Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Radiologist found in breach of Code for failing to interpret CT and MRI scans correctly in two men with liver cancer**

**20HDC00404 and 20HDC00693**

In two reports released today, Health and Disability Commissioner, Morag McDowell, found a radiologist breached the Code of Health & Disability Services Consumer's Rights (the Code). In one of the reports (20HDC00693) Southern District Health Board (now Te Whatu Ora|Health New Zealand) also breached the Code.

The first report (20HDC00404) concerns a man, then in his seventies, who underwent a CT scan in January 2018 at Southland Hospital to investigate a mass in his liver.

The radiologist who interpreted the CT scan, reported that the mass was not cancerous. At a follow-up CT scan in January 2019, the man was diagnosed with cancer that had spread to other parts of his body, and he subsequently died from his illness.

The second report (20HDC00693) concerns the care provided by the same radiologist at Southland Hospital after a man presented at the Emergency Department for stomach pain in 2017. Following an MRI in 2018, the radiologist reported a benign liver lesion and stated that no further follow up was required. In 2019, the man was admitted to hospital with abdominal pain.

An ultrasound identified a substantial increase in the size of the original liver lesion. An internal multidisciplinary radiology meeting found the MRI read by the radiologist in 2018 was consistent with liver cancer. The man was subsequently diagnosed with terminal liver and pancreatic cancer.

In the first report (20HDC00404), Ms McDowell found the radiologist in breach of Right 4(1) for failing to provide services with reasonable care and skill. She was critical that the radiologist did not correct an incomplete CT protocol when he became aware that the imaging was inadequate, which ultimately resulted in substandard interpretation of the CT scan.

Ms McDowell considered that this failure was an error attributable to the radiologist. She determined that Southern DHB did not breach the Code, although she identified several areas for improvement.

Ms McDowell found the radiologist in breach of Right 4(1) in the second report (20HDC00693) for misdiagnosing the man's liver lesion on an MRI as benign when in fact it was suspicious of liver cancer. Ms McDowell commented that this was an

error that fell significantly below the standard of care reasonably to be expected of a consultant radiologist.

Ms McDowell also considered the radiologist did not adhere to radiology reporting standards (as set out in the Royal Australian and New Zealand College of Radiologists and International Accreditation New Zealand guidelines) in respect of the man's MRI and therefore breached Right 4(2).

In the second report (20HDC00693) Ms McDowell found Southern DHB breached Right 4(1) for an unacceptable delay in commencing an internal investigation into the radiologist's misread.

Ms McDowell has referred the radiologist to the Director of Proceedings to determine if legal proceedings should be taken.

The radiologist no longer works for Southern DHB.

24 July 2023

***Editor's notes***

The full report of this case will be available on HDC's website. 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 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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