HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Radiologist breaches Code for poor reporting of woman's CT scan

20HDC02040

A radiologist has breached the Code of Health and Disability Services Consumers' Rights (the Code) for poor reporting of a CT scan, which may have delayed a bowel cancer diagnosis for a woman who, sadly, died of a blood infection from a bowel obstruction.

In a report released today, the Deputy Health and Disability Commissioner Carolyn Cooper said a radiologist breached Right 4(1) of the Code – Tautikanga, failure to provide an appropriate standard of care.

The woman had been extremely ill and had a noticeable abdominal mass. An abdominal and pelvic CT scan request form noted significant clinical concerns and a possible malignancy.

The radiologist's report on the subsequent CT scan noted two minor issues but 'no obvious malignancy'. The radiologist recommended an ultrasound follow up in three months and, the woman was advised by another doctor that her CT scan had not shown any obvious issues.

Several weeks later, the woman was readmitted to Whangārei Hospital severely ill. At this point, the radiologist re-reviewed her abdominal and pelvic CT scan and picked up an abnormality, which was not noted in the initial review. The radiologist updated the CT scan report with an addendum which reported this abnormality and the need for further assessment. The radiologist did not document whether communication of the addendum to the CT requestor had occurred.

Two days later, another doctor noted the addendum. A further medical review was completed that day, and an MRI scan discovered a cancerous mass causing a bowel obstruction.

Sadly, the woman died a few weeks later. The Coroner found she had died of septicaemia due to a perforated bowel which had become obstructed by a tumour.

Deputy Commissioner, Ms Carolyn Cooper found the radiologist breached the Code for the inadequate reporting of the CT report, including the failure to mention several important anatomical structures and whether these structures appeared normal within the report.

“I consider that the CT report was inadequate as it did not mention the gastrointestinal tract, the retroperitoneal structures, or the pelvic organs, and whether or not these appeared normal.”

Ms Cooper made an adverse comment about Health NZ Te Tai Tokerau. “I am critical of the alert system and the process that was in place for documentation of addendums. Clear documentation of when and how the addendum was conveyed to the relevant parties could have prevented confusion in Mrs A’s care and the subsequent delay caused by the confusion.”

Ms Cooper has made several recommendations which are outlined in detail in the report and include that Health NZ Te Tai Tokerau provide a formal apology to the woman’s whānau.

12 August 2024

Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC’s naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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