IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1044

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	**JULIE-ANNE MARIE KETTLE**
Delivered on:	24 May 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	24 May 2021
Findings of:	**KATHERINE LORENZ, CORONER**
Counsel assisting the Coroner:	**Senior Sergeant Jen Brumby, Police Coronial Support Unit, Coroners Court of Victoria**
Other matters:	*Person placed in care*

HER HONOUR:

INTRODUCTION

1. Julie-Anne Kettle was born on 15 July 1961. She was aged 56 years and was a resident of a group home operated and managed by the Department of Health and Human Services (**DHHS**) Disability Accommodation Services at 83 Williams Rd Wangaratta. Julie-Anne died in hospital from bronchopneumonia in the setting of high lithium levels on 4 March 2018.

THE CORONIAL INVESTIGATION

2. Julie-Anne's death was reported to the coroner as she was considered to be a person placed in custody or care under section 3(1) of the Coroners Act 2008 (**the Act**) and so fell within the definition of a reportable death under the Act. When a person dies 'in care' an inquest into the death is mandatory unless it is a death from natural causes. The Act recognises that people 'in care' are vulnerable, and affords them protection by requiring that the circumstances of their death are investigated by a coroner, irrespective of the medical cause of death and by mandating that as part of that investigation there should be an inquest or formal public hearing. Julie-Anne's care arrangements fell within this definition because she resided in a group house provided by DHHS at 83 Williams Road, Wangaratta. On 26 May 2019, this group home was transferred from DHHS to a community services organisation, Home@Scope.

3. A coroner independently investigates reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.

4. Victoria Police assigned a Coroner's Investigator for the investigation. The Coroner's Investigator conducted inquiries, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from a DHHS representative, treating physicians, the forensic pathologist who examined her and investigating officers, as well as other relevant documentation as set out below.

5. The Court also obtained Julie-Anne's medical records and her DHHS client file.

6. Coroner Jacqui Hawkins directed this coronial investigation until my appointment as a coroner on 8 February 2021, when I assumed the responsibility for it.

Disability Services Commissioner

7. As part of this investigation, I have considered the *Investigation Report into disability services provided by the Department of Health and Human Services to Ms Kettle* issued on 21 May 2019 prepared by the Disability Services Commissioner (**DSC**) (**Investigation Report**) which was provided to the Court for the purpose of the coronial investigation and inquest. The DSC investigation was conducted under the auspices of the Disability Act 2006 with a different scope to that of a coronial investigation (although it can overlap). Consistent with the Act, a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.

8. I note that the DSC Investigation Report revealed concerns about the adequacy of the provision of disability services provided to Julie-Anne and determined that it was necessary to issue a Notice to Take Action to DHHS pursuant to s.128 of the Disability Act dated 21 May 2019 (**Notice to Take Action**).

9. I have also considered the response of the DHHS to the Investigation Report and the Notice to Take Action dated 17 July 2019 (**DHHS Response**), the statement of Catherine Cerolini, the Assistant Director, Disability Accommodation Services, Disability and NDIS Branch, East Division, Department of Human Services and a letter from the Department of Families, Fairness and Housing dated 14 April 2021, containing updated information about the implementation of actions set out in Ms Cerolini's statement.

10. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. Julie-Anne was under the care of a general practitioner (**GP**), Dr Molina-Chavez, since August 2015. Dr Molina-Chavez consulted with Julie-Anne at least every three months and more frequently when she was unwell. During the time he treated Julie-Anne, most of her medical issues involved management of her behaviours, intermittent constipation and diarrhea and treatment for recurrent falls. The Adult Community Mental Health Service at Albury Wodonga Health provided mental health care to Julie-Anne and Dr Molina-Chavez managed her medical care. Julie-Anne was commenced on lithium by a psychiatrist in

December 2016, initially on a dose of 250 mg/day, which was increased to 1000 mg/day on 9 February 2017 and again to 1250 mg/day on 25 February 2017.

12. On 1 December 2017, Julie-Anne had a consultation with Dr Molina-Chavez. Her carers reported to him that Julie-Anne had been drinking excessively, had gained more than six kilograms of weight in six weeks, had swollen legs and loose, undigested stools. Her carers also reported that they had restricted her fluids and the swelling had decreased. Additionally, they reported to Dr Chavez-Molina that a resident in the home had died and this had distressed Julie-Anne. On examination, Dr Molina-Chavez found bilateral crackles on her lung bases and bilateral ankle pitting oedema. Dr Molina-Chavez considered that Julie-Anne had fluid in her lungs and ordered a range of blood tests including lithium serum blood levels, urea and electrolytes, liver function tests and magnesium and calcium levels and an abdominal x-ray to look for constipation. Dr Molina-Chavez recommended capping fluid intake to 3 litres per day, that she be given compression stockings and weighed every second day.

13. On 2 December 2017, the blood taken was reported to show a lithium level at 0.8mmol/L, which is in the therapeutic range.

14. Julie-Anne saw her GP on 8 February and 15 January 2018. Additionally, Dr Chavez-Molina spoke with Julie-Anne's carers by telephone on 27 January 2018 and on 2 February 2018.

15. On 16 February 2018, Dr Chavez-Molina saw Julie-Anne and noted pitting oedema to her knees and signs of fluid in her lung bases. Her carer reported that she had been drinking excessively. Dr Chavez-Molina recommended that fluid intake be restricted to 1.5 litres per day. Dr Chavez-Molina did not consider lithium toxicity on during this consultation as he was reassured by the therapeutic lithium level reported on 2 December 2017 and considered that her lithium levels were likely to have remained therapeutic. A review appointment was scheduled for 9 March 2018. Staff were instructed to contact the clinic again if they had concerns.

16. It was observed from the health notes and file notes that Julie-Anne continued to feel sleepy, nauseous and needed encouragement to eat her meals. PRN Metoclopramide was administered for nausea on 16, 17, 20, 22 and 26 February 2018.

17. Between 16 February and 28 February 2018, Julie-Anne continued to experience episodes of nausea, poor appetite and was sleepy or lethargic at times. Staff contacted the GP clinic on 28 February 2018 for advice. Dr Chavez-Molina ordered a chest x-ray, blood tests and a

urine test. It was observed that staff had difficulty obtaining a suitable urine specimen for testing and described Julie-Anne's urine as appearing 'concentrated'.

18. On 1 March 2018, staff documented that Julie-Anne was still very lethargic, was shaking and dribbling saliva. The notes indicated that Julie-Anne found it very difficult to eat due to 'constant jerking' and that she was sleeping in her chair for most of the time.

19. On 1 March 2018, the chest x-ray was reported to show an enlarged heart and congested lungs consistent with left ventricular failure.

20. On 2 March 2018, staff again documented that Julie-Anne was very lethargic, was sleeping in her chair for most of the time and found it difficult to eat because of 'constant jerking which appeared involuntary'. Staff contacted the GP clinic because she remained unwell, had become increasingly unsteady and seemed confused. Dr Chavez-Molina saw Julie-Anne and requested staff to withhold her usual Risperidone. A CT scan of Julie-Anne's brain was ordered as she also complained to the GP that her head hurt. Staff were directed to continue with Julie-Anne's 1.5 litre per day fluid restriction, supervise her eating and watch for aspiration.

21. On the afternoon of 2 March 2018, Dr Chavez-Molina received Julie-Anne's blood test results which indicated that her serum lithium level was too high.[1] Dr Chavez-Molina asked staff to arrange Julie-Anne's transportation to Wangaratta hospital, to occur as soon as possible.

22. Julie-Anne was admitted to hospital on 2 March 2018.

23. On 4 March 2018, group home staff received a phone call from the hospital to say that her condition had deteriorated. Julie-Anne passed away later that day.

DSC INVESTIGATION AND FINDINGS

24. On 15 March 2018, the DSC commenced its investigation pursuant to s 128I of the Disability Act 2006, into disability services provided by DHHS to Julie-Anne. The scope of the investigation conducted by DSC related to the provision of disability services delivered in the context of the circumstances of Julie-Anne's death. The purpose of the investigation was to understand issues in the services being investigated, and to consider any action that the service provider should take in response to those issues or to otherwise improve the services being investigated.

[1] Lithium toxicity occurs when the blood serum lithium concentration is greater than 1.5mmoI/L, although it can sometimes develop when the lithium blood serum concentration is within normal therapeutic range

25. On 27 June 2018, the DSC wrote to the Court requesting advice from the Coroner's Prevention Unit (**CPU**) for advice to assist its investigation. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners. The DSC request was:

'We seek the advice of CCoV as to whether an increased risk of lithium toxicity exists in the context of Ms Kettle's fluid restriction, and whether the health concerns documented proximate to Ms Kettle's hospital admission were reasonably representative of symptoms of lithium toxicity.'

26. On 14 August 2018, Coroner Jacqui Hawkins gave a direction to the CPU to give advice about the request made by the DSC.

27. On 27 August 2018, the CPU confirmed that Julie-Anne's fluid restriction had likely contributed to the chronic lithium toxicity but acknowledged that patients who are compulsive fluid drinkers are difficult to manage. Additionally, in the opinion of the CPU after reviewing Julie-Anne's medical records, North East Health Wangaratta had recognized the lithium toxicity on admission on 2 March 2018 and gave Julie-Anne appropriate treatment with the involvement of family.

28. I accept the advice of the CPU as to the appropriateness of medical care within the context of high lithium levels.

29. DSC Investigation

30. On 21 May 2019, the DSC provided the Court with a copy of its Investigation Report and Notice to Take Action issued to the DHHS. The DSC investigation revealed concerns about the adequacy of the provision of disability services provided to Julie-Anne.

31. The DSC findings can be summarised as follows: a failure to escalate the delay in obtaining compression stockings prescribed by Julie-Anne's GP, the lack of a behavioural support plan in place even though restrictive interventions were being applied, unauthorized use of chemical restraints, a failure to adequately address the issue of incompatibility between Julie-Anne and a co-resident, inadequate management of falls risks and deficient record practices. I note these concerns were not directly related to either Julie-Anne's cause of death or the circumstances of her death but they are of concern to me in the context of the vulnerability of residents in care homes.

32. As a result of their findings, the DSC determined it necessary to issue the Notice to Take Action to the DHHS to take actions to improve the disability services it had investigated.

Department of Health and Human Services response

33. On 17 July 2019, the Secretary of DHHS responded to the Investigation Report and the Notice to Take Action, and included a 'Disability Accommodation Action Plan' (**Action Plan**) and a De-Identified Medication Audit and Action Plan for 83 Williams Road Wangaratta (**Medication Action Plan**), specifically developed to address the Notice to Take Action following the DSC investigation into Julie-Anne's death. DHHS undertook to work with Home@Scope to ensure all improvements are implemented. The Action Plan included an audit of all health records for all current residents, identifying a number of improvement actions for residents including medication documentation, a practice instruction on falls prevention, escalation practices related to resident's medical needs and managing resident incompatibility.

34. Additionally, upon review of the DSC Investigation Report, Coroner Hawkins determined that some outstanding issues fell under the preventative jurisdiction of the Coroners Court and sought a response from DHHS to outstanding concerns held in relation to Julie-Anne's death. These were:

    (a) Information about whether there have been any changes to relevant department processes, procedures or training since Julie-Anne's death;

    (b) Information about what the DHHS has done to improve document management and record keeping since Julie-Anne's death;

    (c) Whether the DHHS has discussed the DSC findings with relevant departmental staff;

    (d) Information about the outcomes of Julie-Anne's death and the DSC review; and

    (e) Practical examples of how the DHHS complies with the Charter of Human Rights and Responsibilities Act when dealing with similar cases.

35. A response to the information sought by Coroner Hawkins was provided in a statement of Catherine Cerolini, Assistant Director, Disability Accommodation Services, Disability and NDIS Branch, East Division, Department of Health and Human Services dated 9 September 2019.

36. On 14 April 2021, following a request from the Coroner's Court for an update on the implementation actions set out in the Action Plan, the Department of Fairness, Families and Housing[2] confirmed that it is satisfied after reviewing the completed audits and action plans

[2] The responsibility for disability care was transferred to the new Department of Families, Fairness and Housing in February 2021.

that Home@Scope has completed all outstanding improvement actions recommended by the DSC at 83 Williams Road, Wangaratta, including the completion of actions arising from the medication audit.

SUMMARY INQUEST

37. The actions DHHS took to address the concerns about Julie-Anne's care were consistent with the findings in the DSC Investigation Report and Commissioner's Notice to Take Action. These actions and the additional response to the further concerns raised by Coroner Hawkins has obviated the need to hear witness evidence. Accordingly, I determined that this matter would be appropriately finalized by way of a Form 37 *Finding into Death with Inquest* and to hand down my findings at the conclusion of a summary inquest. Interested parties were informed of my determination by way of a Summary Inquest Notice dated 12 April 2021.

IDENTITY

38. On 4 March 2018, Raelene Hill visually identified Julie-Anne Marie Kettle, born 15 July 1967, who she had known for three years.

39. Identity is not in dispute and requires no further investigation.

CAUSE OF DEATH

40. On 7 March 2018, Dr Melanie Archer, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine, performed an examination and provided a written report of her findings dated 18 July 2018. In that report, Dr Archer concluded that a reasonable cause of Julie-Anne's death was *Bronchopneumonia in the setting of supratherapeutic lithium levels.*

41. Dr Archer commented as follows:

    (a) Lithium toxicity was clinically suspected to be the cause of the Julie-Anne's initial presentation to hospital. However, autopsy did not reveal the reason why lithium levels became supratherapeutic.

    (b) Lithium toxicity can result in confusion, seizures, tremors, renal impairment, diarrhoea, nausea and vomiting. It may be caused by acute ingestion of a high dose of lithium, or the drug may accumulate more slowly in the system due to infection, dehydration, renal impairment or the effects of certain other drugs, including non-steroidal anti-inflammatory agents, or ACE inhibitors.

(c) Neuropathology examination did not reveal a reason alternative to lithium toxicity for the seizures, drowsiness and tremors. There was no evidence of central nervous system infection, which was confirmed by post-mortem microbiology performed on cerebral spinal fluid and a meningeal swap.

(d) There was renal impairment noted on admission to hospital, which appeared new in comparison to apparently normal renal function in December 2017. Autopsy also did not reveal the reason for this renal function deterioration. In particular, there was no pyelonephritis (kidney infection). Lithium can cause damage to the kidneys over time, but no obvious evidence of this was seen within the limits of post-mortem histology.

(e) It was severe bronchopneumonia, bacterial infection of the lung, which appeared likely on histology to be have been caused by aspiration of gastric contents. Julie-Anne's drowsiness and reported chewing difficulties would have been potential risk factors for aspiration. Bronchopneumonia was the probable explanation for Julie-Anne's cough, fever and oxygen desaturations. Bronchopneumonia can cause death due to a combination of respiratory impairment and bacterial sepsis.

(f) There was detection of prescription medications and paracetamol in keeping with therapeutic use.

42. I accept and adopt Dr Archer's opinion as to Julie-Anne's medical cause of death.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008 (Vic), I make the following comments connected with the death:

43. Julie-Anne had complex physical and intellectual disabilities and required assistance with all the activities of daily life, including assistance in accessing medical attention and treatment. She was entirely dependent others for her care and wellbeing.

44. The coronial investigation and the earlier investigation by the DSC identified a number of shortfalls in the care provided by DHHS at the group home where Julie-Anne resided. None of these shortfalls directly related to either the cause of death or the circumstances of the death, but nonetheless are cause for concern in the context of caring for residents with complex needs, such as Julie-Anne. DHHS has made appropriate concessions about the concerns raised by DSC and this Court. I am satisfied the issues identified have been adequately addressed.

45. The investigation into Julie-Anne's death highlights the importance of reporting the deaths of similarly vulnerable members of our population. At the time of her death, Julie-Anne was 'in care' pursuant to section 3 of the Act; she was "*a person in the care of the Secretary to the Department of Health and Human Services"*. Julie-Anne's care arrangements fell within this definition because she resided in a group house provided by DHHS at 83 Williams Road, Wangaratta. On 26 May 2019, this group home was transferred from DHHS to a community services organisation, Home@Scope. From October 2019, the DHHS maintains management for only 10 group homes in the State of Victoria. All the remaining group homes were transferred to community service organisations in order to implement the National Disability Insurance Scheme in Victoria. Deaths in group homes transferred to community service organisations do not meet the definition of '*in care'* pursuant to section 3 of the Act. This means the deaths are no longer be mandatorily reportable to the Coroners Court of Victoria unless they fall within one of the other categories of reportable deaths under s 4 of the Act.

46. There are many Victorians, like Julie-Anne, who are vulnerable by the dependence on others to provide care or assistance with their daily living activities. It is essential that there is effective and independent investigations by the Court to examine the circumstances of their death and make recommendations to contribute to the reduction in the number of preventable deaths and promoting public health and safety and the administration of justice, even where the deaths are by natural causes.

47. I agree with the views expressed by other Coroners that the Coroners Act should be amended to ensure that all vulnerable persons in care in Victoria are encapsulated within the definition of '*in care'* regardless of the classification of those person, such as funding or management arrangements. These anticipated amendments have been made in New South Wales and Queensland and should be made in this jurisdiction.

FINDINGS

Having investigated the death of Julie-Anne Kettle and having held an Inquest into her death, I make the following Finings pursuant to s 67(1) of the Coroners' Act 2008 (Vic):

48. The identity of the deceased is Julie-Anne Marie Kettle, who was born on 15 July 1961, and who died on 4 March 2018 at North East Health, Wangaratta, Victoria from *Bronchopneumonia in the setting of supratherapeutic lithium levels*.

49. Julie-Anne Kettle resided in a DHHS provided 'group home' at 83 Williams Road, Wangaratta. As such, I find that she was 'in care' immediately before her death pursuant to the definition contained within section 3 of the Coroners Act 2008 (Vic).

50. Julie-Anne Kettle presented to North East Health, Wangaratta on 2 March 2018 with symptoms of lithium toxicity. In the weeks leading up to her death, Julie-Anne's health declined and she was reviewed by her GP a number of times. On the last visit to the GP on 2 March 2018, blood tests indicated that Julie-Anne's lithium levels were too high. Dr Chavez-Molina arranged for transportation to Wangaratta Hospital, too occur as soon as possible.

51. I have not found any shortcomings in the care provided by Dr Chavez-Molina or Wangaratta Hospital and I acknowledge the complexity involved with managing a patient such as Julie-Anne, who had intellectual disabilities, limited communication skills and multiple co-morbidities. The records indicate that the clinical care provided was timely and appropriate.

52. I have not identified any concerns about the care provided to Julie-Anne by her carers. The evidence indicates that the staff at the home were diligent and escalated medical care when appropriate. The issue relating to the delay in providing compression tights was unfortunate but was not the result of a lack of care by the staff immediately caring for Julie-Anne. In any event, the delay in proving the compression tights did not cause or contribute to Julie-Anne's death.

53. I do have concerns about the care provided by DHHS in the lead up to Julie-Anne's death, including:

    (a) Failure to treat swollen legs in a timely way;

    (b) Management of her behaviours;

    (c) Management of falls risks;

    (d) Inadequately addressing the issue of incompatibility with a co-resident; and

    (e) The unauthorized use of restrictive interventions.

54. I do not find, however, that Julie-Anne's death would not have occurred had the identified shortfalls not occurred. The nature of Julie-Anne's co-morbidities and the excess fluid consumption made treatment complex. Further, the drowsiness and reported chewing difficulties were risk factors for aspiration which probably caused the bronchopneumonia.

55. I acknowledge and accept the concessions made by the DHHS in relation to Julie-Anne's care.

PUBLICATION

Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

I convey my sincere condolences to Julie-Anne's family.

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

Ms Joy Kettle Holinger, Senior Next of Kin

Secretary, Department of Health and Human Services

The Disability Services Commissioner

Dr Chavez-Molina, Wangaratta Medical Centre

North East Health, Wangaratta.

Signature:

KATHERINE LORENZ

CORONER

Date: 25 June 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.