2025

THE LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

ELEVENTH ASSEMBLY

Inquest into the death of Peter Hanisch

Government Response

Presented by
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INTRODUCTION

On 19 August 2021, Mr Peter Hanisch collapsed after a sudden onset of chest discomfort. An ambulance was called, and he was transported to Calvary Public Hospital Bruce (now North Canberra Hospital). Doctors identified that his collapse might be due to one of several conditions, including aortic dissection. A Computed Tomography (CT) Angiogram was conducted on the date of his admission, which showed the presence of a thoracic aneurysm and a dilated aortic root. The radiologist who reported the CT scan did not identify that the aortic aneurysm had started to dissect. At around 1745 on 22 August 2021, Mr Hanisch was declared deceased.

Mr Hanisch's death was referred to the ACT Coroner and Coroner Archer handed down his final finding on 9 April 2025, making one recommendation.

The ACT Government acknowledges Mr Hanish's family and the impact his loss has had on them.

CORONERS REPORT

Coroner Archer's report indicates the CT scan performed on 19 August 2021 was misread by the radiologist and that the significant finding of aortic dissection was missed. Coroner Archer noted if there had been timely treatment of the aortic dissection, there were very reasonable prospects of saving Mr Hanisch's life.

Coroner Archer determined that there was a matter of public safety arising from the inquest into Mr Hanisch's death, as Canberra Health Services (CHS) does not have a clear policy about the peer review of medical imaging reports. To address the matter of public safety, Coroner Archer provided the following recommendation:

1. CHS develop and publish guidance as to peer review systems and procedures for imaging services provided within CHS and by private providers providing services on behalf of CHS. That guidance should apply to all imaging produced within the CHS including:
    a. out of hours imaging; and
    b. imaging undertaken by private providers at Canberra Hospital and North Canberra Hospital.

GOVERNMENT RESPONSE

The ACT Government acknowledges Coroner Archer's findings and accepts the recommendation made following the inquest into Mr Hanisch's death.

Recommendation 1:

ACT Government Response	Implementation Timeframe
Agreed	July 2026

The CHS Medical Imaging Department has commenced drafting a *Medical Imaging Peer Review Procedure* which establishes a standardised peer review process for medical imaging reports to ensure diagnostic accuracy, maintain quality standards and promote continuous professional development within the radiology department. A minimum of 5 per cent of all reports completed by CHS will be reviewed monthly and will be worked into daily workflow.

The procedure will apply to all CHS radiologists, radiology registrars and imaging reports generated within the department, including but not limited to:

- diagnostic radiology reports
- interventional radiology procedures
- nuclear medicine studies.

As part of a Service Agreement with North Canberra Hospital (NCH), QScan is contracted to report medical imaging. QScan undertake peer review of 2 per cent of all reported cases on a weekly basis for Magnetic Resonance Imaging (MRI), CT, ultrasound and X-ray imaging.

Everlight Radiology is also contracted to report on imaging performed at NCH, as well as some imaging performed at Canberra Hospital. Everlight has a peer review program which involves peer review of a minimum of 5 per cent of all reported cases. In line with contractual arrangements, Everlight provides a monthly summary report of its peer review results.

CHS will continue collaboration and engagement with QScan and Everlight for quality assurance of diagnostic imaging reports.

CONCLUSION

The ACT Government is committed to continuous improvement in the care delivered to patients and their families. While every effort is taken to deliver safe care, CHS acknowledges that errors do occur, even with the best controls in place. CHS is committed to transparency and openness to rectify shortcomings in the delivery of treatment and care, and to improve systems and process that support effective clinical decision making.

Since the handing down of Coroner Archer's recommendation, CHS has commenced developing a peer review system and procedures for imaging services provided within CHS and by private providers providing services on behalf of CHS.

The ACT Government sincerely apologises to Mr Hanisch's family and loved ones for their loss.