The Royal Australian and New Zealand College of Radiologists®

Dr Avril Diamente
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street, SOUTHBANK VIC 3006
Via email: cpuresponses@coronerscourt.vic.gov.au

Dear Dr Diamente,

Re: COR 2015 005857

The Royal Australian and New Zealand College of Radiologists (RANZCR) would like to thank the Coroners Court of Victoria for the letter dated 17 May 2018, outlining recommendations for developing systems for communicating imaging results. I note the full recommendation below;

That the Royal Australian and New Zealand College of Radiologists, the Australian Association of Nuclear Medicine Specialists and the Royal Australasian College of Physicians collaborate to develop a set of Standards dedicated to systems for the communication of imaging results. The Standards should be as explicit as possible in setting out the roles and responsibilities of diagnostician and referring doctor and the required manner of communication in different situations consistent with the conclusions and comments in this case.

RANZCR has developed a set of practice standards - ***Standards of Practice for Diagnostic and Interventional Radiology*** (currently being updated for version 11). Item 5.5.3 of these Standards outline best practice for the communication of imaging findings and has been provided in Annexure A. In 2017, the RANZCR Safety, Quality and Standards Committee acknowledged the need for a position statement regarding notification of critical test results. This statement is in the final stages of review and will be published as supplementary guidance. The recommendations arising from the inquest herein relate to communication of critical test results and will be taken into consideration by the RANZCR Safety, Quality and Standards Committee in the drafting of the final version of this position statement.

Efforts to address communication of critical imaging findings were highlighted in the RANZCR quarterly newsletter, *InsideNews*, in September 2016. The article, 'Case Study: Management of Patients with Urgent and Significant Findings', remains available on the RANZCR website: https://www.ranzcr.com/documents/4221-2016-inside-news-september-newsletter-final/file.

The College commits to publicising its upcoming *Critical Test Result Notification* position statement through multiple channels including its e-News, InsideNews, the RANZCR website as well as other suitable channels. Emphasis will be given to the concept of duty of care and the professional responsibility for patient handover, relevant to the radiologist.

RANZCR and the Australasian Association of Nuclear Medicine Specialists (AANMS) have conferred on the recommendations from this inquest. We provide mutual acknowledgement for our respective positions, whilst recognising nuances between each discipline.

We recognise the Coroner's report as a valued educational experience for our members, and moving forward, will be pleased to facilitate the recommendations within programs of work.

Yours sincerely

Natalia Vukolova
Chief Executive Officer
The Royal Australian and New Zealand College of Radiologists

Annexure A: 5.5.3 Communication of Imaging Findings and Reports

The practice shall ensure that reports are made available in a clinically appropriate, timely manner and shall carry out regular reviews at least once every year on the time between the performance of the study and the issuing of the report.

Services should refer to the ACR Practice Guideline for Communication of Diagnostic Imaging Findings as a guideline for further detail [15].

When considering the framework to identify urgent and non-urgent findings, it is recommended that practices refer to the Massachusetts Coalition for the Prevention of Medical Errors Communicating Critical Test Result recommendations for guidance [16].

Indicators

1. The practice has a documented policy for report turnaround times which sets out expected turnaround times for defined urgent and non-urgent findings.
2. The practice maintains records of regular reviews of reporting turnaround times in accordance with this policy and implements and records corrective action should there be any indications that the designated reporting times are not being met.
3. If there are urgent and significant unexpected findings, there is a protocol which ensures that:
    a) the reporting radiologist uses all reasonable endeavours to communicate directly with the referrer or an appropriate representative who will be providing clinical follow-up;
    b) a record of actual or attempted direct communication is maintained by the practice;
    c) and the reporting radiologist co-ordinates appropriate care for the patient if they are unable to communicate such findings to the referring clinician.