LOCAL COURT OF NEW SOUTH WALES

Coronial Jurisdiction

Inquest:	**Inquest into the death of Alana GOLDSMITH**
File number:	2011/390097
Date of findings:	22 August 2014
Place of findings:	State Coroners Court Glebe
Findings of:	Magistrate Mark Douglass, Coroner
Findings:	Alana GOLDSMITH died on the 22 July 2011 at Summer Hill Railway Station of multiple injuries sustained when she intentionally stepped in front of a moving train whilst suffering from anorexia nervosa.
Representation:	Sgt Young as counsel assisting
	Gabrielle Bashir (counsel) instructed by Vivian Evans for the family
	Matthew Johnston (counsel) instructed by Scott Graham for Wesley Hospital
	Mark Walsh (counsel) instructed by Nicholas Lennings for Dr Mondraty
	Stephen Thornton (counsel) instructed by John Kamaras for Professor Russell & Dr Tanner
	Ms Doust for the NSW Nurses & Midwives Association

REASONS FOR DECISION

Introduction

1. Alana Goldsmith died on 22 July 2011 from injuries sustained from being struck by a train at Summer Hill. She intentionally stepped into the path of the moving train. Her death was the intended result. It is likely that she could no longer endure the burden of living with her mental condition anorexia nervosa. Her death stunned, traumatized, and saddened her family and friends - they continue to grieve.

2. A sudden, traumatic death raises distressing questions and issues for those who mourn but also for the wider community as what harms one community member may harm many others. One of the most important questions for the Goldsmith family is whether more could have been done by Alana's doctors or the health system to prevent her death?

3. An inquest is a search for truth. It is intended to be an independent, objective, fair examination of the available evidence relating to the circumstances of a person's unexpected or unnatural death. The evidence available to a Coroner is necessarily incomplete because the primary witness to the circumstances of her or his death is the deceased person. Accordingly the search for truth, therefore, may not answer all the questions raised by an unexpected or unnatural death. However, after this inquest, it is clear on evidence, anorexia nervosa, an insidious mental illness/condition contributed.

4. A proper inquest is neither a criminal or civil trial. Coroners do not seek to blame nor prosecute. Coroners investigate the facts of a case in part to help the living understand how a sudden death came about.

5. Coroners also seek to learn from an inquest to help prevent similar sorts of deaths recurring. Although it would be disrespectful of a coroner to believe that he or she can 'bring closure' to grieving families, an inquests objective to seek ways of preventing further similar deaths can sometimes provide comfort to the surviving family members.

Alana

6. At the time of her death Alana was a young woman with intelligence, talent and potential. She was a high achiever academically and the dux of her school. She was loved by her parents and her sister. Unfortunately from 2002 she suffered from an eating disorder which developed into anorexia nervosa. The nature of that mental illness/ condition was described as having complications, additional to the generally known restriction on food intake and distorted body image. Anorexia also affects sufferer's brain functioning with sufferers displaying very rigid thinking, difficulty with therapeutic engagement, difficulty with compliance in eating, and an overall difficulty dealing with therapeutic concepts. This articulates anorexia nervosa from many mental illnesses/conditions in that it attacks body function and the brain processing.

7. Alana's anorexia was long-standing. Her history shows, sadly, she struggled on and off over the years, sometimes so badly that she had to be admitted for treatment to hospital.

8. In early November 2010 Alana was admitted to the Northside Clinic, a specialist unit for treating eating disorders. Records indicate that Alana absconded from the clinic on a number of occasions, but each time returned to the clinic voluntarily.

9. In early January 2011 Alana discharged herself against medical advice from the Northside Clinic, but was re-admitted on the 18 February 2011. Eventually she was transferred to the Northside Clinic Intensive Care Unit (a locked ward) because of a slow pulse, and due to her history of absconding. On the 22 February 2011 Alana absconded from the ICU at Northside, and was formally discharged from the Unit on the 23 February 2011.

10. On the day of her discharge, Alana returned to her mother's home and was agitated and distressed. Judy pleaded with Alana to return to the Clinic. Alana stated she wanted to die and spontaneously made an attempt to take her own life. Alana was restrained by Judy and her friend, and police were called. As a result Alana was conveyed by police to the Emergency Department at Royal North Shore Hospital under section 22 of the Mental Health Act 2007.

11. Alana was assessed by the medical officer, and was scheduled under section 19 of the Mental Health Act 2007, as the medical officer believed Alana was

a high suicide risk. Alana was admitted briefly to the PECC Unit (Psychiatric Emergency Care Unit), and was discharged as a voluntary patient into the care of her mother Judy, Dr Jan Orman (a general practitioner experienced in outpatient management of eating disorder patients), and Gail Rice (Clinical Psychologist) on the 25 February 2011.

12. Alana's third admission to the Northside Clinic was from early April 2011 to 23 May 2011. Alana did not abscond during this admission, and gained weight steadily. The admission ended when Alana went to Russia with a family member for a holiday. The admission was positive.

13. Alana was treated by numerous health care professionals over the nine years that she was suffering from anorexia nervosa. By way of example, from October 2010, she was seen by Professor Jan Russell who was Alana's treating psychiatrist, and between 14 October 2010, Professor Russell oversaw Alana's three admissions to Northside, or Royal North Shore Hospital, and saw Alana on the Saturday 16 July before her admission to the Wesley Eating Disorder Clinic on the Monday 18 July. Professor Russell was aware of Alana's history of absconding.

14. It needs to be noted that from 2002 Alana was fortunate, to have the strong support of her loving family and that the heavy burden of anorexia nervosa would have been borne not only by Alana, but with great patience and courage by the Goldsmith family.

15. Unfortunately, in mid 2011 Alana's mum had again assisted her to seek professional medical help and she was recommended urgent hospitalisation. However, Northside had no beds and the Wesley Eating Disorder clinic was the next option. Unfortunately, this meant a lack of continuity in Alana's care and treatment, and this is relevant given that effective treatment is founded on trust.

16. Whilst Alana was reluctant to enter hospital her hospitalisation was necessary and her opposition was symptomatic of anorexia nervosa.

Wesley Eating Disorder Clinic (WEDC)

17. In early July 2011, Judy Goldsmith and Alana attended Wesley Hospital for an interview with Dr Mondraty. Judy was not asked about Alana's medical

history. Dr Mondraty found Alana had an eating disorder consistent with anorexia nervosa. Dr Mondraty was concerned as Alana's weight was in the moderately severe range of 42 kilograms. He also noted evidence of cardio vascular compromise with bradycardia and low blood pressure. In addition a recent blood test revealed Alana had a low neutrophil count. Dr Mondraty worked as a consultant psychiatrist in the management of eating disorder and mood disorder patients in specialist clinics at Wesley Hospital and the Northside Clinic since 2003. Dr Mondraty has also been the acting director of the Northside Eating Disorder Clinic and the director of the Wesley Centre for Eating Disorders since 2009.

18. When Dr Mondraty saw Alana in July 2011 he was sent a one page referral from Dr Jan Orman from the University Health Service, University of Sydney. Dr Mondraty's assessments appear to have been carried out thoroughly and were considered by Professor Russell and Gail Rice clinical psychologist, who were both long term treators of Alana, in written correspondence from him.

19. Dr Mondraty noted that Alana does experience suicidal ideation but indicated that these were not intense or active. He also noted that Alana denies previous episodes of depression or trials of antidepressant medication and she denied a previous history of self-harm or suicide attempt. He also noted there was no evidence of previous anxiety disorders and there is no history of psychiatric illness in her family. He was not given discharge summaries of prior hospitalizations nor did he obtain them.

20. In Dr Mondraty's opinion, Alana presented as a cooperative but obviously emaciated young woman. He also concluded that Alana was eager to emphasise that in the last week she had actually been eating better and had put on weight and did not need hospitalisation.

21. In Dr Mondraty's opinion, Alana's effect was depressed but reactive. She had depressed cognitions of worthlessness, hopelessness and suicidal ideation and in his opinion there was no evidence of psychosis or delirium. Alana stated she was motivated to recover but was adamant that she did not need to come into hospital.

22. Dr Mondraty recommended hospitalisation as soon as a bed becomes available. Her admission to WEDC as a voluntary patient was accepted by two of her previous primary treators, Professor Russell and Gail Rice as

being appropriate. Dr Mondraty corresponded with the previous doctors and WEDC. His assessment letter in the hospital's notes is evidence of a professional approach to Alana's care.

23. Wesley Eating Disorder Centre is a specialised 12 bed unit, located within a designated wing of the main hospital's premises. Inpatient program overview specifies that initial treatment is an inpatient setting with supervision and group program. The multi-disciplinary team consists of nurses, dieticians, clinical psychologists, art and exercise therapists, physicians and psychiatrists. The centre is registered and compliant with accreditation.

Admission

24. On 18 July Alana was admitted to WEDC. On admission she was highly anxious even frightened about her admission. With reassurance from her mother and nursing staff, Alana was persuaded to stay. It was a voluntary admission. Alana requested Zyprexa for her anxiety, and in response nursing staff contacted Dr Mondraty and the medication was prescribed.

25. The admitting nurse conceded that she failed to complete the suicide risk assessment guide document which formed one page of a seven page nursing admission document and couldn't explain why. That nurse stated that she had not been trained regarding completing the suicide risk assessment document.

26. WEDC did not obtain the discharge summaries form from Alana's previous admissions to hospital.

27. The admitting nurse made observation that during her shift she did not notice anything remarkable about Alana's presentation, in her opinion Alana appeared depressed and anxious but was reactive. That nurse stated that this presentation is similar to many patients admitted with anorexia nervosa. However, it is clear Alana's risk categorisation on admission was probably lower than it should have been.

28. Alana, on admission day, was also seen by Dr Mihir Roy, medical practitioner who conducted a medical assessment of Alana. Dr Roy states that Alana's mood was low and that Alana had denied having any self-harm or suicidal thoughts.

29. On 19 July 2011 another young person was admitted to the Eating Disorder Clinic and became Alana's roommate. In her statement Alana's roommate, who was excused from giving evidence, recalls Alana saying she didn't need to be admitted into Wesley because she could get better outside of a hospital environment.

30. Dr Mondraty again saw Alana on 19 July and reviewed her mental state. It was, in context, an extensive review and there were concerns raised about re-feeding syndrome Dr Mondraty intended on seeing Alana on 22 July 2011.

31. According to Alana's roommate on Friday 22 July 2011, Alana did not attend the morning group session. Her roommate returned to her room and saw Alana. Alana said, "I just went to the Ashfield Station because I wanted to end everything". The roommate didn't take Alana's comments about taking her own life seriously as she had often made veiled threats about taking her own life to her parents whenever she felt angry or frustrated. She also recalled Alana making comment to her that she couldn't handle putting on weight because she didn't want to look fat. I have said this before but it is worth one more repetition anorexia nervosa ravages the body and the brain articulating it as a very insidious and debilitating mental illness/condition.

32. Alana's roommate did not speak to staff members at WEDC about her conversation with Alana.

33. There is no reliable evidence that Alana had been orally expressing suicidal ideas to staff in the period before her death. In addition, there is little persuasive evidence that those who were treating her knew or ought to have known Alana was formulating any concrete plans to take her own life.

34. There is also little evidence that Alana's behaviour and her presentation would have seen her allocated a nurse special or made an involuntary patient. Having the discharge summaries would not have demanded she become an involuntary patient either noting there was nothing in that history or presentation including, her discharge summaries, that in any way could have predicted the method she would use to take her own life. If any thing her discharge summaries indicated a tendency to voluntary return to treating facilities

35. This is not advancing an argument that the discharge were redundant or of no forensic value. Alana's discharge summaries should have been obtained.

36. On 22 July 2011, Alana left the WEDC twice. The first time Alana left WEDC in the morning her absence went unnoticed and it follows without consequence.

37. A clinical psychologist at the facility, reported Alana missing at 2.15pm following a group session. A search was conducted and an attempt was made to contact Alana on her mobile phone. Of concern is the period of time that passed before staff detect that Alana had left the hospital. Alana was last sighted by staff between 12.10 and 12.45pm. The clinical psychologist was the first person who articulated that Alana may have left the clinic a significant period of time after the group session she had given (which did not include Alana).

38. Tragically at 2.18pm on 22 July 2011, a young female, walked across platforms 1 and 2 at Summer Hill Railway Station and stepped into the path of a moving train.

The issues

39. As stated above The *Coroners Act* requires me to identify the person whose death is being investigated, the date and place of the death and the cause and circumstances of the death. In this inquest, the focus has been on the circumstances of Alana's death. In particular, the inquest set out to and has considered a number of issues. Through a flexible approach all of the original issues were adequately examined.

40. The primary issues now are whether more could have been done by Alana's doctors or the health system to prevent her death and what changes should be made to reduce the risk of further deaths?

The Evidence

41. In making findings of fact, I must rely upon the evidence, i.e. the evidence given by the witnesses and the evidence contained in the exhibits. Additionally I listen to and consider the submissions of all parties. I must apply my common sense.

42. In making findings evidence is unacceptable I have considered amongst other things:
    (1) Contradictory evidence of the same events or incidents from another witness;
    (2) Contradictory evidence from contemporaneous documents;
    (3) Inconsistencies or contradictions within a witness's own evidence;
    (4) Evidence of conduct or behaviour, which is inconsistent with contextual norms.

43. In making findings of fact I am reluctant to place too much reliance upon the demeanor of any witness. Apparent nervousness and inconsistencies may be easily explained or contextualized.

44. In making findings evidence is reliable in this matter the court has amongst other things been assisted by corroboration of disputed facts by a number of witnesses some being independent witnesses including reports and journals.

Conclusion

It is clear on the evidence that there were failings in Alana's care, incomplete and imperfect documentation and a failure to obtain discharge summaries for prior hospitalization reduced her level of care. Not having her prior discharge summaries, which disclosed an earlier attempt to take her life when she previously had been discharged from hospital and a propensity to abscond, meant her care and treatment was not at its optimal level for reducing the risk of suicide. Such information may have changed her risk category within the WEDC and may have led to more supervision and potentially an intervention in the planned suicide.

Not being aware that Alana twice left the WEDC on the day of her death until it was too late to initiate a response is also a failing and of concern. If staff had detected her absences, particularly her first absence there would have been interventions and a change of her risk category that would have demanded regular checks perhaps at ½ hour intervals.

In addition, there was a lack of professional rigor in maintaining attendance checks at all programs, meals and after meals – a critical period. There was also a lack of procedure following a patient's non-attendance. It was also easy for a patient to leave the WEDC, even though all admissions were voluntary, undetected.

As stated above one of the most important questions for the Goldsmith family is whether more could have been done by Alana's doctors or the health system to prevent her death? I have found here was a loss of potential positive suicide interventions founded on some of the failings at WEDC. Noting that the potential intervention are speculative and possibilities. There is not a way of predicting Alana's response to intensive scrutiny. However, considering all of the evidence and detailed submissions, none of the failings were causative of Alana's death. Her treatment at WEDC was adequate but not optimal. The staff members were caring and Dr Mondraty presented as a dedicated professional.

As is the case with most inquests other issues must be explored and considered. In this regard, one of the acknowledged problems of suicide is that it is "simply not possible to predict suicide in an individual patient, and any attempt to *subdivide patients into high-risk and low-risk categories is at best unhelpful and at* worst will prevent provision of useful and needed psychiatric care"[1]. In general some suicides are impulsive acts. In other cases, suicide may be planned but the victim conceals his or her intentions from family members and clinicians. Nearly all suicides are carried out in circumstances that would not allow intervention making suicide prevention difficult to predict and prevent. This is not to say that patient safety or a hospitals duty for vigilance can be abandoned.

Professor Russell in her experience as a psychiatrist, asserted that it not possible to identify in all cases a patient who is just contemplating suicide. She said that you have to rely on what a patient tells you and they don't always tell you the truth. Professor Russell also said that Alana was very impulsive on prior admissions and that Alana had denied any suicide ideations.

In Alana's case, however, it appears that she received adequate and compassionate treatment in WEDC. It was evident that Dr Mondraty, and other staff who had the day-to-day care of Alana at WEDC, sought to address her condition in a professionally caring way and were vigilant in their assessment of risk of self-harm by visual observation even though the observations were not reflected in paper work.

Whilst genuine concerns have been expressed about the failures in Alana's care, I did not consider that those failures had a causal connection with Alana's death.

[1] Ryan CJ, Large MM. Suicide risk assessment: where are we now? *Med J Aust* 2013; 198: 462-463. Exhibit 19.

Causation is founded on the factual context connected to Alana's death and includes acts and omissions.

The unpredictable nature of suicide makes prevention difficult. The mistakes and failures at WEDC did not lead to Alana's death. The failures and mistakes represent a loss of an opportunity for intervention that may or may-not have prevented the death. One possible intervention was a change to her risk status founded on her discharge history. However, even if WEDC had her discharge history and up graded her risk status I am not satisfied the consequential constant regular checks on Alana would have short-circuit her plan to take her own life.

There was not a misdiagnosis regarding Alana's mental condition. There is very little evidence that Alana should have been scheduled under mental health legislation or that she should have been a patient that required a nurse special. Alana's presentation was as expected. She denied suicidal ideation and did not tell any staff at WEDC of her plan nor could her plan be inferred from her presentation.

Despite the treatment and the love and support Alana received from her family and friends, Alana seems to have found her life living with Anorexia nervosa and receiving the treatment she desperately needed so heavy a burden that she ultimately could not bear to carry it any longer. It is clear the mental illness /condition Anorexia Nervosa played a foundational role in Alana Goldsmith's decision and ultimately her tragic death.

Prevention

There are a number of foundational treatment criteria for the optimal treatment and care of people living with anorexia nervosa. A comprehensive summary of each individual patient's treatment history should be collated and reviewed by a treating hospital. The individual patient summaries should be easily accessible to future treating hospitals and should be a mandatory component of admission. In addition, the location of a registered patient should be known to hospital staff at all times during a voluntary admission. In addition, continuity of treatment is also foundational to optimal management treatment and care as there is a critical need to gain the trust of a voluntary anorexia patient. In this regard, Alana could

not be treated by people that had earned her trust over a long period of time because there were no beds available, and she took the first available bed at WEDC after waiting a number of days.

In response to the death of Alana, Wesley Mission conducted a review of the hospital policies and procedures and facilities, and have implemented the following additional practices. Firstly security has been enhanced through the installation of a CCTV system and the reduction of unrestricted points of egress at the hospital. This was achieved through the installation of three key only accessible doors or electromagnetic locked doors linked to the fire alarm and a complete removal of non essential access doors. Secondly a new procedure establishing care categories and associated observation checklist forms has been introduced and finally, regular staff meetings containing a standing item reminding staff to ensure admission procedure and risk assessments are completed thoroughly. Wesley Mission in this case appear to have implemented appropriate 5 steps to reduce the risk of absconding and today use a risk assessment guide to categorise patients at risk.

Whilst the hospital has made appropriate changes it is noted that more can be done to reach optimal treatment and care for maximizing suicide risk prevention. Specifically, in relation to obtaining patient summaries and knowing the whereabouts of all registered patients at all times.

The hidden cost

There are a number of people that would have affected by Alana's suicide and an unquantifiable financial cost increasing the need to prevent such deaths. The driver of the train, those that had to attend the location, such as police and ambulance, the commuters at the train station have all been considered and should be taken into account when assessing the impact suicide can have on a community.

To Alana's family

I and the court staff that assisted during the inquest offer the Goldsmith family and Alana's friends our most sincere condolence and respects.

Magistrate Mark Douglass

22 August 2014