



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of Margaret Patricia Kenney

Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that:

- a) The identity of the deceased is Margaret Patricia Kenney;
- b) Mrs Kenney was born in Sydney on 16 November 1933 and was aged 83 years;
- c) Mrs Kenney died on 13 November 2017 at the Mersey Community Hospital (MCH) in Latrobe; and
- d) The cause of Mrs Kenney's death was an upper gastrointestinal bleed.

Background

The investigation of this death was undertaken after Mr Gregory Kenney, a son of Mrs Kenney expressed concerns related to his mother's medical care over the months preceding her death. That investigation has been informed by:

1. A Police Report of Death.
2. An affidavit provided by Mr Kenney.
3. A review of Mrs Kenney's records at the MCH carried out by clinical nurse, Ms L K Newman.
4. A report from Dr Champa Jinadasa of Victoria Street Clinic.
5. A report from Dr Helen McArdle, the Acting Director for Medical Services at Tasmanian Health Service (THS).
6. A report provided by Dr A J Bell as medical adviser to the coroner.

Circumstances Surrounding the Death

The investigation shows that:

- Mrs Kenney's past medical history included glaucoma, retrosternal goitre, hypertension, type 2 diabetes and asthma.
- Dr Jinadasa had been Mrs Kenney's general practitioner since May 2008. His report reveals the following matters relevant to the death:

- That in 2015 he diagnosed Mrs Kenney with Gastro Oesophageal Disease (GORD). She was prescribed pantoprazole. The dose was 40mg daily.
- In August 2017 Mrs Kenney began complaining of shortness of breath and a cough. Its investigation included an ECG carried out on 7 September. Dr Jinadasa interpreted this to indicate tachycardia and an abnormal rhythm. He reports that he advised Mrs Kenney of the results and explained that an option for her was to present at hospital. However, she was unwilling to do so.
- That he last saw Mrs Kenney on 11 October. She reported that her shortness of breath was improving but she was tired and lethargic. A referral was made for her to see a cardiologist at the Heart Centre in Launceston.
- That Mrs Kenney presented at the MCH on 11 September and reported increasing shortness of breath, worse at night, and decreasing exercise tolerance. Her vital signs were stable but her heart rate was 128 bpm. An ECG showed atrial fibrillation with left bundle branch block and a rapid ventricular response. A chest x-ray showed congestive cardiac failure and bilateral small pleural effusions. A CT scan of the pulmonary arteries showed no evidence of pulmonary embolism but evidence of congestive cardiac failure, pleural effusions and the known retrosternal goitre. Mrs Kenny was treated for congestive cardiac failure. Her heart rate was controlled with metoprolol. The anti-coagulate apixaban was commenced. Frusemide and spironolactone were also commenced. Her condition gradually improved and she was discharged home on 17 September.
- That Mrs Kenney re-presented at the MCH on 18 September with chest pain. An ECG showed atrial fibrillation, left ventricular ejection fraction of 56%, left ventricular hypertrophy, dilated left atrium and no evidence of heart failure. She was discharged after two days. No medication changes were made.
- On 29 October Mrs Kenney returned to the MCH. She complained of an increased shortness of breath over the previous three days associated with vomiting, intermittent diarrhoea and decreased fluid intake. She had lost over 6kg in weight over the previous month. An ECG showed atrial fibrillation with a rapid ventricular response and left bundle branch block. There was also evidence of acute renal failure. A diagnosis of fluid depletion was made and intravenous fluid administered. The apixaban was ceased and replaced with subcutaneous Clexane (enoxaparin).
- On 31 October further testing showed thyrotoxicosis and a urinary tract infection. Treatment was commenced and the kidney function returned to its previous levels.
- On 3 November Mrs Kenney complained of abdominal pain and nausea. She became oliguric (decreased production of urine) and her kidney function deteriorated. Her therapy was changed with a slow improvement in her condition.

- In the days leading up to 12 November, Mrs Kenney was making a slow but gradual improvement. However, that evening she passed three stools which were described as melaena (faeces containing digested blood). At around midnight she had a cardiac arrest. During resuscitation attempts she emitted blood-stained vomitus. Resuscitation was ceased at 12.24am on 13 November 2017 and Mrs Kenney was declared deceased.
- The MCH issued a death certificate which stated the cause of death to be gastrointestinal bleeding with haemodynamic compromise following anti-coagulation for atrial fibrillation over two months. Significant contributing factors were stated to be thyrotoxicosis, congestive cardiac failure, hypertension, dyslipidaemia and diabetes mellitus Type II.

I have noted above that in 2015 Mrs Kenney was diagnosed with GORD for which Dr Jinadasa prescribed pantoprazole, a proton pump inhibitor (PPI). A question arises whether MCH continued to administer this medication to Mrs Kenney during her last admission. On this subject it is noted that the records make no reference to the drug being administered, ceased, or substituted. The only relevant entry was made by a pharmacist where it was recorded; '*Patient requests pantoprazole....*'. In her report, Dr McCardle acknowledged that pantoprazole was recorded as one of Mrs Kenney's medications at the time of her last hospital presentation but there is not any record of the drug having been administered during the admission. All of this leads me to find that Mrs Kenney was not administered pantoprazole or an alternative PPI for the duration of her last admission. Whether this was by oversight or was intentional is not apparent.

In his report, Dr Bell expresses these opinions:

1. That the ECG carried out on 7 September 2017 indicated a significant change in Mrs Kenney's heart rhythm. It warranted her transfer to hospital at that time.
2. Thyrotoxicosis (also known as hyperthyroidism) occurs when the thyroid gland produces too much of the hormone thyroxine. Classic symptoms include weight loss, heat intolerance, tremor, palpitations, anxiety, increased frequency of bowel movements and shortness of breath. Weight loss, shortness of breath and atrial fibrillation occur more commonly in younger than older patients.
3. Anticoagulation should be considered in hyperthyroid patients with atrial fibrillation. In Mrs Kenney's case it was appropriate for her to be anticoagulated with enoxaparin and the correct dosage was administered.
4. Patients with long-standing large goitres, such as Mrs Kenney, may develop symptoms of obstruction due to progressive compression of the trachea.
5. That the most likely source of Mrs Kenney's haemorrhage was either a gastric or duodenal ulcer. The haemorrhage would in all likelihood have been avoided if Mrs Kenney had continued to be administered a PPI.
6. That the death certificate correctly describes the cause of death.

The report provided by Dr McCardle advises that the circumstances of Mrs Kenney's death were the subject of an internal death review where specific issues were identified and some recommendations made, namely:

- a) That Mrs Kenney was not reviewed by the surgical team although she presented with gastrointestinal symptoms and undifferentiated abdominal pain.

It was recommended that all cases involving un-differentiated abdominal pain should be reviewed by the surgical team in the first instance regardless of the results of abdominal CT scans.

- b) That there was no clear documentation regarding medications being withheld and the rationale behind it. There were no alternative medications sought for any medications that had to be withheld.

It was recommended that there should be clear and unambiguous documentation concerning any medications being withheld and the rationale behind doing so. If considered necessary, alternatives should be sought to continue treating any pre-existing chronic diseases.

- c) In the case of pantoprazole, there was no attempt made to find out the ongoing need for the drug, and to prescribe an alternative agent if indicated. The dosage of pantoprazole would indicate that Mrs Kenney's condition required a higher dose of a PPI and withholding it may lead to a deleterious consequence. This was even more essential for a patient being coagulated.
- d) That it was an error to treat symptoms such as nausea and vomiting without attempting to diagnose their underlying cause.

Findings, Comments and Recommendations

I have found earlier in these findings that Mrs Kenney was not being administered pantoprazole or an alternative PPI during her final admission to MCH, notwithstanding that she suffered from GORD which had been treated with that drug since 2015. As I have also said, the reason for that drug's discontinuance is not apparent. Dr Bell has opined that in all likelihood Mrs Kenney experienced a gastric or duodenal haemorrhage on 12 November 2017 which would have been avoided if the pantoprazole or an alternative PPI had been maintained. I accept this opinion. Most regrettably the haemorrhage led to Mrs Kenney suffering a cardiac arrest which was followed by her death. It follows from these findings that in all likelihood Mrs Kenney's death would have been prevented if she had continued to receive her regular dosage of pantoprazole or a suitable alternative PPI.

I acknowledge the death review undertaken for THS and accept that the recommendations made will, if followed, reduce the risk of a similar preventable death occurring in the future.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how her death occurred and the particulars needed

to register her death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Mrs Kenney's family and loved ones.

Dated: 18th day of April 2019 at Hobart in the State of Tasmania.

Rod Chandler
Coroner