HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Sonographer and radiologist breach the Code for ultrasound scans during pregnancy across two HDC complaints

22HDC01223 & 23HDC00906

Note: the events outlined in this report took place in 2021-2022.

Deputy Commissioner Rose Wall has found a sonographer and radiologist breached the Code of Health and Disability Services Consumers Rights (the Code) for misdiagnoses of multiple ultrasound scans for two pregnant women. The same combination of sonographer and radiologist were performing and reporting on the ultrasound scans in question.

In the first complaint, the radiologist and sonographer failed to identify signs of congenital pulmonary airway malformation (CPAM) in the fetus through multiple ultrasound scans. CPAM was identified by a different radiologist at 36 weeks. At that stage the mother learned that if action had been taken at 20 weeks, when the condition was noticeable on the ultrasound scan, the outcome could have been different. Subsequent interventions would likely have been less invasive and more of her baby's healthy lung tissue could have been saved.

Following the late diagnosis of CPAM, urgent interventions were initiated in utero. These were not successful, leading to the baby being born by Caesarean section, and requiring multiple surgeries, including the complete removal of the right lung.

The report noted that three of the four scans performed by the sonographer had suboptimal images, did not adhere to the guidelines in place at the time, and on numerous occasions had incorrect labelling.

Ms Wall found that the radiologist failed to recognise the cystic mass and failed to recommend the pregnant woman for tertiary referral at the time of the anatomy scan.

She also determined that the radiologist held overall responsibility for the reporting of each ultrasound scan and was required to provide the sonographer with feedback if their images were not of the expected quality or as required in the guidelines of the Royal Australian and New Zealand College of Radiologists (RANZCR) standards of practice.

Accordingly, Ms Wall found both the radiologist and sonographer breached the Code for failing to provide services with reasonable care and skill.

In the second complaint, the sonographer and radiologist failed to identify signs of renal agenesis through multiple ultrasounds of a twin pregnancy despite there being evidence of possible anomalies in the first twin from the 20-week scan onwards. The woman had a total of five ultrasound scans throughout her twin pregnancy, all of which were performed by the same sonographer and reported on by the same radiologist. Sadly, one of the twins died three days after birth.

In this second case, the fetal anatomy imaging for both twins were incomplete. The images from the nuchal translucency (NT) scan taken at 12 week's gestation were inadequate with suboptimal visualisation of the brain, extremities, kidneys and heart in both twins and neither bladder was imaged. The expert advisor for this case concluded that a renal anomaly for the first twin who was small for gestational age could not have been excluded and an obstetric review should have been recommended at 28 weeks' gestation.

The radiographer in this second case signed off reports without having seen all the required images or anatomy as set out in the Guidelines.

As a result, Ms Wall found the sonographer and radiologist breached the Code in this second case for failing to provide services with reasonable care and skill.

Ms Wall said, in conclusion, that the report emphasized the importance of a scheduled maternity ultrasound scan as a principal opportunity to identify fetal developmental issues in utero. The common element in both cases was the failure of the sonographer and radiologist to maintain their respective standard of clinical practice during the performance of multiple ultrasound scans.

"In each case, this resulted in missed opportunities to diagnose medical issues with the developing fetus at the earliest opportunity. This delay in diagnosis had a profound and lasting impact on the consumers concerned and their wider whānau."

Due to concerns about the competence of the sonographer and radiologist, Ms Wall made a referral to Medical Council of NZ (MCNZ) and Medical Radiation Technologists Board (MRT Board).

Since these events, the radiology service has implemented changes, including additional training for staff and an audit of previous scans to prevent future occurrences. In her report, Ms Wall made further recommendations for the radiographer and sonographer and the radiology service.

25 November 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 group 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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