IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 002766

FINDING INTO DEATH WITHOUT INQUEST

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

I, Michelle Hodgson, Coroner, having investigated the death of **SYDNEY HUGH KENNEDY**

without holding an inquest:
find that the identity of the deceased was **SYDNEY HUGH KENNEDY**
born on 13 February 1947
and the death occurred 24 June 2013
at Ballarat Base Hospital BALLARAT 3350 VIC

from:

1a COMPLICATIONS OF CHRONIC LITHIUM THERAPY

ABOUT A CHAMBERS FINDING

The Coroners Court is different from other courts. It is an inquisitorial rather than an adversarial system. In other words, there is no trial, with a prosecutor and a defendant. Instead, there is an inquiry that seeks to find the truth about a person's death – to establish what happened, rather than who is to blame. The Coroner is more flexible in the evidence that they will accept, but they cannot punish.

When making a chambers finding, coroners carefully consider all the submissions that come before them. Not every issue makes it way into the final report but everything has been weighed up and analysed.

Sydney Kennedy was 66 years of age at the time of his death.

Mr Kennedy had a mild-moderate intellectual disability who lived in care and had maintained a level of self care until recent months.

Mr Kennedy had been diagnosed by Grampians psychiatric Service as having hypomania and psychosis and was commenced on psychoactive medications of lithium and olanzepine.

His general practitioner referred him to private psychiatrist Dr Shashjit Varma who reviewed Mr Kennedy annually, in July 2008 diagnosing Mr Kennedy with bipolar affective disorder.

The general practitioners at the Ararat Medical Centre provided ongoing care of Mr Kennedy including the monitoring of his physical health, mental state and effects of lithium.

On 15 June 2013, Mr Kennedy was admitted to the Ararat Hospital with a lithium level of 1.9 mmol, at which point, Dr Edgardo Lou ceased the lithium and commenced treatment which decreased the lithium level to 0.7mmol by 18 June 2013. Mr Kennedy developed hypernatreamia (raised sodium), deteriorated and was transported to Ballarat Base Hospital.

He was treated for hypernatreamia, hyperkalcaemia (raised potassium) and hyperglycaemia (raised blood sugar level).

There is evidence of a decision for restricted resuscitation efforts (10 minutes CPR) and restrict access to high dependency care (not suitable for HDU as not for intubation/defribillation) were made within 24 hours. Resuscitation Plan completed on 20 June 2013 records the rationale as "futility". Palliation commenced at 7.15 pm on 21 June 2013. Mr Kennedy died at 2.55 pm on 24 June 2013.

Mr Kennedy had a current Administration Order under the Guardianship and Administration Act 1986 for review on 30 June 2016, but did not have a guardian.

It is difficult to assess Mr Kennedy's functional level and level of disability based on the information available.

The clinical records of the Ararat Medical Clinic document a clinical picture of increased weight loss, dysphagia, falls , tremor and deterioration since June 2012 with an acute deterioration on 29 April 2013.

The medical record detail is scant but there is evidence of regular investigations and treatment of Mr Kennedy's weight loss, hypertension, cardiac problems, falls and tremor.

Mr Kennedy was prescribed Perindopril an ACE inhibitor listed as a specific drug interaction because it decreases lithium excretion but it appears Mr Kennedy had been prescribed it in at least August 2012 and related adverse events are usually within initial months of use.

Dr Pieter Pretorius recorded Mr Kennedy as having some renal impairment in August 2012 but this has not triggered a review of the dose of lithium by the general practice of treating psychiatrist Dr Shashjit Varma. On 29 April 2013, when Mr Kennedy presented as unwell and was reviewed by Dr Chee Sheng Wong and his lithium level as 1.1 mmol/L a review of the dose of lithium did not occur.

Dr Wong did make a referral to the Ballarat Health Service for a medical review appointment for Mr Kennedy in which there was a request for an urgent appointment because "I am quite worried about him, because of recent marked changes I would therefore be very grateful if you could see him as soon as possible." This appointment was made for 27 June 2013 some 7 weeks after the referral.

Dr Arvind Jhamb then reviewed Mr Kennedy on 13 June 2013 when he presented as still unwell and Dr Jhamb ceased the lithium.

The monitoring by Ararat Medical Centre was appropriate however there appears to have been no recognition of Mr Kennedy's presentation in the months leading up to his admission to hospital being related to lithium when he had therapeutic target serum concentrations of lithium. Further more in the six weeks after the target serum concentrations of lithium was above 1.0mml/L there were no links made between the lithium level and Mr Kennedy's presentation.

There appears to be limited understanding of the presentation and signs and symptoms of lithium toxicity, both with a target serum concentrations of lithium above recommended ranges and at therapeutic range. In addition there appears to have been no account of the impact on Mr

Kennedy's ability to excrete lithium of the renal impairment, use of ACE inhibitor, age and sixteen-kilogram weight loss and anorexia as contributors to the accumulation of lithium and possible toxicity.

The Ballarat Health Service gave Mr Kennedy an appointment for seven weeks after Dr Wong requested an urgent review. It is unknown if this is a usual timeframe for this type of referral but it is unclear if the review would have changed the outcome.

The decision to palliate Mr Kennedy appears precipitous for a 66 year old man; however a review of the guiding documents for medical staff and with advice from the Office of the Public Advocate, there are no identified issues that would result in adverse findings. Nevertheless, Mr Kennedy did not have a guardian or nominated responsible next of kin therefore the decision was made solely by medical staff and the documentation of the decision making process is scant.

RECOMMENDATIONS-

I recommend that the Therapeutic Goods Authority (TGA) issue an alert to prescribers to exercise caution when prescribing lithium over the long term for ageing patients and patients with medical co morbidities. In particular the alert should draw prescribers attention to the increased risk of toxicity in patients who take the drug long-term, and the possibility that even when target serum concentration of lithium is within recommended parameters, clinical presentation changes (including but not limited to the recognised signs and symptoms of lithium toxicity) may indicate lithium toxicity.

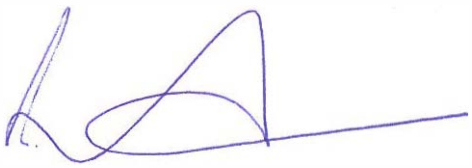
COMMENTS-

In Victoria, end of life decisions made by medical staff for patients without a guardian or nominated responsible family member are guided by the Office of Public Advocate Advocacy and decision-making in relation to medical and dental treatment and other health care and "The Australian Medical Association 2007 The Role of the Medical Practitioner" in end of life care. The goal of public health services is to have contemporaneous policies for staff that reflect best practice.

CONCLUSION-

Mr Kennedy died of

1(a) Complications of chronic lithium therapy

Signature: 

Date: 10.12.2014