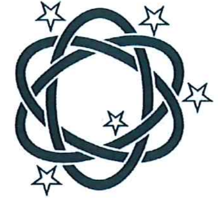

4 September 2018

Ms Avril Diamente
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Via email: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Diamente

Re: COR 2015 005857

The Australasian Association of Nuclear Medicine Specialists (AANMS) acknowledges receipt from the Coroners Court of Victoria of the *Finding into Death with Inquest (Inquest into the death of Mettaloka Malinda Halwala) COR 2015 5857* (the Finding) and the accompanying letter of 17 May 2018 outlining recommendations for developing systems for communicating diagnostic imaging results.

The recommendation in the Finding directed towards the AANMS (and to the Royal Australasian College of Physicians [RACP] and the Royal Australian and New Zealand College of Radiologists [RANZCR]) is:

> *That the Royal Australian and New Zealand College of Radiologists, the Australian (sic) 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.*

The AANMS Board has reviewed the Finding in detail. The AANMS considers the matters raised in the Finding should be brought to the attention of its Fellows and Members. I would also note that Professor Lee brought this matter to my attention personally as soon as the Finding was published and asked that the information be circulated to the AANMS Fellows and Members

in order to provide advice and assistance to nuclear medicine specialists in relation to the communication of imaging results.

The AANMS has communicated with both the RANZCR and RACP on this matter. In relation to the RANZCR, the AANMS is in regular communication about a wide range of issues relevant to diagnostic imaging, including such quality assurance measures.

In discussing the particular matters raised in the recommendation above, both organisations have already developed, or are in the process of developing or updating appropriate guidelines for their members. It should be noted that the RANZCR and AANMS acknowledge that while the detail may be addressed differently by the two organisations due to the nature of the existing standards, policies and codes of the two organisations, there will be similarities in the roles and responsibilities of the diagnostic imaging provider in communicating imaging results as set out in the standards, codes and guidelines, particularly those relating to results of a time critical nature.

The AANMS will seek to ensure in its Code of Professional Conduct and in any future communications policy and practice guidelines that may be developed that guidance for communication between the referring clinician and the nuclear medicine specialist, particularly in relation to urgent and time critical results, is clearly set out.

As noted above, the AANMS has contacted the RACP on this matter and we have drawn the attention of the RACP to the recommendation and sought discussions. We understand that the RACP has recently contacted the Coroner's office for a copy of the documentation and correspondence. At the time of sending this letter, we have been unable to meet with the RACP to discuss this matter. The AANMS does not believe that, from the perspective of improving communication of results from diagnostic imaging specialists to referrers, the inability to discuss the matter with the RACP to date is a significant issue. The AANMS will still seek to meet with the RACP would hope that the RACP may provide guidance to its consultant physician membership on ensuring imaging requests contain sufficient detail to facilitate all communications and particularly those of an urgent nature.

In terms of the specific actions being taken by the AANMS to address the recommendation, the AANMS is currently engaged in:

- a review of the existing AANMS Code of Professional Conduct and the development of a section specifically relating to the communication of time critical imaging results;
- the circulation of a de-identified version of the Coroner's Findings to all Fellows and Members with the recommendation that they review the complexities of the case and the manner in which such situations may arise and take appropriate action to upgrade their own communication procedures if appropriate; and
- establishment of a review schedule for any code or policy to maintain currency of information.

The development of a more detailed communication guideline for nuclear medicine scanning results, together with a review and changes to practice guidelines is under consideration. This will be discussed further with the RANZCR in terms of the most appropriate approach given the issues involved are common to both organisations.

As AANMS President I will be communicating directly with our Fellows and Members in relation to the above and the AANMS will include relevant information on the AANMS website. The AANMS Code of Professional Conduct is a Code that is adopted by the full membership and therefore the amended Code will be taken to the membership for adoption in due course.

I undertake to provide to the Coroner a copy of the ratified AANMS Code of Professional Conduct once it is available.

The AANMS considers such matters to be a valuable educational experience for our members for both the improvement of quality of care and also the avoidance of risk in the future. Unexpected deaths are a tragedy and we hope that our attention to this matter and that of our colleagues at the RANZCR in also addressing these specific issues will minimise such risk in the future.

Please contact me if further information is required at this stage.

Yours sincerely

Associate Professor Paul Thomas FRACP FAANMS
PRESIDENT