IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 1876/08

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of GAYLE MAREE JOHNSON

Delivered On:	April 12, 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	February 15, 16, 17 and 18, 2011
Findings of:	JUDGE JENNIFER COATE
Representation:	Mr Murdoch of Counsel for Northeast Health

Police Coronial Support Unit: Senior Sergeant Jenny Brumby

I, JUDGE JENNIFER COATE, State Coroner having investigated the death of GAYLE JOHNSON

AND having held an inquest in relation to this death on February 15, 16, 17 and 18 February, 2011 at Melbourne

find that the identity of the deceased was GAYLE MAREE JOHNSON[1]

born on May 20, 1956

and the death occurred between May 2 and May 3, 2008

at 31 Halls Road, Myrtleford, Victoria 3736

from:

1a. COMPLICATIONS OF ANOREXIA[2]

in the following circumstances:

Summary

1. Ms Gayle Maree Johnson was aged 51 at the time of her death. She had been living in a relationship with Douglas Falconer but at the time of her death, although they were still living in the same house which they jointly owned, she and Mr Falconer were no longer in a relationship together.[3]

2. Ms Johnson had a past history of severe and on-going anorexia nervosa, alcohol misuse, marijuana use, depression, laxative abuse, financial stress, relationship difficulties, history of falls and ataxia.[4]

3. Her ex-partner, Mr Falconer, was known to police and had a significant psychiatric history as well as known issues of domestic violence with Ms Johnson. Ms Johnson was apparently estranged from her mother.

4. Ms Johnson was being treated at the Standish Street Surgery in Myrtleford. She attended the clinic fairly frequently. She was described as being difficult to get to comply with treatment and management plans.[5] One of her regular doctors at the surgery, Dr Cavini, described her as tending to resent any medical intervention.

5. She was also known to psychiatric services in Wangaratta who were treating her depression and had a plan in place to try to maintain her weight at 45kgs.

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1 Identified by Douglas Falconer, ex partner of 7 years

2 Autopsy report of Dr Paul Bedford Forensic pathologist with the Victorian Institute of Forensic Medicine. At the Directions Hearing on August 6 2010, there was a discussion as to whether or not any issue was taken with the cause of death provided to the coroner by Dr Bedford. Ms Ararat on behalf of Wangaratta Hospital confirmed that no issue was taken with the cause of death.

3 Statement of Douglas Falconer May 3 2008

4 History provided by Dr Cavini, treating GP of Ms Johnson

5 Statement of Dr Cavini 15.8.2008

6. Ms Johnson attended Dr Cavini's rooms on April 29, 2008 complaining of a bout of diarrhea. At the time of this visit to Dr Cavini, he was so alarmed by her physical condition he recommended Ms Johnson present herself to Wangaratta Hospital immediately. Ms Johnson would not do that but after considerable negotiations with Dr Cavini, she agreed to go the next day. That next day, April 30, Ms Johnson collected a letter from Dr Cavini's rooms and then went to the Wangaratta Hospital as agreed. The letter she carried from Dr Cavini expressed his considerable concern about Ms Johnson's history of anorexia and psychiatric problems.

7. Ms Johnson was treated at the hospital from April 29 to May 1.

8. Ms Johnson was actually discharged twice from the hospital over those couple of days.

9. On the first occasion ("the first discharge"), Ms Johnson was apparently discharged at 12.45am on the morning of April 30. It would appear that she did not in fact leave the waiting area of the Emergency Department and was found in very poor condition at 8.30am that morning still sitting in the Emergency Department. The evidence of what the discharge management plan was for Ms Johnson on this first discharge remained unclear.

10. On the second occasion, a day later, after a review by a hospital medical registrar, Dr Matthew Brooks, in the context of finding Ms Johnson to be adamant that she did not want to stay, it was determined that she was medically stable enough to go home. She was discharged on May 1 at 5.00pm.

11. The management plan at the second discharge was to have follow up psychiatric management with the first appointment arranged for May 7th 2008 (6 days after discharge) and a referral sent to the Eating Disorders Unit at the Austin. There was no evidence of any medical plan to have support for nursing visits or doctor's appointments arranged for Ms Johnson.

12. After this second discharge, Ms Johnson went home to Myrtleford late on the afternoon of Thursday May 1 2008. There is no evidence as to how Ms Johnson travelled home. There is evidence however that she was at home in bed all day on the Friday May 2.

13. According to Mr Falconer, during this day of Friday May 2, 2008 Ms Johnson remained in bed, weak and unwell all that day. Mr Falconer went into her room a couple of times during the day but Ms Johnson had not communicated with him, although Mr Falconer stated he could hear her breathing.

14. The next morning (Saturday May 3) at about 6.00am when Mr Falconer checked on her again, he could not see any movement but decided to let her rest. By 11.00am, concerned for her welfare he touched her face and felt her cold to touch. He contacted 000 after which time police arrived.

15. The police did not find any suspicious circumstances about the scene upon their arrival or during their investigation.

16. According to the autopsy report, at the time of her death, Ms Johnson weighed 39 kg and measured 168 centimetres in length. According to the autopsy report she had a body mass index of 13.82. At Wangaratta Hospital Ms Johnson's BMI was calculated as between 12.1 and 13, and she was initially weighed in at 35kgs.

17. Her examination at autopsy produced evidence of myxoid degenerative change in the bone marrow consistent with the effects of anorexia.

18. Dr Paul Bedford, forensic pathologist who performed the autopsy, assessed that Ms Johnson died as a result of the complications of anorexia.

Issues

19. At the Directions Hearing on August 6 2010, I identified that the issues for investigation at inquest into the death of Ms Johnson were (a) the nature and quality of the psychiatric assessment of Ms Johnson, (b) the decision not to involuntarily detain her under the *Mental Health Act,* (c) the appropriateness of the decision to discharge her in the circumstances and (d) the discharge plan and what liaison there was with the medical team.

Background

20. As at 2007 Ms Johnson was known to have a long-standing eating disorder. Her situation was complicated by significant alcohol and marijuana abuse and concerns about her relationship which was thought to be abusive. However, Ms Johnson did agree to a treatment plan that included the option of referral to a metropolitan eating disorder unit.[6]

21. Ms Johnson had been referred by her treating doctor to a neurologist because of an apparent gait disturbance. The MRI performed by the neurologist showed cerebellar degeneration which was assessed as probably due to alcohol abuse.[7]

22. Ms Johnson attended Dr Cavini, her main treating GP on April 18 2008. Ms Johnson told Dr Cavini that she had been exercising constantly claiming that it made her feel good. She advised Dr Cavini that the gym owner where she was exercising had expressed concern to Ms Johnson about her level of exercise and physical condition and requested a doctor's certificate from her to say that she was fit to continue at the gym.

23. Dr Cavini told her he would not give her such a certificate until she reached 50kg (being 43kg at that time). Dr Cavini stated that she left "crying and angry." Dr Cavini stated that Ms Johnson sought a doctor's certificate from two other doctors at Standish Street who also declined to provide her with one.

6 Statement of Dr Carey: Exhibit I
7 Ibid

24. Ms Johnson next attended upon Dr Cavini on April 28, 2008 presenting with diarrhoea. Dr Cavini was so concerned about her condition by then that he told her she may die without hospital treatment. He wanted her to attend the hospital that day but Ms Johnson refused. However, she did agree to attend the next day according to the evidence of Dr Cavini.

25. He prepared a letter for her dated 29.4.2008 which is contained in the hospital file confirming that Ms Johnson both collected it and provided it to Northeast Health Wangaratta ("Wangaratta Hospital"). The letter noted that Dr Cavini was "very concerned" about Ms Johnson with her past history of anorexia and "psych problems". The letter also stated that Ms Johnson had been exercising excessively. He noted she had some cerebellar degeneration due to past alcohol abuse and had lost a great deal of weight recently.[8]

Wangaratta Hospital Tuesday April 29, 2008

26. Ms Johnson's movements throughout the hospital were not easy to follow as the statements and hospital records and chronologies of times and dates and entries were not easy to decipher. At times there were conflicts between statements and entries in hospital files. This process was not assisted by receiving the files piecemeal during the investigation.

27. Doing as best the evidence provides, and with the assistance of the chronology prepared by the legal representative for Northeast Health for the purpose of briefing a psychiatrist the hospital sought to include in the witness list, Professor Keks, it would appear that Ms Johnson presented herself to the Emergency Department of the Wangaratta Hospital at about 3.30pm on the afternoon of 29 April 2008.

28. She was seen in triage and the notes indicate that at about 15.33 her temperature was 32. 5. She was assessed as hypothermic and dehydrated, with low sodium and chloride, moderately elevated liver function test results, marked first degree heart block and extremely low body weight. Ms Johnson was refusing to eat or drink.

29. As noted above, she was weighed at the hospital as 35kgs and estimated to be about 5.7" which produced a BMI that was calculated at 12.1.

30. It would appear that Ms Johnson was seen by a community mental health nurse who did not record the result of a mental state examination, if one was done, but did indicate that Ms Johnson could be appropriately followed up in the community once she was medically stable.

31. According to the first discharge summary, Ms Johnson was formally admitted to the hospital at 17.01 on April 29, 2008. She was seen by the medical registrar who concluded that although her problems were not insignificant, she would not be best managed in an acute medical setting to which she was resistant.

[8] Exhibit 3

The first discharge

32. At 12.45am on April 30 2008 Dr Miles Andrews attended upon Ms Johnson. He found her minimally cooperative and expressing a desire to go home. He also noted that she repeated her need to take her laxatives and that she did not find the food or drink at the hospital suitable. Dr Andrews found her to be dehydrated, with abnormal liver chemistries and abnormal cardiac conduction possibly related to hypothermia and extreme low body weight. Ms Johnson was receiving intravenous hydration including glucose. Both her blood sugar and her cardiac condition were being monitored.

33. Dr Andrews attended upon Ms Johnson again at 1.16am and directed her discharge ("the first discharge"). The record notes that she was unable to walk unassisted and was escorted to the waiting room. She was taken to the ATM to get money for a taxi fare to take her home to Myrtleford from Wangaratta, a trip of about 46 kilometres.

34. In evidence, Dr Andrews stated that although he had directed her discharge in the middle of the night, he had believed that Ms Johnson would be physically staying in the bed in the Emergency Department until the next morning. Dr Andrews stated he thought that this would happen based on the last conversation he had with Ms Johnson. He agreed that there was not a nurse with him when he conducted his examination, there was no evidence of this plan having been communicated to any hospital staff and there is no note to that effect in the discharge summary which is timed at 1.16am. Indeed, as noted above, the staff commenced to act on the discharge direction by assisting Ms Johnson to the waiting room and to the ATM at the bank to obtain funds for the taxi journey home to Myrtleford.

35. Dr Andrews stated that whilst Ms Johnson appeared to know where she was she was preoccupied with not wanting to stay at the hospital and needing to get access to laxatives. However, later in his evidence he described Ms Johnson as being ambivalent as to whether or not she wanted to go in the middle of the night. He was also aware that Myrtleford was a considerable number of kilometres away and an expensive taxi ride in the middle of the night.[9]

Wangaratta Hospital, Wednesday April 30, 2008

36. At about 8.00am that morning (30 April 2008), Dr Bowmaker arrived to commence work that day at the hospital. She was the senior doctor in the Emergency Department that morning. She found Ms Johnson sitting in the waiting area of the Emergency Department. Dr Bowmaker described Ms Johnson as "very ill looking." Dr Bowmaker assumed that she was waiting to be seen and asked the nursing staff to bring her into a cubicle.[10]

37. Ms Johnson was formally medically examined in the cubicle in the Emergency Department at 9.30am. She was found to be drowsy and confused. Dr Bowmaker stated that Ms Johnson said to her "I can't go home like this". Dr Bowmaker stated that Ms Johnson was drifting off to sleep in mid sentence

[9] Transcript 103
[10] Statement of Dr Bowmaker 13.2.2010

and needed assistance to stand and transfer to the wheelchair. She was repeating herself and frequently asking the same question. Ms Johnson agreed to being admitted.

38. Ms Johnson was not considered medically well enough for a community psychiatry assessment at this time.

39. At about 1.15pm that day (April 30 2008) Ms Johnson was readmitted and placed in a ward by 6.30pm.[11] She was admitted under the care of Dr Bolitho, consultant physician. She was admitted for re-hydration, correction of her hypoglycaemia and general stabilization of her medical condition.[12] She was still refusing to eat and was receiving intravenous hydration. Her ECG was recorded as abnormal.

40. Dr Bowmaker obtained social work assistance for Ms Johnson and also made contact with the Austin Eating Disorders Unit. There was some conflicting evidence about what information was obtained from the Eating Disorders Unit and their policy about whether or not they would take patients with a BMI of less than 13. Dr Bowmaker did complete a referral to the Eating Disorder Unit at the Austin noting the reason for referral being: "Cognitively impaired by starvation and low body weight. Patient refusing to eat or drink anything except laxatives. Patient is hypothermic and bradycardic."[13] On that same form, Dr Bowmaker has noted under risk assessment: "Unable to assess due to cognitive impairment".

41. Ms Johnson was further examined at about 10.00pm that evening and found to have low blood sugar and a slow heart rate[14] which the examining doctor concluded was consistent with asymptomatic bradycardia and hypoglycaemia.

42. At 11.25pm Ms Johnson was recorded as being in 2-3rd degree heart block and with a Glasgow Coma Scale of 13.

The second discharge (Thursday May 1, 2008)
Medical assessment

43. Early the next morning, Dr Lynn, Medical Registrar examined Ms Johnson at 2.00am and found her to be bradycardic (heart rate was 26 beats per minute) and hypothermic (body temperature was 32°C). Her blood pressure was stable at 120/60. The cardiac monitor showed non-sustained episodes of secondary heart block. At that time, Ms Johnson's management consisted of gradual re-warming with a bear hugger blanket and warm intravenous fluid and continued cardiac monitoring. By 5.00am, on re-examination by Dr Lynn, Ms Johnson's temperature had gone up to 33.4 and her heart rate had increased to 45 beats per minute. Dr Lynn requested the nursing staff to continue re-warming Ms Johnson gradually and to continue the cardiac monitoring.[15]

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11 Statement of Dr Miles Andrews 10 October 2008
12 Statement of Dr Bolitho 14.2.11 Exhibit 9
13 Dr Jenkins gave evidence that patients with eating disorders can have bradycardia as one of the heart's responses to low body weight. She explained that the heart, when not getting enough calories will try and save energy by lowering blood pressure and lowering pulse rate.
14 Statement of Dr Ghosh 10.12.2009
15 Statement of Dr Lynn dated 23.10.2009

44. Dr Brooks examined Ms Johnson at 8.30am on May 1 2008 and again later that day. He found significant protein-calorific malnutrition and a body mass index of between 12 and 13. Dr Brooks found bradycardia fluctuating from ventricular rate of 60bpm to 40bpm, but haemodynamically stable with a blood pressure of 120/80. She was hypothermic at 34.6. Dr Brooks considered that Ms Johnson was alert but difficult to engage, with no evidence of significant obvious focal neurology.

45. Dr Brooks stated that Ms Johnson had severe anorexia nervosa with "associated complications" of renal impairment and abnormal liver function tests and bradycardia secondary to hypothermia.

46. Dr Brooks stated that Ms Johnson was well known to the psychiatry team and concluded that she clearly required specialist management in an Eating Disorders Unit to prevent further medical deterioration.[16] Dr Brooks made contact with the Eating Disorders Unit at the Austin and made enquires as to the criteria for admission and the availability of a bed. He established that there was no fixed criteria for BMI exclusion, but that a bed was not available for immediate transfer.

47. Dr Brooks stated that he discussed options relating to her on-going treatment which included remaining in Hospital at Wangaratta awaiting a bed at the Austin. Dr Brooks stated that Ms Johnson was adamant that she wanted to go home and "whilst the medical manifestations of her anorexia were by no means thought insignificant , it was believed that she was stable in the short term to return home with the planned psychiatry follow up and admission to eating disorders unit...."[17] Dr Brooks confirmed that Ms Johnson confirmed that she would accept the offer of community psychiatric follow up.

48. Dr Bolitho, the consultant physician, stated that he first saw Ms Johnson at about 10.15 to 10.30 on May 1, 2008 on his morning ward round. He stated that she was being assessed by the Community Psychiatry Liaison nurse at that time and so, apart from asking her if she was comfortable, he did not examine her. She expressed a wish to go home to Dr Bolitho.

49. Dr Bolitho was the consultant Physician under whose care Ms Johnson had been re-admitted. Dr Bolitho did not medically examine Ms Johnson but had discussions with the medical registrars about her. In his statement[18] he stated his understanding was that after having been seen by Community Psychiatry that day, Ms Johnson was considered not suitable for involuntary detention or for forced naso gastic feeding. He noted that Ms Johnson was refusing to eat and stating her right to be discharged. According to Dr Bolitho Ms Johnson was noted as being "oriented (although variable)" and defensive and resistant to all interventions.

50. Dr Bolitho stated that the final discussions and liaison about Ms Johnson's discharge were made without direct consultation with him, although he was satisfied that the discharge from the medical unit with psychiatric follow up in the community was appropriate. Dr Bolitho stated that Ms Johnson's

16 Statement of Dr Brooks: 25.11.2009
17 Ibid
18 Statement of Dr Bolitho 14.2.2011

blood sugars and her temperature at 34.6 and her respiratory signs were "satisfactory". Her pulse was regular and her blood pressure was listed as 121/76 which Dr Bolitho considered normal.

51. Dr Bolitho also stated that Community Psychiatry felt there were adequate measures in place.

The mental health assessment

52. As set out above, Ms Johnson also underwent a mental health assessment on May 1 which was performed by an experienced registered psychiatric nurse, RPN Smith, in company with a social worker. On assessment, Ms Johnson was found to be able to follow a conversation although she was noted to have impaired judgment in that she believed she was able to look after herself.

53. The psychiatrist supervising this community psychiatry team at the relevant time was Dr Carey. Dr Carey did not personally examine Ms Johnson but relied upon the examination of the experienced registered psychiatric nurse. The evidence was that this is very common practice.

54. Contrary to the condition she had been found in by Dr Bowmaker less than 24 hours earlier, Ms Johnson was found to be alert, oriented and spontaneous and focused on leaving the hospital and agreeing to further community assessment and treatment.[19]

55. Ms Johnson was discharged home again ("the second discharge") from Wangaratta Hospital at 5.00pm on May 1. There was no evidence as to how Ms Johnson got home that afternoon.

Management plan on discharge

56. The Mental Health Team discharge management plan was to follow up with Ms Johnson in 6 days with a visit and referral to the Eating Disorders Unit. The medical discharge management plan appears to have been to rely upon the Mental Health Management Plan.

57. There was no evidence of any liaison with any person in a support or caring role with Ms Johnson, and no evidence of any discussion with Mr Falconer about any safety issues or instructions or advice as to her care prior to or upon this second discharge. Indeed, there is no information about Ms Johnson's circumstances at home other than a note in the community mental health notes of 1.5.2008 that Ms Johnson did not want Mr Falconer to participate in the care plan.

58. According to Mr Falconer,[20] Ms Johnson remained ill and weak in bed all of the next day, Friday May 2, and by the morning of Saturday May 3, less than 48 hours after her discharge from Wangaratta Hospital, she had died of complications from her anorexia.

19 Statement of Dr Carey Ex 1
20 Statement of Douglas Falconer

The nature and quality of the psychiatric assessment of Ms Johnson

59. The Wangaratta Hospital has a community psychiatry team attached to it to enable patients requiring mental health support as well as medical support to be treated for both needs through the one facility. Presumably, the rationale for such a structure is to enable a holistic approach to patient needs. Again, presumably, the further rationale no doubt is to enable liaison between the treating disciplines to remain well informed about the patient's needs and risks and to interpret those needs and risks through the contribution of each of the specialties to make a more fulsome management/treatment plan and risk assessment for the complex patient.

60. Dr Carey was a psychiatrist working through Northeast Health at the relevant time. As noted above, she was the psychiatrist overseeing the care of Ms Johnson during her second discharge.[21] Dr Carey had met and treated Ms Johnson prior to May 2008. Dr Carey was aware that Ms Johnson had a diagnosis of severe long standing anorexia complicated by her substance abuse[22] and she was aware that Ms Johnson had been assessed as having cerebellar degeneration as a result of her past history of alcohol abuse. Dr Carey also, together with the local police, had had serious concerns about Ms Johnson's safety from domestic violence at the hands of Mr Douglas Falconer.

61. Dr Carey stated that Ms Johnson's insight and judgment regarding the severity of her physical state was poor.[23]

62. In evidence Dr Carey stated that treating people with a long standing eating disorder is a very difficult thing and requires a "good team of persistent clinicians, a GP, a dietician, often psychologists and community mental health workers" to achieve stability. Dr Carey stated how complex Ms Johnson was to manage at a community treatment level, compounded by her lack of connection to the Myrtleford community and her lack of any apparent reliable carer at home.

63. The assessment and mental state examination of Ms Johnson was performed by RPN Carmel Smith on May 1 2008 who thereafter discussed her examination of and treatment plan for Ms Johnson with Dr Carey.

64. As to her involvement with the assessment of Ms Johnson during the period from April 29 to May 1 2008, Dr Carey did not see Ms Johnson herself or have any discussions with Ms Johnson's treating doctors before either the first discharge or the second discharge. Dr Carey's evidence was that she believed that Ms Johnson's medical condition had improved by May 1 and that she would be discharged and thus she, together with RPN Smith,[24] were formulating a community treatment plan for Ms Johnson. Dr Carey gave evidence that she relied on RPN Smith's advice to her about Ms Johnson's medical condition being stable.[25]

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21 It is unclear who the psychiatrist was overseeing the first discharge.
22 Oral evidence February 15, 2011
23 Statement of Dr Carey : Exhibit I
24 Registered psychiatric nurse
25 Transcript 24

65. In evidence Dr Carey stated that she recalled that RPN Smith had told her that Ms Johnson's mental state was "pretty much the same as 2007". She was not psychotic, not delirious and not assessed as at risk of suicide.

66. RPN Smith, both when making her statement and later in evidence, had little recollection of the actual assessment. However, when the entry in the hospital notes was put to her, Ms Johnson was noted to be "physically unable to participate" in the assessment, RPN Smith stated that she had badly worded this and she meant that she was *unwilling* rather than *unable* to participate in the assessment. Under further examination, she did agree that the note was more likely to be accurate rather than her memory some years on.[26]

67. The question of whether or not Ms Johnson should have been involuntarily detained under the *Mental Health Act* was raised on the evidence and identified as an issue at the Directions Hearing. The questions raised by the evidence focused on whether or not, given Ms Johnson's physical and mental state and her impaired judgment or cognitive ability, this should have caused a decision to be made to detain her under the *Mental Health Act.*

68. Dr Carey explained that she did turn her mind to this issue and decided that she was faced with the requirements of balancing self determination, autonomy and the use of the powers for involuntary detention in the *Mental Health Act.* Given Ms Johnson was accepting of community treatment at the time of her medical discharge, she did not think it appropriate at that time to seek involuntary detention.[27]

69. Dr Carey stated that she also took into consideration that patients such as Ms Johnson can also deteriorate once under involuntary care and may well be traumatised by their experience which may involve sedation to insert tubes and physical restraints with Velcro strapping to stop patients from removing feeding tubes. Dr Carey also stated that such patients are difficult patients to nurse.

70. Dr Carey explained that given Ms Johnson had voluntarily sought treatment at the hospital she was hopeful that would mean that her community engagement would be workable. Dr Carey, when giving evidence, emphasised that whilst, with the benefit of hindsight, she may look at the decision differently not to involuntarily detain Ms Johnson, she made the best decision she could with the facts she had at the time and weighing up all of the competing considerations.

71. Dr Carey stated that she understood that years of malnourishment would have affected Ms Johnson's ability to think clearly and that her insight would be affected, but restoring her to good health would be a long term proposition, best attempted in a community setting.

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26 Transcript 251
27 Transcript 16

72. RPN Smith was asked, given she was aware that the discharge of Ms Johnson was imminent, whether or not she had taken into account the risk that Ms Johnson would continue not wanting to eat as an on-going manifestation of her eating disorder. RPN Smith stated that this "would possibly have been a consideration" and that is why a follow up appointment in 6 days was made for Ms Johnson.[28]

73. Dr Carey was very clear that her treatment plan was based on her understanding that Ms Johnson was medically stable enough to be discharged. Dr Carey explained that she gained her understanding of Ms Johnson's medical condition from RPN Smith. RPN Smith was unable to recall how she obtained that information.[29]

Independent Expert Opinions

74. An independent expert psychiatric opinion was sought as to the assessment and management response of Ms Johnson. Dr Kym Jenkins was the consultant psychiatrist offered by the Royal Australian and New Zealand College of Psychiatrists to perform this role in this case, on the basis of her specialisation in the area of women's health and eating disorders.

75. Dr Jenkins gave evidence that she had previously been in practice as a GP and had developed a special interest in women's health. In that context, she had treated many patients with eating disorders and thereby developed a special interest in the area. She estimated she had been working with eating disordered patients for about 25 years, both as a GP and as psychiatrist.[30]

76. Dr Jenkins has worked as a psychiatrist in the public health system looking after patients in hospital with very low body weights and needing re-feeding in a medical setting. Dr Jenkins noted that there were not many psychiatrists who treated people with eating disorders as a sub specialty, but she is one of them. She is a senior lecturer at Monash University and Deputy Chair of the Board of Education at the College of Psychiatrists.

77. Dr Jenkins was provided with all relevant material in possession of the Court and in return provided an opinion in a report dated June 15, 2009.[31] Unfortunately, it was only during the inquest that it became clear that there had been a separate psychiatric file at the hospital. This file had not been in the possession of the Court at the time Dr Jenkins was requested to provide her opinion. Dr Jenkins was provided with access to the file before giving evidence on the day she attended Court.

78. Dr Jenkins gave evidence that in her opinion the psychiatric assessment of Ms Johnson was far from comprehensive and not sufficiently tailored to someone who was as unwell as Ms Johnson and suffering from that level of severity of eating disorder. Dr Jenkins gave a number of examples of the sort of information that should have been obtained and recorded such as documentation of the patient's eating patterns, attitude towards food, use of substances, use of laxatives, vomiting and purging and attitude to body image. Dr Jenkins stated that Ms Johnson may not have given answers but it was still

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28 Transcript 253
29 Transcript 246
30 Transcript 345
31 Exhibit 14

necessary to try to get them. Indeed her commentary goes beyond this in that Dr Jenkins was indicating that the standard form of mental health assessment tool used was not useful for a patient with a severe eating disorder.

79. Dr Jenkins stated that in her view the key issue was the need to be aware and take into account the cognitive impairment Ms Johnson was likely to be suffering as a result of her history of alcohol abuse and her state of malnutrition and her very low BMI. It was Dr Jenkins' opinion that at such a low body weight Ms Johnson was extremely likely to have had her ability for abstract thought impaired and an inability to reason and have poor judgment. Dr Jenkins expressed "severe doubt" that during the period 29 April to 1 May 2008 that Ms Johnson could have had the capacity to make informed decisions about the management and treatment of either her medical or psychiatric condition. Dr Jenkins stated that inherent in the diagnosis of anorexia nervosa is a marked denial and lack of appreciation of the seriousness of one's condition.

80. Issue was taken with whether or not Ms Johnson's cognitive functioning would have been affected. Dr Jenkins stated that standard enquiries as to orientation in time and place as part of a mental state examination will not address the impact on the higher order cognitive functioning of the eating disordered patient. She stated most anorexia patients will be oriented in time and place and pass all of the usual questions.[32]

81. In essence, Dr Jenkins did not think Ms Johnson should have been discharged as her condition would have been such that she would have not been able to think rationally and that her judgment would have been poor. It was the view of Dr Jenkins that Ms Johnson could have been certified under the *Mental Health Act* or placed on a guardianship order.

82. Dr Jenkins also questioned what was known about Ms Johnson's home circumstances and support available to her especially given the knowledge of Mr Falconer's own mental health history and the issues of domestic violence in the relationship.

83. It was Dr Jenkins' view that Ms Johnson's body-mass index recorded at 12.1 was barely compatible with life. In Dr Jenkins' opinion in these circumstances it would have been essential for a consultant psychiatrist to review Ms Johnson and make a fully informed psychiatric assessment and that if it were not possible to transfer her to a psychiatric ward, then she should have been kept in a medical ward with increased psychiatric assistance. Despite accepting that patients with eating disorders are notoriously difficult for staff to manage in acute medical inpatient units, it was Dr Jenkins' view that Ms Johnson should have been involuntarily detained on the basis that her physical and medical and psychiatric presentation meant that at that time Ms Johnson did not have the capacity for self determination.

84. On the issue of involuntary detention, Dr Jenkins agreed that it was a very difficult decision to make and that the forced treatment on anorexic patients is an extremely difficult decision to make with many factors to weigh up. Anorexic patients do not want to be treated. That is the nature of the

32 Transcript 327

condition. Dr Jenkins painted a very graphic picture of how difficult and resource intensive it can be to treat patients with eating disorders at the severe end. However, she stated it was her view that she would rather save the life and deal with working through the patient's unhappiness with the intervention down the track. She stated that it was the actual condition that deprived the patient of the capacity to reason adequately for themselves.

85. In her view Ms Johnson's condition was such that she needed medically supervised re-feeding with specialist psychiatric support. She agreed that it was very challenging for medical staff because most patients wanted to get better and would co-operate with that process but eating disorder patients are refusing treatment as part of their condition and it is easy for resentment and frustration to build up without a good understanding of what is going on for the patient.

86. In the wake of the receipt of this opinion from Dr Jenkins, the legal representative on behalf of North East Health sought leave to have a further expert psychiatric witness obtained by them and then accepted into evidence at inquest. Leave was granted.

87. That witness was Professor Nicolas Keks, a psychiatrist holding a number of positions including Deputy Chairman of the Rehabilitation, Psychiatry and Pain Clinical Institute at the Epworth Hospital, Adjunct Professor of Psychiatry at Monash University and Head of the Psychotropic Drug Information Service at the Mental Health Research Institute of Victoria. Professor Keks provided a written report[33] and also gave oral evidence.[34]

88. Professor Keks stated that he was not an "anorexia psychiatrist" particularly, although he had been involved in clinical cases before. It was unclear how many cases and in what context and over what period of time.

89. Professor Keks was very sympathetic to the limitations of the rural regions and noted that whilst ideally Dr Carey should have seen Ms Johnson, it was important to understand the pressures on rural health services and the limited resources.

90. Professor Keks stated that in his opinion Ms Johnson was diligently and competently and appropriately and comprehensively assessed by Wangaratta Hospital by both medical and psychiatric staff and it would be "entirely inappropriate" to criticise their actions.

91. In his written report produced to the Court, Professor Keks stated that with the benefit of hindsight he too would have been inclined to have Ms Johnson involuntarily detained, even though he was very firm that should not lead to any implied criticism of Wangaratta Hospital medical or psychiatric staff. He did also state in his report that ideally, not only would Ms Johnson have been assessed by the consultant psychiatrist but also by the physician and they then would have spoken to each other.

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33 Exhibit 13
34 Pages 269 to 314 Transcript

92. Notwithstanding that he came to this view initially about involuntary detention, Professor Keks was initially adamant that one could not conclude that Ms Johnson would have been suffering from a cognitive impairment as a result of organic brain syndrome. He stated that once rehydrated and apparently able to hold a long conversation with Dr Brooks about treatment options, and assessed by RPN Smith as able to follow a conversation and contribute to it, he concluded that, contrary to the opinion of Dr Jenkins, Ms Johnson would not have been suffering from organic brain syndrome or significant cognitive impairment at the time of the second discharge such that she could be considered incompetent to make decisions.[35]

93. It was his view that the anorexia patient has cognitive distortions limited to body image but that most clinicians would not think of this as cognitive impairment and that patients with anorexia nervosa are usually quite competent in making all sorts of decisions about their life. He did agree though that true cognitive impairment can occur in anorexia at the extreme end, when it is coupled with hypoglycemia, electrolyte disturbances and other metabolic dysfunction and that there was "*some possibility that Ms Johnson was suffering from a degree of organic brain syndrome or delirium on the night of April 28 and May 1 2008.*"[36] He went on to re-state though that when Ms Johnson was assessed by RPN Smith on the morning of May 1 and Dr Brooks on the afternoon of May 1 2008 there was not evidence of "*cognitive dysfunction indicative of an organic brain syndrome.*" Professor Keks rejected Dr Jenkins' opinion that rational thought was not possible with extreme starvation, but he later stated that severe long term starvation definitely has some cognitive impact just like significant alcohol intake and he accepted that Ms Johnson had both pre-conditions.[37] He remained of the view, contrary to Dr Jenkins, that it was a simple assessment to see how significant any cognitive dysfunction was. In the end, I was left uncertain as to whether Professor Keks thought Ms Johnson, given she was in a state of extreme starvation and with impairment from alcohol abuse, had a cognitive impairment.

94. Professor Keks did not comment on her condition at the time of the first discharge.

95. So Professor Keks in his written report, whilst acknowledging the complexity of the decision making and the benefit of hindsight, he too, like Dr Jenkins would have directed involuntary detention for Ms Johnson but that his reasoning for doing so appeared to be to endeavour to persuade Ms Johnson over time to adopt more functional behaviour. He added that such a strategy would have no certainty of working.

96. However, in oral evidence, Professor Keks did not adopt this part of his statement, stating that he had thought much more about the case and discussed it with at least 20 other peers and had subsequently changed his view on the question of involuntary detention. He stated he wished his position to be recorded as not sure what he would have done in the same circumstances.[38] He stated that his position at the time of giving evidence was it would only be after he was able to conduct the psychiatric assessment of the patient that he could come to a conclusion about the course of action he would adopt.

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35 Ex 13 p 15
36 Exhibit 13 p 12
37 Transcript 300
38 Transcript p 269

97. Professor Keks' opinion was that an anorexia patient is not psychotic or delusional within the meaning of psychiatry. Therefore even though one might not agree with the choice being made by the patient, the patient is making rational decisions about themselves within their own distortion and therefore they should be allowed to hold those views and that traumatically force feeding whilst held against their will is a very difficult decision to make and might not result in long term survival anyway but may have an adverse impact on their therapeutic engagement. Professor Keks noted that there was a strong view amongst his colleagues that anorexia was untreatable by psychiatry.[39] Dr Jenkins rejected the view that anorexia was a personality disorder but rather stated it was an eating disorder and that was an illness, not a personality issue.

Involuntary detention and treatment options

98. It was raised with Dr Jenkins that involuntary detention under the *Mental Health Act* required there to be psychiatric treatment available for the patient. Dr Jenkins' view was that there was a continuum of treatment available. Dr Jenkins' view was that the first essential part of Ms Johnson's treatment required improving her physical condition before being able to do psychotherapy with her to improve the factors that may be contributing to her long term anorexia nervosa. She stated that one may consider very low doses of anti anxiety medication to assist in reducing her anxiety about eating and at times, anti psychotic medication with anti anxiolytic properties can be used to help patients reduce their anxiety about eating and/or to facilitate them becoming more tolerant of naso gastric feeding. She stated lots of emotional support around the patient would be needed during a re-feeding program. (I should note that Ms Johnson had been receiving re-hydration intravenously whilst in hospital and whilst she may have been stating she did not want to stay at the hospital on May 1, there is no evidence that she was pulling out the IV lines or refusing to have them inserted.)

99. On the issue of whether or not Ms Johnson was delusional, Dr Jenkins stated that the generally accepted view in 2011 is that eating disorder patients are not delusional in the psychiatric sense, but that such a conclusion did not alter her view that involuntary detention for life saving medical and psychiatric treatment was necessary in this case.

100. On the issue of "cognitive functioning" and "cognitive impairment", Dr Jenkins, after having perused the hospital psychiatric file and Professor Keks' report explained that the cognitive issues for anorexia nervosa are very different to testing for general cognitive functioning such as orientation in time and place. It is the higher functioning such as judgment which is being affected in a condition such as this. As Dr Jenkins stated, the patient lacks judgment and insight as to the seriousness of what is going on as a diagnostic criteria for the condition.

101. As to the final position of the hospital on Ms Johnson's discharge, Dr Elcock, the Director of Medical services provided a letter dated August 6, 2010. In that letter he confirmed that the hospital staff were well aware that Ms Johnson was suffering from significant medical complications associated with her anorexia, but that once she withdrew her consent to treatment, and was assessed as not in such

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a condition as to justify involuntary detention, then the staff felt bound to comply with Ms Johnson's request to refuse treatment. Dr Elcock does go on to concede that the possible effects of Ms Johnson's state of malnutrition on her mental functioning was not fully recognized when formulating her management plan.

The Management Plan on discharge (May 1, 2008):

102. It was the view of Dr Jenkins that the discharge management plan for the second discharge was both precipitous and poor, with an absence of adequate psychiatric and community care. It was her view that discharge back to the "community" into the care of an ex partner with no training and no liaison with him and the promise of a community psychiatric service in the following week was inappropriate.

103. In evidence Dr Jenkins expanded on this by explaining that the best outcome would have been to send Ms Johnson to an Eating Disorders Unit. In the absence of that she should have been kept alive in the hospital until an appropriate treatment plan could be made. Dr Jenkins stated that she would not have discharged Ms Johnson home to a house with no support and no carer and an appointment 6 days later. Dr Jenkins stated Ms Johnson needed at least daily visits at home assessing her physically and psychiatrically. She said : *"This is a woman who has not been eating or drinking, she has been in heart block, she's been hypothermic up to 24 hours before and she is discharged to look after herself because she says she will."*[40]

104. Dr Jenkins came to this view after considering that Ms Johnson had a BMI level below what was acceptable to the specialised eating disorders unit because this made her too medically unstable for the unit; she had a history of rapid weight loss in the preceding weeks, she was bradycardic, hypothermic and in first degree heart block 24 hours before discharge with a long term history of chronic anorexia, no one caring for her at home and a history of poor response to outpatient management and refusing to eat in hospital and stating she wanted to go home to get to her laxatives. Dr Jenkins firmly rejected the proposition that a stabilising of her electrolyte results and an increase in her temperature were the only appropriate considerations to measure the risk to this patient on discharge.

105. When asked what if any consideration was given to how Ms Johnson would manage over the next 6 days after discharge, RPN Smith stated that "*We weren't going to be sure that she wasn't going to eat.... she said she would eat her own food at home ....it was hoped that she'd be able to manage, I assume*" ..... According to RPN Smith, this was based on Ms Johnson's statement to them that she would take care of herself once discharged.[41] RPN Smith, despite having 29 years of experience as a psychiatric nurse stated that she had only case managed one or two patients with eating disorders and they had been much younger than Ms Johnson.

106. Professor Keks strongly disagreed with the conclusions of Dr Jenkins that Ms Johnson's discharge was precipitous and ill planned. Having reached the conclusion that Ms Johnson was able to make decisions for herself, in the clear knowledge that she was at risk of dying, it appeared to be the

40 Transcript 344
41 Transcript 253

view of Professor Keks that Ms Johnson discharged herself and thus the hospital should not be criticised for the poor planning attached to that decision made by Ms Johnson. It was his view that once the hospital decided not to use involuntary detention, the discharge plan was reasonable.

107. When asked was it reasonable, in circumstances where the patient insisted on discharge, to have a plan in which she was not to be seen for anther 6 days reasonable, Professor Keks answered: "Daily follow up .... to what end?".[42] He described Ms Johnson as *"desperately needing to be in hospital, that's so clear"* and agreed that was as a result of her medical state.

108. Professor Keks appeared to be vacillating between holding the view that anorexia was untreatable as it was a form of personality disorder to accepting that whilst there was no pharmacotherapy for it there might be value in supportive treatment in hospital and that was the value of certification, but always measured against the risk of long term trauma and the end to help seeking behaviour. However, his view about Ms Johnson was that the probability of being able to provide anything other than short term intervention was very low.

Conclusions as to discharge

109. As to the first discharge, neither Wangaratta Hospital staff, nor Dr Elcock attempted to defend the first discharge in the early hours of April 30. In my view, the circumstances surrounding that discharge pass neither the common sense nor the common humanity test.

110. As to the second discharge, neither senior doctors for each team examined Ms Johnson personally, nor discussed her case or discharge management plan with each other.

111. There is no coherent evidence that either the medical or mental health team turned their minds separately or together to whether or not Ms Johnson, a long term anorexia sufferer, refusing to eat in hospital, would survive 6 days if she continued her laxative abuse and food refusal, in the physical condition she was in when she left the hospital. Whilst one can see that hope and optimism might be good qualities for a mental health and medical team to have, hope is not a strategy in and of itself.

Response of the hospital since the death of Ms Johnson

112. Dr Elcock advised that in the wake of the death of Ms Johnson the hospital had conducted a review and introduced a number of changes as a result of the issues identified during that internal review of this case.

Structured communications

113. On the identified issue of the need to improve communications between medical and psychiatric consultants, a working group of both mental health staff and medical staff was initiated to develop a policy for the management of patients with eating disorders. A documented guide has been developed

[42] Transcript p 283-4

together with an education program focusing on significant medical problems associated with mental health disorders. Further, the hospital has reviewed its management of patients with severe eating disorders in order to ensure that the assessment of similar patients is competent and comprehensive and that a high level of communication occurs between medical and mental health teams involved in the management.

Improved understanding of eating disorders

114. On the identified issue of the need to improve the understanding generally amongst hospital personnel of the complexity of patients with eating disorders, a program has been introduced for general medical nursing staff highlighting the severity of physical disorders that can be associated with eating disorders and the cognitive implications of severe physical illness.

115. Dr Elcock advised that the education program is directed to the permanent nursing staff so that staff can support the decision-making of junior medical staff.

Assessing patients' mental health in a medical setting

116. Dr Elcock also advised that a nurse practitioner in mental health has been appointed whose primary focus is the improvement of the initial assessment and management of patients with mental health problems who are admitted through the Emergency Department.

117. The changes have also been directed at ensuring that the likely impairment of a patient's ability to make rational decisions about their treatment will be recognised by the practitioners involved in the care and that decisions about discharge from North-East Health Wangaratta are made at consultant level in these sorts of circumstances.

Conclusions

118. The evidence leads to the overwhelming conclusion that the treatment of patients with severe eating disorders is complex, demanding, resource intensive and a highly specialised area in psychiatry and medicine and related disciplines. All of these complexities are exacerbated by less access to specialised resources and services in rural regions.

119. As to the evidence of the differing views as between Professor Keks and Dr Jenkins, given Dr Jenkins had significantly more experience in and understanding of the treatment of patients with eating disorders, I have preferred the opinions of Dr Jenkins over those of Professor Keks where the two experts differ in their views. I am satisfied that given the state Ms Johnson was in as at May 1 2008, she should have been either detained under the *Mental Health Act* and treated medically until she could be transferred to the Austin Eating Disorders Unit or similar, or if she was to be discharged home, she needed medical and nursing support daily to supervise her and maximise her chances of survival from this disorder.

120. Counsel for the hospital submitted in essence that even though it was conceded that Ms Johnson died as a result of complications of anorexia, that given that the **precise** mechanism that caused Ms Johnson's death was not known, it is not possible to conclude that she would not have died anyway even if she had been kept in hospital. The proposition has little to offer this investigation. Given it has always been the position of the hospital that Ms Johnson did die as a result of the physical complications of her anorexia, the exact final mechanism seems to add little to this investigation and its findings.

121. On the issue of Ms Johnson insisting on discharge according to the hospital, and thus the requirement to discharge, it should be noted that the evidence was that Ms Johnson took herself to the hospital. When discharged on the first occasion she in fact did not leave but stayed overnight in the waiting room of the hospital. She was compliant with treatment all the way through her stay to the extent that she was not pulling out drip lines or getting out of bed and trying to leave, although she was clearly refusing to eat and repeating her wish to go home. Expert support at that stage may have been able to persuade her to stay without the need for involuntary detention. In any event, once an involuntary detention order was signed, the evidence supports a conclusion that with expert support, forced restraint may not have been required.

122. The changes made by the hospital in the wake of Ms Johnson's death and its review of the need for improvement in the area of care for patients with eating disorders obviate the need to make any further comment or recommendations in this sad case.

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

Mrs Diane Day, mother
Mr Douglas Falconer
Office of the Chief Psychiatrist
S/C Brendan Achammer, investigating member
Dr Kym Jenkins
Professor Nicholas Keks
Director of Medical Services, Northeast Health
Minter Ellison, Ms Lisa Ridd, Solicitors for Northeast Health
Dr Steven Cavini, treating general practitioner

Signature:

JUDGE JENNIFER COATE
STATE CORONER

Coroners Court of Victoria

Date: April 12, 2012