CITATION: *Inquest into the death of Clare Louise Harrison*

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0006/2015
DELIVERED ON:	10 July 2015
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HEARING DATE(s):	9 July 2015
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Care; treatment for "Anorexia Nervosa"; Mental Health detention**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
NT Dept. of Health	Greg Macdonald

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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No. A0006/2015

In the matter of an Inquest into the death of
CLARE LOUISE HARRISON
ON 26 JANUARY 2015
AT ALICE SPRINGS HOSPITAL, ALICE SPRINGS IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Clare Louise Harrison ("Ms Harrison") was a Caucasian female born on 10 August 1985 at Shepparton, in the State of Victoria, Australia. She was originally diagnosed with Anorexia Nervosa ("Anorexia") in approximately 2003 at just 17 years of age. Following that diagnosis she sought treatment from time to time in New South Wales, Queensland, Victoria, South Australia and the Northern Territory.

2. On 5 January 2015 Ms Harrison was found by her mother in a hypoglycaemic state in her bedroom. St John Ambulance ("SJA") was called and Ms Harrison was conveyed to the Alice Springs Hospital ("ASH") and admitted. Her condition fluctuated during the course of that admission, but on 25 January 2015 she deteriorated significantly and on 26 January 2015 a decision was made; in consultation with her family and her medical and mental health teams, that active treatment would be futile and was therefore withdrawn. On that day, at approximately 6.20pm, Ms Harrison passed away with her family present.

3. This death was reportable to me because at the time of her death, Ms Harrison was an involuntary patient at the Alice Springs Hospital. As a

result she was a "person held in care" pursuant to the definition contained in s12 of the *Coroners Act* ("the Act") which includes:

> "A patient who, pursuant to the *Mental Health and Related Services Act* is in custody whether in a hospital or temporarily removed from a hospital"

Therefore, pursuant to s15(1) of the Act, this inquest is mandatory.

4. Pursuant to s34 of the Act, I am required to make the following findings if possible:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*.

(v) Any relevant circumstances concerning the death"

5. Section 34(2) of the Act operates to extend my function such that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

"(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.

(2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the

administration of justice connected with a death or disaster investigated by the Coroner.

(3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

6. This inquest was held on 9 July 2015. Ms Jodi Truman appeared as Counsel assisting and Mr Greg Macdonald appeared for the Northern Territory Department of Health. A total of four (4) witnesses were called to give evidence at this inquest, namely; Detective Senior Constable Barrie Bahnert, Mrs Margaret Harrison, Dr Elna Ellis and Dr Christopher Turnbull. I note that in addition to her mother being present, Ms Harrison's younger sister Mrs Emma Davis, with baby, was at court and so too was her grandfather Mr Bill Slee. I thank those family members for attending and for the respect that they showed. Their presence was very important to the coronial process.

7. A brief of evidence containing various statements, together with numerous other reports, police documentation and medical records were tendered at the inquest. Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Senior Constable Barrie Bahnert for his investigation.

Background

8. I had tendered before me detailed information in relation to Ms Harrison's history and I consider it important to set that out in detail to provide a context for the decisions that were made in relation to her treatment during the course of her final admission.

9. Clare Louise Harrison was the second child of Margaret Ann Harrison and Henry Vincent John Harrison. She had an elder brother Paul and a younger sister Emma. Following her birth, Ms Harrison lived with her family in Mooroopna, Victoria, until she was approximately 8 years of age. Her family then moved to Bega, NSW where she attended high school until leaving early in year 11. It was during her time in Bega that her family first noticed Ms Harrison having issues with her body image.

10. Ms Harrison was first diagnosed with depression when she was approximately 16 years of age; however her mother strongly believed that even then Ms Harrison was developing the early stages of Anorexia. There were no services for people living with Anorexia in Bega and so attempts were made to seek assistance in Melbourne and Bendigo. These were unsuccessful and eventually Ms Harrison returned to live with her parents in Bega. When she was approximately 19 years of age she moved to Canberra. She obtained employment and commenced a relationship; moving in with her partner. She accessed some psychiatric assistance but it was periodic and she failed to connect in any real way with any medical professional in Canberra.

11. After some time Ms Harrison and her partner moved to Brisbane, Qld and she commenced employment as a personal assistant. Unfortunately her Anorexia worsened. She complained to her mother that she was getting "tingling" in her feet and her mother persuaded her to seek medical assistance. Ms Harrison attended at the Princess Alexandra Hospital in Brisbane and was involuntarily admitted on 6 April 2009. Ms Harrison was diagnosed as suffering ongoing hypoglycaemia and electrocardiogram ("ECG") abnormalities. Her body mass index ("BMI") at the time was 13.9 and she weighed just 43kgs. I received evidence that a healthy BMI for an adult female is between 19 and 25.

12. Ms Harrison was in hospital for approximately 8 weeks and was eventually discharged on 1 June 2009 on a "community involuntary treatment order". This appears to be the equivalent of a community management order under the Northern Territory *Mental Health and Related Services Act* ("MHRSA").

13. It is apparent from the statement of Mrs Margaret Harrison that this involuntary admission in Brisbane caused her daughter significant distress primarily because she was forced to undergo nasogastric ("NGT") feeding. This is where a tube is inserted into the stomach via the nose to provide food. Mrs Harrison stated that her daughter hated such treatment and would often pull the tubing out through her nose causing her physical pain and injury. It was however the treatment that was finally able to get Ms Harrison's weight to a stage where she could be discharged. Ms Harrison left the hospital with a BMI of 16 and weighing 49.6kgs. Unfortunately however such forceful treatment made Ms Harrison extremely reluctant to seek medical assistance and very mistrusting of any admission to hospital. This reluctance and mistrust lasted throughout the years for Ms Harrison.

14. Following her discharge, Ms Harrison and her partner moved to Townsville, Qld. Her illness however continued to plague her and there were problems with the transfer of her community involuntary treatment plan from Brisbane to Townsville. It took a number of weeks for her case to be transferred properly but by that time her Anorexia had a very strong hold and she was very unwell. Her mother recalled in her statement that Ms Harrison even attempted to "*hide*" from the mental health workers at that time so as to avoid treatment.

15. In approximately October 2009, Ms Harrison moved to Alice Springs to live with her parents. She obtained employment and also connected with the Central Australian Aboriginal Congress ("Congress") Medical Clinic where her mother was then employed. Things initially progressed reasonably well, but in about February 2010 Ms Harrison's illness worsened again. Mrs

Harrison spoke with the Congress Medical Clinic and because a decision was made by the doctors to apply under s.34(3)(a) of the MHRSA for an involuntary admission for psychiatric examination. At that time Ms Harrison had a BMI of 11.8 and her weight was 36.5kgs.

16. This was again a very distressing experience for Ms Harrison, particularly when police and an ambulance attended to take her to the hospital. Eventually Mrs Harrison drove her and she was admitted on an involuntary basis. Mrs Harrison stated that in retrospect she believed the decision to proceed on an involuntary basis was counter-productive as it resulted in her daughter "*fighting*" the medical staff at the ASH "*the whole way*" and putting up barriers that she never withdrew. This impacted on Ms Harrison's future contact with the ASH.

17. Ms Harrison was involuntarily admitted from 26 February until 12 March 2010. During that time however her illness further deteriorated and she was transferred to the Flinders Medical Centre in Adelaide, SA. Initially she was admitted into the Intensive Care Unit ("ICU") where she was diagnosed as suffering from encephalopathy (impaired brain function) due to malnutrition. The plan was to get her well enough to then have her admitted into their eating disorders unit. However by the time Clare was well enough to be transferred, she was also well enough to be a voluntary patient. When asked if she wished to be admitted to the eating disorders unit, she stated she wished to go home and because she was now a voluntary patient, she was permitted to leave.

18. Ms Harrison returned to Alice Springs but lost even further weight. Again she was unwilling to be admitted to hospital so a warrant for her detention was issued by the Mental Health Tribunal to bring her to hospital for a mental health assessment. On 7 April 2010 she was taken by the police to the ASH where she was once again admitted on an involuntary basis under the MHRSA. At that time she had a BMI of 10.97 and a weight of 34kgs.

She was given oral re-feeding and one on one nursing observation. In spite of this, Ms Harrison in fact lost weight by the time of her discharge on 20 April 2010 and weighed just 33.75kgs.

19. On 2 June 2010 Ms Harrison and her mother again attended at the Flinders Medical Centre in Adelaide. On this occasion Ms Harrison agreed to be admitted to the eating disorders unit. She was however extremely unwell and was initially treated in the ICU for hypotension, bradycardia and hypothermia. She was deemed not suitable for total parenteral nutrition, or TPN, which is used where patients cannot or should not get their nutrition through eating and instead receive a combination of sugar, carbohydrates, proteins, lipids and electrolytes via a needle or catheter. As a result Ms Harrison agreed to undertake oral feeding in a general ward but soon after she requested to be discharged and was permitted to leave just two days later on 4 June 2010.

20. Upon returning to Alice Springs her Anorexia worsened. Her mother was so concerned that she approached the ASH about a potential admission, but was initially advised that because it was just before the Queen's Birthday long weekend they were concerned about whether they were able to provide for Ms Harrison's complex needs particularly with the Finke Desert Race also being run. Mrs Harrison complained about that response and was subsequently told that her daughter could be admitted if she required.

21. By Sunday 13 June 2010 Mrs Harrison was extremely concerned and she and her husband decided to try and get Ms Harrison admitted to the Royal Melbourne Hospital in Victoria where they had heard there was a good clinic that may have been able to treat Ms Harrison's Anorexia. There were no flights available however and Mrs Harrison was also scared that her daughter was not physically capable of flying. As a result she and her husband put Ms Harrison in the car and arranged to meet their other daughter Emma in Adelaide and continue driving together to Melbourne.

22. During that drive, Ms Harrison's condition deteriorated significantly at about Two Wells, approximately 40kms from Adelaide. A decision was made to drive on and at their motel, located just near the Royal Adelaide Hospital ("RAH"); they called 000 for an ambulance. As a result, on 14 June 2010 Ms Harrison was admitted to the RAH for hypoglycaemia. Her condition was very serious and she had suffered a seizure. The family were told by medical staff that it was unlikely that Ms Harrison would survive. After intensive treatment however she did improve and after one week she was admitted to a general ward. Unfortunately her condition again deteriorated and she suffered a number of strokes. Ms Harrison was also diagnosed with meningitis, pneumonia and a staphylococcus aureus (or staph) infection. Her immune system was breaking down and she was transferred to the ICU. Her family were again told Ms Harrison was unlikely to survive, but she rallied once more and on 1 September 2010 she was discharged into the care of her mother. On discharge she had a BMI of 12.1 and weighed 37.7kgs.

23. It is clear from the evidence that Ms Harrison's Anorexia was taking an enormous toll on not just her body, but also her mental and emotional health. After that admission, Ms Harrison "*vowed*" to "*never go near another medical service again*" and for over four years, she was true to her word. Because of her level of distress from those involuntary admissions her mother also agreed to allow Ms Harrison to make her own decisions as to how she dealt with her illness. From that time, it appears that things went reasonably well and Ms Harrison was living with her Anorexia. She did however continue to exercise at significant levels; walking extremely long distances (sometimes up to 34kms per day). She was known as a regular at the Todd Tavern; walking there each day at about 4.00pm and having a drink and was also known around town as "*the lady who walks*".

24. In April 2014 Mrs Harrison went on an overseas holiday but when she returned she noted her daughter's Anorexia had worsened. By then Ms

Harrison was only eating every second or third evening and she then began to eat in her room rather than with the family. Her condition further deteriorated in about late November/early December 2014 when Ms Harrison developed Plantar Fasciitis. This is caused by a strain of the plantar fascia ligament that connects the heel bone to the toes. It can cause significant pain in the foot and it was this pain that resulted in Ms Harrison being unable to walk as much as she wanted. Consequently Ms Harrison also further reduced her eating.

25. By the time she was able to start walking again; Ms Harrison's calorie intake had gotten so low her immune system had very little resistance and she developed a cold with a significant cough. On the evening of 25 December 2014, Mrs Harrison told her daughter that she was concerned that she may have pneumonia again and asked her to seek some medical assistance. As an indicator of just how ill she was, Ms Harrison actually agreed to attend at the afterhours clinic operated by Congress at the ASH. Ms Harrison was seen by a doctor there but nothing unusual was detected in her lungs. She was provided with some antibiotics and allowed to leave. Mrs Harrison stated that her daughter took all her antibiotics but did not appear to improve.

26. On 2 January 2015 Ms Harrison again agreed to attend an appointment at the Central Clinic and saw Dr Wendy Zerk who recorded the following amongst her notes:

> "*Clare was initially quite hostile, stating that she did not want to be here.*
> *She was also quite clear in her desire not to eat and not to be sent to ASH. Threatened self harm if she was sent to ED.*
> *Says she's simply not well because of a recent viral illness. Coughing a bit.*
> *In complete denial about her eating disorder or any other mental health*

issue, e.g. depression.
Insists that she's fat.
Declined to be weighed today."

27. Dr Zerk noted that she spoke frankly with Ms Harrison and her mother about her condition and the fact that Ms Harrison "*could die from this condition*". There was also discussion about Ms Harrison being involuntarily admitted if she was no longer competent to make decisions. Ms Harrison refused a referral to mental health services but agreed for blood tests to be taken. At that time Dr Zerk considered Ms Harrison still had capacity and she was therefore allowed to leave.

28. On Sunday 4 January 2015 at approximately 8.30am Ms Harrison was found by her mother to be unresponsive in her room. Mrs Harrison thought her daughter had in fact passed away and she rang 000 for an ambulance. During that call she was able to rouse her daughter a little and the ambulance arrived and took Ms Harrison to the emergency department ("ED") at ASH. Ms Harrison's medical records reveal that upon her admission she was found to have bilateral pneumonia and was hypoglycaemic. Despite the seriousness of her condition, Ms Harrison did not wish to be admitted and was upset at her mother for "*reviving*" her. The notes record discussions held between Ms Harrison and medical and mental health professionals. ED Staff Specialist, Dr Tan, relevantly recorded as follows:

"I have also confirmed that Clare is
NOT FOR RESUSCITATION IF ARRESTS
NOT FOR CPR
NOT FOR INTUBATION IF ARRESTS.
I have evaluated her capacity to understand and she appears rational, explains her reasons for refusal, can explain her current situation and

what would happen if she does not have treatment.
I believe she is competent to refuse care"

29. Ms Harrison was also assessed by the on-call psychiatrist, Dr Megan Chambers who noted as follows:

> "*She was able to talk about her thoughts about dying. She did not wish to actively kill herself and has been OK with living on: but is tired of the struggle. …*
>
> And:
>
> "*She denied overt suicidality.*
> *She expressed the importance to her of having control over what happens to her and of having control over what treatment happens.*
> *Impression: Clare is not showing signs of her thinking about her current physical illness being distorted by mental health concerns.*"

30. After the various assessments, a compromise was reached with Ms Harrison that she would be permitted to return home with her mother on condition that she return the next day for review, that she took antibiotics and glucose gel with her, and that her mother was permitted to call an ambulance if she needed help. Ms Harrison agreed and was discharged. During the evening Ms Harrison became hypoglycaemic again and her mother "forced" the glucose gel into her. The next morning an ambulance was called to assist her in getting to hospital and upon her arrival Ms Harrison was admitted.

Final admission commencing 5 January 2015

31. The ASH records note that upon her admission Ms Harrison was suffering "*severe anorexia – BMI 9.36*". The records further note that she was "*very high risk of refeeding*". This is a reference to a syndrome where too rapid an increase in nutritional intake results in metabolic disturbances in the body and can be fatal. Ms Harrison was seen by ICU specialist, Dr Raj

Gould who noted that she was "*of sound decision making capacity*" and was "*refusing to be transferred to ICU or HDU or medical wards/refusing PICC lines/CVC and wants to go home tomorrow*". Dr Gould, noted:

> "*I feel that it would be in her best interest to continue current management in ED. Given her extreme malnourished state she is not a candidate for aggressive ICU therapies like intubation/mechanical ventilation including NIV/high dose vasoactive meds/dialysis. If she worsens to a state needing these therapies instituting these is not going to change her outcome and would be harmful*".

32. A later note from Dr Gould that day recorded:

> "*She does not want aggressive therapies like CPR, mechanical ventilation, etc. in case of deterioration. In such instances she would prefer to die.*
> *Given her premorbid state aggressive therapies are going to be futile and is likely to result in more adverse consequences than benefits.*
> *She would be managed in ED and is not for ICU/HDU*".

33. Dr Chris Turnbull was the psychiatrist on duty that day and gave evidence before me. He had not been previously involved in the treatment of Ms Harrison. He stated that when he saw her on 5 January 2015 she "*presented as insightful into the nature of her situation*" and he formed the opinion that she had capacity to make most medical decisions. He deemed her refusal for intubation and CPR to be "*competent*", but considered her decision making for some treatments was "*influenced*" by her fear of weight gain and therefore her mental state "*impaired*" some of her decision making, but not to the extent that she reached the criteria for an involuntary admission. Following further discussions with her, Ms Harrison agreed to accept lifesaving treatment and a plan was reached to treat her in the ED on a voluntary basis.

34. Dr Turnbull gave evidence that he discussed Ms Harrison's case with a psychiatrist at Flinders Hospital Eating Disorder Unit. In his report tendered into evidence (exhibit 6) he noted that he received advice that:

> "*… assertive compulsory treatment for weight gain would be unhelpful and likely unsuccessful and that allowing discharge when medically stable would be appropriate given family support, but that if Ms Harrison's fear of weight gain (due to her Anorexia) were to interfere with her treatment it would be appropriate to treat her as being of 'diminished capacity'*"

35. Over the following days, Ms Harrison did substantially accept the proposed medical treatment however her oral intake was still extremely limited. Discussions were held between the medical staff, mental health staff, allied health staff, dieticians and Ms Harrison's family about possible forced NGT feeding and involuntary admission under the MHRSA. In fact it appears on the evidence that discussions about Ms Harrison's treatment were held every day and a strong collaborative approach was taken. At that time however it was agreed that a "*forced*" approach was likely to be "*counter-productive*". Dr Turnbull also sought advice and assistance from the Royal Melbourne Hospital Eating Disorders Unit and a plan was agreed to continue treatment in the short term at ASH.

36. Unfortunately, whilst Ms Harrison did in fact increase her oral intake each day she still did not meet clinical recommendations and on 13 January 2015 she "*became severely medically unwell*". Dr Turnbull set out within his report that during this time he noted that Ms Harrison's refusal of treatment would only occur when NGT feeding or eating were discussed. As a result he considered that her eating disorder was now interfering with her medical treatment. During his evidence he highlighted Ms Harrison's low oxygen and blood sugar levels and the impact this had on what he referred to as impairment of "*executive function*" and therefore her decision making

capacity. As a result Dr Turnbull stated he considered Ms Harrison "*met the criteria for involuntary treatment*" and accordingly he made her an involuntary patient under s.42(1) of the MHRSA.

37. At this time review was also undertaken by ICU specialists and again a decision was made that Ms Harrison was not to be transferred to the ICU and that she was in fact "*at end stage*" with "*no role for ICU level interventions*". This was discussed both with her medical and mental health teams.

38. On 14 January 2015 a peripherally inserted central venous catheter (or PICC) line was inserted which Ms Harrison agreed to after being told it would not be used for TPN. The records note that at this time Ms Harrison was suffering ongoing chest consolidation, liver dysfunction, thrombocytopaenia (reduced platelet count) and a pericardial effusion (fluid accumulating around the heart).

39. On 16 January 2015 Ms Harrison's involuntary status was reviewed by the Mental Health Review Tribunal and upheld. The order approved NGT feeding "*if necessary*". Dr Turnbull provided evidence that discussions were held regarding the insertion of NGT but this was "*deferred*" several times because of risks associated with its placement. In his evidence he stated that the decision about whether to commence NGT feeding was "*very difficult*" and he had "*many discussions*" with "*many people*" about its use and highlighted the following as the significant reasons against its use:

    1) "*Firstly, Clare was vehemently opposed to it*". He noted that he had seen it used previously where a patient was opposed in circumstances like Ms Harrison and "*it is horrible*". Dr Turnbull stated that he was concerned that if NGT was used when Ms Harrison was so opposed then it "*would have significantly disrupted whatever little rapport we were achieving with Clare, particularly if we were ever going to be able to engage with her long term and I did not want to do that*".

2) "*It was also potentially dangerous*". Within his statement Dr Turnbull highlighted the medical risks of NGT feeding in circumstances where it would have been resisted by Ms Harrison and therefore likely to have required her physical restraint. This risked further physical injury to Ms Harrison either from the restraining itself or by her removing the nasogastric tubing as she had done in the past. The tubing itself would also have resulted in impairment of her cough and further reduced her ability to clear any secretions from her throat. Dr Turnbull also identified that it would have made provision of adequate oxygen difficult as Ms Harrison was using nasal prongs which would not have been able to continue at the same time as NGT. He also highlighted that there were also recognised risks of accidental insertion of the NGT into the lungs which would have had "*potentially serious consequences given Ms Harrison's frail physical state*".

3) "*Clare also knew to a large degree what was going on and therefore the possibility of NGT provided her encouragement to increase her own oral nutrition*". Dr Turnbull highlighted that on a long term basis Ms Harrison taking control of increasing her oral intake was more beneficial to the ultimate treatment of her anorexia.

40. Despite some recorded improvement after the involuntary treatment order was made; on 25 January 2015 Ms Harrison developed respiratory distress and a fall in oxygen levels. Her treating physician, namely Consultant Endocrinologist and General Physician Dr Elna Ellis stated that chest x-rays revealed "*worsening bilateral pneumonia*". Her antibiotics and oxygen were increased but Ms Harrison continued to deteriorate. A meeting then took place between family, ICU, dieticians and the medical and mental health teams and a decision was made on 26 January 2015 to withdraw active treatment as it was determined to be futile. Ms Harrison subsequently passed away with her parents both present at 6.20pm on 26 January 2015.

Cause of death

41. Given the circumstances of Ms Harrison's background, her lengthy medical history and treatment for Anorexia Nervosa and the circumstances of her death, I deemed that an autopsy was not required if her family were in agreement and there was no dispute as to her cause of death. This was agreed.

42. As a result Dr Elna Ellis certified the cause of death and during her evidence before me she stated that it was her opinion that Ms Harrison's cause of death was multi-lobe community acquired pneumonia and respiratory failure. She also stated that other significant conditions that contributed to Ms Harrison's death, but did not cause it, were severe malnutrition, Anorexia Nervosa and multi-organ dysfunction. I accept these findings.

Comments and Conclusion

Care provided at the Alice Springs Hospital

43. As I indicated during the course of the evidence, after hearing all that Ms Harrison had gone through over the 13 years that she had been living with Anorexia Nervosa, I was extremely surprised she had been able to survive for so long; I have no doubt that, together with medical support, this was due to the great level of care, love and attention bestowed on her by her family. She had experienced numerous episodes of involuntary treatment in her life time and it is clear that these episodes were extremely distressing to her, had taken an enormous toll upon her and were something that she desperately wished to avoid. I also note the evidence contained in the statement of Dr Turnbull as to the significant mortality rate identified in long term follow up studies of Anorexia Nervosa patients where "*approximately 10%* (of sufferers) *will die*".

44. It was in this context that I considered the care and treatment provided to Ms Harrison during her final admission to the ASH. In this regard, I

consider it important to indicate that I was extremely impressed by the evidence given by both Dr Elna Ellis and Dr Chris Turnbull. It is clear that Ms Harrison's treatment was placed in extremely good hands with these professionals involved in her care. It was obvious to me that both doctors were greatly concerned for Ms Harrison and took great care in their decision making as to the appropriate treatment for her and were very respectful of both Ms Harrison but also her family. During the course of her oral evidence, Mrs Margaret Harrison highlighted in particular the care and treatment provided by Dr Turnbull and stated as follows:

> "*I wish I'd known Dr Chris Turnbull was there earlier because I think it would have made a big difference. He was the first to value Clare's opinion and she trusted him*".

45. Mrs Harrison also set out the following relevant evidence in her statement as to the treatment her daughter received in the lead up to, and during, that final admission. As to St John Ambulance:

> "*... they were absolutely marvellous and you know brought her back and that and she went to hospital ...*"

46. As to staff in ED at ASH:

> "*... oh look I can't speak highly, more highly of the staff in emergency, they were great, they actually showed dignity and respect to Clare, I think they had actually read her notes and knew what battles they'd had in the past and so they'd learnt from that so they consulted, they were agreeable ...*"

47. As to the treatment provided generally at ASH:

> "*... look once again I think the whole hospital staff treated Clare really well this time with dignity and respect and had a better understanding of the eating disorder and consulted the whole time with her ...*"

And:

> "*So I feel very comfortable that we did what Clare wanted and she was able to die with dignity … and not be fighting the system*".

Further:

> "*I think she was treated really well and with dignity and respect and her, they consulted with her continually ah all the time I can't fault really …*".

Finally:

> "*… the nursing staff were fabulous, the medical team were fabulous, the ICU team fabulous, the downstairs were great, I can't fault them this time and I think um Clare really had, if you can say a sort of a nice few days before she passed away with some of the nurses, there was this um Irish nurse that she was really connected with Clare and you know there was, it was respectful I think if you can that, there was … so I can't fault the medical team …*".

48. It is clear from the evidence that all levels of care at the ASH were consulted with, and considered, during the course of Ms Harrison's final admission. There was a multidisciplinary approach taken in relation to Ms Harrison's treatment. It was coordinated and collaborative. Dr Turnbull also made contact with interstate experts to assess whether anything further could, or should, be done to treat Ms Harrison.

49. After considering the evidence carefully, I am of the opinion that the care and treatment provided to Ms Harrison prior to her death was not just appropriate, but it was to a high standard. I make no criticism of the care given both in terms of her psychiatric care and her medical care. I do not consider anything occurred during Ms Harrison's period of admission that

contributed to her death and I do not consider anything more could have been done by the professionals responsible for her care.

Further matters raised on behalf of the family

50. The family of Ms Harrison provided to me a list of "questions and thoughts" that they had as a family (exhibit 4). I considered this material carefully during the course of the evidence and I am aware that their main concern was that they did not wish for Ms Harrison's death to be in vain. I note that both Dr Ellis and Dr Turnbull also provided evidence to me in an attempt to address some of these concerns and I took this into account during the course of my deliberations. I will now attempt to address each concern raised by the family:

1) More power to the medical profession without the need for "orders"

a) It is clear that involuntary treatment orders caused a great deal of anger and resentment to Ms Harrison and made her feel as if she had lost all control. This is something that her family considered had a massive impact upon Ms Harrison's attitude to seeking treatment because she was always "*in fear*" that if she did, she would then be subject to an involuntary treatment order.

b) Whilst I can understand and sympathise with the concern raised by the family in this regard and accept there was clearly a negative impact upon Ms Harrison, I was impressed by the evidence of Dr Turnbull when he stated that he was "*just a doctor*" and he was "*not sure that I should have that sort of power*". Dr Turnbull highlighted that orders ensured that there were "*appropriate guidelines and monitoring in place*" to protect those persons made subject to them and "*I am not sure that I would want to be able to force a patient to have treatment without an order*".

c) I agree with the view expressed by Dr Turnbull as to the importance of such orders to ensure that proper steps and monitoring occurs in relation to the care and treatment of an individual who is no longer able to make decisions concerning their treatment. I therefore do not propose to recommend any changes in this regard.

2) A lack of continuity between the States and Territories

a) In this regard the family highlighted the different approaches to treatment and orders between a number of States and the Northern Territory. As I stated during the course of the evidence this is one of the problems of the federal system and is an issue that arises in many different areas, including domestic violence and children in need of care to name just two. Change takes a coordinated approach and normally the agreement of States and Territories to "hand over" powers to the Commonwealth. This is not always welcomed, nor appropriate. Whilst I understand the family's concern I comment that relevant federal and territory government agencies should reflect on the facts of this death with a view to better communication of medical information.

b) I do note however that during the course of Ms Harrison's final admission, Dr Turnbull stated that he found it difficult "*to identify the best legislative pathway*" in relation to the possible involuntary treatment of Ms Harrison. It is clear that this did not ultimately have a significant impact upon Ms Harrison's treatment as she was in fact involuntarily admitted on the basis of a "mental disturbance" rather than a "mental illness", but it is clear there is a need for a clearer understanding of the appropriate legislative approach.

c) This is particularly so in these circumstances where Ms Harrison had previously been involuntarily admitted under the "mental illness" criteria with her Anorexia identified as the mental illness.

Dr Turnbull gave evidence that on this occasion however, when he discussed the appropriate approach to be taken in relation to Ms Harrison, he received advice from a senior psychiatrist that it was likely that Anorexia would only be held by the Mental Health Review Tribunal to be a "mental disturbance" under the MHRSA.

d) I note the evidence tendered before me contained in an affidavit of Dr Dinesh Arya that assistance has recently been sought from the Minister for Health to provide greater clarification on these issues and I encourage the Department and Minister to keep working on this issue to assist those, like Dr Turnbull, who are on the "front line" to make the best and most appropriate decisions in relation to the care and treatment to be afforded to their patients.

3) <u>Lack of consideration of a patient's cognitive ability</u>

a) Mrs Harrison gave evidence that in her experience of Clare's treatment a general approach was taken that "*low BMI indicated low cognitive ability*". She did note however that a very different approach was taken in Ms Harrison's final admission and she considered that this had may have made a significant difference, and potentially have changed the outcome for Clare, had such an approach been taken earlier.

b) In relation to this concern Dr Turnbull agreed that "*it is important that we not look at all patients in the same way*". He stated that there was data however to support the conclusion that a certain BMI level did impact upon a person's cognitive ability. He stated however that there had been research that he had seen recently to suggest that this may not be so for everyone, but it was not yet clear. Dr Turnbull stated that it was his opinion that "*capacity should be assessed on an individualised basis*" and this is what he did for Ms Harrison.

c) After hearing all of the evidence I am confident that this is the type of approach that is the more likely one to be taken now in relation to persons living with Anorexia than it was several years ago and I therefore do not consider it necessary to make any particular recommendations in this regard.

4) More support for families

a) As I commented during the course of the evidence, Ms Harrison's capacity to have lived with her diagnosis of Anorexia for so long was in part a testament to the level of support provided to her by her family. It is also clear on the materials that persons diagnosed with Anorexia appear to have stronger prospects of recovery when they are able to receive the continued support of their family. I therefore agree with Mrs Harrison that an approach that involves family in the decisions to be made as to treatment and provides them with support is important. However I am also confident that this type of approach is the more likely one to be taken now and I therefore do not consider it necessary to make any particular recommendations in this regard.

b) I also note that there is no doubt that Ms Harrison's Anorexia had not just a significant impact upon her, but also upon her family. As I stated at the conclusion of the evidence; in circumstances where a person passes away after having spent such a lengthy period in hospital it is important that those family members who have been with them during that period are offered counselling and support following their death. I do hope that these findings provide a reminder to medical professionals of the importance of providing support to such families following the death of a loved one.

5) <u>That Anorexia Nervosa be recognised as a mental illness</u>

a) I received evidence that although Anorexia is recognised under the American Psychiatric Association Diagnostic and Statistical Manual, Volume V ("DSM V") as a "mental illness", the opinion provided to Dr Turnbull was that it was unlikely that the Mental Health Review Tribunal would find that Anorexia met the criteria of "mental illness" as specifically defined under the MHRSA.

b) Dr Turnbull gave evidence that the MHRSA provided that in order to fall with the definition of a "mental illness" there was required to be the presence of at least one of a number of symptoms, one of which was "delusions". Dr Turnbull set out within his statement that although a person diagnosed with Anorexia would have a "*disturbance in the way that they experienced their own body weight or shape*"; it was not ordinarily a "delusion" as that symptom is ordinarily understood. As such there was arguably an anomaly between Anorexia that was defined as a "mental illness" under the DSM V and Anorexia as a "mental illness" under the MHRSA.

c) It is fortunate that this potential anomaly did not cause any difficulties or delays in the ability of Dr Turnbull to have Ms Harrison treated on an involuntary basis. Instead the application was able to be made on the basis that Ms Harrison had a mental disturbance. Although this had no impact upon Ms Harrison, there is a difference in how long a person can be held on an involuntary basis when admitted because of a "mental illness" (not longer than 3 months) or "mental disturbance" (not longer than 14 days). This could have therefore had an impact upon Ms Harrison's longer term treatment for Anorexia had she survived.

d) It appears on the evidence however that this is an issue that has been clearly identified as one that needs to be clarified in order to assist those working under the provisions of the MHRSA. Given this issue had no causal link to Ms Harrison's death; I do not intend to make a recommendation about any legislative changes. I do however encourage the Department of Health and its Minister to consider carefully and promptly whether legislative change is necessary in order to clarify this issue and therefore assist those attempting to work within the mental health system.

Finally

51. It is clear that Anorexia is a complex mental illness. I received evidence that it more commonly occurs in women, than men, with an onset usually in teenage or young adult years and is often a chronic illness. I note the significant mortality rate earlier referred to in these findings which makes it clear that Anorexia is a serious illness and one that deserves proper attention by government due to the significant burden it places on the medical and mental health systems.

52. Providing the necessary funding however is obviously a difficult issue and one that I simply do not have sufficient information about in the context of this inquest in order to make recommendations. I note there is no specialist eating disorders unit in the Northern Territory, however there does not appear on the evidence to be a specific need for one to be established given what appears to be the relatively low numbers of patients being treated for Anorexia in the Northern Territory.

53. I do note however the evidence of Dr Turnbull that additional expert assistance in relation to the provision of services for those that have Anorexia in Alice Springs was something most welcomed by him. I note this evidence was given in response to Mrs Harrison's evidence as to arrangements she had made through fundraising following her daughter's

death to have "The Butterfly Foundation" visit Alice Springs later this year. I too was very impressed with Mrs Harrison's efforts in this regard and given Dr Turnbull's response, I encourage the Department of Health to consider attempting to further engage with services like "The Butterfly Foundation" to look at ways of improving the current provision of services to persons diagnosed as having an eating disorder in the Northern Territory.

Formal Findings

54. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings:

i. The identity of the deceased person was Clare Louise Harrison who was born on 10 August 1985 in Shepparton, in the State of Victoria.

ii. The time and place of her death was 6.20pm on 26 January 2015 at the Alice Springs Hospital.

iii. The cause of death was multi-lobe community acquired pneumonia and respiratory failure.

iv. Particulars required to register the death:

a. The deceased's name was Clare Louise Harrison.

b. The deceased was not of Australian Aboriginal or Torres Strait Islander descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by Dr Elna Ellis, Consultant Endocrinologist and General Physician on 26 January 2015.

e. The deceased's mother is Margaret Ann Harrison and her father is Henry Vincent John Harrison.

f. The deceased was unemployed at the time of her death.

Recommendations

55. I have no recommendations arising from this inquest.

Dated this day of 2015

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GREG CAVANAGH
TERRITORY CORONER