



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> days of July 2012 and the 13<sup>th</sup> day of June 2013, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Judith Ann Lambert.*

*The said Court finds that Judith Ann Lambert aged 69 years, late of 8 Dewey Street, Elizabeth East, South Australia died at Elizabeth East, South Australia on the 16<sup>th</sup> day of February 2010 as a result of left pontine haemorrhage. The said Court finds that the circumstances of her death were as follows:*

### **1. Introduction and cause of death**

- 1.1. Judith Lambert died on 16 February 2010 at her home address. She was aged 69 years. An autopsy was carried out by Professor Byard of Forensic Science SA who gave the cause of death as left pontine haemorrhage<sup>1</sup>, and I so find. In his report Professor Byard commented that death was due to haemorrhage into the pons associated with hypertensive vascular disease. Although Ms Lambert was not found until 17 February 2010, she was last seen alive by a neighbour at approximately 9am on 16 February 2010. She was to have attended a routine medical appointment with her general practitioner later that day. She failed to attend that appointment. For this reason I consider it likely that she died that day.

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<sup>1</sup> Exhibit C2a

## 2. **Background**

- 2.1. Ms Lambert had a medical history which included tuberculosis, Bell's palsy, reflux oesophagitis, irritable bowel syndrome, diabetes mellitus, hypertension, hypercholesterolaemia and zero positive rheumatoid arthritis.
- 2.2. On 2 February 2010 Ms Lambert attended her general practitioner, Dr Tan, for a routine visit. The purpose of the visit was for bloods to be taken for a review of her rheumatoid arthritis condition. Dr Tan also took Ms Lambert's blood pressure. During the consultation Ms Lambert complained to Dr Tan of a two week history of slurred speech. Dr Tan did not notice any neurological symptoms, but on the strength of that complaint he referred Ms Lambert to Benson Radiology for a CT scan of her head. In his referral Dr Tan mentioned Ms Lambert's clinical symptom as 'slurry speech'. He also mentioned that she had short term memory loss and a history of rheumatoid arthritis<sup>2</sup>. A follow-up appointment was made for Ms Lambert for 16 February 2010. It was this appointment which, as I have noted above, she failed to attend.
- 2.3. Nine days after her appointment with Dr Tan, namely 11 February 2010, Ms Lambert attended at Benson Radiology for a CT scan of her head. While conducting the initial scan the radiographer, Ms Gregory, noted an abnormality which she drew to the attention of the radiologist, Dr Shan Bau. After consulting with Dr Bau, Ms Gregory conducted a further scan using IV contrast. The second scan was performed and Ms Lambert was asked to remain on the premises for 15 minutes afterwards as required by the Benson Radiology protocol for IV contrast use<sup>3</sup>. However, Ms Lambert was not asked to remain on the premises to await the CT scan images. As a result Ms Lambert left the premises before Dr Bau reviewed the pre and post contrast scans. She carried out that review around midday, approximately an hour and a half after Ms Lambert's appointment time. She identified a mass on the left side of the pons. The radiology report that was prepared by Dr Bau states under conclusion as follows:

**'Hyperdense area within the left side of the pons. The possibilities are between a hypertensive bleed or hypercellular tumour. Further evaluation including MRI is advised.**

**Dr Tan was notified by phone'<sup>4</sup>**

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<sup>2</sup> Exhibit C11b

<sup>3</sup> This was a precaution against any adverse reaction to the contrast fluid

<sup>4</sup> Exhibit C13a

The report was digitally signed at 12:37pm that day. Prior to signing the report, Dr Bau contacted Dr Tan by telephone as is apparent from the note to that effect in the report. I will deal with the content of that conversation later in this finding. It is sufficient at this point to note that Dr Bau conveyed her findings to Dr Tan and requested that Ms Lambert be asked to attend his surgery for referral for neurological opinion. She also informed Dr Tan that Ms Lambert had left the radiology department at that time and Dr Tan agreed to contact Ms Lambert. Dr Bau caused a copy of her report to be faxed to Dr Tan's surgery. Furthermore, an electronic copy of Dr Bau's scan was emailed to Dr Tan's surgery at 9am the following morning, Friday 12 February 2010.

- 2.4. Efforts were then made by Dr Tan's receptionist, Ms O'Doherty, to make contact with Ms Lambert by telephone. I will detail these further later in this finding. For present purposes it is sufficient to say that the efforts were not successful and Ms Lambert was found deceased by her daughter in the late afternoon of 17 February 2010.

### **3. Expert opinion**

- 3.1. An expert opinion was obtained in this matter from Dr Boundy, neurologist<sup>5</sup>. Dr Boundy made the following remarks in her report. If Ms Lambert had been reviewed by a neurologist or a neurosurgeon then:

'... adequate care particularly of her blood pressure (which has been chronically elevated) would have occurred.

In light of her stable clinical state at that time and the position of the haemorrhage, it is unlikely that they would have drained this surgically. She may have been at risk of further injury from the surgery.

However, superimposed hypertension could lead to re-bleeding and this could have been avoided. At the time the CT was performed, the haemorrhage was not acute, possibly at least two weeks old.'

Dr Boundy added that it is likely that if Ms Lambert had had her scan more urgently, or been referred to a neurosurgical unit after her scan, that the outcome could have been different. She noted that there is almost always some deficit after a brain stem haemorrhage. Nevertheless, Ms Lambert was quite stable at what appeared to be two weeks after the onset of the symptoms. Dr Boundy noted that the post-mortem findings suggested that death was due to re-bleeding and this may have been

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<sup>5</sup> Exhibit C15, page 2

minimised by good control of blood pressure. While accepting that Ms Lambert may have had some neurological deficit and may not have recovered completely, Dr Boundy summarised her conclusion as follows:

'The terminal event however, may have been a re-bleed into the brain stem. This might have been able to be avoided with good blood pressure control. She could have been referred to either the Lyell McEwin Stroke Service or a major hospital or the Neurosurgical Service at the Royal Adelaide. It is possible that she had uncontrolled high blood pressure which had been noted during previous GP consultations and this led to the re-bleed and terminal event.'<sup>6</sup>

#### **4. Ms Lambert's blood pressure**

- 4.1. Dr Tan gave evidence about Ms Lambert's complex medical history<sup>7</sup>. She had very severe rheumatoid arthritis, nodal arthritis, diabetes mellitus Type 2, hypertension, she was an active smoker, she suffered with asthma, chronic obstructive airways disease, she had past renal tuberculosis, she had fatty liver, gastritis and oesophageal pyrosis and previously Bell's palsy.
- 4.2. Dr Tan had carefully tracked Ms Lambert's blood pressure having regard to her hypertension<sup>8</sup>. Dr Tan regarded her blood pressure as being under reasonable control over a period of time. In short, Dr Tan had formed the opinion that for a woman with her comorbidities, her blood pressure control was reasonable.
- 4.3. In this light I think that I should say something about Dr Boundy's remarks about what she referred to as Ms Lambert's 'uncontrolled' blood pressure. Dr Boundy was not called to give evidence and was therefore not examined on this matter. Certainly it was never suggested in submissions by counsel for Dr Tan that Dr Boundy was incorrect to suggest that with good blood pressure control the re-bleed might have been avoided. If any such suggestion had been made, Dr Boundy could have been called and the issue considered in greater detail. I am confident that Dr Boundy's evidence should be interpreted as not suggesting that Ms Lambert's blood pressure was 'uncontrolled' over a long period. It is probable that Dr Boundy would acknowledge that the chronic hypertension which Ms Lambert suffered had been controlled as well as might be expected in a patient such as Ms Lambert. However, against the background of the evidence of haemorrhagic lesion revealed by the CT

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<sup>6</sup> Exhibit C15, page 3

<sup>7</sup> Transcript, page 16

<sup>8</sup> Exhibit C11a

scan, more aggressive management of her blood pressure in a neurological setting might have prevented a re-bleed. Certainly, this would appear to me to be the flavour of Dr Boundy's report: I note that Dr Boundy refers to Ms Lambert as having had chronically elevated blood pressure<sup>9</sup>. In summary, it is my view that the long term general management of Ms Lambert's blood pressure by Dr Tan is not something that Dr Boundy overlooked. Indeed, no such suggestion has been made by counsel for Dr Tan or anyone else. Dr Boundy's opinion that conservative management of Ms Lambert's blood pressure might have prevented a re-bleed was never challenged. Indeed, Dr Boundy offered the alternative possibility of surgical intervention. Presumably, if Ms Lambert had been reviewed by a neurosurgeon, and it was not possible using conservative management to reduce the risk of a re-bleed by more aggressive blood pressure control, the surgical option would have been considered.

## **5. The telephone conversation between Dr Bau and Dr Tan**

- 5.1. Dr Bau gave evidence that she contacted Dr Tan by telephone immediately after seeing the images to notify him firstly of her findings and secondly that Ms Lambert had already left the department<sup>10</sup>. She said she informed Dr Tan that 'to again expedite treatment for the patient that the best place would be a hospital'<sup>11</sup>. She told Dr Tan that it was her opinion that the scans were more likely indicative of a haemorrhage than a hypercellular tumour<sup>12</sup>. Dr Bau told Dr Tan that Ms Lambert would probably need a neurosurgical opinion and that was probably best obtained at the Royal Adelaide Hospital. At this point, according to Dr Bau, Dr Tan asked her to send the patient back to him, a request that surprised her in view of her previously having informed Dr Tan that Ms Lambert had already left the department. She responded to Dr Tan by repeating that Ms Lambert had already left the premises. At that point Dr Tan informed her that he would contact Ms Lambert<sup>13</sup>. In response to a question asked by Dr Tan's counsel in cross-examination as to the immediacy or the urgency conveyed by Dr Bau to Dr Tan, Dr Bau gave the following evidence:

'I believe in my phone conversation with him that I made sure that it was an urgent - the sense of urgency was conveyed. However I'm unaware as to when he made any calls.'<sup>14</sup>

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<sup>9</sup> Exhibit C15, page 2

<sup>10</sup> Transcript, page 125

<sup>11</sup> Transcript, page 126

<sup>12</sup> Transcript, page 126

<sup>13</sup> Transcript, page 126

<sup>14</sup> Transcript, page 148

- 5.2. It is true that Dr Bau did not expressly convey a sense of urgency for follow-up treatment in the written report. When this was put to Dr Bau in cross-examination, she said that as a medical officer she believed Dr Tan should understand the urgency of her written findings<sup>15</sup>. In his evidence Dr Tan had no recollection of the content of that conversation, although he recalled that it took place. From the report, he concluded that it was important that Ms Lambert be contacted as soon as possible so that she could be referred to a hospital for an MRI. When asked what he meant by ‘as soon as possible’ he said that she should be contacted within 2 or 3 days<sup>16</sup>.
- 5.3. I note that in his medical records Dr Tan made an entry about his conversation with Dr Bau of 11 February 2010. It is clear from that entry that Dr Tan understood that it was urgent for Ms Lambert to seek further review, indeed he used the expression ‘STAT’, a medical expression for immediately<sup>17</sup>.

**6. Evidence with respect to contacts made by Ms O'Doherty to Ms Lambert's telephone line**

- 6.1. Evidence was received from the Telstra Corporation of telephone calls made from Dr Tan's surgery<sup>18</sup>. The records demonstrate that no telephone call was made to the home of Ms Lambert on 11 February 2010 by Dr Tan's surgery.
- 6.2. On Friday 12 February 2010, 14 attempts were made to contact Ms Lambert from the telephone at Dr Tan's surgery. None of these attempts was successful. No attempts were made to contact Ms Lambert from the telephone at Dr Tan's surgery on Saturday 13 February, Sunday 14 February and Monday 15 February 2010.
- 6.3. On Tuesday 16 February 2010 Ms Lambert had an appointment at 10:10am at Dr Tan's surgery which she did not keep. The Telstra Corporation records show that one attempt was made to contact Ms Lambert by telephone following the missed appointment on 16 February 2010. This attempt was not successful<sup>19</sup>.

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<sup>15</sup> Transcript, page 148

<sup>16</sup> Transcript, pages 37-38

<sup>17</sup> Exhibit C9

<sup>18</sup> Exhibit C10

<sup>19</sup> Exhibit C10

- 6.4. On Wednesday 17 February 2010 two attempts were made to contact Ms Lambert by telephone, neither of which was successful<sup>20</sup>.
- 6.5. Dr Tan acknowledged that at no stage between 11 February and 17 February 2010 did he instruct Ms O'Doherty or otherwise cause contact to be made with either the South Australia Police or the South Australian Ambulance Service to conduct a welfare check upon Ms Lambert. Dr Tan acknowledged that he should have sought the assistance of South Australia Police for a welfare check.
- 6.6. It is clear from Dr Tan's evidence and from his medical notes that he appreciated the urgency of the matter on 11 February 2010. He understood that between 11 February and 17 February 2010, 17 telephone calls were made from Dr Tan's surgery, presumably by Ms O'Doherty. Dr Tan did not suggest that he made any effort to contact Ms Lambert personally. In that period a weekend intervened (13 and 14 February 2010).
- 6.7. In my opinion it was not sufficient for Dr Tan to do no more than he did. In my view he should have put in place a plan to ensure that Ms Lambert was contacted no later than close of business on 12 February 2010. Dr Tan himself acknowledged that she needed to be contacted within 2 or 3 days. If that was his opinion on 11 February 2010, a Thursday, then he needed to take into account that the weekend was imminent. The only way to achieve his timeframe would have been to make certain that a plan to ensure that contact was made was in place no later than close of business on the Friday. Dr Tan failed to make any such arrangement. The matter was urgent, Dr Tan appreciated the urgency and did not take sufficient steps to ensure that Ms Lambert be contacted.

## **7. Dr Bau's responsibilities**

- 7.1. Dr Bau frankly acknowledged that she should have asked the radiographer, Ms Gregory, to ask Ms Lambert to wait for her scans to be reported<sup>21</sup>. However, the opportunity for that having passed, Dr Bau did appropriately convey the urgency of the situation to Dr Tan. She contacted him by telephone and she made it plain to him that Ms Lambert had left the radiology premises and that she needed to be sent for neurological follow-up. She expected that as a medical officer Dr Tan would have

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<sup>20</sup> Exhibit C10

<sup>21</sup> Transcript, page 145

appreciated the urgency of the situation. In her evidence she said that she attempted to convey a sense of urgency in the telephone conversation. In my opinion she ought not to be criticised for her role in this unfortunate matter.

7.2. Benson Radiology has initiated policy changes in response to this event. That policy is entitled Management of Patients with Urgent Unexpected or Sinister Findings<sup>22</sup>. In my opinion that document is commendable.

### 7.3. **Recommendations**

7.4. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

7.5. I recommend that the Minister for Health negotiate with the Australian Medical Association, the Royal Australian College of General Practitioners, or another appropriate body representing general practitioners in South Australia, to ensure that when urgent, unexpected or sinister findings are reported following medical imaging, the general practitioner should ensure that if the patient concerned is not notified within 48 hours of the finding (or less if clinically indicated), the general practitioner must make contact with the South Australian Ambulance Service or South Australia Police to ensure that a welfare check is conducted and that the patient is advised to contact his or her general practitioner.

*Key Words: Haemorrhage; General Practitioner (contact)*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 13<sup>th</sup> day of June, 2013.*

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*State Coroner*