Southern District Health Board
(now Te Whatu Ora Southern)

A Report by the
Health and Disability Commissioner

(Case 20HDC00167)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report highlights the importance of clinicians following up on radiology reports ordered for their patients, and for there to be appropriate systems in place to support them to do so. In 2019, a woman in her seventies had an MRI scan at a public hospital, Southern District Health Board (SDHB) (now Te Whatu Ora Southern). The off-site reporting radiologist considered that the scan showed metastatic disease that required further evaluation. However, the woman was discharged two days later, and there was no follow-up of her MRI scan until two weeks later.

Findings

2. The Commissioner found that SDHB breached Right 4(1) of the Code as its system failed to support its clinicians adequately to follow up the MRI report in a timely manner, and there was unnecessary delay in the woman receiving the follow-up care she required. The Commissioner also found SDHB in breach of Right 4(2) of the Code owing to the inadequacy of clinical documentation during the woman's admission, which omitted important details regarding her care.

3. In addition, the Commissioner made adverse comment in relation to an orthopaedic surgeon, who was the clinician responsible for reviewing the findings of the MRI report and arranging any follow-up required.

Recommendations

4. The Commissioner recommended that Te Whatu Ora provide a written apology to the complainant for the breaches of the Code identified and conduct an audit of 500 radiology results from the last six months to confirm that all results were acknowledged by the responsible clinicians within acceptable timeframes. Further recommendations included that Te Whatu Ora inform HDC on what is being done to resolve issues concerning the lack of time scheduled for clinicians to carry out clinical non-contact duties (such as the reviewing of imaging reports), and for it to consider how its electronic system can be improved to better support clinicians in their duties of reviewing clinical results that require follow-up.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her mother, Mrs A, at Southern District Health Board (SDHB) (now Te Whatu Ora Southern).[1] The following issue was identified for investigation:

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to SDHB now refer to Te Whatu Ora Southern.

- *Whether Southern DHB provided Mrs A with an appropriate standard of care in Month1[2] and Month2 2019.*

6. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
SDHB	Provider

7. Also mentioned in this report:

Dr C	ED house officer
Dr D	Consultant orthopaedic surgeon
Dr E	Consultant spinal surgeon
Dr F	Consultant radiologist
Dr G	Senior orthopaedic clinician

8. Independent advice was obtained from an orthopaedic surgeon, Dr Tom Geddes (Appendix A).

Information gathered during investigation

Introduction

9. This report concerns the care provided to Mrs A by SDHB in 2019.

10. On 21 Month1, Mrs A (aged in her seventies at the time) underwent an MRI scan at the public hospital after presenting with pain in her leg and back. There were also concerns about her raised inflammatory markers and because she had a history of breast cancer. Mrs A was discharged on 23 Month1, as it was thought that her MRI scan showed no malignant cause for the pain. The scan was reported on by an off-site radiologist, who sent the report to the public hospital. The radiologist considered that the scan showed metastatic disease that required further evaluation. Unfortunately, due to the systems in place at SDHB at the time, the MRI report was not seen by the SDHB clinicians until several days later.

11. Nearly two weeks after Mrs A was discharged on 5 Month2, she was informed about the results of the MRI scan by a nurse at her GP surgery. Subsequently, Mrs A was provided with palliative care, and she died a few weeks later. I take this opportunity to extend my condolences to her family.

12. Mrs A's daughter complained to my office not only about the above episode of care, but also about the diagnosis and treatment of her mother's cancers between 2005 and 2019 at SDHB. However, as my preliminary assessment did not identify any apparent departures

[2] Relevant months are referred to as Months 1–2 to protect privacy.

from the standard of care between 2005 and 2018, my investigation has focused only on the care provided to Mrs A following her presentation to SDHB in 2019.

Hospital admission — 20–23 Month1

13. At 11.21am on 20 Month1, Mrs A called for an ambulance because of back pain. The Ambulance Care Summary stated that Mrs A had experienced lower back pain and sciatica[3] down her left leg for the past two weeks, which had worsened overnight, and that painkillers were ineffective.

14. Mrs A was transferred to the Emergency Department (ED) at the public hospital and arrived at 3.14pm. She was assessed by ED house officer Dr C, who noted her history of lower back pain, and flagged her age and history of cancer. As well as ordering blood tests and a full set of observations, Dr C recorded a plan for Mrs A to have a post-void bladder ultrasound — a scan that shows the amount of urine left in the bladder immediately after the patient has urinated (known as a post-void residual, or PVR).

15. Nursing notes from 8.46pm that day state that Mrs A did not feel like urinating, and that a bladder scan was carried out. The scan showed a PVR of 600ml. After Mrs A had urinated 400ml, a second bladder scan showed a PVR of 488ml. Dr C told HDC that this was a high PVR that raised concerns about cauda equina syndrome — a serious condition caused by compression of the lower spinal nerves. For that reason, Mrs A was referred to Orthopaedics at 9.38pm. However, she remained in the ED until late the next morning as no inpatient beds were available at that time.

16. Mrs A was placed under the care of consultant orthopaedic surgeon Dr D.

17. An orthopaedic registrar reviewed Mrs A in ED at 00.37am on 21 Month1. He documented that an X-ray had confirmed that Mrs A had degenerative scoliosis,[4] and that an MRI scan should be considered because of her history of cancer and raised inflammatory markers (WCC 12 and CRP 36).[5]

18. At 11.03am on 21 Month1, orthopaedics house officer Dr H requested a semi-urgent MRI scan of Mrs A's "lumbar spine +/- rest of spine". The request form noted Dr D as the responsible consultant, along with clinical details of back pain and sciatica, urinary retention, and a query of "[m]alignancy causing cord compression". SDHB told HDC that Dr D had responsibility for reviewing the MRI and arranging appropriate follow-up.

19. Mrs A was discharged from the ED and admitted to inpatient services at 11.36am. At 12.45pm, Dr H documented that an MRI had been requested, and that Dr D was the

[3] Pain felt along the path of the sciatic nerve, which branches from the lower back and down each leg. It generally refers to nerve pain in the leg caused by a problem in the lower back.
[4] Abnormal curvature of the spine.
[5] WCC and CRP stand for "white cell count" and "C-reactive protein". CRP and WCC results of over 10 and 11 (respectively) are considered abnormal.

responsible consultant, and that they would "[discuss with] [Dr E] after MRI". This is in reference to Dr E, a consultant spinal surgeon employed by SDHB at the time.

20. The MRI scan was carried out at 3.18pm on 21 Month1 and sent off site for interpretation. SDHB told HDC that the MRI scan reporting is frequently outsourced owing to a shortage of radiologists able to report MRI examinations at that hospital. SDHB said that at the time of Mrs A's MRI scan, the only radiologist employed by the public hospital "with MRI [reporting] in their specific clinical responsibilities" was on leave.

Subsequent care and discharge

21. Mrs A was discharged on 23 Month1. The discharge form dated 23 Month1 at 12.03pm states that Mrs A was discharged on 22 Month1 at 12.49pm. However, it appears that this was written in error and should have stated the date as 23 Month1. The clinical progress notes also document that Mrs A continued to receive physiotherapy, occupational therapy and nursing care that afternoon, and that she was discharged shortly after 1.57pm that day.

22. House officer Dr H documented in the discharge form that the MRI scan "showed no sinister cause for pain/sciatica". This was the first reference to the results of the scan in SDHB's clinical records. However, at the time of writing the discharge form, the formal MRI report was not yet available for review by SDHB clinicians.

23. The primary diagnosis at discharge was sciatica, with a secondary diagnosis of urinary retention. The discharge summary noted that Mrs A was fitted with a catheter to manage the urinary retention, and prescribed gabapentin to relieve the sciatica pain.

24. Regarding his reasons for recording that the MRI scan showed no sinister findings, despite not having seen the formal radiology report, Dr H told HDC:

> "I recall being advised that the scan had been discussed between my seniors (consultants and registrars) and the consensus was that there was no spinal cord compression. I do not recall being advised of any discussion of features of the scan other than relevant to the spinal cord compression. I was not party to those discussions."

25. Dr H stated that his involvement was limited to documenting the ward rounds and the decision to discharge Mrs A based on the advice he received as a result of the discussions between senior clinicians regarding the MRI scan.

26. Dr D told HDC that prior to discharge two MRI verbal reports were received "which is all we had access to acutely". Dr D was unable to recall the name of the on-call radiologist who provided the initial verbal report, or the timing of that discussion.

27. Dr D also discussed the MRI with Dr E, who reviewed the images and was advised of the initial verbal report. Dr D said that Dr E "saw no cause for concern, hence the diagnosis of sciatica with urinary retention secondary to pain". Dr D told HDC that it was Dr E's verbal report that Dr H noted in the discharge summary ("no sinister cause for pain/sciatica").

28. There is no record of the verbal or provisional reports on the MRI scan prior to completion of the formal report on 23 Month1 (see next section). SDHB said that if provisional reporting by non-radiologists occurred, it should have been documented in Mrs A's clinical records.

MRI report

29. In fact, the results of the MRI scan were formally reported (in writing) by the consultant radiologist, Dr F, and sent to SDHB at 1.01pm on Friday 23 Month1. This was less than 48 hours after the MRI scan was taken.

30. The report noted the clinical reasons for the scan as: "History of breast cancer. Presented with back pain and sciatica. Urinary retention. CRP 40. Malignancy causing cord compression."

31. Dr F's report concluded that the scan showed multiple lesions that were in keeping with metastatic disease (cancer). He also reported that as a pelvic cystic[6] lesion had increased in size since Mrs A's previous CT scan in 2015, ovarian metastasis could be considered. Dr F recommended further evaluation with a CT scan of the chest and abdomen.

32. SDHB's Radiology Information System (RIS) in place at the time of these events required that a member of its administrative staff manually authorise all radiology reports before they could be made accessible to clinicians on its electronic system. This did not occur before the weekend, and administrative staff usually responsible for authorising such distribution were absent over the weekend.

33. The MRI report was not made accessible to SDHB clinicians until Monday 26 Month1 at 10.26am. From that time, the MRI report could be accessed by clinicians on two different systems — Health Connect South (HCS), and the picture, archiving and communication system (PACS).

34. SDHB's Electronic Acceptance Policy in place at the time of these events (see Appendix B) stated that it was the responsibility of the SMO (Senior Medical Officer) or delegated clinician to ensure that all results were accepted in a timely manner on HCS (clinicians are unable to accept a report when accessing it through PACS). The policy stated:

> "[A]cceptance confirms that any action required has been taken or organised. If results are not accepted there will be uncertainty as to whether the result has had the required action taken. For this reason no results should be left unaccepted for a period greater than four weeks from date of report being available."

35. As discussed further below, Dr D told HDC that as there was no time allocated to clinicians for clinical non-contact responsibilities or for clinical administration tasks, that made it a challenge to review and manage Mrs A's MRI report despite Dr D being the responsible clinician. A copy of the report was not sent to Mrs A's GP at this time, as this had not been requested on the MRI request form by anyone at SDHB. However, SDHB said that at the time of Mrs A's care, all SDHB radiology reports were available for a patient's GP to view on the

[6] A cyst is a fluid-filled growth or lump.

HealthOne system (a secure electronic record that allows a person's healthcare providers to access all their health information).[7]

Delay in review of MRI report

36. There was a delay of several days before any clinician accessed Mrs A's MRI report on SDHB's electronic system, and Dr D was not involved in the follow-up care provided.

37. In relation to the lack of follow-up on Mrs A's MRI report, Dr D told HDC that system issues at the DHB made it more difficult to review the report in a timely manner. Dr D stated:

a) There is no time allocated for clinical non-contact time or clinical administration, and "[a]ll of our clinical time is in clinic or operating or ward rounding"; and

b) The system is clogged with thousands of normal routine blood results, normal X-ray reports, and unreported fracture clinic X-rays "for patients under my name whom I have never met as are entirely brought through or discharged from fracture clinic without me ever having seen them". Dr D said that this makes it "almost impossible to see the wood for the trees" and "clog[s] the system for those whose reports need addressing such as [Mrs A's]".

38. Dr D told HDC that because the two provisional verbal assessments received were that the MRI scan showed no sinister findings, there was "less concern to prioritise [the] formal report". Dr D did not receive any alert when Mrs A's MRI report became accessible via PACS and HCS and was unaware of the report being made available.

39. Dr D stated:

> "My usual practice is to keep a list of outstanding patients whose reports I have not seen and look them up individually on the PACS system, not using HCS. There is no cross communication between the two systems so you are unable to accept when looking at the imaging on PACS."

40. Dr D told HDC that HCS is seldom used to access reports, and that accepting reports on HCS is "not a time efficient process".

41. Dr D would normally follow up the outstanding patients on the list and other reports at the end of the week after on-call duties but acknowledged that that process "is not fail proof".

42. SDHB stated that to support its clinicians with following up on all reports assigned to them, HCS identifies any reports that have not been accepted in the "Work assigned to you" section of HCS, and said that this would be the usual way in which reports needing review would be identified and monitored. SDHB further stated:

> "The Clinical Director and Service Manager receive a weekly report detailing the number of outstanding laboratory and radiology reports that have not been acknowledged on

[7] GPs do not receive notifications to tell them when a new report is uploaded to HealthOne.

> Health Connect South. This information is available to the individual clinicians on Health Connect South as well."

43. SDHB confirmed that no specific notification or alert relating to Mrs A's MRI report would have been generated by the system and sent to Dr D. SDHB told HDC:

> "It would be the usual expectation that the report was viewed and actioned at the earliest opportunity following the generation of the report and not greater than seven days."

Follow-up of MRI report

44. The first clinician to review Dr F's MRI report was Dr C, who had treated Mrs A in the ED on 20 Month1.

45. Dr C viewed the MRI report on 29 Month1, on 3 Month2, and again on 5 Month2. Dr C told HDC that his practice as an ED doctor is to follow up on all patients he has seen. He stated: "This provides feedback on my initial clinical impression and plan. This feedback is invaluable for my progression and development as an ED doctor."

46. In relation to Mrs A, Dr C recalled:

> "In following up on the MRI result of [Mrs A], I noted that the formal report made mention of 'multiple lesions in keeping with metastatic disease'. On reviewing the discharge paperwork, I could see that this was not the impression of the orthopaedic team. I am well aware that it can sometimes take a few days for formal reports to be reviewed and acknowledged by the requesting team. As such, I initially thought that this is what had happened i.e. the formal report had been sent to the requesting consultant and that this would be actioned in due course."

47. After viewing the MRI result for the third time on 5 Month2 and seeing that it appeared that the requesting team had yet to review or act on the report, Dr C called Mrs A's general practice to ascertain whether the MRI findings concerning possible metastatic disease were being followed up.[8] Dr C told HDC:

> "During this phone call, it became clear that the primary care team were not aware of these results and the nurse I spoke to … reassured me that she would ensure that this was promptly followed up on."

48. A nurse practitioner accessed the MRI report on 5 Month2 at 3.36pm. At that time, she was only the second clinician after Dr C to have done so.

49. In an appointment with Mrs A on 5 Month2, the nurse practitioner documented having discussed with Mrs A the MRI results showing metastasis and suspicious lesions. Mrs A also reported having had a persistent cough for three months, shortness of breath, and a small

[8] SDHB stated that GPs are not sent notifications that there are new reports available for them to view when these are received on the system.

lump between her breasts. The nurse practitioner recorded the plan to refer Mrs A to Oncology and completed an urgent oncology referral to the public hospital at 6.21pm that evening, which stated:

> "MRI on 20 [Month1] showing multiple metast[a]ses in spine and abdomen, needs staging and investigation. [P]revious breast cancer. Also persist[e]nt cough for 12 weeks with [shortness of breath] and lump … between breasts."

50. The nurse practitioner discussed the referral with a medical oncologist the following day. The medical oncologist advised that he would order a CT scan of the chest and abdomen.

51. Subsequently, Mrs A was diagnosed with metastatic carcinoma (cancer) of uncertain origin. Having discussed her prognosis and treatment options with a consultant medical oncologist, Mrs A was accepted for palliative care. She passed away a few weeks later.

Further information

SDHB

52. SDHB stated that there was a failure in process in Mrs A's care:

> "[T]he patient was admitted to orthopaedics with back pain and discharged with an MRI described as normal. It was subsequently reported as abnormal and then her GP [practice] noted that result and contacted [the medical oncologist] to arrange further testing."

53. HDC asked SDHB whether it considered that the treating clinician's review of the radiologist's report on Mrs A's MRI scan, and the follow-up action taken, were sufficient and appropriate. SDHB responded that "[a] suitably robust mechanism for follow-up of the formal MRI results was not in place". It stated that a significant contributing factor to the delay in follow-up of the formal MRI results was the "lack of timely reporting and inability of the reporting system to flag results that [were] discrepant to a provisional result", and that "[t]he situation with [Mrs A's] examination report was exacerbated by the additional delay caused by the responsible administration staff being absent over the course of the weekend".

54. A senior orthopaedic clinician at SDHB, Dr G, stated:

> "Despite having a policy that reports would be reviewed in a timely manner, as a matter of history, Southern DHB has not provided scheduled, clinical non-contact time to review and sign off the laboratory and radiology reports attributed to its surgeons at the public hospital. This has been in violation of the provisions of the ASMS MECA[9] agreement for over 17 years, and has been the subject of repeated efforts to have this time embedded in clinicians' schedules. The rostered hours of [Dr D] and the other members of the Department of Orthopaedic Surgery are fully scheduled to the clinical contact duties of Clinics and Theatre, but do not take into account the need to …

[9] Association of Salaried Medical Specialists — Senior Medical and Dental Officers Collective Agreement.

perform routine administrative tasks such as the review and sign-off of laboratory and radiology results."

55. Dr G further stated:

> "The medical record of [Mrs A's] care is not clear in its discussion regarding the provisional reading of the MRI obtained 21 [Month1]. Most of the specific information regarding the patient's working diagnosis is inferred from the daily plan of care and discharge summary as opposed to its concurrent documentation in the progress notes."

56. In relation to the "clogging" of electronic reporting systems referred to by Dr D earlier in this report, Dr G told HDC:

> "When the change was made to electronic reporting, there was no effort made to rationalise the attribution of tests ordered such that x-rays and laboratory tests requested by Registrars, but without the Consultant's knowledge, became assigned to the Consultant. While most of the results are routine in character, it has resulted in a glut of reporting to the Consultant's responsibility which they have no context for. This burden of spuriously attributed results has been the subject of many discussions regarding how to manage the unintended outcome of electronic reporting. Several years of attempted refinement have been fruitless, however, and have created resentment regarding the need to keep up with the task of reading and signing off each and every report. This resentment is exacerbated by the lack of time recognition for the task."

57. Dr G stated that in the current system there is also no way to prioritise results such that unexpected abnormal findings are highlighted or conveyed directly to the clinician, which he said "had been a professional courtesy and practice in the past".

Dr D

58. Dr D said that had there been a direct alert about the MRI results when they became available on 26 Month1, Mrs A would have been informed and Oncology would have been involved urgently. Dr D told HDC:

> "I was not aware of this report. I do make suggestions to my junior staff to follow up formalised results including those of MRI's or histology or microbiology for example which can sometimes also, be delayed. Unfortunately, this did not happen in this circumstance or [it] would have alerted me to address it sooner. On a busy on call week this is not a fool proof system and I agree needs to be more robust with an URGENT alert system to relay an unexpected result which is differing from the verbal report although this had not been documented as a preliminary report and contradicted the final documented report."

59. When asked how Dr D believes the MRI report would have been followed up had ED house officer Dr C not done so, Dr D told HDC: "I would have reviewed the report (later than the ED house officer) when given time allocation for this clinical duty."

60. Dr D further stated that as the public hospital does not have a spinal surgery facility and Dr D is not a spinal surgeon, spinal cases were discussed with either another hospital or Dr E if he was available.

61. Dr D said that the standard of documentation regarding Mrs A's care was poor and could have been better, in particular with regard to the verbal MRI report as an inpatient and discussions with Dr E. Dr D now endeavours to ensure that documentation of patients is more thorough, clear and comprehensive "as opposed to it being only th[r]ough the discharge summary". Dr D stated:

> "Although we cannot be sure [knowing about] the result would have changed the outcome, the process in which the GP had the finalised report to action is certainly less than satisfactory when it is an inpatient investigation requested under my care and for that I am extremely sorry for the distress it has caused [Mrs A] and her family and delay in oncological input."

Dr H

62. Dr H stated:

> "I acknowledge the short-comings in documenting the initial discussions regarding the MRI scan and the delay in the provision of the full report. The action to discharge was one made by my team. I believe what was recorded on the discharge was a fair and accurate recount of the events that occurred during the admission, based on what was relayed to me as a House Officer on the team — the MRI findings were not of any sinister cause that would cause permanent neurological deficit. I do believe a more timely report of the MRI scan could have assisted with further investigation and the discharge planning process."

Responses to provisional opinion

63. SDHB was given the opportunity to respond to the provisional report. SDHB acknowledged the proposed findings and made no further comment in relation to them. Regarding my proposed recommendations, it agreed to provide a written apology to the complainant.

64. Dr D was given the opportunity to respond to relevant sections of the provisional report. Dr D sent sincere apologies "[for not acknowledging] the MRI sooner and act[ing] upon the abnormal result and the subsequent impact this has had". Dr D further stated:

> "I have also taken the time to reflect and ensure despite process limitations to acknowledge results in a timely manner as is my responsibility as the clinician responsible for care of my patients."

65. Ms B was given the opportunity to respond to the "Information gathered during investigation" section of the provisional report. Ms B said that she does not believe that the care provided from 21 Month1 made any difference to the length of her mother's life, but noted that due to the poor reporting in this case, her mother was discharged "without the knowledge of the true extent of her condition and went another 13 days before knowing

the truth and without the appropriate medicaton to relieve her extreme pain". Ms B told HDC:

> "In closing, it's my hope that inpatient reporting is done in a more timely fashion, reported more accurately and that recommendations for further testing are acted upon. My mother was let down by SDHB and for that I would like a formal apology from the parties involved."

Opinion: Southern District Health Board — breach

Summary of care

66. On 21 Month1, Mrs A underwent an MRI scan because of concerns about her raised inflammatory markers and history of cancer. The images were sent off site for interpretation, as the only radiologist at the public hospital with specific duties for MRI reporting was on leave. The formal MRI report was completed and sent to SDHB on Friday 23 Month1 at 1.01pm. The reporting radiologist's findings noted probable metastatic disease and recommended a CT scan for further evaluation.

67. There was a delay in reviewing these findings at SDHB, and Mrs A was discharged from the public hospital on the afternoon of 23 Month1 with a diagnosis of sciatica but no identified cause. The discharge form stated that the MRI "showed no sinister cause" for the sciatica but did not note that this was a provisional finding by Dr D based on informal readings of the MRI images in consultation with other senior colleagues. No action was taken by SDHB staff on the formal MRI report until 5 Month2, when ED house officer Dr C contacted Mrs A's general practice to alert them to the MRI results. Subsequently, Mrs A was diagnosed with incurable metastatic cancer and, sadly, she died a few weeks later. My condolences go out to her family.

68. In determining whether the care provided to Mrs A was of an appropriate standard, I carefully considered the evidence obtained during the course of the investigation, including relevant clinical notes, policies, responses from providers, and the independent advice provided to my Office by orthopaedic surgeon Dr Tom Geddes.

Preliminary assessments of MRI imaging

69. Dr D told HDC that prior to discharging Mrs A two verbal MRI reports had been received from consultant spinal surgeon Dr E and the on-call radiologist, "which is all [they] had access to acutely" before the formal MRI report was available. Dr D said that these verbal reports identified no cause for concern, hence the diagnosis of sciatica with urinary retention secondary to pain. Dr D told HDC that it was these verbal reports that were noted in the discharge summary, which recorded that there was "no sinister cause for pain/ sciatica".

70. Dr Geddes was not critical that the preliminary assessments of Mrs A's MRI imaging at the public hospital failed to identify any metastatic disease or sinister cause for her pain. He stated that limited viewing of extensive series of images is frequently the case on busy ward rounds or in busy clinics, and it is quite possible that an orthopaedic consultant/registrar/ radiologist could make a quick assessment of the spine looking for a cause of the presenting complaint and flick through the images where the metastatic disease was not evident and feel that no sinister cause was identifiable.

71. Dr Geddes also advised that it is not infrequent for radiologists to identify problems on the scans that the referring physicians are unaware of and/or are unable to identify themselves, and that this occurrence therefore requires a robust reporting system and a clear line of communication between the reporting radiologist and the referring/treating doctors.

72. I accept Dr Geddes' advice and am not critical that the preliminary assessments of Mrs A's MRI imaging by Dr D and the other senior physicians consulted did not identify the multiple lesions consistent with metastatic disease.

Timely access to MRI report

73. SDHB's system at the time of these events required that one of its administrative staff manually authorise radiology results in order to make them accessible to clinicians on HCS and PACS. However, the administrative staff responsible for authorising the distribution of radiology results to clinicians were absent over the weekend on which Mrs A's MRI results were reported, and consequently the results were not accessible to SDHB clinicians until 26 Month1, three days after the results were in SDHB's system.

74. Dr Geddes stated that one of the most concerning issues in this case was the "inability of the treating medical staff at the hospital to obtain timely reports on MR scans". He advised that in his clinical environment (Middlemore Hospital) where there is excellent access to radiologists, the management of Mrs A's scan report would be regarded as a severe departure from an acceptable standard of care. In relation to the public hospital's environment, Dr Geddes advised:

> "If hospitals are to offer high tech imaging then it is only appropriate that these images are reported in a timely manner with the appropriate treating doctors notified. The inability of a smaller hospital to arrange this is still a departure from acceptable standards … Getting MRI images reported off site is certainly acceptable and in fact essential for smaller centres. Developing a system that gets these reports to the treating doctors and highlights unexpected findings is essential … The delay in getting reports to the treating physician in a haphazard manner I believe is a significant risk to patients and a significant departure from acceptable practice."

75. I accept Dr Geddes' advice and am very critical that Mrs A's treating clinicians did not have timely access to the MRI report, which contained serious and concerning findings requiring urgent follow-up (ie, a CT scan). It is particularly disappointing that whilst the MRI report had been completed and was sent to SDHB on Friday 23 Month1 (the day on which Mrs A

was discharged), it was not accessible to the relevant clinicians until Monday. I make further comment regarding the contributing systems issues below.

Discharge without diagnosing cause of sciatica

76. Dr Geddes considered that the predominant shortcoming in Mrs A's case was that she was sent home without the cause of her sciatica being diagnosed, and that appropriate reporting and recording of the MRI would have avoided this.

77. Dr Geddes explained that sciatica is a constellation of symptoms, predominantly leg pain, which is caused by the irritation of the sciatic nerve or the smaller nerves that combine to make up the sciatic nerve. The cause of Mrs A's sciatica was not identified by the treating team before she was discharged. After reviewing Mrs A's clinical notes, Dr Geddes advised that there was a significant improvement in, though not complete resolution of, Mrs A's symptoms on a standard analgesic (pain relief) regimen. He also stated that once symptoms have settled satisfactorily, it is quite acceptable to send a patient home with a catheter with a plan for removal at a later date, and that generally it is acceptable to treat sciatic pain symptomatically in the expectation that it will diminish over time.

78. I have carefully considered Dr Geddes' advice on this point and accept that it was reasonable to discharge Mrs A home given that there had been a significant improvement in her symptoms through a standard analgesic regimen. However, I note that the MRI report was in SDHB's electronic system from 1.01pm on 23 Month1, and Mrs A was not discharged until approximately 2pm that day. Whilst I consider that the delay in being able to access the MRI report is a mitigating factor for the treating clinicians in the decision to discharge Mrs A, I remain critical that SDHB did not have in place an appropriate system to provide senior clinicians with access to the report.

System issues

79. SDHB acknowledged that a suitably robust mechanism for the follow-up of formal MRI results was not in place at the time of Mrs A's care. SDHB also told HDC that "it would be the usual expectation that the report was viewed and actioned at the earliest opportunity following the generation of the report and not greater than seven days". However, I note that the Electronic Acceptance Policy provided for a time frame of up to four weeks for when the results could be reviewed and acted on. I am critical that a discrepancy existed between SDHB's seven-day expectation and its documented policy. I consider that SDHB's expectation of a seven-day timeframe for viewing and acting on a report of this kind should have been made clearer in its Electronic Acceptance Policy.

80. I am also concerned about the systems issues both Dr D and Dr G raised with my Office. In particular, they advised the following:

a) There was no time allocated for clinical non-contact duties to review and sign off the laboratory and radiology reports attributed to surgeons at the public hospital.

b) There is no way to prioritise results so that unexpected abnormal findings are highlighted or conveyed directly to the responsible clinician.

c) The electronic systems are clogged with thousands of normal blood results, X-ray reports and unreported scans assigned to Dr D (some for patients not previously met), which Dr D considers makes it "almost impossible to see the wood for the trees" and increases the risk that reports in need of addressing, like Mrs A's, would be missed. In relation to this issue, Dr G also stated: "When the change was made to electronic reporting, there was no effort made to rationalise the attribution of tests ordered such that x-rays and laboratory tests requested by Registrars, but without the Consultant's knowledge, became assigned to the Consultant. While most of the results are routine in character, it has resulted in a glut of reporting to the Consultant's responsibility which they have no context for."

81. I am concerned by the above issues raised by Dr D and Dr G. I am also concerned that SDHB's system at the time required an administrative staff member to authorise radiology results manually before treating clinicians could access them on the HCS and PACS systems. As this case has illustrated, such a manual system is inefficient and potentially prone to error.

82. I am pleased to learn that since these events a new Radiology Information System has been installed. As a result of this change, diagnostic scan reports are now automatically distributed to clinicians on the electronic system upon receipt, and no longer require manual authorisation by administrative staff to enable clinician access to scan reports.

83. Notwithstanding such changes, I remain critical that SDHB's systems at the time resulted in an unnecessary delay in Dr D and fellow clinicians having timely access to salient clinical information — namely Mrs A's MRI report. I am also concerned about the divergence in expectations between the Electronic Acceptance Policy and the seven-day expectation, as well as the concerns raised by Dr D and Dr G.

Clinical documentation

84. The Medical Council of New Zealand (MCNZ) documentation standards in place at the time of Mrs A's care[10] stated that clinicians must keep clear and accurate patient records that report relevant clinical findings and decisions made at the same time as the events being recorded or as soon as possible afterwards.

85. SDHB clinicians Dr G and Dr D both acknowledged that the documentation regarding Mrs A's care was not clear in the progress notes, particularly regarding the provisional verbal reports of the MRI obtained on 21 Month1. Dr H also acknowledged the shortcomings in recording the initial verbal reports on the MRI scan.

86. Dr Geddes advised that the inpatient notes made during Mrs A's admission are "extremely brief" and contain no mention of the MRI results. He said that although details of the MRI provisional report and diagnosis are included in the discharge summary, overall the lack of clinical documentation, including details of diagnosis and scan results in the progress notes, was a moderate departure from expected standards.

[10] "The maintenance and retention of patient records" (2008).

87. Dr Geddes and SDHB agree that the documentation in the clinical progress notes during Mrs A's admission was not clear and fell short of expected standards. In particular, I note the absence of documented evidence about how SDHB staff reached the conclusion that Mrs A's MRI "showed no sinister cause for pain/sciatica", as noted on her discharge summary.

88. My expectation is that all information relevant to a patient's care, including informal reports relied upon in any key clinical decision-making such as the decision to discharge, and the source of any such information, is documented in the patient's clinical record. It is therefore of concern that in this case SDHB staff omitted to document important details regarding Mrs A's care.

Conclusion

89. SDHB's system failed to support its clinicians adequately to follow up Mrs A's MRI report in a timely manner, and there was an unnecessary delay in Mrs A receiving the follow-up care she required. The delay could have been even longer were it not for the fortunate actions of a clinician who did not have direct responsibility for Mrs A's care but noticed that her MRI report had not been actioned on HCS and took appropriate steps to ensure that this was addressed. Accordingly, I find that SDHB failed to provide Mrs A with an appropriate standard of care and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[11]

90. In addition, the standard of clinical documentation during Mrs A's admission at the public hospital was inadequate and omitted important details regarding her care. SDHB acknowledged that the documentation was not clear and fell short of expected standards. Accordingly, in failing to adhere to MCNZ's documentation standards, I also find that SDHB breached Right 4(2) of the Code.[12]

Other comments

I am concerned that it appears that whilst clinicians have made efforts in the past to ensure that they have clinical non-contact time scheduled into their workload, SDHB has not yet resolved this issue. I will follow up with Te Whatu Ora Southern about the systems it has in place to ensure that its staff have the time they need for all aspects of their clinical work.

Opinion: Dr D — adverse comment

91. Dr D was the consultant with responsibility for reviewing the findings of Mrs A's MRI report and arranging appropriate follow-up. When Dr D was asked by this Office how the MRI report would have been followed up had ED house officer Dr C not done so, Dr D would have reviewed the report "when given time allocation for this clinical duty".

[11] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[12] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

92. While I understand the difficulties imposed by a lack of time allocation and other system issues at SDHB, in my view this is not an acceptable response, noting that there was no imminent prospect of such time being allocated. In my view, Dr D should reflect on personal responsibilities in relation to Mrs A's care — in particular that Dr D was the clinician responsible for reviewing and acting on the findings of the MRI report in a timely manner.

Changes made since events

93. SDHB told HDC that following the above events it installed a new Radiology Information System across its services, and this occurred at the public hospital on 16 November 2020. As a result of this change, diagnostic scan reports are now automatically distributed to clinicians on the electronic system upon receipt, and no longer require manual authorisation by administrative staff to enable clinician access to scan reports.

94. In relation to the standard of clinical documentation, SDHB stated that it is actively working on improvement in the standard of medical documentation in general and in its electronic discharge summaries in particular. SDHB said that as a result of the criticisms about the clinical record-keeping in Mrs A's care, an additional training session on documentation was organised, and the session is included in its orientation for house officers.

95. SDHB further stated that its "Electronic Acceptance Policy" for the acknowledgement of final results for radiology investigations underwent a substantial review. SDHB provided HDC with a copy of the revised and current policy, which states that all laboratory and radiology results "must be accepted [on HCS] within five working days from the date of the report being available".

96. Dr D told HDC that the Orthopaedic Department discussed the issue concerning the lack of a system in place for alerting the responsible senior medical officer to radiology reporting in need of review. In relation to this comment, Dr G told HDC:

> "As a department, we are managing our risk by producing synoptic [summary] progress notes that reflect the verbal communication and following up on the written report as an open Task for the clinical team."

Recommendations

97. I recommend that Te Whatu Ora:

a) Provide a written apology to Ms B for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms B.

b) Report to HDC, within three months of the date of this report, on what is being done by Te Whatu Ora to resolve the issues identified in this report concerning the lack of time scheduled for clinical non-contact duties of its staff, such as the checking of clinical results and reports.

c) Conduct a random audit of 500 radiology results of chest, pelvic, abdominal and spinal imaging from the last six months to confirm that the results were accepted by the responsible clinicians within acceptable timeframes. If any results remained unaccepted for longer than would be expected, please advise how many, and any corrective action taken to rectify this. The results of the audit and any corrective actions taken should be provided to HDC within three months of the date of this report.

d) In my provisional report, it was recommended that Te Whatu Ora provide an update on how it is supporting its clinicians to know when reports and results for which they are responsible become available on Te Whatu Ora's system, and to flag results that are abnormal and/or unexpected. In response to that recommendation, Te Whatu Ora stated: "[HCS] already identifies results that have not been viewed to individual clinicians and, in the case of blood test results, abnormal results are colour-coded as red. It remains the responsibility of the requesting clinician to ensure that the results and imaging are viewed and the necessary action taken."

In my view, this response does not address the issues that Te Whatu Ora's own clinicians have flagged with regard to how the current system does not adequately support them in being able to follow up on clinical results in a timely way. They alerted me to the issue of HCS being clogged with imaging and results that do not require review, which impacts on their ability to follow up on results that do require review. Therefore, I recommend that Te Whatu Ora further review how it can improve its system in a manner that takes heed of its clinicians' feedback and better supports them in their duties to carry out the appropriate follow-up of clinical results on that system. Te Whatu Ora should report back to HDC regarding its review within three months of the date of this report.

Follow-up actions

98. A copy of this report with details identifying the parties removed, except SDHB/Te Whatu Ora Southern and the advisor on this case, will be sent to the Health Quality & Safety Commission and the Royal Australian and New Zealand College of Radiologists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from orthopaedic surgeon Dr Tom Geddes:

> "My name is Thomas Geddes. I am an Orthopaedic Surgeon practising at Middlemore Hospital. I have subspecialty interest in spinal surgery. I have no conflict of interest with the parties named in the complaint.
>
> I have been provided with documentation to review which includes:
>
> 1. The complaint submission dated 24th January 2020.
> 2. A response from the Southern DHB dated 24th March 2020 and 23rd December 2020.
> 3. A response from [a consultant general and breast surgeon] dated 6th March 2020.
> 4. Over 500 pages of clinical records from both the Southern DHB and [the] Medical Centre.
> 5. Copies of [Mrs A's] radiology images which includes CTs, x-rays, nuclear medicine scans and MR scans from 2014 to 2019.
>
> I have been asked to review this documentation and comment upon the care provided to [Mrs A] by the orthopaedic surgeon and staff at Southern DHB. In particular I have been asked to comment on:
>
> 1. Whether or not the management of [Mrs A] during her admission to [the public hospital] in [Month1] was consistent with accepted practice particularly:
>
> a) The adequacy of their assessment;
> b) The adequacy of the clinical documentation particularly with reference to imaging results, working diagnosis and overall management plan;
> c) Whether it was reasonable to discharge [Mrs A] on the 22nd [Month1] given her pain levels and finding of urinary retention;
> d) The apparent interpretation of the MR images during [Mrs A's] admission, as showing no significant abnormality and clinical documentation in this regard;
> e) Actions taken by Southern DHB staff once the formal MRI report was received (reported 26th [Month1] and viewed as per audit provided by Southern DHB);
> f) Any other comments on the DHB's response or additional issues identified.
>
> 2. Any other matters I may consider amount to a departure from accepted standards of care.
>
> With regards to [Mrs A's] presentation in [Month1], she was initially assessed by the Emergency Department (ED) in the afternoon of the 20th [Month1] with the primary doctor listed as [Dr C]. She presented with a history of severe back pain and pain radiating down her left leg that had not responded to analgesic treatment from her family doctor. The initial assessment and documentation by the Emergency Department is adequate and the initial treatment management plan was also appropriate for the presentation.

[Mrs A] was subsequently seen by the orthopaedic team and the initial assessment and management plan as documented in the typed ED notes was adequate and appropriate.

[Mrs A] was initially seen by [an orthopaedic registrar] in the early hours of the morning of the 21st [Month1] and this examination and documentation again appears appropriate. At that stage consideration was given around getting an MR scan based on the raised inflammatory markers and a previous history of cancer. [Mrs A] was then accepted for transfer to the orthopaedic team surgical ward for further workup and treatment.

It would appear a ward round was held on the 21st [Month1], unfortunately the documentation from the medical staff during [Mrs A's] inpatient stay is very scant. It was noted that she was experiencing severe back pain radiating into her calf which was felt to most likely represent sciatica, with a positive stretch test. [Mrs A] had been mobilising on the morning of the 21st. It was noted that in the past, though she had been treated for breast cancer, it was not thought that she had any metastatic lesions on her previous follow-up. An MRI was requested. In her notes it states that she looked well and that on her plain x-rays she had a degenerative scoliosis with a moderately raised CRP on blood tests.

Apart from organising an MRI scan, instructions were given to repeat a post void residual assessment and if there was more than 150mls in her bladder after emptying, that an indwelling catheter should be placed. A note was made that the situation would be discussed with [Dr E] after her MR scan. Physiotherapy, occupational therapy and social work were also to be involved.

The medical notes the following day note that she felt well. She had a post residual bladder volume of 460mls and that an indwelling urinary catheter had been placed. The diagnosis was that she had sciatica with urinary retention. The plan at that stage was for a trial of removal of the catheter, starting analgesic medication with Gabapentin (which is an agent that is useful in treating nerve pain) and for her to be discharged when mobilising with physiotherapy with a review in six weeks and then to be seen in [Dr E's] clinic if her symptoms persisted.

Standard physiotherapy treatment for back pain was instigated. She was then mobilised with physiotherapy. Unfortunately, the catheter was unable to be removed as the post void residual volumes in her bladder remained high. This was discussed with a urology registrar where a plan was made for the insertion and use of a Flip-Flo catheter with training on how to use this catheter to be instigated on the ward and then to be seen for review in two weeks by the district nurse and if, at that time, there was no sensation of wanting to void she should be referred to incontinence nursing and if the sensation to void had returned, for the catheter to be removed and a further post residual volume to be done.

After further nursing and occupational therapy, assessment as far as mobilisation was with physiotherapy, she was discharged home on the 23rd [Month1].

Nowhere in the body of the medical notes during her stay was further reference made to results of the MR scan. In the discharge summary dated 23rd [Month1], which was written by the house officer, there is a note made that 'the MRI scan showed no sinister cause for pain or sciatica'. The discharge summary otherwise was completely adequate and reflected her stay and management in the hospital well.

With regards to the MRI scan which was performed on the 21st [Month1], there does not appear to have been any ability for this scan to have been reviewed by radiology on site during the period of [Mrs A's] admission. The scan was reported [offsite] on the 23rd [Month1] with the report uploaded into the hospital system on the 26th [Month1] meaning there would be no formal radiology report available prior to the discharge.

On reviewing the clinical notes, it is not possible to say where the house surgeon that filled out the discharge summary got the information from that there was no sinister cause for the pain and sciatica.

I have looked through the MR scan images myself. The scan consists of 300 images which are broken down into 13 different series, each of which contains between 10 and 45 images. Each of these series demonstrates the anatomy and pathology in a different manner.

If just focussing on the clinical presentation of back pain and left leg sciatica it would be plausible that one might concentrate on the images that are focussed on the central spine canal and the nerve roots, using the series where the anatomy of the nerves is best displayed. In looking for a cause of the sciatica and back pain and if using those series alone it would be quite plausible that no evidence of cancer would be seen. The iliac lesions and subcutaneous lesions are quite evident particularly on the T1 weighted imaging but they are largely outside the field or on the periphery of the field where someone focussing on looking for a cause of sciatica would be looking. It is therefore quite possible that an orthopaedic consultant/registrar/radiologist could make a quick assessment of the spine looking for a cause of the presenting complaint and flick through the images where the metastatic disease was not evident and feel that no sinister cause was identifiable.

This type of limited viewing of an extensive series of images is frequently the case on busy ward rounds or in busy clinics. I would expect however that given the appropriate time and setting to look through the entire scan that any orthopaedic surgeon or radiologist would have identified the metastatic lesions particularly the ones in the ilium and soft tissues.

Back pain with sciatica and urinary symptoms is a relatively common presentation and in general the principles of pain relief, early mobilisation and management of the bladder were reasonably followed in [Mrs A's] case. Where appropriate follow-up is arranged it is reasonable in some cases to send patients home with a urinary catheter and medical management of their sciatica, in the expectation that the pain will settle, and that the catheter will then be able to be removed at a later date. With the increasing pressure on public hospital beds this is becoming more frequent. Except that in [Mrs

A's] case no cause for the sciatica was identified, or if it was, it was certainly not documented in the medical notes.

Given that no cause apart from the sciatica was identified for the urinary retention but that no cause for the sciatica was identified or documented, it would have been more reasonable to have further explored this before [Mrs A's] discharge.

The workup assessment and management by the nursing, physiotherapy and occupational therapy staff was of a good standard.

As far as the actions taken by the Southern DHB staff once the formal MRI report was received, there appears to have been none until [Mrs A] was referred back to the hospital from general regional practice at which time she was managed by oncology appropriately over the terminal part of her life.

The DHB response to the complaint dated 23rd December 2020 notes [Dr C] reviewed the report on the 26th [Month1]. I note that [Dr C] appeared to have been one of the Emergency Department doctors who had subsequently handed over care of the patient to the Orthopaedic Department and I cannot see any documentation of any further correspondence between the Emergency Department and the Orthopaedic Department. I note that the address for the report as given by the off-site Radiologists is to the Emergency Department.

The most concerning issues with respect to this case are:

1. The lack of clinical documentation, diagnosis and scan results in the body of the medical notes which I think does fall short of the expected standard.
2. The inability of the treating medical staff at the hospital to obtain timely reports on MR scans.

MR scanning is a very complex scanning modality, the images produced contain a lot of information outside of that which is specifically asked for by the referring physician. The images are numerous and it is very time consuming to go through them all. It is not infrequent for radiologists to identify problems on the scans that the referring physicians are unaware of and/or are unable to identify themselves. This, therefore, requires a robust reporting system and a clear line of communication to the referring/ treating doctors. In Middlemore Hospital where I work, we have an Alert system where significant or unexpected findings are communicated directly to the referring consultant by way of an Alert email. These emails are also monitored by our clerical staff who highlight their need for follow-up to the treating surgeons. This is in addition to the normal distribution of the report. To date this system appears to be working well in our hospital and is something I think that [the public hospital] would benefit from if it were to be instituted. The forwarding of results automatically to GPs would also be beneficial particularly where patients are admitted and discharged before formal reports are able to be viewed in the hospital.

In this case I don't think the missing of these metastatic lesions by the medical team in hospital in [Month1] would have had a significant bearing on the eventual outcome. This may not be the case for future patients.

There are a lot of unanswered questions in [Mrs A's] case as the actual definitive diagnosis for the primary cancer, that led to her eventual death, has not been made. There is certainly a distinct possibility that she had a new primary source of cancer either in the lung or the ovaries rather than a recurrence of one of her previous cancers.

I would just like to add, after noting the concern of [Mrs A's] daughter, that the cancer may have been present in her back and not adequately investigated prior to her presentation to hospital. I have reviewed [Mrs A's] previous CT scans and nuclear medicine imaging. The metastatic lesions that were present on the MR scan in 2019 did not appear to be present on any of this previous imaging. The abnormalities that were detected previously in [Mrs A's] spine were well explained by the degenerative changes in her spine and no sign of cancer spread was present even in hindsight in the imaging I reviewed.

I trust this has been helpful in your deliberations and I would be very happy to comment further if you wished.

Yours sincerely

Tom Geddes
Consultant Orthopedic Surgeon"

The following further advice was received from Dr Geddes:

"1. The initial notes made in ED and the discharge summary are of an acceptable standard. The inpatient notes made during the admission are extremely brief and contain no mention of the MRI results. Given that this information (though incorrect) and the plan are contained in the discharge summary I would regard this as a moderate departure from acceptable standards.

2. I am not sure that a standard has been set with regards to hospitals without onsite radiology services obtaining timely reports. I practise in an environment where we have excellent timely access to radiologists, we rely on this greatly in our clinical practice. Without this there will always be a significant risk of things being missed on scans particularly if reports arrive after patient discharge and adverse findings are not highlighted. In my environment I would consider the service provided a severe departure from an acceptable standard of care."

The following further advice was obtained from Dr Geddes:

"Your question is quite difficult to answer with a black and white answer, as the notes did not give a detailed level of the symptomatic response that [Mrs A] had when her sciatic pain was treated. Departure from acceptable practice would depend quite bit on [Mrs A's] response to treatment in that:

1. If she had an excellent response to nonspecific treatment for her sciatica i.e. pain gone or virtually gone, then in general it would be acceptable to discharge her from hospital and make follow-up arrangements pretty much as was done. This being on the assumption that the pain was due to some transitory and not malign cause.

2. On the other hand if [Mrs A] did not respond to treatment or was requiring a very significant amount of analgesia to control her pain, for which a cause had not been identified, then I believe that discharging her before some form of diagnosis was obtained with regard to the cause of the pain would have been a departure from acceptable practice of moderate severity."

The following further advice was obtained from Dr Geddes:

"I have gone through all the medical/nursing notes a couple more times. I get the impression that there was a significant improvement though not complete resolution of her symptoms on what could be considered a standard analgesic regime. Once symptoms had settled satisfactorily it is quite acceptable to send a patient home with a catheter with a plan for removal at a later date especially in a public hospital system very stretched for bed space. Many patients are sent home from [the public hospital] system still in pain with an ongoing plan for analgesia/treatment. It is very much at the discretion of the treating medical team as to what level of perceived pain is acceptable. It is a general tenet of orthopaedic surgery that the majority of sciatica pain (caused by disc prolapse) will get better by itself over time.

In summary and in this case

1. It is generally acceptable to treat sciatic pain symptomatically in the expectation that it will diminish over time.
2. Patients are often discharged with a moderate amount of ongoing pain, hopefully made manageable by an appropriate analgesic regime, in the expectation that the pain will continue to settle.
3. It is frequently the case that patients are sent home with catheters in situ with a management plan made in conjunction with urology.

The shortcoming in [Mrs A's] case is predominately that she was sent home without the cause of her sciatica being diagnosed. 'Sciatica' is essentially just a constellation of symptoms, predominantly leg pain, that is caused by irritation of the sciatic nerve or the smaller nerves that combine to make up the sciatic nerve. The cause of this irritation does not seem to have been elucidated by the treating team before discharge. Appropriate reporting and recording of the MRI would have avoided this. I think that it should also be noted that even if the sciatica cause was picked up at the time of this hospital admission it would not have affected the unfortunate final outcome."

The following further advice was obtained from Dr Geddes:

> "With regard to your questions.
>
> 1. If hospitals are to offer high tech imaging then it is only appropriate that these images are reported in a timely manner with the appropriate treating doctors notified. The inability of a smaller hospital to arrange this is still a departure from acceptable standards, I am not sure how much slack you would want to cut them on the basis of being a smaller hospital. Getting MRI images reported off site is certainly acceptable and in fact essential for smaller centres. Developing a system that gets these reports to the treating doctors and highlights unexpected findings is essential.
>
> 2. I think you will find that MRI reporting has not been included in the 'National-criteria-for-community-radiology' that you sent to me.
>
> The delay in getting reports to the treating physician in a haphazard manner I believe is a significant risk to patients and a significant departure from acceptable practice."

Appendix B: SDHB Electronic Acceptance Policy

SDHB's "Electronic Acceptance Policy" in place at the time of these events outlined the requirements for the acknowledgement of final results for radiology tests and investigations. The policy stated:

"Principle of Electronic Acknowledgement

a) All laboratory and radiology results must be accepted electronically using HealthConnectSouth. …

b) Electronic acceptance is the electronic process that replaces the signing of hardcopy paper result and acceptance confirms that any action required has been taken or organised.

c) If results are not accepted there will be uncertainty as to whether the result has had the required action taken. For this reason no results should be left unaccepted for a period greater than four weeks from date of report being available.

…

d) It is the responsibility of the SMO [senior medical officer], or delegate, to ensure that all results are accepted within four weeks of being finalised. Any results not accepted within four weeks of being finalised are considered non-compliant with acceptable clinical practice."