CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 14th and 15th days of December 2011, the 5th, 6th, 7th and 15th days of March 2012 and the 13th day of December 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Mary Patricia Kruger.

The said Court finds that Mary Patricia Kruger aged 69 years, late of the Philip Kennedy Centre, Everard Street, Largs Bay, South Australia died at the Queen Elizabeth Hospital, Woodville Road, Woodville West, South Australia on the 6th day of March 2008 as a result of bronchopneumonia and intracranial tumour. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. Mary Patricia Kruger died on 6 March 2008. A post-mortem examination was conducted and a report prepared giving the cause of death as bronchopneumonia complicating intracranial tumour[1]. I find this to have been the cause of Ms Kruger's death. Neuropathological examination of the brain revealed a massive subfrontal meningioma with brain invasion and obstructive hydrocephalus[2].

2. Background

2.1. Ms Kruger was the eldest of four children and she was raised on a dairy and orchard farm near Murray Bridge. She suffered an accident on the farm when she was 14 years of age and there is a suggestion that she may have suffered a mild brain injury at

[1] Exhibit C2a

that time. She remained on the farm with her parents until her mother died and her father moved to live with family in Bendigo. She then went to live with a family on a neighbouring property. Despite the head injury Ms Kruger's younger sister, Josephine Kelly, remembers Ms Kruger as being a normal girl who rode horses and played with her siblings.

2.2. In 1996 Ms Kruger moved into a Housing Trust unit in Murray Bridge and lived alone and independently. Her sister, Ms Kelly, visited her regularly and stated that her house was always clean and tidy and her health and eyesight were good.

2.3. In around the year 2003 Ms Kruger told her sister that she was having difficulty with the sight in her left eye. However, she was still mobile and could see well enough to get about. In 2004 and 2005 Ms Kelly noted a change in her sister's living conditions. Her unit was becoming dirty and smelly. Ms Kruger's eyesight in her right eye was also failing and her personality had changed. Ms Kelly noted that Ms Kruger had become aggressive and argumentative and was difficult to deal with.

2.4. In November 2006 Ms Kruger had a fall at home. As a result of this she was taken to Murray Bridge Hospital. During her admission she was treated for a urinary tract infection and seen by a social worker who investigated her living arrangements. An Aged Care Assessment Team assessment was undertaken with a view to placing Ms Kruger in a nursing home. There are a number of entries in the casenotes relating to Ms Kruger's short-term memory loss but the notes do not reveal a formal diagnosis of dementia. At the Inquest I heard from the doctors who saw Ms Kruger during her admission and the Inquest focussed upon the question of whether there was in fact a diagnosis made during this admission.

2.5. In December 2006 a placement was approved for Ms Kruger at the Philip Kennedy Centre in Largs Bay. She was taken there on 8 December 2006. A nursing discharge summary dated 6 December 2006 from the Murray Bridge Hospital casenotes describes her principal diagnosis as acopia, which is not a medical term, but which is intended to convey that the patient is unable to care for himself or herself or to maintain independence. There is also a medical discharge from the Murray Bridge Hospital dated 7 December 2006 which states that the principal diagnosis was dementia with secondary conditions being a urinary tract infection and cataracts. The

[2] Exhibits C4a and C4b

medical discharge was signed by a Dr Tommy van Wyngaard who gave evidence at the Inquest and I will discuss that evidence shortly. Although the medical discharge might imply that there was a formal diagnosis of dementia during the admission to Murray Bridge Hospital, as the evidence showed, it was far from clear that there was any proper basis for this. Nevertheless, the label of dementia stuck and featured heavily throughout the Philip Kennedy Centre casenotes and the subsequent handling of Ms Kruger's case. Ms Kruger settled in well initially at the Philip Kennedy Centre but after approximately a month, behavioural difficulties became apparent. Ms Kruger displayed intrusive and disinhibited behaviour and would often wander into other residents' rooms at night. She would sometimes become aggressive and would threaten violence. She was under the care of a local general practitioner who consulted at the nursing home, Dr Warwick Pye. She was also attended to by a physician, Dr Jason Ng. Over the course of the following six months Ms Kruger's behavioural problems escalated and her eyesight deteriorated further. She then developed a marked tremor of her hands. By December 2007 she was noted to have involuntary movements of the body with shaking of hands and inability to hold utensils at meal time without difficulty. At that time the general practitioner, Dr Pye, began to suspect Parkinson's disease. He prescribed a dose of sinemet with a review in three weeks however the tremors continued and by the end of January 2008 Ms Kruger required the use of a wheelchair. She was referred to Dr Ng who saw her in February 2008. He formed the opinion that she had early Parkinson's disease but in the setting of her dementia he could not exclude the possibility of Lewy Body disease. He advised the continued use of sinemet. Throughout February 2008 Ms Kruger had brief periods of alertness but for the most part she was sleepy, disoriented and had difficulty feeding herself or walking without assistance. On 5 March 2008 she was found unresponsive in her bed at 0515 hours. An ambulance was called and she was taken to the Queen Elizabeth Hospital. A CT scan undertaken at that hospital the same day revealed a large meningioma causing gross mass effect on the frontal lobes bilaterally. There was also hydrocephalus and possible filling of the pituitary fossa. Ms Kruger was transferred into the palliative care ward and died at 12 noon the following day, 6 March 2008.

2.6. At the Inquest I heard evidence from treating medical practitioners and expert evidence from neurologist, Dr Karen Boundy. I also heard expert evidence from geriatrician, Associate Professor Whitehead.

3. Dr Andrew Mills

3.1. Dr Mills gave evidence that he was Ms Kruger's treating general practitioner in Murray Bridge. He described her as living independently in the late 1990s. She was able to get to the clinic for appointments, although things had to be explained simply. It was his impression that she had a mild intellectual deficit but was certainly oriented as to time and place. Dr Mills described seeing Ms Kruger on 20 October 2005 when he made a note that her house was reportedly untidy and unhealthy. Prior to that Dr Mills had no indication that Ms Kruger was not coping. Dr Mills arranged home and community care assistance so that Ms Kruger could continue to live at home.

3.2. The next significant event from Dr Mills' point of view was that on 15 May 2006 Ms Kruger presented at the clinic complaining of a loss of vision in her left eye. Dr Mills arranged a referral to an eye specialist and took routine blood tests. He referred her to ophthalmologist, Dr Peter Cooper, whose report he described as inconclusive.

3.3. Dr Mills was away in early November 2006 and returned to work at the clinic on the 20th of that month. He was therefore not at work when Ms Kruger was admitted to the Murray Bridge Hospital earlier that month. On the day of his return he was consulted by Ms Kelly (Ms Kruger's sister) who informed him that her sister was in hospital. Dr Mills' casenote for that appointment reads as follows:

> 'Discussion with Jo Kelly re sister Mary Kruger (28876) in hospital with UTI dementia encouraged to stay there. Jo is keen for Mary to be placed in nursing home near her at Semaphore. Agrees with AWM plan to institute Guardianship Board procedure. Has been concerned that neighbours are getting money out of her because Mary does not quite know what is going on. Needs eye appointment with P Cooper. Appointment for Monday December 11th 4:30pm. Jo to get Power of Attorney for future care for Mary if can. Bev Scarvelis at SMH involved may agree to go to Semaphore Nursing Home voluntarily. If does this would solve a number of issues. Review PRN.' [3]

3.4. Dr Mills gave evidence that the reference to 'UTI dementia' in that casenote was information given to him by Ms Kelly who explained that as being the reason for Ms Kruger's admission to hospital.

3.5. Dr Mills went to see Ms Kruger the following day. He said that he found her to be quite cheerful and pretty much the normal Ms Kruger that he knew. He could tell that she had been diagnosed with a urinary tract infection and he knew that could lead to

[3] Exhibit C5a

confusion and behaviour that was out of character. He said that this is not an uncommon occurrence with older female patients. He noted that a mini-mental examination had been carried out giving a score of 24 out of 30. He said that would normally be concerning but he considered that with Ms Kruger it was explained by the urinary tract infection and her normal mild intellectual deficit. His view was that she had not experienced a decline in her cognition and executive function. He was aware that her urinary tract infection was being treated and was getting better. His evidence was that he did not contemplate a diagnosis of dementia because he did not think that Ms Kruger fitted the criteria for that diagnosis and that there were a number of other reasons to explain her episode earlier in the month. His plan was to get her seen by the ophthalmologist, Dr Cooper, and an appointment was made for 11 December 2006 at 4:30pm for that purpose. Dr Mills' evidence was that during that admission up until 29 November 2006, he had not had cause to consider investigating Ms Kruger for dementia. He explained what he would have done had he thought that necessary. He described how investigations for dementia have changed over time. He said that between 2000 and 2007 the tendency became to increasingly use CT scans and that in that period 80% of his diagnoses involved using CT scans. He explained that the purpose of a CT scan is one of exclusion. The scan does not make the diagnosis of dementia, but it serves to exclude other treatable causes for the patient's presentation[4].

3.6. Dr Mills explained that on 29 November 2006 he went away on holidays and handed over his care of Ms Kruger to another general practitioner at the Murray Bridge Clinic, Dr van Wyngaard[5]. Dr Mills said there was a verbal discussion between himself and Dr van Wyngaard. Dr Mills asked if Dr van Wyngaard would agree to take over the care of Ms Kruger and that he would have given a verbal outline of where he thought she was up to. It was Dr Mills' expectation that when he came back from his holiday, Ms Kruger would likely still be in the Murray Bridge Hospital. Although he was aware that there was to be an ACAT assessment to find a place for a nursing home, he did not expect that such placement would occur during the period he was on leave[6]. When Dr Mills returned from his leave Ms Kruger had been discharged from the Murray Bridge Hospital and he did not see her again. Dr Mills also explained that because of his own personal circumstances concerning his wife's

[4] Transcript, page 41
[5] Transcript, page 43
[6] Transcript, page 44

mother, he was 'hypersensitive' about using the term 'dementia' inappropriately[7]. He went into some detail in his evidence to describe those family circumstances which do not need to be repeated here. As a result his evidence was that he was well aware of the significance of a diagnosis of dementia and would not have arrived at such a diagnosis without a proper workup because of his 'hypersensitivity' which was current at the time of Ms Kruger's admission to the Murray Bridge Hospital. Dr Mills never received a copy of the patient discharge summary I have previously referred to which had a principal diagnosis of dementia[8]. His evidence was that had he seen that document with that diagnosis he would have been concerned about it because a diagnosis of dementia had not been established at that stage[9]. It was Dr Mills' evidence that the discharge summary would have been printed by Dr van Wyngaard and filled out by hand and that he then must have taken it to the hospital without putting a copy of it on the clinic notes[10].

3.7. Dr Mills was asked about the ACAT assessment which was carried out by an ACAT assessor called Kay Bignall, who also gave evidence at the Inquest. The ACAT assessment[11] records at page 25 that Ms Kruger had dementia. Dr Mills gave evidence that Ms Bignall did not speak to him about a diagnosis of dementia. He did not have any recollection of Ms Bignall speaking to him on the day of the assessment which was 28 November 2006 and therefore prior to him handing over to Dr van Wyngaard[12]. He said that it was inappropriate for someone in Ms Bignall's position to make a diagnosis of dementia and that if Ms Bignall had informed him that she was going to record that diagnosis on the ACAT assessment, he would not have agreed to that proposal because he had not come to that diagnosis at that stage. He said:

> 'My diagnosis was of somebody who had a mild intellectual disability with getting over a significant urinary tract infection and loss of vision which I didn't think we got to the bottom of as yet.' [13]

Dr Mills acknowledged that Ms Kruger's sister had mentioned dementia when he saw her on 20 November 2006 and explained that he did not feel alarmed at the mention of dementia because at that stage he had not seen Ms Kruger, but knew that she was in hospital. He simply had no opinion one way or the other, but he certainly was not of the opinion that Ms Kruger did in fact have dementia.

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[7] Transcript, page 49
[8] Transcript, page 54
[9] Transcript, pages 54-55
[10] Transcript, page 58
[11] Exhibit C7

4. Evidence of Dr van Wyngaard

4.1. As a result of the evidence of Dr Mills and his denial that he had diagnosed Ms Kruger with dementia, it was necessary to call Dr van Wyngaard. Dr van Wyngaard was a general practitioner who qualified in South Africa in 1998. He came to Australia in 2006 and started work in November 2006 at the Bridge Clinic with Dr Mills and the other practitioners at that location. He presented as a very straightforward witness and gave his evidence in a forthright and frank manner. He said that he had just started working at the hospital and the clinic and he remembered his conversation with Dr Mills at the Murray Bridge Hospital about Ms Kruger. He said that Dr Mills asked him to look after Ms Kruger until she went to a nursing home[14]. Dr van Wyngaard said this conversation took place in the duty room at the Murray Bridge Hospital. He said that Dr Mills personally asked him to look after Ms Kruger while he was on leave. He said Dr Mills said that unfortunately Ms Kruger was still in hospital and would Dr van Wyngaard look after her until she was discharged to the nursing home. Dr Mills, according to Dr van Wyngaard, said that the patient was elderly with dementia and had experienced a slow cognitive decline. She had been admitted acutely with a urinary tract infection but the acute condition had ceased under treatment. She was now stable and he had arranged a transfer to a nursing home as she could not care for herself and had been living in squalid conditions[15]. Dr van Wyngaard said:

> 'Whether he said demented state or dementia, that would be speculation, but I heard the word dementia and that would be to state her cognitive situation at that stage. ' [16]

Dr van Wyngaard said this handover discussion probably took 6 to 10 minutes[17].

4.2. Dr van Wyngaard said that he looked in on Ms Kruger periodically between 29 November 2006 and 8 December 2006 when Ms Kruger was discharged to the nursing home. The previous day Dr van Wyngaard had been told that Ms Kruger would be discharged the next day and that he needed to do the prescriptions and a discharge letter. He said that he queried with the nursing staff whether the discharge letter and prescriptions had not already been done by Dr Mills because Dr Mills had

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[12] Transcript, page 61
[13] Transcript, page 62
[14] Transcript, page 292
[15] Transcript, page 292
[16] Transcript, page 293
[17] Transcript, page 294

told him that he had arranged for a transfer and Dr van Wyngaard assumed that meant that he had done these things[18]. These things had not been done and accordingly Dr van Wyngaard went to the hospital to write the discharge summary. He acknowledged that he had written the principal diagnosis as dementia and stated:

> 'I wrote this information as Dr Mills supplied me with it and from what I got from the clinical notes and I made an arrangement, made it clear, that I would not be following up the patient and that follow up appointments were to be made with Dr Mills, or the doctor attending the area of placement. So I was happy that the diagnosis that I'd written there was in line with what Dr Mills had told me and referred that back to him, so if he would see the patient again, he would have full view of this diagnosis and summary that I wrote on his behalf.' [19]

4.3. It was also Dr van Wyngaard's evidence that his understanding was that after the completion of the ACAT assessment Ms Kruger's status was to change from a hospital patient to that of a nursing home patient. The effect of this would be that there would be no Medicare funding for a doctor's attendance upon her unless her condition changed and she required specific attention. This evidence is supported by a form contained within Ms Kruger's Murray Bridge Hospital casenotes[20].

4.4. Dr van Wyngaard had no recollection of Dr Mills having told him that Ms Kruger was likely to be still in hospital when he returned from his leave. He had no recollection of Dr Mills stating that he did not expect Dr van Wyngaard to be the discharge doctor either[21]. Dr van Wyngaard said that he was not aware of the nursing discharge summary which gave a diagnosis of 'acopia'. He denied that he told the nurse who wrote the discharge summary to include that term. He said it was a term he himself would not use.

4.5. It was put to Dr van Wyngaard that there was no dementia 'workup' in Ms Kruger's hospital notes. He said that is why he went on Dr Mills' information. He said that he was not troubled by the absence of a workup in the notes explaining that doctors do not write everything in the notes. Dr van Wyngaard elaborated:

> 'There was no written diagnosis, he never wrote it down but that might not have been - because he knew the patient, he's been the long-term carer. So when I sat down with Dr Mills he asked me if I would be available to be there should there be need, what he verbally explained to me is that this is a 68 year old patient, she's got dementia and she's

[18] Transcript, page 299
[19] Transcript, page 302
[20] Transcript, pages297-298
[21] Transcript, page 311

> going to a nursing home. That has all been arranged but yes you're right, he did not qualify the exact kind of dementia, the exact diagnostic classification of the dementia.' [22]

4.6. In summary, Dr van Wyngaard flatly denied the proposition put to him by Dr Mills' counsel, namely that Dr Mills did not tell Dr van Wyngaard that Ms Kruger had dementia or was demented.

5. Dr Mills is recalled

5.1. Following the evidence of Dr van Wyngaard I took the view that it was necessary to recall Dr Mills. When recalled, Dr Mills maintained his earlier evidence that he had simply informed Dr van Wyngaard that Ms Kruger was in hospital with an intellectual disability and she was recovering from a urinary tract infection. She had a visual problem which Dr Mills had not gotten to the bottom of, but he had made an appointment for her to see an eye specialist upon his return. He knew that an ACAT process had started and that she was now a nursing home type patient because the hospital was no longer actively investigating any acute issues. He denied telling Dr van Wyngaard that there was a diagnosis of dementia for Ms Kruger. He was however unable to definitively rule out the possibility that the words dementia or demented might have occurred in the conversation with Dr van Wyngaard. However, he found it difficult to see how those words might have come up given that he himself did not consider that Ms Kruger had dementia at that point and he was hypersensitive about the use of the term[23]. Furthermore, it would seem unlikely that in his conversation with Dr van Wyngaard, Dr Mills might have mentioned the word dementia or demented in reference to his earlier conversation some 9 days previously with Ms Kruger's sister in which the latter had told Dr Mills that her sister was in hospital with urinary tract infection dementia. It seems to me to be unlikely that Dr Mills would have made use of that word merely because he was harking back to a conversation with a lay person, namely Ms Kruger's sister some 8 days previously. In short, Dr Mills could not offer any explanation why he might have used the words demented or dementia. It is true that he could not, after 6 years when giving evidence, recall specifically that he did not use either of those words. However, he was a careful witness who was not willing to deny on his oath the possibility that he might have used those words. His evidence was clear though that he did not think his

[22] Transcript, page 322
[23] Transcript, page 556

patient had dementia and that he would not have conveyed any such opinion to Dr van Wyngaard.

5.2. Dr Mills did give evidence that his casenotes for Ms Kruger did contain a cross reference to his consultation with Ms Kruger's sister and that anyone referring to Ms Kruger's casenotes subsequently would have had access to the note of the consultation with Ms Kelly by calling up Ms Kruger's computer record. The implication is that Dr van Wyngaard may have seen the reference to dementia in that manner. However, Dr van Wyngaard was never asked about that matter and this is merely speculation.

5.3. Dr Mills repeated his earlier evidence that when he saw Ms Kruger in the hospital he regarded her as having a similar cognitive state as that which she had when he last saw her and he did not think that she had dementia[24]. Finally, Dr Mills' attention was drawn to the ACAT assessment that had been prepared by Ms Bignall, the ACAT assessor, in which she recorded a diagnosis of dementia. Dr Mills said that he had not spoken to Ms Bignall at any time about Ms Kruger having dementia. His opinion was that a classification such as that in an ACAT assessment should only come from hospital casenotes or from the treating doctor[25].

6. Conclusion as to events at Murray Bridge Hospital

6.1. On a close examination of the evidence of Dr Mills and Dr van Wyngaard I am unable to reach a conclusion as to what transpired between them on 29 November 2006. I found them each to present as a good witness and I am simply not in a position to believe one over the other. However, it can certainly be concluded that the recording of the diagnosis of dementia in the discharge summary produced by Dr van Wyngaard, whether of his own accord or upon the advice of Dr Mills, was a very serious matter which set in train a course of events that resulted in Ms Kruger's untimely death.

6.2. Finally, in relation to Ms Kruger's stay in Murray Bridge Hospital, I should mention that she was also seen by Dr Mills' colleague, Dr Beckoff, during that period. Indeed, he was the doctor who admitted her. His evidence was that he considered that Ms Kruger had a urinary tract infection and he commented that such an infection in a

[24] Transcript, page 562
[25] Transcript, pages 576-578

person her age often contributes to confusion and a diagnosis of delirium. After antibiotic treatment that would improve over an appropriate length of time[26]. Dr Beckoff said he did not consider a diagnosis of dementia. He said that was because dementia is a slowly progressing thing and that Ms Kruger's circumstance was delirium and a confused mental state attributable to an acute condition, namely a urinary tract infection, which was treated resulting in her improvement. He did not consider having a CT scan on the basis that if a patient improves with such treatment that would be sufficient to warrant doing no further investigations at that time[27].

7. Treatment for Ms Kruger's eyesight while living at Murray Bridge

7.1. Dr Mills had referred Ms Kruger to ophthalmologist Dr Peter Cooper by a letter of referral dated 26 June 2006. Dr Cooper gave evidence at the Inquest. He saw Ms Kruger in June 2006 and said that she was complaining of reduced vision in her left eye and that the problem had been occurring over a period of years. Dr Cooper said that Ms Kruger was a difficult historian, no doubt due to her intellectual deficit and, as a result, he found it difficult to obtain the actual facts from her[28]. He noted her corneas as being normal but that the pupils were poorly reactive in both eyes. However, that in itself was not diagnostically significant. He noted that she was getting cataracts and his examination recorded that the optic discs were both normal[29]. He commented that this meant that at the time Ms Kruger did not have significant optic nerve disease and therefore did not have any significant optic nerve compression. He noted that she had macular degeneration. He noted that the vision in her left eye was what he described as vision of hand movements which means that the only sight she had from that eye was an ability to see a hand moving in front of it. He did not think that the cataracts and macular degeneration of themselves was sufficient to account for such poor vision in the left eye. Dr Cooper's plan at that stage was to obtain some more information. He realised that her glasses had not been recently checked and so referred her to her optometrist to ensure that there was no refractive error in the glasses. His intention was to review her following that. Dr Cooper said that he obtained a reply from the optometrist stating that Ms Kruger had been provided with new glasses. However Ms Kruger did not attend on the date made

[26] Transcript, page 105
[27] Transcript, page 107
[28] Transcript, page 78
[29] Transcript, page 80

for the review appointment[30]. A further appointment was arranged for 11 December 2006 but it was cancelled due to Ms Kruger's move to the Philip Kennedy Centre with a note on Dr Cooper's file stating that she would make an appointment for follow-up at the Queen Elizabeth Hospital. Dr Cooper did not consider ordering any radiology. He said that he did not consider that there was any intracranial pathology because it was his observation that Ms Kruger had a healthy optic nerve[31]. He was unable to obtain a measurement of the intraocular pressure of Ms Kruger's eyes because she would not cooperate in that examination[32]. He did not note any optic nerve pallor. He noted that a healthy optic nerve is a light pink colour and if it changes from that to a white colour, that is what is described as optic nerve pallor[33]. His evidence was that most intracranial tumours do not press on the optic nerve[34] and therefore it is not uncommon to have an intracranial tumour that does not cause optic nerve pallor. He agreed that in the initial stages of optic nerve compression from a tumour one might experience visual symptoms but without damage to the nerve at that point[35].

7.2. Dr Cooper said that optic nerve pallor can be explained by the presence of a number of pathologies. He said the most common one in an elderly person would be something akin to a small stroke. Multiple sclerosis might also be a reason for such pathology. He referred also to the effect of illicit drugs as another explanation[36].

7.3. I have noted that Ms Kruger did not keep her appointment to be reviewed by Dr Cooper. In fact, she attended the practice a week later than that appointed time. On that occasion she was seen by Dr Cooper's colleague, Dr Murchland. Dr Murchland said that when he examined Ms Kruger on 25 September 2006 he made a notation querying the possibility of pallor of the optic disc. He said that he compared the optic disc of the left eye with that of the right and noticed that there was a slight difference in the appearance of the colour, the left being slightly paler than the right. He made a note to this effect, but had formed the opinion that the difference was within the normal physiological variance which often occurs from one side of the body to the

[30] Transcript, page 83
[31] Transcript, page 85
[32] Transcript, page 88
[33] Transcript, page 89
[34] Transcript, page 91
[35] Transcript, page 91
[36] Transcript, page 96

other[37]. He said that he did not have a concern about the health of that part of the eye because the difference between the colour of the two nerves was not sufficient to warrant that[38]. He said that he did not consider the possibility that she may have been suffering from a meningioma and commented that he could only remember seeing two or three patients with a meningioma whose optic nerve had been affected during his career[39]. Dr Murchland said that his observation was a matter of subtlety and he would not have been surprised if it had also been observed by Dr Cooper but that the latter may not have thought that the differences were sufficient to make a note.

7.4. In my opinion it would appear that the pallor observed by Dr Murchland at that time, which was obviously not observed by or commented upon by Dr Cooper, was of a very subtle nature.

8. The ACAT assessment in Murray Bridge Hospital

8.1. Ms Kay Bignall gave evidence at the Inquest. She was the ACAT assessor who reviewed Ms Kruger in November 2006. She explained that the purpose of an ACAT assessment is to determine a person's eligibility for Commonwealth funding for nursing home accommodation. She performed the assessment on 28 November 2006 and spoke with a registered nurse and a social worker. A copy of the assessment appears in Exhibit C7. Of significance is that it contains a record that Ms Kruger had the disease dementia under item 28 of the form. This was inserted by Ms Bignall. She was asked why she wrote 'dementia' under that part of the form. She could not remember where that information came from, but she said that she would not have 'just plucked it out of the air'[40]. She went on to say that in her view dementia is a 'generic umbrella term' to indicate a cognitive impairment which might be Alzheimer's, multi-infarct, Korsakoff, brain injury, brain lesions – or simply cognitive impairment[41]. She said that she was not qualified to, nor is it part of her role, to make a diagnosis. She said that in fact she did not make a diagnosis of dementia but that:

> 'It would have come from another source but I've got no recollection where it was mentioned.' [42]

[37] Transcript, page 278
[38] Transcript, page 279
[39] Transcript, page 282
[40] Transcript, page 258
[41] Transcript, page 258
[42] Transcript, page 258

She said that she did not think that an ACAT assessment would be relied upon to determine future medical treatment[43]. She said that she assessed Ms Kruger as being eligible for high level residential care[44]. She said that she did not and would not include dementia as part of the diagnosis in order to obtain a 'fast track' placement[45].

8.2. Ms Bignall could not remember whether she spoke to any of the hospital doctors in relation to Ms Kruger's assessment[46]. Ms Bignall's evidence may be summarised by the following passage:

> 'It's unlikely that I would've written down dementia without having heard it mentioned by a nursing staff or in our clinical meeting. But again, I don't know, I can't remember. I cannot remember what led me to write 'dementia'.' [47]

9. The events following Ms Kruger's transfer to the Philip Kennedy Centre

9.1. Ms Kruger was transferred to the Philip Kennedy Centre on 8 December 2006. Her treating general practitioner at the Philip Kennedy Centre was Dr Pye who was a visiting general practitioner to that Centre. Dr Pye's evidence was that it was his practice in patients of Ms Kruger's age group to arrange for a CT scan before diagnosing dementia[48]. He was not aware that this had not been done in relation to Ms Kruger until he had a contact from the Queen Elizabeth Hospital in March 2008 seeking the results of an assumed CT scan. Dr Pye then checked his notes and discovered that he did not have a copy of a CT scan. He informed the doctor from the Queen Elizabeth Hospital that Ms Kruger had been transferred from Murray Bridge Hospital and that institution would probably have the information. It was his assumption that there would be a CT scan in existence.

9.2. He first saw Ms Kruger on 4 January 2007. The problem on that occasion was mild peripheral oedema. He also made a referral to Dr McGovern, ophthalmologist, for follow-up of Ms Kruger's eye problems. He had no recollection though of what led to him doing so[49]. It is possible that this was a result of information handed over from Murray Bridge Hospital to the nursing home, but I am merely speculating.

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[43] Transcript, page 259
[44] Transcript, page 259
[45] Transcript, page 260
[46] Transcript, page 263
[47] Transcript, page 267
[48] Transcript, page 148
[49] Transcript, page 150

9.3. Dr Pye gave evidence that Ms Kruger was seen soon after that consultation by one of his colleagues in his practice, Dr Ramsay. On that occasion Dr Ramsay referred Ms Kruger to Dr Ng who is a physician with an interest in geriatrics. Dr Pye's next notable event in his treatment of Ms Kruger was when she was thought to have a Parkinsonian tremor in late 2007. On that occasion he prescribed the drug sinemet on 19 December 2007. This was reviewed in January 2008 when it was temporarily halted because Ms Kruger was very sleepy. However, it was reinstituted shortly thereafter because of a recent history of 3 weeks of gross tremor and fasciculation, especially in the upper limbs. She had also experienced a loss of mobility, especially walking. Dr Pye was concerned that there had been no response to the sinemet and he ordered blood tests and requested a review, once again by Dr Ng, to query Parkinsonism. Dr Pye conceded that in retrospect, considering the records as to Ms Kruger's level of function when first admitted in early December and her presentation on 4 January 2007, he should have considered more carefully the diagnosis of moderate to severe dementia[50]. However, it remained his position that he assumed a proper diagnosis had already been made, and although the blood test pathology results from the Bridge Clinic, which were present on the Philip Kennedy Centre nursing home notes, were suggestive that radiology reports had not been done, he responded that he had assumed that the radiology tests had been done outside the hospital[51]. He said that over her period in the Philip Kennedy Centre her condition deteriorated slowly following a progression that he considered compatible with a diagnosis of dementia[52].

9.4. Dr Pye was unable to find any report or information following his referral to the ophthalmologist, Dr McGovern, either in his notes or in the Philip Kennedy Centre notes. In fact there was no such report as will appear from my discussion of Dr McGovern's evidence hereunder. In any event, Dr Pye was closely questioned about whether he had noted a lack of response. His evidence was that it was his normal practise if he did not hear a response following a referral with a specialist, to make contact with the specialist[53]. The Philip Kennedy Centre patient notes for Ms Kruger[54] contain a progress note on 18 March 2007 as follows:

> 'No information received from eye specialist regarding outcome from February. Contact Dr Pye 19/3/07 to enquire if he received any information.'

[50] Transcript, pages 171-173
[51] Transcript, page 174
[52] Transcript, page 175
[53] Transcript, page 150
[54] Exhibit C8

There is a further note on 20 March 2007 as follows:

> 'Contact from MO[55] Pye's surgery regarding request for information from eye specialist visit in February. No information has been received from eye specialist's rooms to MO.'

Dr Pye acknowledged that the import of these notes in the Philip Kennedy Centre records indicated that Dr Pye's rooms at least were aware that there had been no response from Dr McGovern. Furthermore, that the issue was not followed up by Dr Pye's rooms[56]. This is a significant issue as will become apparent when I discuss the evidence of Dr McGovern.

9.5. In summary, it was Dr Pye's evidence that he did not question Ms Kruger's diagnosis of dementia when she was transferred to the Philip Kennedy Centre and that he had made the assumption that the diagnosis would have been properly founded and that a CT scan would have been performed[57]. It was his evidence that with a diagnosis of moderate to severe dementia he considered a patient's treatment to be palliative and that was the way he dealt with Ms Kruger, treating symptoms as they arose and keeping her as comfortable as possible[58]. So far as his failure to follow-up the lack of response from Dr McGovern, he could only say:

> 'I mean occasionally unfortunate things happen, I have no excuse for it. I have no explanation for it, I don't know why it wasn't done.' [59]

9.6. Dr Pye said finally that he has changed his practice since this event. He now makes it a policy to make an appointment to see the family within two weeks of accepting a patient who has been transferred to his care in similar circumstances. Furthermore, he makes sure that in such a case he obtains the full investigations relating to the patient's condition. He no longer is content to assume that there is no need to question a diagnosis[60].

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[55] Medical Officer
[56] Transcript, page 178
[57] Transcript, pages 188-189
[58] Transcript, page 194
[5959] Transcript, page 197
[60] Transcript, page 200

10. The evidence of Dr McGovern - a lost opportunity

10.1. Dr McGovern is an ophthalmologist and he gave evidence at the Inquest. He did not recall Ms Kruger and he only saw her on one occasion. He had received a referral note from Dr Pye which was as follows:

> 'Dear Stephen
>
> Please see Mary Kruger, a female with dementia at Philip Kennedy Centre. Past history ? cataract left eye.
>
> Thanks, Warwick'

10.2. On examination Dr McGovern was able to recall, having regard to his notes, that he found no vision in Ms Kruger's left eye. There was no perception of light. Dr McGovern was unable to obtain any history independently from Ms Kruger, no doubt because of her cognitive impairment[61]. He found that there was a minimal cataract. He noted that the right optic disc was normal but that the left had the appearance of optic atrophy which is a generalised pallor of the left optic disc[62]. He was unable to recall from his memory exactly what it was that he observed in Ms Kruger, but according to the description in the notes he said that it would have been a generalised optic atrophy or a total optic atrophy. He said that this is a clinical sign with a number of possible causes including vascular causes, a stroke of the nerve, glaucoma, inflammatory conditions, trauma, thyroid eye disease and compressive lesions such as brain tumours[63]. He said that a brain tumour in a female of Ms Kruger's age was a very uncommon cause[64]. He said that the causes of optic atrophy must be investigated and excluded so his next step in a situation such as this would be to seek a history from the general practitioner or any other sources he could to determine whether it was a pre-existing condition and whether the patient had been seen by an ophthalmologist previously. It would be necessary to investigate whether there was a documented episode of either inflammation, a vascular event or trauma which might have been the cause of the optic atrophy[65].

10.3. Dr McGovern said that he would have been seeing approximately 40 patients per day at the time of seeing Ms Kruger. His system was to see the patient and to send the patient's notes to either go to dictation or to filing. All of the dictation notes would

[61] Transcript, page 125
[62] Transcript, page 126
[63] Transcript, page 127
[64] Transcript, page 127

then come to him and he would dictate a letter from there. His routine in dictating a letter is to list all relevant diagnoses and to make a comprehensive summary of his evaluation of the patient, starting with history and examination findings and then moving to a diagnosis or a list of differential diagnoses and then investigations if required or management if management could be instituted immediately, and follow-up[66]. In the present case Dr McGovern frankly admitted that there was no letter dictated or no evidence of a letter having been dictated in Ms Kruger's notes. He said:

> 'Well, the only explanation that I would have would be that the notes were mistakenly filed rather than put in the file for dictation. There's no other explanation. If they were in my dictation file, they would have been dictated.' [67]

Dr McGovern was not aware of any request having been made to his clinic for a report from the referring general practitioner[68]. Dr McGovern was asked if he gave consideration to ordering a CT scan when he saw Ms Kruger on 27 February 2007. He responded that he did not consider a CT scan because, although the causes of optic atrophy include brain tumours, they are a rather uncommon cause. It is much more likely to be something like a previous vascular event. It was therefore his intention at that stage to seek a history from the general practitioner or a previous ophthalmologist and to see if the event had previously been documented, in which case there would be no need for a CT scan[69]. Dr McGovern was asked what a note, had it been sent to Dr Pye, would be likely to have said. His response was as follows:

> 'Yes, I think I could. It would have said, I would think 'Blind at left eye, optic atrophy, macular degeneration and mild cataracts' I would think. So that would be the problem list and then the letter would probably go along the lines 'Dear Warwick, thank you for referring this 69-year-old lady with poor vision in the left and right eyes of indeterminate origin. Her dementia precluded an adequate history but she clearly has a blind left eye from optic atrophy. The cause of this optic atrophy needs to be determined. Are you able to supply any details as to whether she has had previous events or seen another ophthalmologist or optometrist for this condition. She has some retinal vascular changes suggesting systemic hypertension. I would appreciate if you could let me know whether she has any underlying vascular problems'. Then once I have this information I'll be able to determine whether further investigations such as (inaudible) and angiography or CT or neuroimaging is necessary.' [70]

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[65] Transcript, page 127
[66] Transcript, page 218
[67] Transcript, page 129
[68] Transcript, page 129
[69] Transcript, page 130
[70] Transcript, page 132

10.4. Dr McGovern was shown the notes of the examinations conducted by ophthalmologists, Drs Cooper and Murchland. He commented on them as follows:

> 'The transcription shows certain features which when compared with mine, for example the visual acuity was hand movements and mine was down to no light perception. The optic discs were described as normal in the first, although on the 25th of the ninth the disc was described as pale. So that would indicate to me that there had been a progression, it's not clear whether that progression was a gradual progression from 26 June 2006 to when I saw her, or whether she had had an event, for example a vascular event in that time. But it certainly would have shown that this was not a long-standing pre-existing finding, the left optic atrophy and blind left eye. So the only - that would have prompted me to investigate with neuroimaging, either a CT scan or an MRI.' [71]

He said that upon such imaging he would be looking out for either an optic nerve sheath meningioma or another brain tumour of another sort compressing the optic nerve[72].

10.5. The obvious conclusion is that had Dr McGovern's office not made a filing error, or had Dr Pye followed up the lack of response from Dr McGovern, or had Dr Pye obtained all previous relevant medical notes concerning Ms Kruger's eye history, most pertinently the notes of Drs Cooper and Murchland, Ms Kruger would have been referred for scanning shortly after February 2007 that would have almost certainly detected the meningioma. This was an opportunity lost more than a year prior to her death. This reflects poorly on the Philip Kennedy Centre nursing home for failing to more persistently follow-up the lack of response from Dr McGovern, albeit that the Centre did take at least the step of contacting Dr Pye's rooms to ascertain whether they had received anything. It certainly reflects extremely poorly on Dr Pye. Dr Pye made little effort to establish appropriate background material for the referral to Dr McGovern. It is difficult to ascertain why it was that he even decided to make the referral and I can only infer that it was done because Philip Kennedy Centre was aware that the pre-existing referral to Dr Cooper for December 2006 could not be kept. They may have had that information from Ms Kruger's sister. In any event, had Dr Pye bothered to find out why it was necessary to arrange for an appointment, he might also have taken the step of obtaining copies of the notes of Drs Cooper and Murchland. That then would have armed Dr McGovern with important information which would have led to an immediate referral that may have saved Ms Kruger's life.

[71] Transcript, page 134
[72] Transcript, page 134

10.6. Finally, Dr McGovern cannot escape criticism for a failure in his systems to send a report of his examination to Dr Pye with the appropriate suggestions of the follow-up information, most of which I must accept, should have been proffered by Dr Pye in the first place. If any of these three things had happened, it is reasonable to expect that Ms Kruger's situation may have been retrieved at that point.

11. The evidence of Dr Ng

11.1. In January 2007 while in the Philip Kennedy Centre Ms Kruger's case was referred to physician, Dr Jason Ng, by Dr Ramsay who is a colleague of Dr Pye. The reason for the referral were incidents that are recorded in the Philip Kennedy Centre casenotes. In one such incident Ms Kruger grabbed a male resident and kissed him and in another she was found in a male resident's room. In short she was exhibiting disinhibited sexual behaviour. Dr Ng was a physician who would often attend at nursing homes to examine patients[73]. Dr Ng gave evidence that he had received a letter of referral from Dr Ramsay[74]. The contents of that letter are, to say the least, extremely brief. The only information apart from age and date of birth contained in the letter was as follows:

> 'Thank you for seeing Mary Patricia Kruger, aged 68 years, for an opinion and management. I gather that she has a behavioural problem. Warwick is away and she needs to be assessed re her behaviour.'

Armed with that letter Dr Ng attended upon Ms Kruger. Apart from the letter Dr Ng spoke to Lyn Walsh, a member of the staff at Philip Kennedy Centre. He also referred to the notes. He established that Ms Kruger had been living alone and was in a 'squalor situation' for some months before she was retrieved into the Murray Bridge Hospital. She was then transferred to the Philip Kennedy Centre to be close to her family. He was also told that Ms Kruger had a behavioural problem and that was the reason for the referral[75]. When Dr Ng saw Ms Kruger she was in the Moonta Ward at Philip Kennedy Centre which is a secure dementia unit.

11.2. Dr Ng said that he spoke to Ms Kruger and asked how she ended up in the Philip Kennedy Centre. She told him that she was living in Murray Bridge and her family thought she was not managing well at home and her family wanted her to come to live

[73] Transcript, page 206
[74] Exhibit C17a
[75] Transcript, page 210

closer to them. She recalled that she was in the Murray Bridge Hospital before she came to the Philip Kennedy Centre. Dr Ng asked her how she felt about the move and she said that she accepted it but was unhappy about moving away from her home and felt miserable and lonely[76]. Dr Ng mentioned to Ms Kruger that the staff had some concern about her behaviour. Ms Kruger expressed surprise and asked what had been complained about. Dr Ng said that 'in a gentle and subtle way' he told her that the staff felt she was getting a bit too close to some of the male residents. Ms Kruger denied this and said she was just feeling a bit lonely and unhappy at times and maybe she was feeling a bit more friendly towards some of the residents but she denied that there was anything wrong with her behaviour[77]. Dr Ng did not do a physical examination. He noted though that Ms Kruger was fully ambulatory and he had no concern about any of her physical function. Dr Ng did not carry out a formal mini mental state examination or any other formal form of mental state examination. Nevertheless he asserted that he did assess her mental state on an informal basis. He said that a mini mental examination is 'only a screening tool'[78]. His assessment of her was that she was in strong denial of anything wrong with her physically or medically. He said by way of explanation for not carrying out a mini mental examination that he did not think it would be:

> '…appropriate to impose upon her a formal score system which may include calculations, spelling backwards and drawing diagrams and I think it would be quite offensive to her.' [79]

11.3. This passage of evidence struck me as unusual bearing in mind that the very purpose of questions of the kind that Dr Ng thought might be offensive is to establish a person's mental status. If the possibility of giving offence is a reason not to do one, then it would seem to me that a medical practitioner would always have that dilemma.

11.4. Dr Ng's assessment of Ms Kruger is set out in his letter to Dr Ramsay dated 1 February 2007[80] which says:

> 'Thank you for referring Ms Kruger whom I saw at Philip Kennedy Centre today. She is a single woman who was found to be living in a squalor situation late last year. She normally lived in Murray Bridge but was eventually placed in institution care in November 2006. At that time she had a MMSE score of 24/30. Since her placement at

[76] Transcript, pages 212-213
[77] Transcript, page 214
[78] Transcript, page 216
[79] Transcript, page 216
[80] Exhibit C17a

> Philip Kennedy Centre she was found to be behaving inappropriately towards certain male resident with some degree of sexual disinhibition. There was no improvement despite her transfer to a different ward. During the interview she was alert and cooperative. She did not see anything wrong with her behaviour. She said she accepted her need for institution care but she was feeling very lonely and at times unhappy. Her behaviour was due to a combination of depression, adjustment disorder and dementia. I put her on Zoloft 50mg mane.'

11.5. Dr Ng was asked how he made the diagnosis of dementia. He responded that dementia was based on his clinical assessment. He said that it was 'based on the history of the onset'[81] and what he described as a few months of not managing in her own home and being in a squalor situation. He described it as 'a gradual onset over the preceding 6 months or 9 months' and said that 'there was some element of cognitive impairment which could be a form of dementia'[82].

11.6. He was asked whether he thought a CT scan should be performed. He said that based on what he described as 'the rate of progress' and 'the lack of any acute decline' and the lack of 'any physical signs of weakness' he did not think a CT scan was indicated.

11.7. By contrast he said that patients with:

> '… meningioma or any brain tumour were those with acute change in mental function; they have got acute confusion rather than a gradual decline in function, and I think they had trouble with communication and conveying a message and they have some physical signs of weakness, sensory changes.' [83]

Dr Ng said that on the day of that first examination he spent some 45 minutes with Ms Kruger.

11.8. Dr Ng saw Ms Kruger only once more, some 12 months later, on 8 February 2008. On that occasion he was called to see her because she had developed Parkinsonian features of tremor. He did not consider any imaging at that stage. He thought that Ms Kruger had declined over the 12 months in a manner consistent with the form of dementia he believed she had. He thought that she may be developing early Parkinson's disease but with the possibility of Lewy bodies disease. Given that this consultation was so proximate to Ms Kruger's death one month later, I do not propose to give it a close analysis as I consider that the opportunities to prevent Ms Kruger's death had largely been squandered by that stage.

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[81] Transcript, page 219
[82] Transcript, page 219
[83] Transcript, pages 221-222

11.9. Dr Ng agreed with the proposition that a lack of information from the referring doctor, Dr Ramsay, impeded his assessment of Ms Kruger. He said:

> 'It did. I think if I had more information going back to a longer history I think I would have had a different assessment given more information.' [84]

11.10. Interestingly, when asked what aspect of his diagnoses of depression, adjustment disorder and dementia he attributed Ms Kruger's inappropriate behaviour to, Dr Ng responded that it was the depression[85]. This is rather a surprising conclusion given that frontal lobe dementia is often responsible for such behaviour. Dr Ng was asked about that and then changed his answer to suggest that the inappropriate behaviour was attributable to a combination of both depression and frontal lobe dementia. I did not find his response particularly convincing.

11.11. Dr Ng was not aware of Ms Kruger's history of difficulty with her eyesight[86]. Dr Ng's attitude to CT scanning was rather unusual. His position was that he did not think that CT scanning is generally very helpful but added that if he thought there was any clinical indication that he was dealing with a pathology in the brain other than dementia, he would not hesitate to order it[87]. The difficulty with this answer is that he had not sufficient information in his possession, nor did he seek sufficient information, to make a decision about whether there was any clinical indication suggestive of a pathology in the brain other than dementia. He simply did not inform himself nor did he seek any information in addition to that wholly inadequate history provided to him by Dr Ramsay. He went on to say on no less than three occasions that if placed under pressure by family members then he would oblige with a CT scan[88]. Dr Ng maintained that even in retrospect he would not have changed his decision not to order a CT scan. He explained:

> 'I've done some research myself and there were lots of studies, actually literature recently and there was one in fact even done by our local radiologist at Flinders Medical Centre and they have looked at 400 patients over a few years period. All these patients presented with behavioural problem, depression and some people with dementia. They look at 400 scans over a few years and they did not find a single brain tumour or any abnormality that would suggest that they need to change their cause. The cause is either

[84] Transcript, page 232
[85] Transcript, page 233
[86] Transcript, page 235
[87] Transcript, page 234
[88] Transcript, pages 234, 235 and 236 'But if a family is pushing "are you sure there is no brain tumour?", maybe I have to give in.'

> continuing with antidepressant or treat as dementia. So they find zero cases of any abnormalities in the brain in 400 patients that they have studied.' [89]

11.12. This is in my opinion a startling proposition. Dr Ng appears to be saying in that passage that he would not reconsider his decision about ordering a CT scan in this case on the basis of a study of 400 patients. In my view that is an insufficient basis to rule out a CT scan that may be life saving, such as a CT scan that might hypothetically have been ordered by Dr Ng himself in February 2007.

12. The evidence of Dr Karen Boundy

12.1. I heard evidence from Dr Karen Boundy who provided an expert report. Dr Boundy is a neurologist and is senior visiting neurologist at the Queen Elizabeth Hospital. Dr Boundy explained that a meningioma is a polypoid type of brain tumour[90]. It arises from the lining of the brain and can be anywhere on the inside of the skull. A meningioma is usually slow growing and is often completely asymptomatic. They may increase slowly in size or may stay the same size. They may progress over many, many years to actually occupy space and then, once having run out of space, start to press on normal brain tissue leading to symptoms. Dr Boundy explained that with a meningioma growing in the frontal lobe part of the skull the symptoms may depend on precisely which part of the brain the meningioma is compressing. She said that a disturbance of behaviour would be characteristic and may be gradual. She said that there might be agitation, pacing, hyperphasia or hypersexual behaviour and summarised it overall as disinhibition and social inappropriateness[91]. She explained that it is perfectly possible for a meningioma to press upon the optic nerve if the meningioma were under the frontal lobes of the brain and growing downwards. She commented that in medical school students learn that if someone presents with optic atrophy the students must consider not only eye disorders, but also the possibility that the optic nerve is being compressed from above, but she added that this would not be a typical presentation of a frontal syndrome[92].

12.2. Dr Boundy said that it would probably have been possible to operate on Ms Kruger's meningioma had it been detected earlier. She explained that depending on the size and symptoms of a meningioma it may be managed conservatively simply by

[89] Transcript, page 236
[90] Transcript, page 345
[91] Transcript, page 346
[92] Transcript, page 347

observing them with a yearly CT scan. She said that she thought that it would have been possible to debulk Ms Kruger's meningioma if detected early enough[93]. Dr Boundy said that she thought that the nature of Ms Kruger's clinical presentation could have been related to the tumour. She added that the pathology reports, including the microscopic and macroscopic brain examinations, did not reveal any evidence of any other brain pathology that might have accounted for the symptoms, and in particular no form of degenerative brain disorder, for example Alzheimer's or frontal lobe dementia[94].

12.3. Dr Boundy commented that if the meningioma were large enough to cause pressure on the optic nerve she would expect that it would have been detectable, particularly with MRI but most likely with CT scanning as well[95]. Dr Boundy commented that if the meningioma had been removed it would have improved Ms Kruger's wellbeing in that it may have stopped any further loss of vision, it may have assisted with her gait and her walking, improved her mood and interest and changed her personality, hopefully back to how it had been previously[96]. Dr Boundy commented that it is not unusual for a meningioma to be only partially removed so as to remove the large bulk of it and hence the expression 'debulking'. She said it is not uncommon to leave some of the meningioma if it is in a dangerous place and then to treat with radiotherapy[97].

13. The evidence of Associate Professor Whitehead

13.1. An overview of Ms Kruger's case was obtained by counsel assisting from Associate Professor Whitehead.

13.2. Much of his evidence concerned the circumstances surrounding Ms Kruger's initial diagnosis, or lack of a diagnosis of dementia. A I have been unable to resolve the conflicting evidence about how that arose, I will not release Associate Professor Whitehead's evidence on that subject. He commented that once that had occurred, and Ms Kruger was in the Philip Kennedy Centre, it was reasonable for Dr Pye to assume the diagnosis was properly founded. He was prepared to agree that the same was true for Dr Ng, although as a specialist the latter had a need to apply a higher

[93] Transcript, pages 349-351
[94] Transcript, page 351
[95] Transcript, page 357
[96] Transcript, page 358
[97] Transcript, page 387

level of expertise than a general practitioner. I make it quite clear that I do not criticise either Dr Pye or Dr Ng for their acceptance of the diagnosis initially. I am critical of the former for the paucity of information accompanying his referral of Ms Kruger to Dr McGovern, and particularly for his failure to follow up a response following that referral. As to Dr Ng, I accept that his assumption of the correctness of the diagnosis of dementia was understandable. His evidence about the utility of a CT scan and the circumstances in which he would order one was perplexing, but as it was reasonable for him not to have considered that need in any event, his views as to their utility may be treated as a mere curiosity.

13.3. The impact of Associate Professor Whitehead's evidence is that once the diagnosis of dementia is applied to a person who then enters the nursing home setting, there is unlikely to be a further opportunity for review. Associate Professor Whitehead used the analogy of a seagull in a group of seagulls to illustrate the difficulty in picking out the one who should not, as it were, be in the group. For that reason I propose to recommend that the Minister for Health directed that nursing homes must, on admitting a new patient with a diagnosis of dementia, view the CT scan report that formed part of the diagnostic workup. If no such report or scan exists, the nursing home must ensure that a medical practitioner specifically consider the correctness of the diagnosis and in doing so, order a CT scan to exclude other explanations or provide written reasons for not doing so.

14. Conclusion

14.1. I conclude that Ms Kruger's death was preventable. If the wrong diagnostic label had not been applied at Murray Bridge Hospital, it is likely that the meningioma would have been detected and treated. Ms Kruger may never have needed admission to a nursing home at that time, or not until later in her life. Secondly, had Dr Pye obtained appropriate information for the purposes of his referral to Dr McGovern, the meningioma may have been detected and properly treated. Thirdly, had Dr McGovern's rooms not misfiled Ms Kruger's notes, a proper report from Dr McGovern would have led to further investigations so that the meningioma may have been detected and properly treated. Fourthly, had Dr Pye, after prompting from the Philip Kennedy Centre and of his own initiative, followed up the lack of response from Dr McGovern, the meningioma may have been detected and properly treated.

14.2. Had the meningioma been detected and treated in early 2007, it is likely that Ms Kruger's quality of life would have been improved. Her death would probably have been prevented.

15. Recommendations

15.1. 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.

15.2. I recommend that the Minister for Health direct that nursing homes must, on admitting a new patient with a diagnosis of dementia, view the CT scan report that formed part of the diagnostic workup. If no such report or scan exists, the nursing home must ensure that a medical practitioner specifically consider the correctness of the diagnosis, and in doing so order a CT scan to exclude other explanations or provide written reasons for not doing so.

Key Words: Misdiagnosis; Medical Treatment – Medical Practitioner;

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 13th day of December, 2012.

State Coroner