of self-harm and provided text messages from Sid in early 2019 where he asked his family to take him home to have a break from the hospital and to be managed as an outpatient.[11]

[6] Clozapine is a second-generation antipsychotic medication used in treatment-resistant schizophrenia. While there is good evidence of efficacy, there are also many potential side effects that range from mild to life threatening. Prescribing is restricted to patients who fail to respond to other antipsychotic therapy. Clozapine is a part of the Commonwealth Highly Specialised Drugs Program and only registered centres should prescribe it and only by medical practitioners registered at each of the centres.
[7] CB, Statement of Prof Christos Pantelis, 30.
[8] Ibid.
[9] Ibid, 31.
[10] CB, Statement of Dr Naveen Thomas, 36.
[11] CB, Family concerns, 83.

18. After this initial period, clinicians reported that Sid responded well to the AMHRU environment and was able to engage well with staff and with activities on the unit. He was generally polite and co-operative and able to participate in ward activities.[12]

19. This is disputed by Sid's family who stated that Sid "*lost all hopes [sic] that he can come home*" and "*stopped caring about his health, looks, hygiene, etc*."[13]

20. Part of Sid's treatment included electroconvulsive therapy (**ECT**) which commenced in December 2018. In March 2019, Sid withdrew consent for ECT. Involuntary treatment with ECT is a separate application and hearing with the MHT to Treatment Orders and can only be performed when a patient does not have capacity to decide about receiving ECT as treatment.[14] Clinicians assessed Sid as having capacity to withdraw consent and there were no further sessions of ECT.[15]

21. Sid's persisting behavioural disturbances and psychotic symptoms were usually characterised by an observable change in his mental state. Sid would become sullen, withdrawn, become non-communicative, and would appear confused. Staff would assess for these changes regularly, particularly in the context of unescorted leave. Further investigation of these unresponsive episodes was planned at the time of Sid's death.[16]

22. Sid's medications at the time were:

    - Clozapine 375mg at night
    - Benztropine[17] 1mg in the morning
    - Lamotrigine[18] 200mg in the morning (gradually increasing)
    - Zuclopenthixol[19] depot 400mg fortnightly intramuscular injection

[12] CB, Statement of Professor Christos Pantelis, 31.
[13] CB, Family concerns, 75.
[14] See MHA Division 5; MHWA Part 3.5.
[15] CB, Statement of Christos Pantelis, 36.
[16] CB, Statement of Christos Pantelis, 31.
[17] An anticholinergic medication used to manage side effects of some medications such as involuntary movements and facial twitches.
[18] An anti-epileptic medication.
[19] An anti-psychotic medication.

- Lorazepam[20] 2mg at night (gradually reducing)
- Cholecalciferol[21] 1000 units in the morning
- Coloxyl and Senna[22] 100/16mg twice a day[23]

23. Staff were also concerned about ongoing drug use, particularly marijuana and synthetic cannabis which had previously been linked to deterioration in his mental state.[24]

24. Sid was an involuntary patient throughout his admission. This required periodic review by the Mental Health Tribunal (**MHT**) at hearings towards the expiry of each ITO.[25] The MHT continued to issue subsequent ITOs for the duration of Sid's admission after each hearing having determined that he met the criteria for involuntary treatment and admission.

25. These criteria are set out in section 5 of the MHA and are replicated in the new MHWA in section 143. They are that:

    a) The person has mental illness; and
    b) Because the person has mental illness, the person needs immediate treatment to prevent—
        i. Serious deterioration in the person's mental or physical health; or
        ii. Serious harm to the person or to another person; and
    c) If the person is made subject to a treatment order, the immediate treatment will be provided to the person; and
    d) There are no less restrictive means reasonably available to enable the person to receive the immediate treatment.

26. Sid and his family continued to raise objection to ongoing inpatient treatment at MHT hearings. Sid's mother frequently asserted that Sid could be managed in the community and strongly advocated for this throughout Sid's admission.[26] Sid also engaged the Second

[20] A benzodiazepine used for its sedating effects.
[21] Vitamin D replacement.
[22] A dual-action laxative for constipation.
[23] CB, Statement of Prof Christos Pantelis, 31.
[24] Ibid.
[25] Only the MHT can issue Treatment Orders (MHA section 52; MHWA section 192).
[26] CB, Family concerns, 71-87.

Psychiatric Opinion Service[27] and applied to the MHT to revoke his ITO but was unsuccessful.[28]

Scope of the Coronial Investigation

27. The coroner's power and obligation to investigate arises from a particular death, and so the circumstances to be investigated are those which are proximate and causally relevant, and not remote, to that death.

28. As Nathan J held in *Harmsworth v The State Coroner* [1989] VR 989, "*A coroner does not have general powers of enquiry or detection. The enquiry must be relevant, in the legal sense to the death or fire, this bring into focus the concept of 'remoteness' ... Enquiries must be directed to specific ends. That is the making of the findings as required ... As a general proposition the greater the time lapse between the event enquired of is from the allegedly causative factor, the less relevant as an initiating cause that factor will be.*"

29. In *R v Doogan* [2005] ACTSC 74 the Full Court of the Supreme Court of the Australian Capital Territory considered, among other things, the scope of a coroner's inquiry stating, "*a line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative.*"

30. Finally, in *Re State Coroner; Ex parte Minister for Health* [2009] WASCA 165 Buss JA held at [46] that "*[s]ection 25(1)(c) does not, however, authorise a coroner to undertake a roving Royal Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other.*"

31. With these considerations in mind, the primary inquiry in my investigation was the appropriateness of Sid's ground leave arrangements including whether it was appropriate to grant leave on 11 August 2019. The overall care and management provided to Sid including

[27] CB, Report from the Second Psychiatric Opinion Service, 267.
[28] CB, Statement of Reasons of the MHT, 249.

the appropriateness of clozapine as pharmacotherapy and the circumstances around dosing and compliance was also relevant.

32. In various communications with the court, Sid's mother raised concerns about whether Sid could have been managed in the community and not on ITO. Sid was an inpatient for an extended period because of his complex condition. There was consensus amongst the treating team, MHT, Second Psychiatric Opinion Service, and an independent expert that Sid was at greater risk of harming himself and others without an ITO.

33. On that basis, and in considering the scope and role of the coronial investigation, I do not consider it appropriate to investigate the appropriateness of the consensus medical opinion. Instead, the focus of this coronial investigation was the overall care provided to Sid while he was an inpatient, namely, questions about the appropriateness of clozapine and use of ground leave.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

34. On 6 August 2019, Sid was reviewed by two psychiatry consultants and the psychiatry registrar. The team discussed Sid's unresponsive episodes with him. Sid described psychotic symptoms during these episodes including paranoid thinking and suicidal ideation. The team also planned for increased supervision for medication after blood test results suggested lower than expected levels of clozapine.[29]

35. The psychiatry registrar documented Sid's ground leave arrangements in a Clinical Risk Assessment and Management (**CRAAM**) plan. The CRAAM document stipulated that Sid could have up to six periods of unescorted ground leave of 15 minutes each – three in the morning and three in the afternoon. Ground leave was to be cancelled if Sid went off-ground entirely and withheld if Sid had an episode of unresponsiveness.[30]

[29] CB, Statement of Dr Naveen Thomas, 38; Statement of Prof Christos Pantelis, 31; Progress notes, 214-6.
[30] CB, Medical Records, 210.

36. On 7 August 2019, there was family meeting with clinicians and Sid's mother. During the meeting, Sid's mother requested discharge or to take Sid home on day leave. The treating team explained that discharge and day leave were not yet appropriate. Sid's mother also encouraged Sid to have an MRI and other investigations for his unresponsive episodes, to which he agreed.[31]

37. On 8 August 2019, Sid was 20 minutes late returning from ground leave. Upon return, the nurse in charge suspended leave for the rest of the day.[32]

38. On 9 August 2019, Sid was granted ground leave following a risk assessment from nursing staff. Sid used ground leave appropriately and returned on time.[33]

39. On 10 August 2019, Sid reported his mood as "good" and did not describe any thought disturbances. Staff did not observe any psychotic symptoms.[34]

40. On 11 August 2019, at about 6.58am, Sid presented to the nursing station requesting 15 minutes of ground leave. The nurse noted that Sid presented as warm and reactive with no early warning signs and no suicidal ideation.[35] At about 7.10am, a nurse arriving to work at the unit reported that they had seen Sid walking down the street outside of hospital grounds.[36]

41. At 7.30am, staff commenced the absence without leave protocol after attempts to contact Sid and his parents were unsuccessful.[37] A nurse filled out an Apprehension of Patient Absent Without Leave form[38] which included that he had previously been found on railway train tracks and was on the sexual offenders list. The form was faxed to the local police station and the police were notified via phone.[39]

[31] CB, Progress notes, 218; Statement of Prof Christos Pantelis, 31; Statement of Dr Naveen Thomas, 37.
[32] CB, Progress notes, 219.
[33] Ibid, 220.
[34] Ibid, 221.
[35] Ibid, 224; Statement of Duan Davies, 43.
[36] CB, Statement of Solomon Alem, 45.
[37] CB, Statement of Lige Li, 41.
[38] CB, Medical Records, 226.
[39] CB, Statement of Duan Davies, 43; Progress notes, 224; Medical Record, 226.

42. Meanwhile, at 7.17am, Metro CCTV footage captured Sid entering the railway track pit from platform 2 and lying over the railway track in front of the train wheels.[40]

43. Shortly afterwards, the train departed from Ginifer station. The train drivers were unaware that Sid was on the tracks and had been struck by the train as it departed. According to the train driver and supervisor, it was raining, and the tracks were wet. It was a normal departure from the station, there were no reports of trespassers in the area nor evidence of anybody on the tracks when the driver checked the platform side mirror and performed other safety checks.[41]

44. At 7.45am, a member from Metro trains saw a body lying on the train line at Ginifer railway station on security camera footage. At about 8.00am, officers from Victoria Police arrived at Ginifer railway station where they subsequently identified the body as Sid.[42]

Identity of the deceased

45. On 14 August 2019, Coroner Phillip Byrne made a determination that the identity of the deceased was Sidarthan Gajaharan, born 2 November 1992. This determination was based on the Victoria Police report of death (Form 83), an identification report from the Victorian Institute of Forensic Medicine (**VIFM**), and a fingerprint report.

46. Identity was not in dispute and did not require further investigation.

Medical cause of death

47. VIFM Forensic Pathologist Dr Victoria Francis conducted an external examination on 12 August 2019 and provided a written report of the findings. In writing this report, Dr Francis also considered a post-mortem CT scan and the Victoria Police report of death (Form 83).

48. The external examination showed significant craniocervical disruption.

49. Toxicological analysis of post-mortem samples identified the presence of lamotrigine.

[40] CB, Statement of Sergeant Shayne Wallace, 47.
[41] CB, Statement of Emily McNiel, 27; Statement of Mark French, 29.
[42] CB, Statement of Andrew Spiteri, 64-5.

50. Dr Francis formulated the cause of death as: *1(a) Craniocervical injuries following a train collision (pedestrian).*

51. I accept Dr Francis' opinion.

Toxicology

52. Coroner Jamieson noted that neither zuclopenthixol nor clozapine were present of the post-mortem toxicological analysis and requested further information from the Toxicology Department at VIFM.

53. Chief Toxicologist Dr Dimitri Gerostamoulos clarified that the laboratory did detect zuclopenthixol but at levels less than the reporting limit of 30ng/mL (~17ng/mL). Dr Gerostamoulos confirmed that the laboratory did not detect clozapine but did detect a metabolite of clozapine at less than the reporting limit.[43]

54. Dr Gerostamoulos commented that the dose of zuclopenthixol provided to Sid is consistent with the concentration determined in the toxicology analysis. Further, if clozapine was consumed by Sid daily, then it would be expected to be detected in post-mortem samples.[44]

FAMILY CONCERNS

55. In addition to a statement provided to the Coroner's Investigator, Sid's mother submitted additional concerns across various correspondence.

56. These can be summarised broadly as:

    a) Inpatient management was inappropriate for Sid, and he could be managed safely in the community.
    b) Sid's family were not permitted to visit as much as they should have.
    c) Sid should not have been permitted to start smoking and involuntary patients generally should also not be permitted to start smoking.

[43] CB, Additional Toxicology Comments, 10.
[44] Ibid.

d) Sid should not have been granted unescorted leave and unescorted leave should not be granted to patients at risk of committing suicide.
e) Sid did not receive adequate psychosocial supports. The psychosocial needs and supports for each patient should be customised accordingly.
f) Alternative health perspectives were not considered.
g) Clozapine was not an appropriate medication for Sid.
h) There was an unacceptable delay in the coronial investigation.

57. In other correspondence with the Court, Sid's father also raised concerns that he could only discuss Sid's care with a junior doctor and not the consultant psychiatrist, that his concerns about Sid receiving subtherapeutic doses of medications were ignored, and that Sid was able to access cannabis while an inpatient.

FURTHER INVESTIGATION

Review by NWMH

58. Sid's death was reviewed by NWMH in a Root Cause Analysis (**RCA**) and reported to Safer Care Victoria (**SCV**). There were two recommendations from the report which have both since been implemented.[45]

59. The first was to implement a structured risk assessment and engagement tool for nursing staff to use on the unit. The second was to improve the medical governance for the management of consumers. There are now weekly consultant review meetings which review management plans of each consumer. The Registrar EFT has also increased from 1.0 to 1.5.[46]

Expert Opinion

60. I requested that an independent expert provide an opinion about the care and management of Sid. This was provided by Associate Professor Peter Doherty, consultant psychiatrist.[47] In addition to a general assessment of Sid's care, A/Prof Doherty was specifically asked to

[45] CB, Letter from Peter Kelly, 88.
[46] CB, Recommendation Monitoring Report, 89.
[47] CB, Expert Opinion Report of A/Prof Peter Doherty, 97-103.

comment on the appropriateness of Sid's unescorted ground leave, the appropriateness of the indication and dose of clozapine, and to comment on the post-mortem toxicology analysis.

Ground Leave

61. A/Prof Doherty outlined of the legal basis for granting ground leave which he classified as falling under section 64 of the MHA.[48] This section facilitates temporary suspension of an ITO and other compulsory orders to allow for an approved leave of absence. There are mandatory considerations that an authorised psychiatrist must make before granting leave which includes a risk assessment of the health safety of the patient and any other person.[49]

62. A/Prof Doherty noted the "*usual policy within mental health services is that in the day-to-day clinical management of patients, leave can be cancelled by any staff member, most commonly by nursing staff, but can only be reinstated by medical staff or jointly by medical and nursing staff. The day-to-day management of leave should be within whatever conditions are imposed by the delegated/authorised psychiatrist.*"

63. As such, A/Prof Doherty characterised the cancellation of leave on 8 August 2019 as requiring reinstatement by an authorised psychiatrist.

64. A/Prof Doherty was also concerned that Sid's ground leave request on 11 August was assessed by night shift staff. A/Prof Doherty opined that day shift staff are more suited to perform a risk assessment prior to granting leave. However, A/Prof Doherty concluded that, in his opinion, there was "*no clear or absolute clinical contraindication to the granting of ground leave on 11 August*."

Clozapine

65. A/Prof Doherty commented clozapine is indicated for the treatment of treatment-resistant schizophrenia and was an appropriate medication for Sid. A/Prof Doherty provided the expected therapeutic plasma levels of clozapine but cautioned that there is no evidence that

[48] The equivalent sections are replicated in Part 4.7 of the new MHWA.
[49] MHA s 64(2)(b); MHWA s 214(b).

this threshold must be met. Instead, the clinical response of the patient is the determining factor in assessing an appropriate dose.

66. A/Prof Doherty noted that the estimations of clozapine levels taken by AMHRU staff were all in range but at fluctuating levels and believed to be sub-therapeutic as Sid remained having active psychosis. A/Prof Doherty opined that the fluctuation indicated likely noncompliance or patchy compliance and possibly the effect of smoking cigarettes, which is known to affect clozapine metabolism.

Additional Comments

67. A/Prof Doherty concluded that it was clinically appropriate that Sid was admitted to AMHRU. However, the management of clozapine dosage was "*less than ideal, and the full potential positive effect of the use of clozapine was not achieved*."

68. A/Prof Doherty noted that an in-depth review of the clinical care could not be undertaken with the materials provided and suggested that the risk assessment processes and the decision making around cancelling and re-instating ground leave should be considered.

NWMH Response

69. NWMH were afforded an opportunity to respond to the expert opinion report of A/Prof Doherty. This was provided by A/Prof Peter Burnett, Director Clinical Governance at NWMH in a letter dated 23 August 2022.[50]

Ground Leave

70. A/Prof Burnett explained the clinical rational behind ground leave. This is based both on the principle of "*least restrictive treatment*" in the MHA and AMHRU's aims to promote recovery and rehabilitation. This involves teaching patients to self-manage medications, finances, substance use, and brief periods outside the ward environment. Ground leave is typically used

[50] CB, Response Statement of A/Prof Peter Burnett, 104-7.

by patients to attend the hospital kiosk to purchase small consumer items or to attend the hospital cafeteria.

71. This inevitably involves a degree of risk-taking. To minimise risks, decisions around leave start with "*small steps such as escorted ground leave and then may progress to brief periods of unescorted ground leave to 1, 2, or 4 hours, then progress to overnight and eventually weekend leave as clinical and social circumstances permit.*"

72. A/Prof Burnett concluded that "*the approval of leave is a graduated, incremental, and thoughtful process*" and in this case, it was reasonable for Sid to be granted 15 minutes of unescorted ground leave on 11 August.

73. A/Prof Burnett noted A/Prof Doherty's concern about leave processes and opined that, in this case, leave was appropriately authorised by the psychiatrist and nursing staff always checked Sid's mental state before any episode of leave, including his specific risk factors.

Clozapine

74. A/Prof Burnett agreed with A/Prof Doherty's assessment that clozapine was an appropriate treatment for Sid in the context of a "*severe schizophrenic illness which did not respond to other treatments.*"

75. A/Prof Burnett agreed with A/Prof Doherty's assessment that the fluctuating blood levels were patchy adherence with oral clozapine and the effects of smoking cigarettes.

Additional Comments

76. A/Prof Burnett concluded that:

> "*Mr Gajaharan suffered from a very severe, chronic schizophrenic illness with fluctuating levels of risk. Treatment of such illnesses requires attention to the pharmacological management, the psychological management and social rehabilitation. Periods of leave from the unit are an important component of social rehabilitation. The care provided to Mr Gajaharan included all of these elements, and the granting of leave was conditional on his mental state at the time.*"

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Ground Leave

77. While noting that both A/Prof Doherty and A/Prof Burnett agreed that ground leave was appropriate in the circumstances, there was not clear agreement in the evidence about how each classified the granting and revocation of ground leave and who was authorised to do so.

78. A/Prof Doherty's view appears to be that Sid's leave was revoked on 8 August 2019 and needed to be formally reinstated. A/Prof Burnett's view appears to be that Sid's leave was suspended for the day and was not revoked. Both views are consistent with the legal underpinnings of leave in the MHA. Instead, the differences arise out of the different policies at each individual mental health service.

79. Section 64 of the MHA clearly authorises only authorised psychiatrists to grant and revoke ground leave. However, section 64(2) allows an authorised psychiatrist to impose conditions on ground leave. For patients at AMHRU, some of these conditions are outlined in the NWMH Leave Arrangements policy document and include that a risk assessment be performed immediately before granting leave.[51] This is mirrored in the Chief Psychiatrist's guideline.[52]

80. When Sid's leave was cancelled on 8 August 2019, it was done so pursuant to these conditions of leave rather than being formally revoked by an authorised psychiatrist pursuant to section 64(4) of the MHA. Therefore, Sid's leave did not require reinstatement by a psychiatrist and was lawfully and appropriately granted on 11 August 2019 after a risk assessment.

81. I accept the conclusion by both A/Prof Doherty and A/Prof Burnett that ground leave was appropriately granted to Sid on 11 August 2023.

Clozapine

[51] CB, NWMH Leave Arrangements from Inpatient Units, 108-112.
[52] CB, Leave of Absence from a Mental Health Inpatient Unit – Chief Psychiatrist's Guideline, 125.

82. I accept the opinion of A/Prof Doherty and A/Prof Burnett that clozapine was an appropriate treatment for Sid. I note that there were concerns raised about Sid's adherence to clozapine at the clinical review on 6 August 2019 with a plan for increased monitoring of Sid taking his medication. This implies that prior to this, Sid was not monitored as closely when he was administered clozapine.

83. While this is not ideal in hindsight, I accept that this was the materialisation of a known risk pursuant to the aims of AMHRU and the MHA in promoting independence, the least restrictive treatment, and rehabilitation.

Delay in Initiating Absence Without Leave Procedures

84. It is unclear why staff waited 20 minutes after Sid was seen leaving the hospital and 15 minutes after he was due back from leave to initiate these procedures. The delay was possibly to see if he would return of his own volition, which would be reasonable when no immediate risks were identified prior to leave.

85. However, given that Sid was known to have left the hospital grounds, this should have been reported to police immediately. Similarly, there was a documented plan in the case of unauthorised absence to notify the police "*without delay*".[53] Nonetheless, the evidence suggests that Sid died at 7.17am, and so I am not satisfied that earlier contact with police would have prevented his death.

Appropriateness of the ITO

86. The treating team, the MHT, A/Prof Doherty, and the Second Opinion Psychiatry Service all opined that Sid could not be managed safely in the community. I do not think it is appropriate to investigate this issue further given the significant weight of these opinions and because of the difficulty outlined above in meaningfully assessing whether this would have made a difference to the outcome.

87. As outlined by each, there were significant risks associated with both granting or not granting an ITO. I accept that the various statutory bodies and clinicians reasonably reached the

[53] CB, AWOL Process for Sid, 248.

conclusion that Sid met the criteria for compulsory treatment and required an ITO. The current mental health system and infrastructure did not allow for a less restrictive option.

Family Concerns

88. Many of the concerns raised by Sid's family are outside the scope of the coronial jurisdiction. However, these concerns are shared by many families who made submissions in the Royal Commission into Victoria's Mental Health System (**the Commission**).

89. In February 2019, on advice from the Victorian Government, the Governor of the State of Victoria formally established the Commission for the purpose of inquiring into and reporting on how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future.

90. The Commission's final report was tabled in a special sitting of the Victorian Parliament on 2 March 2021.[54] The Commission made 65 recommendations for change in its final report to create a future mental health and wellbeing system that provides holistic treatment, care and support for all Victorians building upon nine recommendations in its interim report.

91. The Victorian Government has committed to implementing all the recommendations made by the Commission. These relevantly include:

    a) Recommendation 12 – which includes a new community rehabilitation model of care in addition to intensive rehabilitation in secure extended care units;

    b) Recommendation 30 – which seeks to develop system-wide involvement of family members and carers including in therapeutic interventions; and,

    c) Recommendation 31 – which seeks to better support families, carers, and supporters.

92. Regarding smoking in mental health facilities, I recognise the competing consideration of patient autonomy, particularly in this subset of patients who are in hospital involuntarily,

[54] Available at <https://finalreport.rcvmhs.vic.gov.au/>.

against the public interest for hospitals to be smoke-free zones. While there are clear and well-known dangers of smoking, it is nonetheless is a legal activity. Further, the added stressors for patients with nicotine addiction from involuntary smoking cessation may hinder mental health recovery.

93. In my opinion, involuntary mental health patients should be permitted to smoke in a way albeit in a way that minimises risks to others. Encouraging nicotine replacement therapy remains an appropriate tool in a clinician's armamentarium, but inpatient environments should allow for otherwise capable adults to make their own decisions about smoking to do so either in designated smoking areas or with appropriate ground leave, including supervised ground leave.

94. Finally, the Act recognises that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends, and other affected the death.[55] Coronial investigations are lengthy by nature. This case was no exception particularly considering the volume of materials and engagement of an expert. Nonetheless, I recognise the distress that this has caused to Sid's family.

FINDINGS AND CONCLUSION

95. Pursuant to section 67(1) of the Act I make the following findings:

    a) The identify of the deceased was Sidarthan Gajaharan, born 2 November 1992
    b) The death occurred on 11 August 2019 at Ginifer Railway Station, Furlong Road, St Albans, Victoria, 3021, from *1(a) Craniocervical injuries following a train collision (pedestrian)*.
    c) The death occurred in the circumstances described above.

96. In doing so, I further find that:

    d) Sidarthan Gajaharan was appropriately admitted as an involuntary patient at the Adult Mental Health Rehabilitation Unit on the Sunshine Hospital campus.

[55] s 8(b).

e) Clozapine was an appropriate treatment for Sidarthan Gajaharan in the circumstances of schizophrenia which did not respond to other treatments.
f) Sidarthan Gajaharan was not taking clozapine daily as prescribed.
g) Sidarthan Gajaharan was appropriately granted ground leave on 11 August 2019.
h) Sidarthan Gajaharan took his own life.

97. The precise precipitating factors that led Sid to adopt the course of action that he ultimately chose will never be known. However, I am satisfied that the evidence supports a conclusion that Sid was very unwell which was contributed by patchy adherence to treatment, particularly clozapine.

98. While being an involuntary inpatient may have also been a factor, I am not satisfied that compulsory treatment in the community or voluntary treatment were reasonable alternatives in the circumstances. I am satisfied with the reasoning of the Mental Health Tribunal, treating team, and Second Psychiatric Opinion Service which suggested that Sid presented an unacceptable risk to himself and to others. I am satisfied that the decision to place Sid on an ITO was reasonable in the circumstances.

99. This is the tragic death of a very unwell person who was receiving appropriate care within the current mental health system. Sid's best chance at recovery and reintegration with society may have been intensive and highly supervised community-based treatment as envisioned by parts of the Commission. However, I am unable to say if this would have changed the outcome nor am I able to find whether Sid's death was preventable.

100. I am satisfied that the RCA by NWMH negates the need for further coronial recommendations.

I convey my sincere condolences to Sid's family for their loss.

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

Mathura Kanapathipillai, Senior Next of Kin
Gajaharan Gangasudhan, Senior Next of Kin
Dr Neil Coventry, Chief Psychiatrist of Victoria

Peter Kelly, NorthWestern Mental Health

Sergeant Andrew Spiteri, Coroner's Investigator

Signature:

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Coroner Katherine Lorenz

Date: 28 February 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.