



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 5857

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: Mettaloka Malinda HALWALA

Delivered On:	10 May 2018
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street SOUTHBANK Vic 3006
Hearing Dates:	29, 30 January and 8 February 2018
Findings Of:	Coroner Rosemary Carlin
Representation:	Mr Robert Harper for the family of the deceased Ms Naomie Hodgson for Austin Health and Associate Professor Sze Ting Lee Mr Morgan McLay for Dr Robin Filshie
Police Coronial Support Unit:	Leading Senior Constable King Taylor, Coroner's Assistant

TABLE OF CONTENTS

Introduction	3
Coronial investigation	4
General purpose of a coronial investigation	4
Focus of the coronial investigation and inquest	5
Sources of evidence	7
Circumstances of death	8
Cause of death	12
Communication of the PET report	13
The position of Associate Professor Lee	13
The position of Dr Filshie	14
Guidelines for the communication of imaging results	17
Evidence of the conclave of experts	19
Evidence as to whether Dr Filshie should have chased the report	22
Dr Filshie's response on 16 November 2015	23
Was Mr Halwala's death preventable?	23
Discussion and conclusions	24
Findings	29
Comments	30
Recommendations	34

INTRODUCTION

1. This case raises important issues about the communication of abnormal medical test results.
2. Mettalo Malinda HALWALA was 58 years old when he died from complications of the chemotherapy he was receiving for Hodgkin's lymphoma. Prompt and effective communication of his abnormal test results may have prevented his death from this cause.
3. Mr Halwala was born on 19 January 1957 in Sri Lanka. He was a New Zealand resident and was married with two adult daughters. At the time of his death he was living alone in a hotel near Shepparton, having moved there to work for Goulburn Murray Water as a civil engineer.
4. On 11 November 2015, a Positron Emission Tomography (PET) scan suggested that Mr Halwala may be suffering from toxicity to his chemotherapy. Despite this, two days later Mr Halwala received another dose of chemotherapy. This occurred because the haematologist who had ordered the scan was unaware of the results.
5. On 16 November 2015, Mr Halwala called his haematologist to report feeling unwell and was told to go to hospital. He never made it. The next morning Mr Halwala was found deceased fully clothed in bed in his hotel room.
6. I held an inquest to determine the adequacy of Mr Halwala's medical management proximate to death. I was particularly interested in the reasons the haematologist did not know the results of the PET scan until after Mr Halwala had received another dose of chemotherapy. As no-one acknowledged responsibility for the communication failure, my investigation necessarily focused on the respective roles and responsibilities of diagnostician and referring doctor in relation to the communication of abnormal test results.

CORONIAL INVESTIGATION

General purpose of a coronial investigation

7. Mr Halwala's death was reported to the Coroner as it was unexpected and unnatural and therefore fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*.¹
8. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and, with some exceptions, surrounding circumstances.² Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.
9. Under the Act, coroners have another important function and that is, where possible, to contribute to the reduction in number of preventable deaths and the promotion of public health and safety by way of making comment or recommendations about any matter connected to the death they are investigating.
10. When a coroner examines the circumstances in which a person died, this is not to lay blame or attribute legal or moral responsibility to any individual or institution. Rather, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future. This prevention role assumes particular significance in this case, as although nuclear medicine physicians and haematologists are very specialised disciplines, the issue of responsibility for communication of abnormal results applies to all diagnosticians and referring doctors.
11. Coroners do not make determinations of guilt or negligence; they are the province of other jurisdictions. Indeed, the Act specifically prohibits coroners from making a finding or comment that a person has, or may have, committed an offence. A coroner should set out relevant facts, leaving others to draw their own conclusions from the facts.

¹ Deaths that occur after a medical procedure where the death may be causally related to the procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death to occur are also reportable. Although Mr Halwala's death followed a dose of chemotherapy, it is doubtful that the administration of chemotherapy could be considered 'a procedure' as defined by the Act.

² Section 67 of the *Coroners Act 2008 (Vic) (the Act)* requires a coroner investigating a reportable death to find, if possible: (a) the identity of the deceased; (b) the cause of death; and (c) the circumstances in which the death occurred unless an inquest was not held, the deceased was not in state care and there is no public interest in making findings as to circumstances.

12. Whilst it is sometimes necessary to examine whether particular conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or a mere background circumstance. That is, an act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behaviour or a recognised duty. If that were not the case many perfectly innocuous preceding acts or omissions would be considered causative, even though on a common sense basis they have not contributed to death.
13. When assessing the conduct of a professional person regard must be had to the prevailing standards of his or her particular profession or specialty. It is important, also, to recognise the benefit of hindsight and to discount its influence on the determination of whether a person acted appropriately.
14. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities with the *Briginshaw* qualification.³ A finding that a person has caused or contributed to death should only be made after taking into account the possible damaging effect of such a finding upon the character and reputation of that person and only if the evidence provides a comfortable level of satisfaction as to the finding.
15. The *Briginshaw* qualification is of particular significance in this case as the professional conduct of two medical practitioners is under scrutiny. Given the serious consequences for medical practitioners of an adverse finding or comment by a coroner, such comment or finding should not be made without clear and cogent evidence.⁴

Focus of the coronial investigation and inquest

16. There were no issues in relation to Mr Halwala's identity, the date and place of his death, nor the medical cause of his death. As already stated, the primary focus of the coronial investigation into Mr Halwala's death was the circumstances in which he died, specifically

³ *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. *'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'*

⁴ *Anderson v Blashki* [1993] 2 VR 89 at 95 and *Secretary to the Department of Health and Community Services v Gurrich* [1995] 2 VR 69 at 74.

the adequacy of his medical management proximate to death, including the communication of his PET scan results.

17. Leading Senior Constable King Taylor from the Police Coronial Support Unit assisted in preparing a coronial brief of evidence comprising relevant medical records, statements and other material gathered during my investigation. I conducted mention hearings on 5 April and 20 September 2017 to determine whether an inquest was necessary. As no concessions were forthcoming an inquest was held on 29 and 30 January and 8 February 2018. Submissions were filed by interested parties on 5 March 2018 and a reply from Austin Health on 14 March 2018.
18. Evidence was given by the following witnesses at inquest, all of whom were doctors and highly qualified in their field of expertise:
 - (a) Dr Robin Filshie, haematologist;
 - (b) Associate Professor Sze Ting Lee, nuclear medicine physician;
 - (c) Dr Christopher James O'Donnell, radiologist;
 - (d) Professor John F Seymour, haematologist;
 - (e) Dr William John McKay, nuclear medicine physician; and
 - (f) Professor Andrew Scott, nuclear medicine physician.
19. Dr Filshie was a full time consultant haematologist at St Vincent's Hospital who became Mr Halwala's treating haematologist because he provided a monthly outreach service to Goulburn Valley Hospital (GVH) in Shepparton.⁵ This outreach service was effectively sponsored by St Vincent's Hospital with the laudable aim of improving patient care in rural areas. Dr Filshie was a very experienced clinical and research haematologist.⁶ He referred Mr Halwala to the Austin Hospital for his PET scan.

⁵ At the first mention hearing to which St Vincent's Health was invited, counsel for St Vincent's Health indicated that Mr Halwala was '*essentially seen as a private patient*'. Dr Filshie explained that the outreach service was provided as part of his employment at St Vincent's hospital and although some patients were billed privately that money was donated to St Vincent's Hospital.

⁶ His Curriculum Vitae disclosed that he qualified as a haematologist in 1994 and obtained a PhD in 1998. He had a number of publications to his name.

20. Associate Professor Lee was a nuclear medicine physician at the Austin Hospital and has since gained a PhD in molecular imaging in oncology. She interpreted and reported on the PET scan.
21. The remaining four witnesses were not involved in Mr Halwala's care, but provided reports commenting on his treatment. Dr O'Donnell and Professor Seymour were engaged by the Court as independent experts, whilst Dr McKay and Professor Scott provided reports at the behest of Austin Health.
22. Dr O'Donnell was, inter alia, a consultant radiologist at the Victorian Institute of Forensic Medicine (VIFM) and Professor Seymour was, inter alia, the Director of the Integrated Clinical Haematology Department, Royal Melbourne Hospital and Peter MacCallum Cancer Centre.
23. Dr McKay was a visiting specialist in Nuclear Medicine at Monash Health, but from 1976 to 1999 he was the Director of Nuclear Medicine & PET at Austin Health. He quite properly declared himself to be '*well acquainted*' with Professor Scott and Associate Professor Lee, both of whom trained or worked under his directorship at various times.⁷ Professor Scott was, inter alia, the current Medical Director of the Department of Medical Imaging and Therapy at Austin Health and therefore also acquainted with Associate Professor Lee, who worked in his department.
24. Dr O'Donnell, Professor Seymour, Professor Scott and Dr McKay gave evidence concurrently, a procedure commonly referred to as a '*hot tub*' or expert conclave. On the day of their evidence, they were presented with a list of questions and allowed to consider their answers in private. The Court reconvened in the afternoon to hear their evidence.
25. Subsequently, Professor Seymour gave evidence separately in relation to other aspects of Dr Filshie's treatment.

Sources of evidence

26. This finding is based on the totality of the material the product of the coronial investigation of Mr Halwala's death. This includes the Coronial Brief (version 5), the oral evidence of all

⁷ Associate Professor Lee clarified that she worked under Dr McKay when she was a registrar at Monash Medical Centre in 2003.

witnesses who testified at inquest, any documents tendered at inquest and the final submissions of Counsel who appeared. It is unnecessary to summarise all of this material. It will remain on the Court file.⁸ I will refer only to so much of it as is relevant or necessary for narrative clarity.

CIRCUMSTANCES OF DEATH

27. On 1 September 2015, Mr Halwala checked into the Tatura Hotel in the Goulburn Valley region. He asked staff to check in on him daily as he had not been feeling well.
28. On 7 September 2015, Mr Halwala presented to GVH complaining of sore throat, loss of appetite, weight loss and fever. Tests were suggestive of Hodgkin's disease. His care was transferred to the Austin Hospital in Melbourne on 14 September 2015 for further investigation.
29. A PET scan conducted on 17 September 2015 at the Austin Hospital showed metabolically active extensive Hodgkin's lymphoma involving multiple lymph node stations on both sides of the diaphragm and splenic and widespread marrow involvement. He received a blood transfusion for anaemia, and on 18 September 2015 commenced ABVD chemotherapy⁹ at the Austin Hospital.
30. Mr Halwala tolerated his first chemotherapy treatment well and was discharged 'home' to Tatura the next day (19 September 2015). Dr Filshie was contacted by a colleague at the Austin Hospital and agreed to supervise Mr Halwala's future treatments at GVH. Dr Filshie attended GVH every four weeks on a Friday, but was often consulted about patients in between visits.
31. Mr Halwala had his second and third ABVD chemotherapy treatments at GVH on 1 and 16 October 2015, before meeting Dr Filshie for the first time on 23 October 2015. According to Dr Filshie, initial investigations revealed that Mr Halwala had advanced high-risk disease 'which carries a lower chance of cure'. By the time he met Mr Halwala 'he had certainly

⁸ From the commencement of the Act, that is, 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

⁹ ABVD is an acronym for the drugs adriamycin, bleomycin, vincristine, and dacarbazine

improved but it was anticipated that recovery would still take quite some time, given that he had deteriorated significantly in the lead up to diagnosis'.¹⁰

32. On 27 October 2015, Dr Filshie hand completed, signed and dated a two-page Austin Health ONCOLOGY REFERRAL FORM FOR PET SCAN, which was faxed to Austin Hospital on the same day from fax number 9288 ..68.¹¹ On the top of the first page he wrote the words 'please book for 10 or 11 November'. In a box headed 'Clinical Information' he indicated the reasons for the scan as 'Hodgkin's Lymphoma Reassess after 2 cycles ABVD Chemotherapy'. He also wrote '[n]ext cycle 30/10/15', although it is clear that he actually meant 'next treatment', being the second treatment of cycle 2, rather than the beginning of a new cycle – a cycle typically consisting of two treatments 14 days apart.
33. In a box headed 'Referring Specialist' next to 'Name' and 'Report to be sent to' was the following typeface:

*Dr Robin Filshie [sic]
St Vincent's Hospital
Haematology Dept – Level 6
Victoria Parade
Fitzroy 3065
Tel: 9288 ..51
Fax: 9288 ..68
Provider No. [completed]*

34. The telephone number on the referral was for Dr Filshie's office, which would divert in the case of non-answer to his secretary or to a message providing contact information. The fax number was that of the closest machine to his office.
35. On the second page of the referral in a box headed 'Indication for PET scan' Dr Filshie ticked the word 'Restaging' and hand wrote 'dose therapy (2 cycles ABVD)'. He also circled the word 'curative' as the management plan intent.
36. On 30 October 2015, Mr Halwala had his fourth ABVD treatment at GVH without incident. His next treatment was scheduled for 13 November 2015.

¹⁰ Letter to the Court from Dr Filshie dated 7 April 2016.

¹¹ All telephone and fax numbers have been partially redacted for privacy.

37. At approximately 5.00pm on Wednesday 11 November 2015, Mr Halwala underwent the PET scan at the Austin Hospital. The scan was performed by Mr Farrell, nuclear medicine technologist. Prior to the scan Mr Farrell met Mr Halwala and asked him a series of questions dictated by a proforma document commonly referred to as '*acquisition notes*'. According to those notes and Mr Farrell's usual practice, he ascertained that Mr Halwala had no sign of any respiratory or other infection or inflammation and did not cough during the procedure.
38. After the scan, a '*PET REPORT*' was prepared.¹² It was commenced by a visiting nuclear medicine physician training in PET, Dr Leung, and '*validated*' by Associate Professor Lee at 6.43pm that day. Associate Professor Lee then printed the report and placed it in the out-tray in the administration area for post and facsimile transmission the next day. The recipient address on the report was '*Dr R Filshie, St Vincents Hospital Haematology Clinic 35, Victoria Pde, Fitzroy 3065, Fax: 9288 ..89*'. The differences between this address and the address on the referral form suggest that however it was completed, it was completed without regard to the referral form.
39. After noting that the PET scan showed an '*excellent*' metabolic response to chemotherapy with normal FDG¹³ activity in the spleen and bone marrow and no sign of disease in the nodes on either side of the diaphragm or elsewhere, the report continued '*[h]owever, there has been interval development of widespread FDG-avid uptake throughout both lung fields*' which '*may be due to bleomycin related pneumonitis. An opportunistic infection is considered less likely if the patient is not clinically septic*'. The report concluded with two points. First, that the findings were '*consistent with an excellent complete metabolic response to treatment*' and second, that the findings were '*consistent with bleomycin related toxicity or opportunistic infection if the patient is septic/ in the right clinical scenario*'. [My emphasis]
40. Two days later, on Friday 13 November 2015, Mr Halwala attended GVH for his next chemotherapy treatment (being the fifth treatment, and the beginning of cycle 3) as planned. Neither GVH nor Dr Filshie were aware of the results of the PET scan at this time. As Mr Halwala complained of a dry cough of five days duration and an itchy or sore throat, he was examined by an intern who found nothing remarkable and prescribed pholcodeine for a presumed viral chest infection. According to Dr Filshie (who had no contact with GVH on

¹² There was no issue with Associate Professor Lee's interpretation of the PET scan nor the contents of the report.

¹³ FDG is a radioactive tracer used in PET scans to show the differences between healthy and diseased tissue.

the day), routine blood tests prior to this round of chemotherapy showed mild anaemia and neutropenia, consonant with the severity of disease and administration of chemotherapy, and not severe enough to warrant a change in treatment.¹⁴ Other blood tests indicated a favourable response to treatment. Mr Halwala therefore received the scheduled dose of chemotherapy, including bleomycin. Dr Filshie's retrospective enquiries with GVH revealed *'there was nothing observed or noted that might have alerted us to lung toxicity prior to the chemotherapy being administered'*.

41. On Saturday 14 November 2015, Mr Halwala saw his family in Melbourne. They described him as *'severely sick with a heavy chest infection'*. He was very weak, *'could hardly breath[e] or walk'* and felt as if his whole body was on fire, especially his throat and ears, even though he was extremely cold.¹⁵
42. On Monday 16 November 2015, Mr Halwala called Dr Filshie's rooms and told Dr Filshie's secretary that he was not feeling well. He apparently did not mention any respiratory symptoms. The secretary telephoned Dr Filshie to relay this message. Dr Filshie believes this occurred mid to late afternoon. He instructed his secretary to call Mr Halwala and tell him to go to hospital for assessment *if* he felt unwell. According to Dr Filshie, this was standard advice given to patients over the telephone *if* they feel unwell. It did not occur to him to seek out the results of the PET scan. Indeed, he could not recall if he remembered at that time that Mr Halwala had recently had one.
43. Later, at the end of the day, Dr Filshie opened his mail and read the PET report for the first time. He explained that this was several hours after his secretary had advised Mr Halwala to go to hospital, *'so I did not telephone him'* as that advice was recent and he had no reason to doubt the advice would be followed. Nor did he telephone GVH as he knew GVH would call him (Dr Filshie) *'when and if the patient attended and/or if he was unwell'*. He planned to contact the oncology staff at GVH the following day, but before he could do so police advised him that Mr Halwala had been found deceased in his hotel room (I note that this must have been some time after 10.15am). He was surprised and upset, having *'assumed the patient had gone to hospital the day before'*.¹⁶

¹⁴ Dr Filshie gave evidence that bleomycin toxicity would not be reflected in blood results, T 233.

¹⁵ Email from family dated 15 March 2017.

¹⁶ The quotations are from two letters Dr Filshie sent to the Court outlining his treatment, dated 7 April 2016 and 28 June 2016. His oral evidence was consistent.

44. In evidence, Dr Filshie agreed that his approach meant that the hospital would not have the benefit of the PET report if Mr Halwala did attend, but he believed the hospital would call him in that event and further *'there was no indication to me that in fact the symptoms that he may have been experiencing were related to that PET scan although it obviously looks different when you look back on it'*.¹⁷
45. Mr Halwala was located by hotel staff at 10.15am in his bed apparently deceased. He had the sheet pulled up to his chest and was wearing jeans and a shirt. A lit torch was on the bed. Police and ambulance were called and attended. It was then that police called Dr Filshie.

CAUSE OF DEATH

46. Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mr Halwala after reviewing a post mortem CT scan and medical notes from Austin Health, GVH, Nixon Street Medical Centre and Dr Filshie. He noted that ABVD chemotherapy is a common treatment regime for Hodgkin lymphoma with possible complications involving the heart and lungs.
47. Dr Young could find no overt evidence of residual lymphoma in lymph nodes, spleen or bone marrow. He found features consistent with chemotherapy-related changes in the lungs, including reactive type II pneumocytes, chronic inflammation, intra-alveolar oedema and interstitial fibrosis. He concluded that the cause of death was *'1(a) Complications of chemotherapy for the treatment of Hodgkin lymphoma'*.
48. No issue was taken by any party with Dr Young's formulation of the cause of death.

¹⁷ T 152.15.

COMMUNICATION OF THE PET REPORT

The position of Associate Professor Lee

49. Associate Professor Lee said that Mr Halwala showed no respiratory distress at the time of the PET scan, as none was reported and such would have been evident during the procedure and on the scan.¹⁸ As at November 2015 Associate Professor Lee had been reporting on PET scans for 10 years. She claimed that a finding of pulmonary opacities on a PET scan in a patient who was not clinically unwell would not '*generally*' require urgent reporting and the expected 24-hour receipt by facsimile was sufficient.¹⁹ She explained that staging and restaging of lymphoma was probably one of the largest indications for doing PET scans – '*we*' do them every day. Although abnormal, she did not consider the findings uncommon as '*we*' would see bleomycin lung toxicity of varying degrees in 10 – 20% of cases. She said Mr Halwala was '*somewhere in the middle in terms of the severity of FDG changes*',²⁰ but, in any event, the intensity of FDG uptake does not determine how unwell a patient is.
50. In this case, Associate Professor Lee did not consider the findings clinically significant because Mr Halwala was not unwell at that time. Nor did she consider them unexpected, because lung toxicity was a recognised complication of ABVD therapy.
51. Despite her report proffering two causes for the observed widespread FDG uptake in the lungs, Associate Professor Lee agreed that the absence of symptoms did make '*bleomycin related pneumonitis much more likely than an infection*' at that snapshot in time.²¹ However, she emphasised an actual diagnosis required a clinical assessment of the patient having regard to all relevant investigations.
52. From the information on the referral, which was '*pretty typical*',²² she believed the treating doctor would use the results to determine future management. She knew it was likely that Mr Halwala would receive further chemotherapy. She also knew that chemotherapy was usually given two to three weeks after the last dose, the last dose being on 30 October 2015.

¹⁸ Although at T72.29 Associate Professor Lee agreed that Mr Halwala would have been able to suppress his symptomatology '*to some extent*', I find it unlikely that he would have chosen to do so and also Dr Scott doubted this could occur at T 313-314.

¹⁹ Unsworn statement signed 14 July 2016.

²⁰ T 69.4.

²¹ T 32.11.

²² T 32.28

However, she did not assume anything about what, if any, further treatment Mr Halwala would receive, nor the timing of it, as it was not her decision and every patient was different. She expected that the referring doctor would see her report before *'giving more chemotherapy'*²³ and if, for some reason, the report had not been received in time, she expected that he would contact Austin Hospital to obtain a copy. Nevertheless, if she had known that Mr Halwala was due to have chemotherapy in two days she *'might have actually called Dr Filshie'*.²⁴

53. Whilst adhering to her decision at the time, Associate Professor Lee said this case had taught her *'to not rely on the referring doctor to read the report'*²⁵ and nowadays in the same circumstances she would call. She noted that if Mr Halwala had been an Austin Hospital patient she could have checked electronically the date of the next chemotherapy or medical review, as was her practice.²⁶

The position of Dr Filshie

54. On 23 October 2015, Dr Filshie wrote to Mr Halwala's general practitioner (GP) outlining prognosis and treatment. He said,

He will be due for treatment again next week and I would like to obtain a PET scan around two weeks after that. If there is any residual uptake on the PET scan, I would like to discuss the possible options of escalating his therapy. I plan to catch up with him again next month.

55. In his correspondence to the Court, Dr Filshie explained that it was common to perform PET scans after the fourth treatment *'to give an early indication of response'* and further to schedule the scans close to the next cycle of treatment *'as this can improve the quality of the result'*.²⁷ He knew the specific risks of AVDB therapy were damage to the heart, neuropathy and lung toxicity from bleomycin, however, *'[t]he PET scan was booked as a predetermined investigation and not for investigation of any anticipated abnormal findings'*. Further, *'[i]n most cases it is not anticipated that the results need to be available a[t] the time of the next*

²³ T 44.20.

²⁴ T 27.15

²⁵ T 49.4.

²⁶ T 51.9 – it is not clear whether that was her practice in 2015.

²⁷ Associate Professor Lee clarified that if the PET scan is done too close to the last round of chemotherapy, there may be changes related to the therapy, rather than the disease, T 29.13. Professor Seymour said sufficient time had to be allowed after chemotherapy to see its benefits and not its acute flare response, but with sufficient time that the results could be obtained before the next round.

therapy (*unless of course there is an unexpected finding*). His intention was to discuss the results with Mr Halwala at his next scheduled appointment, which was Friday 20 November 2015.

56. In evidence Dr Filshie elaborated, He would have liked to receive the PET report before Mr Halwala's next dose of chemotherapy on 13 November 2015. If he had received it, whether by email, facsimile, or otherwise,²⁸ he would have read it and '*without doubt*'²⁹ withheld treatment. However, he never assumed he would review the results before the next treatment. This was because the PET scan was really a prognostic tool (despite the word '*reassess*' on the referral form) – '*It's not ordered to look for possible things that might or might not happen*'.³⁰ A good result at that stage meant a better long term outcome for the patient. Although there was a theoretical possibility of escalating treatment in the event of a poor response, it was '*fairly unlikely*',³¹ as the evidence to support changing therapy was not good and Mr Halwala's age and initial presentation tended against it. Further, he would not have done that without first discussing it with Mr Halwala at his next appointment, that is, after 13 November 2015. To have such a discussion at that stage was not too late.
57. Dr Filshie disagreed with Associate Professor Lee's evidence as to the frequency of lung toxicity in patients undergoing ABVD therapy, both in terms of his experience (including discussions with peers) and his review of the literature.³² He had never seen a PET report like Mr Halwala's during his 19 years of working at St Vincent's Hospital. It was highly abnormal and, in his view, unexpected. Even mild toxicity, which is more common, is still very rare after the first two cycles.
58. Dr Filshie did agree with Associate Professor Lee that '*a radiological finding on a PET scan does not equal a clinical diagnosis*',³³ but he said that is why '*it is important to be notified about unexpected and abnormal results*'.³⁴ Whichever of the two differential diagnosis proved correct did not matter. They both required '*fairly urgent*'³⁵ clinical assessment, that

²⁸ He was quite certain that if the PET report had been emailed to him he would have read it prior to 13 November 2015.

²⁹ T 140.5.

³⁰ T 194.9.

³¹ T 119.13.

³² He cited a recent study that out of 1,200 patients who had completed two cycles of bleomycin, none developed pneumonitis (serious toxicity), T 195.12.

³³ T 199.19.

³⁴ T 199.28. Transcript corrected.

³⁵ T 127.

is, within 24 hours, as the patient could deteriorate rapidly and the severity of the problem (as well as diagnosis and treatment) could only be determined by clinical assessment including relevant investigations.

59. Dr Filshie said in his own practice in reporting on blood test results he would call the referring doctor in the case of abnormal results and that *'there is a reasonably good understanding that unexpected results will be notified in a different way to expected and routine results'*.³⁶
60. Dr Filshie rejected the notion that he ought to have reviewed the PET report before the next chemotherapy as safety to proceed with treatment is determined by clinical assessment on the day; he was not expecting an adverse reaction; and he believed he would have been informed had an adverse reaction (or other significant abnormality) been detected. By way of further explanation Dr Filshie said that when he took over treatment of Mr Halwala, the timetable for his ABVD therapy had already been set. This timetable was not ideal because it was slightly *'asynchronous'* with Dr Filshie's visits to Shepparton, meaning that he could not see Mr Halwala on his treatment days to discuss results. Further, the fact he did not have an appointment to see Mr Halwala on 13 November 2015 meant Dr Filshie did not have his usual prompt to review patient results. As it was not advisable to change the dates of ABVD therapy, Dr Filshie did not do so. Rather, he made the decision in advance to allow one more treatment after the PET scan before he next saw Mr Halwala to discuss the results.
61. Dr Filshie believed that nuclear medicine physicians *'very familiar'* with Hodgkin's lymphoma would understand from his PET scan referral that ABVD therapy was continuing and that it was always 14 days apart.³⁷

³⁶ T 200,13.

³⁷ T 209.

Guidelines for the communication of imaging results

62. The communication of imaging results to referring clinicians is referred to in the standards of practice of several professional governing bodies. Internal hospital guidelines generally follow these standards of practice.

Australian Professional Guidelines

63. The Royal Australian and New Zealand College of Radiology (RANZCR) 'STANDARDS OF PRACTICE for diagnostic and Interventional Radiology'³⁸ has a section dealing with nuclear medicine. Under the heading 'Timeliness of Reporting' it states:

The practice shall ensure that the provision of nuclear medicine reports to referring medical practitioners meet the requirements of the AANMS Standards

Indicators:

The Practice ensures that generally nuclear medicine reports are provided to referring medical practitioners within 24 hours of the examination taking place.

64. The Australian Association of Nuclear Medicine Specialists (AANMS) 'Standards for Accreditation of Nuclear Medicine Practices'³⁹ under the heading 'Timeliness of Reports' states:

The timeliness of reporting will vary with the nature and urgency of the clinical problem. In general, the report should be sent to the referring practitioner within 24 hours of completion of the study. If there are urgent or unexpected findings, the specialist should use reasonable endeavours to communicate directly to the referrer or an appropriate representative who will be providing clinical follow-up. [My emphasis]

United Kingdom Professional Guidelines

65. Whereas the relevant Australian standards only briefly refer to the subject of communication, the United Kingdom has standards devoted to the issue. The 2012, second

³⁸ Version 10.1 – 2016, approved 7 July 2016. The introduction states that RANZCR is the primary organisation in Australia and New Zealand for setting standards of practice for clinical radiology and that 'the document sets minimum standards to support and ensure the delivery of safe, high quality diagnostic imaging and interventional radiology services in both community-based and public hospital settings'.

³⁹ Second Edition, January 2005.

edition, of the Royal College of Radiologists (RCR) Standards, '*Standards for the communication of critical, urgent and unexpected significant radiological findings*', were replaced in 2016 by '*Standards for the communication of radiological reports and fail-safe alert notification*'. The RCR Standards are worthy of close attention.

66. The 2012 RCR Standards suggested the following categories of radiological findings as requiring special attention:

Critical findings. *Where emergency action is required as soon as possible.*

Urgent findings. *Where medical evaluation is required within 24 hours.*

Significant unexpected findings. *Cases where the reporting radiologist has concerns that the findings are significant for the patient and may be unexpected by the referrer.*

67. The 2012 RCR Standards stressed that the referring doctor, the radiologist and the healthcare institution all shared responsibility for ensuring timely communication of radiological findings. Specifically:

(a) The radiologist must produce quality reports that are clear and understandable, emphasise any critical findings and make recommendations for clinical management. The radiologist must also ensure communication of the report to the referrer in a timely manner, that is, in a manner consistent with the above categories of findings. The radiologist should contact the referring clinician if he or she considers '*that there is a danger of unexpected relevant information contained in the report not being acted upon*'. He or she must also document the time and date of the communication or attempted communication.

(b) The referring clinician's responsibilities include having a clear policy as to how to access imaging results and to read and act upon every result as quickly and efficiently as possible.

(c) The healthcare institution must provide appropriate systems.

68. The 2016 RCR Standards essentially repeated and expanded upon these responsibilities with particular emphasis on methods of communication and fail-safe mechanisms. The suggested categories for issuing fail-safe alerts were: '*Critical and urgent findings*' (defined as per the 2012 Standards) and '*Significant, important, unexpected and actionable findings*' defined as

'Cases where the reporting radiologist feels that the findings are important and a fail-safe alert should be added to the normal communication method to ensure that they are acted upon in a timely manner'. The need for fail-safe alerts was said to depend on the knowledge of the radiologist about the processes of the referrer for checking results.

Hospital Guidelines

69. At the time of Mr Halwala's death, Austin Health's only relevant guidelines were contained in a clinical procedure entitled *'Communication of Critical Results – Inpatients and Outpatients'*. As the title suggests, the procedure was limited to a critical result *'that in its own right, represents a clear and immediate threat to the patient's life or limb'* and accordingly *'require[s] urgent clinical intervention'*. The document provided that such results must be communicated promptly and verbally by the diagnostic service to a responsible doctor and set out the procedure for doing so during and after hours. The document also confirmed that the responsibility for checking and *'actioning'* test results rests with the requesting doctor.
70. During my investigation, Peter MacCallum Cancer Centre provided, at my request, a copy of its relevant guidelines for comparison purposes. This guideline was also limited to communication of critical test results and essentially mirrored Austin Health's.

Evidence of the conclave of experts

71. The expert conclave reached consensus on most issues, but were divided on the critical question of the manner of communication of the PET report. The conclave agreed as to the following:
- (a) The information on the PET referral form was typical and sufficient, but optimally it would have indicated when Mr Halwala was next seeing Dr Filshie and having further chemotherapy.
 - (b) Associate Professor Lee could reasonably have been expected to know that it was likely that Mr Halwala would be having further treatment, but not the details.

- (c) 'Some degree' of lung uptake occurs in 'up to 10%' of patients presenting for a PET scan after two cycles (four treatments of ABVD therapy), but the uptake in this case was at the upper range of that 10%.⁴⁰
- (d) The result was potentially 'quite' or 'very' significant because it could impact on treatment planning and required investigation of the cause.⁴¹
- (e) Mr Halwala did not display any signs of coughing or respiratory distress at the time of the scan, however that does not mean 'he definitively had no symptoms'⁴² outside of that time.
- (f) The absence of any obvious symptoms in Mr Halwala made it 'far more likely'⁴³ that the findings represented an inflammatory response to chemotherapy, rather than infection.
- (g) Associate Professor Lee was entitled to expect that Dr Filshie would follow up the result before Mr Halwala received further treatment.
- (h) The results warranted direct and timely communication, but given that Mr Halwala was not displaying symptoms, immediate communication was not required.

72. As to what constituted direct and timely communication, Professor Scott and Dr McKay were of the view that sending the report by facsimile and post was reasonable, or at least 'not unreasonable',⁴⁴ although Dr McKay described it as 'a grey area'⁴⁵ and said that 'in retrospect every one of us here would have made that phone call'.⁴⁶ The 'main reason' for their view was the fact they would have expected the referrer to follow up on the result before implementing any further treatment⁴⁷ (especially as he worked in a major teaching hospital and therefore would be 'no slouch'⁴⁸), but they also relied on the fact that transmission by

⁴⁰ T 249. Professor Seymour later explained that the agreed wording had been carefully chosen by the conclave to cover differences of opinion as to whether it was as high as 10% and the fact the intensity of uptake varied within that 10%.

⁴¹ T 257-258. In his report, Dr O'Donnell said it was significant because both opportunistic infection and lung toxicity from chemotherapy can have a substantial impact on a patient's well-being.

⁴² T 261.28.

⁴³ T 259.25.

⁴⁴ T 278.28, 280.3 and see 270.26.

⁴⁵ T 266.20, 274.29.

⁴⁶ T 266.10.

⁴⁷ T 303.

⁴⁸ T 295.18.

facsimile, followed by post, was a system that had long been used to good effect in the Austin Hospital. Professor Scott elaborated that an audit conducted subsequent to, and because of, Mr Halwala's death identified that 90% of faxes go out within 24 hours (100% if marked urgent) and are also seen by the referring clinician within that time frame.

73. Dr O'Donnell and Professor Seymour agreed with each other but disagreed with their two nuclear medicine colleagues as to the manner of communication. They considered the report warranted *direct* communication, at least by the following morning and in this context *direct* meant communication by telephone or some other method that immediately confirmed that the report had been received and understood and would be acted upon. Sending a facsimile was not sufficient.
74. There was debate within the conclave as to whether the findings were unexpected. Professor Scott, presumably speaking on behalf of Dr McKay, said that Mr Halwala's PET scan result was not unexpected from a nuclear medicine perspective as nuclear medicine physicians are looking for possible complications of treatment and this was a known complication. Professor Scott did acknowledge, however, that the nuclear medicine physician should take into account whether the finding might be unexpected to the referrer in deciding the manner of communication.
75. Professor Seymour and Dr O'Donnell said that from the treating haematologist's perspective, the result was clearly unexpected as the notes and referral indicate there was no clinical reason to suspect the finding, rather the scan was '*a routine re-evaluation of disease response at a pre-specified time point in a patient who appeared to be progressing well*'.⁴⁹ Dr McKay disagreed in that he believed the referring doctor should have been looking for this complication, although he conceded that the degree of FDG uptake would not have been expected by him.
76. Dr O'Donnell explained that he believed the 2012 RCR Standards provided guidance as to how the words '*urgent*' and '*unexpected*' in the AANMS Standards (the applicable standards) should be interpreted. That is, he considered that '*unexpected*' meant unexpected by the referrer (and also significant) and '*urgent*' meant findings requiring medical evaluation within 24 hours. He believed the findings in this case satisfied both criteria.

⁴⁹ T 256.21.

Evidence as to whether Dr Filshie should have chased the report

77. Apart from the expert conclave agreeing that Dr Filshie was entitled to expect timely and direct communication of the PET report (although they disagreed as to what that meant), the evidence in relation to the adequacy of Dr Filshie's management was given by Professor Seymour alone, as he was the only expert haematologist.
78. Professor Seymour considered that Dr Filshie should have ensured that he viewed the PET report before Mr Halwala's next treatment, notwithstanding that it was reasonable for him to expect that he would have been informed of those results. He said, *'while you don't expect an unexpected finding, having sought the information and having that available to you ... you should ensure that you utilise that information in your decision making'*,⁵⁰
79. Professor Seymour gave three reasons for his view. First, any escalation of treatment should optimally occur before cycle 3. Secondly, the PET scan confirms response to treatment, favourable or otherwise. Lastly, the PET scan reveals any incidental findings of clinical significance.
80. As to the first, Professor Seymour agreed that the PET scan could have been performed after cycle 3 and escalation of treatment could have occurred after cycle 3, however, since published literature as to the utility of escalation is based on PET scans after cycle 2 of treatment, that is the optimal time. As to the last, Professor Seymour confirmed that at age 60, Mr Halwala was at increased risk of developing bleomycin toxicity compared to someone younger.
81. Professor Seymour agreed that staying with the pre-set chemotherapy timetable was desirable. However, he said:

So while an overall roadmap is set out, it is absolutely incorrect to say that it is a set and forget program of delivery without evaluation of those three components of treatment. [1] Is it effective against the disease? [2] Is it still safe to continue delivering it from an organ function point of view? And [3] have any toxicities, any unwanted effects from the previous

⁵⁰ T 369.17.

*cycle recovered adequately to allow the next cycle to continue? So there must be an active re-evaluation and confirmation of safety to proceed along that pathway.*⁵¹

82. In his own practice, Professor Seymour clinically reviewed his patients and re-evaluated their treatment after each cycle.

DR FILSHIE'S RESPONSE ON 16 NOVEMBER 2015

83. Dr Filshie knew that Mr Halwala was living in Shepparton for work and understood that his family was in New Zealand. He was confident he would have had his telephone number. His letter to the GP on 23 October 2015 gave Mr Halwala's address as '*c/o Tatura Hotel ...*', indicating that he knew Mr Halwala was staying in a hotel, albeit in evidence he said he did not know the details of his living arrangements.⁵²
84. Professor Seymour considered Dr Filshie's reaction to Mr Halwala's telephone call on 16 November 2015, namely to advise that he should attend hospital, was not necessarily unreasonable. However, once Dr Filshie read the PET report later that day and knowing that Mr Halwala had received another dose of chemotherapy, Professor Seymour believed Dr Filshie should have done more. In particular, he should have contacted the patient, his relatives, or the hospital to ensure that his advice had been heeded and also advised the hospital of the result of the scan. It was not reasonable for Dr Filshie to have done nothing by mid-morning the next day.

WAS MR HALWALA'S DEATH PREVENTABLE?

85. Professor Seymour had never in his 25 years as a consultant haematologist (during which time he had reviewed innumerable PET scans) seen such extensive and severe lung uptake as Mr Halwala's, which he described as at the extreme end of the spectrum. He agreed with Dr Filshie that Mr Halwala likely had a severe and rapid onset bleomycin toxicity.
86. In his correspondence with the Court, Dr Filshie described that type of toxicity as '*much rarer and often not able to be treated successfully, even when identified*'. Professor Seymour agreed that the delivery of prompt optimal treatment (which included withholding the next

⁵¹ T 356.30.

⁵² T 117.9.

round of chemotherapy) would not have guaranteed survival, but he felt the actual chance of survival could not be quantified.

87. Whatever his chances might have been earlier on, Professor Seymour described Mr Halwala's chance of survival on 16 November 2015 as '*probably relatively poor*'⁵³ given that his original adverse reaction had remained untreated and he had received another insult.

DISCUSSION AND CONCLUSIONS

88. As previously explained, my examination of Mr Halwala's medical management was not to find fault, but to find cause, albeit at times the distinction may seem artificial. Mr Halwala's family understandably want to know why their husband and father died and I am obliged to give them answers as best I can. My investigation also sought to identify any systemic failures that contributed to Mr Halwala's death, therefore giving rise to opportunities for prevention in the future.
89. I also reiterate that the conduct of particular individuals must be assessed having regard to the reasonably expected behaviour of a person with the same expertise confronted with the same scenario, without the benefit of hindsight and with due regard to the principles of *Briginshaw*. Acknowledging those parameters, for the reasons that follow I am satisfied that there were shortfalls in the medical management of Mr Halwala on the part of both nuclear medicine physician and haematologist. On the evidence, I cannot be certain that Mr Halwala would have survived even with optimal treatment, but he may have. The shortfalls in his medical management deprived him not only of this chance of survival, but also of the opportunity to have a more comfortable death surrounded by loved ones.
90. I turn first to the position of Associate Professor Lee. Nuclear medicine physicians and radiologists are not just diagnosticians, they are first and foremost medical practitioners. Although they may never meet the people who are the subjects of their reports, those people are still their patients, to whom they owe a duty of care and for whom they have a continuing responsibility until they return care to the referring doctor by communicating the results in a manner that is both effective and appropriate to the circumstances.
91. Counsel for Austin Health and Professor Scott took exception to any reference to the 2012 RCR Standards, which specify '*significant unexpected findings*' as a category of findings

⁵³ T 373.9.

requiring special attention, in assessing the conduct of Associate Professor Lee. Clearly United Kingdom Standards do not, per se, apply to an Australian nuclear medicine physician. However, that does not mean they are irrelevant. Appropriate care is not established simply by proof of compliance with applicable Standards and Guidelines. The point has oft been made by medical experts in this jurisdiction, including Associate Professor Lee and all members of the expert conclave in this case, that Standards and Guidelines can never displace proper clinical assessment and practice in individual cases, but rather should be regarded as laying down a minimum level of conduct.⁵⁴ Further, and in any event, the professional Australian standards that did apply to Associate Professor Lee, the AANMS Standards, include in the category of findings requiring direct communication '*unexpected*' as well as urgent findings.

92. In my view, the only reasonable interpretation of the word '*unexpected*' in the AANMS Standards is that it is referring to the expectation of the referring doctor. As Counsel for the family put it, diagnosticians are not formulating reports for their own gratification and information, they are intending to communicate something to the referring doctor and ultimately the patient.⁵⁵ That is the whole point of writing the report. It makes no sense that they should consider whether a finding is unexpected from their own perspective rather than the perspective of the referring doctor, especially since they may have a high threshold for whether something is unexpected by virtue of their exposure to a much greater range of results.
93. The 2012 RCR Standards are helpful in this regard, not because they were binding on Associate Professor Lee, but because they confirm how the word unexpected should be construed in this context. That is, the 2012 RCR Standards define '*significant unexpected findings*' as '*cases where the reporting radiologist has concerns that that the findings are significant for the patient and may be unexpected by the referrer*'. Defining '*unexpected*' in this way does not require a nuclear medicine physician or radiologist to be a mind reader, but to make an assessment based on the information before him or her of whether the result may be unexpected by the referring doctor.
94. In this case I am satisfied for the reasons articulated by Professor Seymour and Dr O'Donnell that Associate Professor Lee should have appreciated that the result would not have been

⁵⁴ T 48 - 49 and T 309 - 310.

⁵⁵ T 291.20.

expected by Dr Filshie, as in fact it was not. Even if, as Dr McKay said, Dr Filshie should have been looking for such a complication and in that sense, expected it, on the evidence he could not reasonably have expected the extent of the complication. On that issue I accept the evidence of the conclave that the result was at the very upper end of abnormal, not, as Associate Professor Lee said, somewhere in the middle.

95. Since Associate Professor Lee should have known that the result, which was undoubtedly significant, would not have been expected by Dr Filshie, I am satisfied she should have used '*reasonable endeavours to communicate directly to the referrer*'. So much was explicitly required by the Standards of her own profession (the AANMS Standards), quite apart from her general duty to provide reasonable care.
96. As to what constitutes *direct* communication in this context, clearly the AANMS Standards were intending to convey that something over and above the usual method of communication was required for urgent or unexpected findings. I again accept the evidence of Professor Seymour and Dr O'Donnell that what was required was communication that provided immediate confirmation that the report had been received, understood and would be acted upon; in other words actual dialogue. Absent any other means of achieving this, Associate Professor Lee should have picked up the telephone and called Dr Filshie, either that night or the next morning. Instead, she relied on two assumptions. First, that facsimile transmission would ensure the report was received and read by Dr Filshie within 24 hours and secondly, that Dr Filshie would pursue the results before any further treatment. The potential for something to go awry should have been obvious.
97. Austin Health was not able to provide proof that the report was faxed to Dr Filshie because the relevant fax machine was incapable of providing historical transmission reports and, I infer, any contemporaneous transmission record was not retained. Dr Filshie did receive the posted copy of the PET report, but the whereabouts of any faxed copy remained unexplained even at the end of the Inquest.
98. I accept that it is likely the report was faxed on 12 November 2015 in accordance with usual practice. However, as previously noted, the number to which the report was faxed (9288 ..89) was not the number provided by Dr Filshie on the referral form. Just how this wrong number made its way onto the PET report is unclear. Other than saying it was administrative, Associate Professor Lee did not know and she had assumed that it was accurate.

99. The exact location of the recipient fax machine also proved somewhat elusive during my investigation. I was definitively advised after the inquest that it was in the outpatient's department on the ground floor of St Vincent's Hospital and serviced approximately 20 specialties. Dr Filshie's office was on the 6th floor.
100. Not only was Dr Filshie's office on the 6th floor, by historical accident it was situated in a laboratory. There was no discrete haematology department with a dedicated telephone or fax number. The number Dr Filshie provided on the referral form was the closest fax machine to his office, but it was shared by other parts of the laboratory and the microbiology department. Further, as it was both a fax and printer often hundreds of pages came out of it every day. The faxes were generally placed in a tray, but sometimes documents were picked up by the wrong person. Notwithstanding that, Dr Filshie said most faxes arrived in his office within 24 hours.
101. As it happens, on 12 and 13 November 2015 Dr Filshie was at a meeting and away from his office on both days. He had his telephone and pager with him, but did not return to his office. He agreed that even if the PET report had been sent to the correct fax number, he may not have got it. Indeed, it seems highly likely that he would not have got it.
102. The fallibility of fax transmission as a means of communication of important information is illustrated by the above recitation of the facts. This appreciation comes not just from hindsight. I accept that Associate Professor Lee is not responsible for the incorrect fax number on her report and that she was following a practice at Austin Hospital for routine distribution of results, but at the same time she was not familiar with Dr Filshie, his whereabouts, the location of the *correct* fax machine, nor any systems he had in place to ensure receipt of faxes. Anyone who works in a large organisation will be familiar with the scenario of shared combination fax/printers and the potential for documents to be inadvertently collected by the wrong person, placed in a pile next to the machine or just to go missing.
103. It matters not that the subsequent Austin Health audit showed that fax transmission is effective most of the time. It was not suitable in this case. The information was too important.
104. Similarly, Associate Professor Lee's reliance upon her assumption that Dr Filshie would seek out the report before any further treatment was dangerous, even if it was reasonable to expect that he would do so. Good medical care demands not only a collaborative approach

between health professionals, but individual responsibility for patient welfare. True it is that Dr Filshie was Mr Halwala's primary treating physician, but in so far as Associate Professor Lee relied on him to chase the report, she put aside her own duty of care and responsibility for Mr Halwala's welfare. Further, although he worked in a major teaching hospital, Associate Professor Lee did not know Dr Filshie and was not familiar with the manner in which he practised, nor his expectations of her. Relying on him to do something she considered reasonable in those circumstances was particularly risky. Finally, even if Dr Filshie did seek out the report prior to the next treatment, since Associate Professor Lee did not know when that treatment would occur, she could not be confident that his doing so would lead to the prompt clinical assessment which was required.

105. In relation to Dr Filshie, I accept, for the reasons articulated by Professor Seymour, that he should have ensured that he read the PET report before Mr Halwala's next chemotherapy on 13 November 2015. It is not to the point that Dr Filshie might not have ordered the PET scan at all, or might not have ordered it at that time. The fact is he did order it and having done so, it was incumbent upon him to make sure he read the results promptly. It was information that was available to him and he had a duty to make use of it.
106. It is also not to the point that escalation of treatment might have been unlikely, or that it could be implemented after cycle 3. Dr Filshie's letter to Mr Halwala's GP of 23 October 2015 indicates that escalation of treatment was at least a consideration. That being the case, the optimum time for it to occur was before cycle 3. I accept that Dr Filshie would not have altered Mr Halwala's treatment without first discussing it with him and that his next appointment was not scheduled until 20 November 2015, but he could have called Mr Halwala. Further, if Dr Filshie really believed a face to face consultation was necessary, presumably Mr Halwala, who appeared to be a conscientious patient, would have been willing to travel to Melbourne.
107. Finally, Dr Filshie's assumption that Associate Professor Lee would inform him of any significant abnormal results suffers from the same flaws as Associate Professor Lee's assumption about his conduct. Having this belief did not absolve him from his own responsibility to make certain there was nothing untoward in the results. He was the primary treating physician with ultimate responsibility for Mr Halwala's medical care and he ordered the test. Granted he did not expect anything unusual, but it was dangerous to completely rely on his expectation of what another medical professional would do, even if that

expectation was reasonable, especially since he had not worked with her before. Dr Filshie himself appeared to acknowledge the vagaries of human conduct when he said, '*there is a reasonably good understanding that unexpected results will be notified in a different way to expected and routine results*'.⁵⁶ [My emphasis]

108. Counsel for Dr Filshie submitted that a finding that Dr Filshie should have actively sought out the PET scan results would be counterproductive to my prevention role in that it '*would effectively lessen the responsibility of a reporting physician to notify a treating physician of results such as those relating to Mr Halwala's PET scan.*' I disagree. If anything, my finding that Dr Filshie should have done this, when combined with my finding that Associate Professor Lee should have called him, highlights the fact that there is an absolute responsibility on each side of the communication equation.
109. Without derogating from my finding that Dr Filshie should have read the PET report before 13 November 2015, when he finally did open it late in the day on 16 November 2015, I accept Professor Seymour's evidence that Dr Filshie should have made efforts to ensure that Mr Halwala had gone to hospital. Dr Filshie had never before seen such an abnormal result on a PET scan. He knew that the result potentially represented a severe reaction to his chemotherapy. He knew that Mr Halwala had received another dose of chemotherapy since the scan and he knew that he had called that day complaining of feeling ill. In these circumstances, I find that Dr Filshie's response, or more accurately, his lack of response, fell short of reasonable care, especially if, as it appears, he also knew Mr Halwala lived alone in a hotel in Shepparton. The fact that by mid the next morning Dr Filshie had still not attempted to contact Mr Halwala, his family, or the hospital seems remarkably indifferent.
110. On the evidence it is unlikely that medical intervention on the evening of 16 November 2015, or thereafter, would have saved Mr Halwala, but if nothing else it would have prevented him from dying alone, unsupported, in a hotel room.

⁵⁶ T 200.12.

FINDINGS

Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings in respect of the death:

111. Having investigated the death of Mettaloka Malinda Halwala and having held an inquest in relation to his death on 29, 30 January and 8 February 2018, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

- (a) the identity of the deceased was Mettaloka Malinda Halwala;
- (b) Mr Halwala died on 16 or 17 November 2015 at Tatura, Victoria, from complications of chemotherapy for the treatment of Hodgkin lymphoma; and
- (c) his death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

112. This case illustrates the difficulties that may be encountered in patient management where different components of care are delivered by individuals and institutions geographically separated from each other and between whom there is no established professional relationship.

113. Mr Halwala was let down by the medical profession. He may have survived if the results of a crucial PET scan had been conveyed to his treating doctor who had ordered the scan. The evidence exposed a significant disconnect between the expectations of the doctor who performed the scan and the treating doctor in relation to the communication of those results. Both doctors considered their actions entirely reasonable and relied to a great extent on their expectation as to what the other doctor would do, expectations that proved wrong in each case.

114. Professor Seymour observed that communication between PET physician and referring haematologist works best when there is a clear mutual understanding, which *'typically only arises through sustained shared care of multiple patients over a significant time frame and*

shared participation in multidisciplinary team meetings'.⁵⁷ The schism in expectations in this case was no doubt partly attributable to the fact Associate Professor Lee and Dr Filshie worked at different hospitals and did not know each other. However, the fact an expert conclave of medical professionals from each side of the profession were not able to agree as to what constituted a reasonable means of communication suggests that the problem is more widespread. The United Kingdom RCR Standards confirm it.

115. The superseded United Kingdom 2012 RCR Standards explicitly recognised that delays in the communication of imaging results was a real and continuing issue in patient care requiring comprehensive guidance to practitioners. The 2016 successor to this document noted that despite numerous publications on the issue, including the 2012 RCR Standards, *'timely effective communication of all reports with critical, urgent or significant findings remains a problem'*.

116. The *Foreword* to the 2012 RCR Standards identified the issue as follows:

[T]he National Patient Safety Agency (NPSA) highlighted a significant number of serious untoward incidents where patients were harmed by delays in appropriate management due to the clinical teams not having received or read the report to the imaging investigation they had requested ... The RCR issued its initial guidance based on this document in 2008 ... Despite this, there are a significant number of such serious untoward incidents still occurring – some of which result in the death of patients who put their trust in the system ... As the failure of these processes can have profound effects on individual patients' wellbeing, it behoves us to develop fail-safe back-up mechanisms to avoid such failures occurring.

117. The *Background* to the 2012 RCR Standards referred to the United States position where, apparently, the second most common cause of malpractice litigation at that time was the failure to communicate results of radiological examination and both the courts and the American College of Radiology clearly stated that radiologists must verbally communicate urgent or significant unexpected findings to referring physicians, if not also to patients. In fact, *'[i]n the USA, communicating the results of radiological examinations appears to have become just as much the duty of radiologists as is the rendering of interpretations'*. The *Background* concluded:

⁵⁷ In his report to the Court received 3 August 2017.

It is incumbent on trusts, departments and individuals to ensure that the designated pathways between radiology departments and referrers are designed to minimise the risk of serious harm to patients by significant imaging findings being overlooked – even though they have been correctly reported.

118. In light of the above observations in the United Kingdom Standards, it is surprising that Australian professional associations and hospitals do not have more comprehensive and explicit standards and guidelines as to the communication of test results. The circumstances of Mr Halwala's death puts paid to any suggestion that there might not be a need for such guidance.
119. I invited the expert conclave to recommend ways to improve systems for communication of diagnostic results in the future. Whilst recognising that some results would need more urgent and direct communication, the conclave were of the view that electronic distribution of results with confirmation of receipt should be routine. I note that both the 2012 and 2016 RCR Standards also advocated electronic methods of communication, providing adequate Information Technology Systems were in place.
120. When Mr Halwala died in November 2015, Austin Hospital distributed approximately 70% of all PET reports electronically. Faxes were only used in the case of external referrers, as Dr Filshie was. External referrers could obtain reports electronically if they registered with an organisation called Healthlink, whose details were at the bottom of the PET report, but not the Austin generated referral form. There was no requirement for external referrers to register with Healthlink.
121. Dr Filshie sent Mr Halwala to the Austin Hospital as that was where he had his first PET scan and it was advisable to have repeat scans at the same place. He was unaware of the availability of Healthlink. Usually, Dr Filshie sent his patients to Peter MacCallum Cancer Centre for their PET scans, which distributed its reports by means of password protected and encrypted email.
122. Electronic distribution will never be a substitute for direct, generally oral, communication of medical results in appropriate cases. However, it is obviously a vastly superior method of communication to facsimile transmission and, in my view, should be used routinely and in addition to any other more direct method. In this case it is worth noting that had the report been emailed to Dr Filshie, Mr Halwala's death may have been prevented because Dr Filshie

believed he would have received and read an email in time to take action. This is not to say email would have absolved Associate Professor Lee from the need to call Dr Filshie, but rather to demonstrate that email or electronic communication can serve as a kind of fail-safe to other more direct methods.

123. Professor Scott gave evidence that electronic transmission of data is becoming more and more common and that nowadays 90% of Austin Health PET reports are sent electronically. However, according to Dr McKay, faxes are still very commonly used in the medical profession. It is difficult to understand why such an antiquated and unreliable means of communication persists at all in the medical profession. Without presuming to anticipate every scenario, it seems to me that it should be phased out as a means of communicating test results as a matter of priority.
124. I also invited the expert conclave to suggest a formulation of words to cover the type of results requiring direct communication by diagnostician to treating doctor. Given the complexity of this issue, the conclave were of the view it was a matter that ought be referred to the relevant colleges for their consideration, although they noted, and I agree, that words like '*timely*', '*urgent*', '*significant*', and '*unexpected*' without further definition are not particularly helpful.
125. The 2016 RCR Standards introduced the concept of fail-safe mechanisms, which I endorse. It occurred to me that a possible fail-safe would be routine distribution of diagnostic results to patients as well as referring doctors. The *Background* to the 2012 RCR Standards indicates that communication of important results to patients is clearly in contemplation in the United States. Patients may reasonably claim an entitlement to their own information and arguably, nowadays, it is unduly paternalistic not to send results to them. I again invited the expert conclave to consider this issue, particularly since Dr Filshie described Mr Halwala as intelligent and educated. He was interested and understanding of his treatment and compliant with it. It seems likely that if he had received the PET report prior to 13 November 2015, he would have done something about it.
126. The conclave were unanimous that they did not consider that test results should routinely be provided to patients without the '*interpretive filter*'⁵⁸ of the treating doctor, irrespective of the intelligence or knowledge of the patient. On the other hand, they considered

⁵⁸ T 288.20.

communicating with the patient directly to be a good fall back where there are results requiring prompt or immediate action and the treating team cannot be contacted after reasonable endeavours.

127. In my view the distribution of results to patients as well as treating doctors warrants further consideration by the medical profession. Even if not routine, there must be scope for results to be distributed to patients in many cases, if for no other reason than it would constitute an additional safeguard against significant results going unnoticed. I recognise that not all patients would want to receive results directly, so whether it should occur in individual cases could be the subject of discussion between treating doctor and patient.
128. Similarly, this case demonstrates the desirability that the distribution list for the results of tests ordered by specialists include the patient's GP, and in cases where treatment is occurring at a different institution from the specialist, that institution. The referral form completed by Dr Filshie did contain a box containing the words '*Additional copies to:*' which was left blank. If that box had listed the oncology department of GVH and if the PET report had been received by that department prior to 13 November 2015, it is certainly possible, if not likely, that Mr Halwala would not have received his scheduled treatment on that day. Similarly, if Mr Halwala's GP had received the report prior to that day, he may have intervened. There may be a case for rural hospitals administering treatment under the supervision of visiting specialists to develop a memorandum of understanding with those specialists, or their base hospitals, in relation to the receipt of patient results. To that end, I include GVH in the distribution list for this Finding.
129. Finally, this case illustrates that systems for the effective communication of results should encompass not only method of delivery, but also the circumstances of review. For example, in the hospital setting time could be set aside at the beginning of each day for a dedicated clinician within each department to read all results from the previous day. By contrast, Dr Filshie opened the envelope containing the PET report at the end of what was, presumably, a busy day during which he saw many patients. Rather than results being reviewed in an ad hoc way, such as the end of a busy day when comprehension, patient recall and decision making may be compromised by fatigue, results should be reviewed at a time and in a manner conducive to thoughtful analysis and appropriate response.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. 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.
2. That Austin Hospital revise its current ONCOLOGY REFERRAL FORM FOR PET SCAN to include all information that may be relevant to the nuclear medicine physician performing the scan in determining the timeliness and manner of communication of the results.
3. That Austin Hospital phase out fax transmission of imaging results as a matter of priority.

I convey my sincere condolences to the Halwala family on the loss of their husband and father.

I direct that this Finding be distributed as follows:

- (a) Chula Halwala, Senior Next of Kin;
- (b) Dr Robin Filshie;
- (c) Associate Professor Sze Ting Lee;
- (d) Austin Health;
- (e) St Vincent's Hospital;
- (f) The Medical Director of Goulburn Valley Hospital;
- (g) Royal Australian and New Zealand College of Radiologists;
- (h) Australian Association of Nuclear Medicine Specialists;
- (i) Royal Australasian College of Physicians; and

(j) Royal Australian College of General Practitioners.

Signature:



ROSEMARY CARLIN
CORONER
Date: 10 May 2018

