2025

THE LEGISLATIVE ASSEMBLY FOR THE

AUSTRALIAN CAPITAL TERRITORY

ELEVENTH ASSEMBLY

Inquest into the death of Peter Hanisch

Coroner's Report

Presented by
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Minister for Health
September 2025

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Matter Title:	**Inquest into the death of Peter Hanisch**
Citation:	**[2025] ACTCD 2**
Decision Date:	9 April 2025
Before:	Coroner Archer
Findings:	[80] – [81], [88] – [92]
Catchwords:	**CORONIAL LAW** – Coronial proceedings after death from aortic dissection – Misreading of Computed Tomography (CT) – Failure to identify error by treating clinicians and radiologist – Reasonable prospects of saving life if aortic dissection promptly treated – Public safety issue – Processes for reviewing reports of CT scans.
Legislation Cited:	*Coroners Act 1997* (ACT) ss 3BA, 13, 34, 34A, 52, 55
File Number:	CD 255 of 2021

CORONER ARCHER:

Summary

1. On 22 August 2021, Mr Peter Hanisch died at the Calvary Hospital (as it was then known). I will, with respect, refer to him as Peter. He was 69 years old at the time of his death.

2. Peter was at home with his wife Julia Evans on the morning of 19 August 2021. They were both in COVID quarantine at the time. He collapsed after a sudden onset of chest discomfort. An ambulance was called, and he was transported to the (then) Calvary Hospital ('Calvary'). The cause of his collapse was not immediately apparent. His differential diagnosis was stroke, pulmonary embolism and aortic dissection. A Computed Tomography ('CT') Angiogram was conducted on the date of his admission, which showed the presence of a thoracic aortic aneurysm and a dilated aortic root. The radiologist, in error, did not identify when reporting on the CT scan that the aortic aneurysm had in fact dissected. The error was not subsequently identified in circumstances that are addressed below.

3. Peter went into atrial fibrillation in the early morning of 21 August 2021. A Medical Emergency Team ('MET') call was made, his condition was stabilised, and he was monitored and treated in the ward. At around 1728 hours on 22 August 2021, Peter was found unresponsive in his bed. He was last seen by treating staff at about 1500 hours. A MET call was made. Despite resuscitation attempts, he was not able to be revived. He was declared deceased at 1745 hours.

4. The course of Peter's treatment is analysed in detail below.

5. An autopsy established that the cause of Peter's death was thoracic aortic aneurysm with dissection. Findings are made by me (below) as to the cause of Peter's death in those terms.

6. I find that, if there had been timely treatment of the aortic dissection, there were very reasonable prosects of saving Peter's life.

7. A matter of public safety arises from my investigation. I recommend that the Canberra Health Service (CHS) develop and publish guidance as to peer review systems and procedures for imaging services provided within CHS and by private providers providing such services on behalf of CHS.

Jurisdiction

8. Peter's death was reported to the Coroner by Calvary as the cause of his death was unclear. As no medical certificate as to the cause of death had been issued, the Coroner

assumed jurisdiction to investigate the death pursuant to s 13(1)(e) of the *Coroners Act 1997* ('the Act').

Required Findings

9. Having assumed jurisdiction, the Coroner was required to hold an inquest (in the ACT, this is synonymous with conducting an investigation) into the manner and cause of Peter's death and make the findings required by s 52 of the Act. That section of the Act relevantly provides:

> **52 Coroner's findings**
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> (1) A coroner holding an inquest must find, if possible—
>
> (a) the identity of the deceased; and
>
> (b) when and where the death happened; and
>
> (c) the manner and cause of death; and
>
> (d) in the case of the suspected death of a person—that the person has died.
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> ---
>
> (4) The coroner, in the coroner's findings—
>
> (a) must—
>
> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
>
> (ii) if a matter of public safety is found to arise—comment on the matter

Peter Hanisch

10. Peter died at the age of 69. He was a loving and supportive husband to Julia Evans and a proud father to his three children. Peter was a passionate and dedicated teacher with a 36-year career in science and mathematics. He was highly regarded by his colleagues and students for his passion for education and his ability to inspire others. After retiring from full-time teaching in 2017, Peter remained committed to fostering a love for science and mathematics through relief teaching and private tutoring.

11. At the time of his passing, Peter and Julia were planning their retirement.

12. His death occurred during the COVID pandemic. COVID restrictions in place at the time at Calvary meant that during his admission, visitors were not permitted. He died without his family having seen him since he was transported from the family home in an ambulance.

Aortic Dissections – Background

13. An aortic dissection is a relatively rare, but often fatal, condition. Aortic dissections occur most commonly in men over the age of 60. Dissections are categorised broadly into two types – Stanford type A and Stanford type B. The former (present in Peter's case)

involves the ascending aorta. They are the most common and usually the more serious dissections. Type B dissections involve the descending aorta.

14. A dissection usually happens as a result of a tear in the inner wall of the aorta – the major artery that runs from the heart to the rest of the body. Such a tear allows blood to force its way between the inner and middle walls of the aorta, causing them to dissect. This can cause the aorta to rupture, causing severe blood loss and tamponade[1]. The rupture can be catastrophic or happen over a period of time. In Peter's case, the rupture was progressive and occurred over several days.

15. There are a number of recognised causes of aortic dissection, including hypertension (the most common risk factor), atherosclerosis, aortic aneurysms (weakened and bulging artery), genetic conditions and an aortic valve defect (bicuspid aortic valve). Aortic dissection is a life-threatening medical emergency. Early diagnosis and treatment are important to maximise the patient's chance of survival. The method of repair involves either open heart surgery or endovascular surgery (using a catheter). Each process involves the insertion of grafts into the affected area of the artery. In some cases, a replacement of a damaged aortic valve may be necessary.

16. Classic symptoms of the condition include:[2]

    (a) A sudden and severe chest pain;

    (b) Pain in the stomach;

    (c) Shortness of breath;

    (d) Fainting or dizziness;

    (e) Low blood pressure;

    (f) Diastolic heart murmur or muffled heart sounds;

    (g) Rapid weak pulse;

    (h) Heavy sweating;

    (i) Confusion;

    (j) Loss of vision; and

    (k) Stroke-like symptoms, including weakness or paralysis on one side of the body or difficulty talking.

[1] Tamponade involves blood filling the pericardial sac compromising the ability of the heart to pump.
[2] David Levy et al, 'Aortic Dissection', *National Library of Medicine* (webpage, 6 October 2024) Stat Pearls Publishing.

17. Computed tomography ('CT') is considered to be in the first line of diagnostic processes in cases of suspected aortic dissection. It allows production of detailed images of the aorta, showing pathology typically associated with dissection.

18. The prognosis associated with the condition depends on a range of factors, including where the dissection is, its size, pathologies concerning the general integrity of the aortic wall and the timing of any surgical intervention. Acute dissection is associated with high morbidity and mortality, particularly when diagnosis and treatment are delayed, although in recent years, outcomes have improved. A recently updated study has described prognosis for type A dissections in these terms:[3]

> **Stanford type A dissections**
>
> Mortality without treatment
>
> > Type A dissections are considered surgical emergencies due to the high risk of fatal complications, such as cardiac tamponade, aortic rupture, myocardial infarction, and stroke. Without intervention, the mortality rate increases by 1% to 2% per hour within the first 24 to 48 hours, reaching nearly 50% by the end of the first week.
>
> Surgical mortality
>
> > With prompt surgical repair, the in-hospital mortality rate for type A dissections is around 15% to 30%, depending on factors such as patient age, presence of comorbidities, and intraoperative complications. Despite successful surgical intervention, long-term mortality remains high due to risks of recurrence, progressive aortic disease, and associated complications.
>
> Long-term outcomes
>
> > The 5-year survival rate after surgical repair is approximately 70% to 80%, while the 10-year survival rate decreases to around 50% to 60%. Late mortality is often due to complications such as aortic aneurysms, re-dissection, and cardiovascular events.

The Course of the Inquest

19. The inquest was originally allocated to Coroner Louise Taylor (as she then was).

Autopsy

20. At Coroner Taylor's direction, an autopsy was undertaken by Professor Johan Duflou, a senior forensic pathologist. His report, dated 1 October 2021, indicated that the cause of Peter's death was an ascending thoracic aorta dissection. Blood was found in the pericardial sac, around the coronary arteries and down into the abdominal aorta. Microscopic examination confirmed that it was likely a dissection had occurred some days before death and, according to Professor Duflou, likely around the time of the

[3] Ibid.

clinical presentation at Calvary. Professor Duflou identified the presence of an aneurysm of the thoracic aorta, and that there were changes 'consistent with hypertension and coronary artery atherosclerosis'. There was no indication that the administration of an AstraZeneca vaccine on 26 July 2021 caused or contributed to Peter's death.

21. In a subsequent email to the Court, Professor Duflou provided an elaboration of his opinion:

> From both the autopsy findings and clinical information as per medical records, it appears highly likely to me that the deceased had an initial dissection in the days leading up to death, and that this occurred around the time preceding his admission to hospital. This has not resulted in rupture through into the pericardial sac at this time – I say this because such rupture would be readily identifiable on CT angiogram, and because the tissue reaction identified at autopsy involving the pericardium did not give any indication of healing (or organisation). On the other hand, such healing was evident and in keeping with the timing of symptoms within the aorta itself. The inference which I believe can be made is that the deceased had an initial dissection in the time preceding admission to hospital, and then while in hospital and likely in the time preceding his sudden collapse and cardiorespiratory arrest in the afternoon of 22 August he had a further dissection which resulted in blood now entering the pericardial sac preventing the heart form pumping. I note there was an apparent deterioration also in the early hours of 21 August – whether this was an increase in the extent of dissection at that time is unable to be determined.

Expert Radiological Review

22. The CT scans of 19 August 2021 ('the CT scans') were referred to a radiologist, Dr Mohamed Nasreddine,[4] for review. No other supporting material was provided to him and no indication given of any of the surrounding circumstances or the post-mortem results. Dr Nasreddine was asked to report on what he could see on the scans and what should have followed in the clinical setting if the findings he made had been reported on 19 August 2021. Dr Nasreddine summarised his findings as to the observable pathology in these terms:

    (a) Intramural haematoma of the thoracic aortic and likely abdominal aortic wall.

    (b) Mediastinal fat stranding in keeping with interspersed haematoma.

    (c) Presumed intimal defect involving the posterior wall of the ascending aorta. This most likely reflects the site of origin of the above.

    (d) Aneurysmal dilatation of the ascending aorta with root dilatation.

[4] Dr Mohamed Nasreddine graduated from the University of NSW in 1999 with a MBBS BSc (Med). He commenced his RANZCR training at Princess Alexandra and Westmead Public Hospitals, obtaining RANZCR Fellowship in 2008. He completed MRI and Breast Imaging fellowships at Westmead Public Hospital and at the Breast Cancer Institute in 2007, prior to becoming a staff specialist in 2008. In addition to his substantive role at a major trauma centre, he has long term attachments with the Forensic Medicine Service in NSW and the ACT.

(e) Extension of intramural haematoma into the origin of the extracranial vessels and possibly right coronary artery.

23. The effect of Dr Nasreddine's report was that the dissection could be seen on the scans.

24. Dr Nasreddine went on to say that 'in the clinical setting, the above imaging findings when noted would prompt the radiologist to contact the treating ED doctor or treating team (depending on patient admission status/location at time of diagnosis).'

25. In respect of practical issues concerning the process of reading the scans, Dr Nasreddine noted that all medical imaging studies ideally would be interpreted:

(a) On the basis of the clinical presentation and pre-test probability of a particular differential diagnosis;

(b) With optimised imaging protocols and parameters. The post contrast aortogram is optimally timed. However, I note that the post contrast CT study is not cardiac gated which introduces motion artefact and resultant blurring of the image, particularly at the ascending and arch of the aorta. A cardiac gated CT study would improve diagnostic accuracy and confidence of the imaging findings. Not all CT scanners are equipped with cardiac gating functionality;

(c) On appropriate:

i. Viewing monitor/s

ii. Viewing conditions (dimmable lights)

iii. Imaging platform (RIS-PACS, advanced imaging software)

(d) With minimal interruptions, if any;

(e) With adequate resourcing;

(f) With appropriate study review time allocation.

26. Dr Nasreddine was subsequently asked to repeat the reading of the scans but briefed with relevant Calvary records and Professor Duflou's post-mortem report. He was asked if the additional material changed the opinion he had previously expressed. He confirmed his opinion remain unchanged.

Further Investigation

27. The case was amongst a significant collection of older inquests that were handed to me when I became the 'dedicated Coroner' in March of 2022.

28. A request was made of Calvary to provide information regarding Peter's clinical management after his admission. A statement dated 28 July 2022 was received from Dr TA, a consultant neurologist who was Peter's admitting neurologist.

29. By letter dated 5 December 2022, a solicitor provided a response on behalf of the radiologist who reported on the scans, Dr CD. On the radiologist's behalf, it was conceded that the scans had been misread and that 'the imaging does show a mural thrombus causing a thickened aortic wall, which he would usually report as a likely dissection'. An apology was made on his behalf, and it was noted that this was the only instance to the radiologist's knowledge where he had 'failed to report a significant finding apparent on the films', having reported many thousands of images over 26 years of doing such work. His view was that the compromise in the clarity of the images caused by the lack of cardiac gating in this instance did not materially impact on the reporting process – the correct diagnosis 'was evident on the non-gated images'.

Hearing

30. In arriving at the findings a Coroner is required to make, I have a discretion as to whether to hold a hearing (s 34 of the Act). I can dispense with a hearing in the circumstances and according to the processes set out in s 34A of the Act:

> **34A Decision not to conduct hearing**
>
> (1) A coroner may decide not to conduct a hearing into a death if, after consideration of information given to a coroner relating to the death of a person, the coroner is satisfied that—
> (a) the manner and cause of death are sufficiently disclosed; and
> (b) a hearing is unnecessary.
>
> (2) A coroner must not dispense with a hearing into a death of a person, if the coroner has reasonable grounds for believing the death is a death in care or death in custody.
>
> (3) A coroner who decides not to conduct a hearing into a death must give the Chief Coroner and a member of the deceased's immediate family written notice of the decision, including the grounds for the decision.

31. Peter's family was formally notified of my decision not to conduct a hearing when my provisional findings were sent to them. Ms Evans confirmed that in her view a hearing was not required. The ACT Government Solicitor ('ACTGS') acting on behalf of Calvary Health Care and the Territory indicated that their clients agreed a hearing was unnecessary. Similar responses were received from solicitors acting for Dr CD and ACT X-Rays Pty Ltd ('ACT X-Ray Services').

Provisional Findings and the Section 55 Process

32. On 17 December 2024, provisional findings were sent to the ACTGS, Ms Evans, and the solicitors acting for Dr CD and ACT X-Ray Services. Those findings contained a comment adverse to a person identifiable from my proposed findings, namely Dr CD. On 18 December 2024, a solicitor acting for Dr CD indicated he did not wish to provide any

response to the s 55 notice. By letter dated 17 January 2025 the ACTGS provided a response on behalf of the Territory. No submission was made by ACTGS in respect of the error made by Dr CD. On 20 January 2025, ACT X-Ray Services advised it would not make any submission in relation to the proposed findings. Ms Evans made submissions as to a number of issues.

The Evidence

Part 1 – Available Information

33. In making the findings below, I have relied on the following material obtained during the investigation process:

    (a) Medical records from Calvary of the admission, starting 19 August 2021;

    (b) Police coronial report, dated 31 August 2021;

    (c) ACT Ambulance Service records;

    (d) Autopsy report, dated 1 October 2021 (subsequently updated to correct typographical errors), and subsequent email communication with Professor Duflou;

    (e) Letter from Ms Julia Evans, dated 5 October 2021;

    (f) "Blind" report from Dr Nasreddine, dated 16 November 2021;

    (g) Further report from Dr Nasreddine, dated 4 April 2022;

    (h) Letter from Dr TA, consultant neurologist, dated 28 July 2022;

    (i) Letter from the Chair of the Calvary Hospital Clinical Review Committee, dated 17 November 2022;

    (j) Letter from legal firm on behalf of Dr CD, dated 5 December 2022;

    (k) Letter from ACTGS, dated 28 February 2024;

    (l) Statement of Dr CD, dated 31 July 2024;

    (m) Letter from ACTGS, dated 9 December 2024;

    (n) Letter from ACTGS, dated 14 March 2025; and

    (o) Email correspondence from Ms Julia Evans, variously dated.

Part 2 – Chronology of Events

34. Peter's health was generally good, although, relevantly, there was a history of hypertension and hyperlipidaemia (high cholesterol). Both conditions were medicated, although there was some evidence of non-compliance with prescription regimes.

35. Peter and his wife Julia were staying at home on Thursday 19 August 2021. Peter had been deemed a 'close contact' for COVID contact-tracing purposes because of a COVID issue at the Lyneham High School, where he taught. Julia was a secondary contact. Peter had been vaccinated and had tested negative to COVID. He had been administered his second dose of AstraZeneca vaccine on 26 July 2021 without any obvious adverse reaction.

36. Peter collapsed shortly before 1014 hours. A 000 call was made at 1014 hours. On arrival at his home, a history was taken by the paramedics. Peter stated that his legs just 'gave out'. He was shaking. He was given a Glasgow Coma Scale rating of 15.[5] He complained of left sided weakness, vague chest discomfort and lower back pain. An intravenous sedative was given. Peter was transported to Calvary, as it was the nearest public hospital.

37. Peter presented at the Emergency Department at Calvary at 1143 hours.

38. What follows is an attempt to construct an outline of Peter's care, noting that the medical notes were often illegible and untimed.

39. Peter was triaged at 1143 hours. Notes made by a doctor at 1148 hours indicated that the differential diagnosis was '? Dissection', and of neurological causation (post AstraZeneca neurological complications or transverse myelitis[6] were specified as possibly explaining the observed pathology). Scans were ordered, including a CT angiogram.

40. Once Peter was admitted to the ward, he remained (until his death) in COVID isolation. As noted, that meant, apart from anything else, that his wife and family were unable to visit him.

41. A chest x-ray was ordered at 1246 hours and reported at 1312 hours by Dr CD, a radiologist. Peter's lungs and pleural spaces were said to be clear. His heart was said to be enlarged and there was 'unfolding of the aorta'.

42. A CT angiogram of the chest and abdomen was ordered at 1334 hours and undertaken at 1448 hours. The results were reported by Dr CD at approximately 1527 hours. The full text of the relevant part of the report reads:

> The heart is enlarged. There is prominent coronary artery calcification. There is little pericardial calcification. No pericardial effusion is seen. There is scattered atheroma in the

[5] The Glasgow Coma Scale is used to measure a person's level of consciousness. A score of 15 is the highest score that can be obtained suggesting no compromise.
[6] Transverse myelitis is an inflammation of both sides of one section of the spinal cord. The condition causes interruptions of the messages that the spinal cord nerves send throughout the body. Amongst other symptoms it can cause pain, muscle weakness, paralysis and sensory problems.

> aorta. There is dilatation of the aortic root up to 53mm in diameter. The ascending aorta measures up to 44mm in diameter. The descending aorta measures up to 35mm in diameter. No dilatation of the abdominal aorta is seen. No dissection is seen. Apart from minor atheroma the aortic branches appear normal.

43. A note made by a senior medical registrar at 1600 hours was that the CT showed, 'no dissection' indicating that the report of Dr CD had been read. The initial impression reflected in the same note was that there may have been spinal cord pathology. The upward movement in the D-dimer test result was noted as possibly indicating coagulation issues,[7] perhaps related to an AstraZeneca reaction.

44. The matter was referred for neurological review, which occurred soon after at 1620 hours. The notes of that review confirmed the outcome of the scans ('no dissection'). They also indicate that the scans were discussed with the radiologist Dr CD. The poorly written and difficult-to-decipher note in the treatment records was made in these terms:

> d/w Dr CD (radiologist) re CT angiography in view of elevated d dimer – will r/v CTPA & amend report.

45. Following that conversation, the CT scan report was amended at 1635 hours in these terms:

> Addendum
>
> The pulmonary arteries enhance normally. No emboli are seen.

46. Dr CD was asked to provide his recollection of that conversation and of his review. In a statement dated 31 July 2024, he indicated:

> 1. I do not have a clear independent recollection of the conversation with the hospital clinician recorded at 1620 hours on 19 August 2021 in Mr Hanisch's clinical notes at Calvary Public Hospital.
> 2. Having read that clinical entry, and the addendum to the CT Angiogram that I recorded at 1635 hours on 19 August 2021, I believe that I was asked by the clinician to review the images of the CT Angiogram to check Mr Hanisch's pulmonary arteries, in light of Mr Hanisch's elevated D'dimer level.
> 3. I did so and observed no abnormality. I recorded the addendum to the CT Angiogram report which stated 'The pulmonary arteries enhance normally. No emboli are seen'.
> 4. What I am certain about is that the hospital clinician did not ask me to review the CT Angiogram images to re-check Mr Hanisch's aorta, nor did any hospital staff do so at any time after I provided my initial report on the CT Angiogram.

[7] A D-dimer test measures the presence of D-dimer, a protein fragment from blood clots. A positive result can indicate that a blood clot has formed and is the process of breaking down. It was possible that the elevated result was associated with the dissection that was present.

47. On 9 December 2024, the Court received correspondence from ACTGS indicating that they had received instructions from Dr BD as to that conversation. The relevant part of that response is extracted in full:

> *Context or detail regarding the conversation between Dr CD and a neurology clinician (as per clinical records provided)*
>
> The handwritten clinical note recorded at 1620 on 19 August 2021 was made by Dr BD under the heading "Neurology AT BD", the AT meaning Advanced Trainee (in neurology). At the time of making the note and during Mr Hanisch's admission to Calvary Public Hospital (Calvary), Dr BD was employed by Canberra Health Services and seconded to Calvary Health Care.
>
> Dr BD continues to work in neurology but has moved to NSW and is no longer employed by Canberra Health Services. Dr BD has confirmed and provides the following information and understands the responses below will be provided to the Coroner:
>
> 1. Dr BD did not independently recall the details of the conversation she had with Dr CD. However, she was reminded that she had spoken with him on reviewing the note she made;
> 2. At the time Dr BD spoke with Dr CD, Dr CD's report on the chest and abdomen angiography was available in Mr Hanisch's clinical records;
> 3. Dr BD recalls the report did not confirm the presence of an aortic dissection, because if it had, the neurology team would not have been contacted or involved in Mr Hanisch's care;
> 4. The handwritten progress note reads "d/w (discussed with) Dr CD (radiologist) re. (regarding) the CT angiography in view of elevated d-dimer. Will review CTPA and amend report".
> 5. Dr BD recalls walking to Dr CD's office but does not now recall the specific details of the conversation she had with him;
> 6. Having reviewed the notes she made, Dr BD recalls that she suggested Dr CD re-review the CT-angiogram specifically to look at the pulmonary arteries due to Mr Hanisch's elevated D-dimers;
> 7. She and Dr TA considered that Mr Hanisch may have had a pulmonary embolus because he complained of chest pain, and they also considered he may have had an embolus due to his elevated D-dimer;
> 8. An elevated D-dimer is a non-specific finding;
> 9. Mr Hanisch's admission and the conversation with Dr CD occurred in the context of the COVID-19 pandemic. Dr BD recalls there were a lot of cases in which vaccine related issues were considered or questioned. She recalls that Mr Hanisch had had an Astra-Zeneca vaccination not a long time before his presentation to Calvary;
> 10. She recalls that the suggested review of the angiogram was an opportunity to consider or comment on Mr Hanisch's other blood vessels, specifically the pulmonary arteries;
> 11. While Dr BD understands it was specifically an aorta scan due to the initial presentation and suspected diagnoses (of an aortic dissection), she remembers

that she discussed with Dr CD whether he could also look at lung blood vessels as well;

12. The reference in the note to the CTPA refers to this request as a CTPA is a pulmonary angiogram;

13. While Dr BD's notes states "will r/v (*review*) CTPA & amend report" she cannot recall whether Dr CD did say that he was going to amend the report or whether the reference is intended to mean that he will review the CTPA and amend the report as required.

48. The stated plan after that consultation and further report was to admit Peter to 'neurology' to do a CT of the brain, head and neck and an MRI of the spine. That CT was done at 1805 hours on 19 August 2021. No pathology was reported, except for some minor degenerative changes to the intervertebral disc joints. The report was signed by a radiologist other than Dr CD. No other radiology was performed before his death.

49. Thereafter, the focus of those clinicians who reviewed Peter erred towards a neurological explanation of Peter's history and symptoms (stroke or 'spinal infarct', 'transverse myelitis' were expressions used in the notes). Serial electrocardiograms ('ECG') were performed without evident abnormality of the heart.

50. Peter's condition appeared to be generally stable. He complained of a sharper chest pain at around 1300 hours on Friday 20 August 2021. An ECG suggested atrial fibrillation. Both symptoms were in fact consistent with an aortic dissection. Later that evening (the notes are untimed), a spike in body temperature was noted. An ECG performed at around that time showed 'nil acute ischaemic changes'. Sometime after 1800 hours (the note is again untimed), Peter's troponin levels had risen from 6 to 15.[8] His chest pain was reported to have responded to Endone and Paracetamol. Later again that evening (at a time unknown), Peter's troponin levels had increased to 26. His cardiorespiratory rate had also increased.

51. At 0220 hours on Saturday 21 August 2021, a MET call was made following an episode of rapid atrial fibrillation. Again, that symptom was consistent with the aortic dissection that had apparently been excluded by the CT. Peter was stabilised on a dose of metoprolol.[9] Blood screens were ordered. The recorded impression was '? Haemolysis'[10]

[8] A positive Troponin test can confirm damage to the heart muscle. The more damage there is to the heart, the more troponin is released into the blood. A level in this range can indicate heart damage. Elevated troponin is associated with aortic dissection (as well as other heart related conditions) as dissection may cause ischemic damage to the heart: see for example; Mislav Vrsalovic, "Prognostic effect of cardiac troponin elevation in acute aortic dissection: A meta-analysis" (2016) 214 *International Journal of Cardiology*, 277-278.
[9] A medication given to lower blood pressure and heart rate.
[10] A break down in red blood cells.

or underlying malignancy. Subsequently, his heart rate and blood pressure were stabilised.

52. Peter was reviewed at 1215 hours on 21 August 2021 by the neurology team. The moderate rise in troponin was noted. He was still febrile. His C-reactive protein ('CRP') was elevated.[11] The impression was of worsening thrombocytopaenia.[12] Sepsis was considered. The plan was to treat the suspected infection (with IV gentamycin) and administer an anticoagulant (clexane) to address stroke risks associated with the atrial fibrillation. It was noted that if the troponin levels increased further, then cardiology review and admission to the cardiac unit might be required (including a further ECG on Monday).

53. The reviews that occurred for the remainder of the day on 21 August 2021 painted a similar picture. His MEWS score[13] at 1600 hours was "0" indicating a lower risk of deterioration. He was ambulant and self-caring, and his sleeping was not compromised. COVID isolation procedures remained in place. A phone call was made by pathology to the ward at about 1730 hours indicating his troponin level had increased to 47. The resident medical officer ('RMO') was informed. His clinical picture was discussed between nursing staff and the RMO at around 2100 hours.

54. No further changes were noted during the day on Sunday 22 August 2021. Nursing notes at 0340 hours indicated that Peter made no complaint of chest pain. He was described as ambulant and self-caring.

55. The last (near) contemporaneous nursing note was made at around 1435 hours on 22 August 2021. A sample of blood was collected. Some difficulty was experienced in the process of collection and concerns were expressed in the notes as to whether pathology would want the process of collection repeated. The pathology report for Peter records this request time as 1250 hours. Troponin was not added to the pathology request.

56. He was reviewed by Dr TA sometime that afternoon. The exact time of the review is not recorded in the notes. The notes of that review appear after the nursing note just referred to [55]. It was suggested in correspondence sent by ACTGS on 14 March 2025 ('the 14 March 2025 letter') that this review occurred at around 1352 hours when Dr TA is recorded as first accessing the pathology results relevant to the request made at 1250 hours. The pathology results had been reported at 1349 hours. The differential diagnosis

[11] A liver function test.
[12] Low platelet levels.
[13] The Modified Early Warning Score is made up of 6 pieces of information, including heart rate, blood pressure, and breathing rate as a means of identifying risks of deterioration.

at this time was of possible sepsis of unknown origin, spinal pathology or stroke (TIA).[14] Atrial fibrillation was noted, as was Peter's complaint of ongoing back pain since admission. The plan was to continue fluids, withhold the antibiotics, chase blood cultures and seek out cardiology review, an ECG and an MRI of the spine. There is nothing to indicate in those notes that Peter's condition had changed significantly or that he was at risk of imminent collapse.

57. Nursing notes written in retrospect at 2100 hours on 22 August 2021 indicated that the shift handover occurred at about 1320 hours. Peter was described as alert and orientated. He was engaging with medical staff about issues concerning his care, including arranging for a visit by the physiotherapist. During the afternoon, he activated the nurse call button at one stage because the IV machine was making a noise. He complained of leg pain and was wanting the MRI brought forward, and wanted to see a physiotherapist. The pathology results relevant to the request made at 1250 hours were accessed again by Dr TA at 1601 hours. It was put in the 14 March 2025 letter that the reason for accessing the results was 'to give further consideration to Mr Hanisch's diagnosis'. No note appears in respect of that consideration.

58. Peter was discovered unconscious at 1720 hours.[15] Peter was not able to be revived. He was declared deceased at 1745 hours.

59. The notes of the Intensive Care Unit registrar who attended on the MET call considered the possible cause of death. He noted that Peter 'was at risk of dissection', given the thoracic aneurysm and dilated aortic root. However, other causes were considered possible, including acute myocardial infarction, pulmonary embolism or other vascular event. The notes raised pulmonary embolism and 'type A dissection' as possible causes of his death. Dr TA attended the ward after Peter's passing and requested that troponin be added post-mortem to the request made at 1250 hours. The notes record that the troponin result was reported to him at 1924 (after Peter's death). The level was 145ng/L.

60. Given the uncertainty as to the cause of Peter's death, the matter was referred to the Coroner.

Part 3 – Family Input into Care

61. As COVID restrictions prevented Peter's family from seeing him during his admission, it was difficult for the family (particularly Julia) to obtain a clear picture of the care Peter was receiving and the progress of diagnostic processes. Their source of information was

[14] Transient ischaemic attack.
[15] The times of the last observation and the making of the MET call vary within the notes. The MET notes indicate the call was made at 1728 hours with an arrival time of 1730 hours.

largely from Peter himself, although Julia was able to speak to two doctors and a ward nurse to obtain some impression of what was occurring. The symptomatology described by Peter suggested to the family that his underlying condition was cardiac-related and that that should have been the focus of diagnostic processes. Julia was told that the delay (to Monday 23 August 2021) in performing the MRI[16] was due to COVID concerns.

62. The concerns raised by Peter's family after his death, in particular their belief that opportunities to save Peter's life had been lost, are addressed below.

Part 4 – Clinical Review after Death

63. An internal review was conducted by Calvary after Peter's death. At the time of that review, the incorrect reading of the CT scan was not known. The cause of death was recorded as 'unknown'. Once Dr Nasreddine's reports were received, the Emergency Department Mortality & Morbidity Committee reported that whilst aortic dissection was one of the possible diagnoses being considered, that diagnosis was ruled out in light of the CT scan. The Committee went on to say that the changes 'on the CT scan itself are quite subtle and only detectable by a radiologist. There was nothing that would have prompted the clinicians in the Emergency Department to question the initial findings.'

Part 5 – Response to Questions Asked by the Court

64. Calvary was provided the autopsy report on 10 May 2022 and the reports of Dr Nasreddine on 15 June 2022. By letter dated 6 July 2022, the General Manager of Calvary indicated that the Acting Director of Neurology at Calvary and Dr TA (Peter's admitting neurologist), had been asked to reply to the Court's request for information. It was noted that imaging services at Calvary were provided by a third-party provider, ACT X-Ray Services and that the company had been asked for a response. ACT X-Ray Services is part of the Canberra Imaging Group ('CIG').

65. Dr TA's response of 28 July 2022 was received by letter from the General Manager of Calvary to the Coroner dated 9 August 2022. In that letter, the General Manager indicated that ACT X-Ray Services had not responded to her request for information, and she invited the Court to contact them directly. In respect of whether there had been a review of the quality of radiology services provided at Calvary, it was indicated that 'we are undertaking a review of radiology services in the Emergency Department'. It was indicated that the review was likely to be concluding 'in the coming months and Calvary

[16] The planned MRI was in fact for the spine, not the heart. Dr TA in his response does indicate that a 'cardiology consult' was planned for Monday 23 August 2021.

will provide the report to the Coroner at the earliest possibility'. The report was never provided.

66. No report was received from the Acting Director of Neurology at Calvary.

67. By letter dated 5 December 2022, a law firm wrote to the Court to indicate that they acted for CIG (i.e. ACT X-Ray Services) and Dr CD (the radiologist). It was said that the response provided was of CIG, but it was 'also informed by instructions from Dr CD'.

The Response of Dr TA

68. Dr TA responded to the questions that had been to him put by the Court. Relevantly, he indicated that:

    (a) Sometimes verbal briefings were provided by radiologists to treating clinicians prior to the production of a radiology report.

    (b) Although chest pain symptoms continued after the report of the scans was received, they fluctuated over the course of the admission and the lower limb pathology ('although not well documented') was 'thought to represent ischaemic myelopathy'.[17]

    (c) The actual images were not reviewed again 'as the validity of the report was not questioned'.

    (d) An echocardiogram was planned for Monday 23 August 2021. This may have aided the detection of the dissection.

    (e) Calvary could not provide 'telemetric monitoring'[18] outside the coronary care unit. During COVID, access to those beds was rare.

    (f) A small troponin increase would not necessarily trigger coronary unit admission.

    (g) Neurologists are not usually familiar with interpretation of CT scans of the thorax and abdomen.

The Response of CIG / Dr CD

69. The following passage appeared in the response:

> We are first instructed by Dr CD to make a clear statement that he has reviewed the imaging in question and considers that the dissection is in fact apparent on the images. Although it is not a simple dissection which gives an appearance of a false lumen, he agrees with Dr Nasreddine that the imaging does show a mural thrombus causing a thickened aortic wall,

[17] Spinal cord infarction (death of tissue caused by reduced blood flow).
[18] Constant monitoring of the heart undertaken to improve the chances of catching an abnormal heart rhythm when it happens.

which he would usually report as a likely dissection. Dr CD does not know why he did not report this appearance at the time but suspects that the volume of work required affected his usual standard of reporting.

70. The response also relevantly noted that:

    (a) After arriving at work at Calvary between 0800 and 0830 hours, Dr CD would report approximately 40 images that had accumulated overnight and then report continuously during the day.

    (b) Briefings might be given to clinicians in several circumstances:

        (i) If the findings are significant and require urgent treatment;

        (i) If the radiologist requires additional information from the treating clinician; or

        (ii) If the clinician requires clarification of the radiological advice given.

71. The response further observed that:

    (c) If there are no significant findings, the report is issued without a verbal briefing.

    (d) Dr CD's practice was to discuss significant findings with the referring doctor.

    (e) Given the service he worked for had a number of different radiologists rostered on different days, it was difficult to build relationships with clinicians.

    (f) Some clinicians were proactive in approaching the radiologist and some were not.

72. The response also addressed the question of whether reports were or should have been subject to peer review. The following matters were noted:

    (a) Only one radiologist was rostered at Calvary on any given day.

    (b) The hospital's imaging program did not allow images to be sent to other CIG radiologists in private rooms.

    (c) Although images could be sent to radiologists at TCH, there was at the time of the response no arrangement or protocol supporting such a referral.

73. As to whether it was desirable that one radiologist operated alone and independently, the response indicated that was a matter for Calvary to comment on.

74. As noted above, Dr CD did not consider that the lack of cardiac gating had practical significance in this case. The diagnosis was evident, although the appearance of the dissection 'was not that of a simple dissection'.

75. Dr CD did not initially address the conversation with clinicians that did occur after the scans were first reported. This was later addressed in his statement of 31 July 2024.

Part 6 – Calvary Governance

76. The response from CIG indicated that it was their intention to take steps to prevent such an error happening again:

> Both CIG and Dr CD are committed to taking steps to avoid the error happening again by steps such as:
>
> 1. Reviewing and discussing the case with all radiologists working with CIG and emphasising the need to be proactive in communications to clinicians;
> 2. Discussing the case with the Calvary Hospital management and in particular matters such as:
>
> a. The importance of communication between the clinicians and radiologists and increasing the amount of communication which occurs;
>
> b. Encouraging clinicians to request reviews of images if the clinical circumstances are discordant with the imaging report;
>
> c. Reviewing the staffing of the imaging department, the possibility of allowing CIG radiologists access to films taken at Calvary Hospital and exploring the option of a protocol with the Canberra Hospital for any situation where a second opinion is required.

77. Those expressed intentions met a practical obstacle when, on 31 May 2023, Calvary was taken over by the ACT Government[19] and is now known as the North Canberra Hospital ('NCH').

78. By letter dated 11 August 2023, the Court sought advice from the Territory as to whether the system for radiology reporting would continue under the new governance arrangements. A response was received from ACTGS on 28 February 2024:

> We are instructed as follows:
>
> 1. At the time of Mr Hanisch's death, radiology reporting services including x-ray and angiograms (but excluding MRI services) were provided to Calvary Public Hospital by the Canberra Imaging Group, operating under the name "ACT X-Ray Services".
> 2. ACT X-Ray Services ceased providing radiology services to NCH in November 2023.
> 3. Q-Scan took over the provision of the radiology reporting services previously provided by ACT X-Ray Services on an interim basis on Monday, 13 November 2023. The terms under which Q-Scan currently provide those reporting services to NCH are identical to those that were in place with ACT X-Ray Services (save for changes to costs).

[19] See *Health Infrastructure Enabling Act 2023* (ACT).

4. Radiography is conducted by staff employed by the hospital and Q-Scan provides the radiology reporting services. This was also the arrangement with ACT X-Ray Services at the time of Mr Hanisch's death.

5. Currently, x-ray and CT services are available twenty-four hours a day. A Q-Scan radiologist is currently rostered on during business hours at NCH each weekday to report on imaging. NCH also utilises an offsite after-hours radiology service provided by Everlight Radiology. All after-hours CT and ultrasound reporting is undertaken by Everlight Radiology offsite.

6. NCH had a pre-existing relationship with Q-Scan who already provided MRI services to Calvary prior to the transition. This arrangement for the provision of MRI services has continued with NCH following the transition.

7. Negotiations with respect to ongoing radiology reporting service provision by Q-Scan are continuing. It is anticipated that the new arrangement between NCH and Q-Scan will include a mix of on-site and tele-radiology services.

8. Historically, there have been difficulties in arranging for peer and second review of imaging and radiology reports given the sensitive nature of the material to be shared to enable this and the use of different information systems at different locations (bearing in mind, there has historically been only one radiologist on site at Calvary or NCH).

9. The Territory's Digital Data and Technology Solutions division is currently working with Q-Scan and NCH on arrangements to integrate the Q-Scan reporting platform with the Digital Health Record used by the Territory. Once this project is complete, Q-Scan radiologists will be able to send imaging to other Q-Scan radiologists, enabling second review of images and peer review of their reports. It is currently anticipated that this system will be operational by the end of March 2024.

10. Additionally, NCH is seeking to adopt a 'hybrid model' of radiology services by employing a staff radiologist, in order to have one staff radiologist and one Q-Scan radiologist providing services to NCH. This will also facilitate peer review of reporting and second review of imaging.

11. As recruitment initiatives to date have not yielded any eligible applicants, NCH is currently negotiating a cross-Territory staff radiologist model with Canberra Health Services.

79. As part of the s 55 process and given the dynamics of governance and service provision at NCH, an update was requested as to the implementation of the system for radiology services at NCH. This response was provided in the 14 March 2025 letter:

> Radiology services at NCH continue to be provided pursuant to a contractual arrangement with private provider Q-Scan. … There is currently one radiologist in attendance each day at NCH. Peer review of imaging is subject to the terms of the contractual arrangement and specifically 2% of total cases are to be subject to peer review on a weekly basis.
>
> …
>
> The integration will enable second review of images by off-site Q-Scan radiologists and enhance peer review. It had previously been anticipated that this system would be operational by the end of March 2024, however resourcing and configuration delays within both Canberra Health Services (CHS) and Q-Scan have resulted in delay. The current expected completion date is 31 March 2025.

There is a current project underway to develop a networked Medical Imaging service within CHS. It is intended that NCH and TCH will merge their radiology services once NCH's contract with Q-Scan expires or is discontinued. Once the services are merged, radiology services at NCH will likely be governed by the tertiary hospital service and will align with the policies and procedures of the radiology department at the Canberra Hospital (TCH).

After hours radiology services at both NCH and TCH are currently provided pursuant to a contractual arrangement with private provider Everlight Radiology. Historically, after hours radiology services at Calvary Public Hospital and NCH were provided by ACT X-Ray. However, following the expiration of this contract, NCH effectively joined the pre-existing contractual arrangement between TCH and Everlight. Peer review of imaging by Everlight is conducted in accordance with Everlight's internal governance structures. Everlight provide monthly peer review reports to NCH and TCH, the February 2025 report to NCH reflected peer review of 2.8% of all NCH radiology reports for that month.

CHS instructs that there is no formal policy/procedure in place for second review of images and most second reviews occur if the reporting clinician requests a review. Radiology Services at CHS conduct a monthly peer review meeting during which cases are reviewed in retrospect for the predominant purpose of providing learning opportunities and staff development.

Findings – Manner and Cause of Death

80. Based on the evidence before me, I make the following findings as to the manner and cause of Peter's death:

(a) The cause of the symptoms requiring Peter's hospitalisation on 19 August 2021 was a dissection of a thoracic aortic aneurysm.

(b) The dissection that was observed at autopsy did not occur at one time. It is likely to have started on 19 August 2021 around the time of Peter's collapse at home. A complete dissection occurred close to the time of Peter's death on 22 August 2021, resulting in blood entering the pericardial sac, preventing the heart from pumping.

(c) Aortic dissection was identified as a possible cause of Peter's symptoms at the time of his admission. Diagnostic processes included a CT scan with angiogram of the chest.

(d) The CT scan performed at 1448 hours on 19 August 2021 was partly but significantly misread by the radiologist Dr CD.

(e) Dr CD correctly identified that there was an aneurysm and dilation of the aortic root. He failed to report that the aneurysm had dissected.

(f) The dissection was observable on the CT scan. Whilst the diagnosis was evident, the appearance of the dissection was not that of a simple dissection.

(g) Consistent with the concession made by Dr CD, the imaging does show a mural thrombus causing a thickened aortic wall, which Dr CD would usually report as a likely dissection.

(h) The lack of cardiac gating on the relevant CT machine had no practical significance in this case.

(i) There was a discussion between Dr CD and treating clinicians that caused the scans to be reviewed. The content of that discussion is not clearly recalled. The clinical notes and Dr BD's proof of evidence do not suggest that Dr CD was specifically asked to review his conclusions as to the appearance of the aorta, although coagulation issues were raised. A possible pulmonary embolus was raised in that conversation. The conversation did cause Dr CD to look at the images again and to re-consider aspects of his report, which was subsequently amended. That re-consideration did not result in the original error being identified.

(j) I am unable to find why the error in reading the CT scan occurred. The explanations offered by Dr CD are noted. There was no evidence before me suggesting the error was indicative of an ongoing shortfall in clinical competence.

(k) It could not have been reasonably anticipated that clinicians other than radiologists would have been able to detect the dissection by looking at the scans themselves, given:

    (i) that the dissection was not routine in its presentation on the scans; and

    (ii) that the principal responsibility for Peter's care lay with the neurology team, who were not as familiar with CT scans showing signs of pathology in the thoracic aorta.

(l) After the scans were incorrectly reported, and over the next three days, alternative explanations of the symptomology exhibited by Peter were explored.

(m) That symptomology included:

    (i) chest discomfort or pain (intermittently reported);

    (ii) a sore back (intermittently reported);

    (iii) elevated temperature (from the evening of 20 August 2021);

    (iv) atrial fibrillation (from 21 August 2021 addressed by medication);

(v) infection/sepsis;

(vi) increased D-dimer readings consistently indicating coagulation issues; and

(vii) increased troponin levels.

(n) Whilst it is possible with the benefit of hindsight to attribute those symptoms to the limited dissection that had occurred until that point, clinicians reasonably considered other explanations in light of the report of the CT scans and Peter's presentation.

(o) Causes associated with the heart were considered on 21 August 2021, during the neurology review that occurred at 1215 hours. An echocardiogram was to occur on Monday 23 August 2021.

(p) Leading up to the MET call of 21 August 2021, Peter did not present as critically unwell. He was ambulant and able to communicate with clinicians and nursing staff. After his condition was stabilised on that day, he did not present as being critically unwell.

(q) The earlier increase in troponin levels could have had a number of explanations and did not unequivocally speak of major heart pathology. However, the increase that was reported after Peter's death in respect of the modified request at 1250 hours did clearly raise issues of underlying heart related pathology. A troponin level of 145 ng/L is significantly elevated and strongly suggests recent heart muscle damage, potentially indicating a heart attack (myocardial infarction) or other cardiac issues, requiring immediate medical attention. A worsening of the aortic dissection could have caused the elevated reading.

(r) Given there was a documented concern to test troponin to see changes over time [52], and Peter's troponin levels had been increasing, the decision not to include troponin in the request of 1250 hours is questionable. What could have been done if the troponin test had been conducted earlier and included in the pathology report accessed at 1349 hours is a matter of speculation. A further CT angiogram may have been ordered or the scheduled echocardiogram may have been expedited. If that testing and imaging actually indicated aortic dissection (the extent of the dissection that occurred at this time must have been of a lesser order of magnitude than the dissection proximate to Peter's death), emergency remedial surgery may have been undertaken. Whether that surgery could have been scheduled and whether it would have been successful in treating the dissection are matters of speculation.

(s) Given the poor quality and general paucity of the clinical and nursing notes generally and particularly on 22 August 2021, it is difficult to determine the progress of the collapse that occurred that afternoon. The MET alert was made at 1728 hours. Peter is likely to have been unconscious for some unknown period of time before that alert. He was pronounced deceased at 1745 hours.

(t) There is no suggestion that the resuscitation attempts were conducted in anything other than a competent way. The delay in the commencement of CPR and the acuity of the underlying pathology meant Peter's prognosis was very poor.

(u) Peter died of a thoracic aortic aneurysm with dissection.

(v) I find that the failure to diagnose and treat the dissection that occurred on 19 August 2021, and which progressed after that date, contributed to the cause of Peter's death.

Formal Findings

81. For the purposes of s 52 of the Act, I find that Peter Hanisch died on 22 August 2021 at about 1745 hours at the Calvary Hospital, Bruce, in the Australian Capital Territory. The cause of his death was a thoracic aortic aneurysm with dissection.

Section 3BA of the Act – The Failure to Diagnose the Aortic Dissection

82. Throughout the inquest, Julia expressed her belief that had Peter's aortic dissection been diagnosed in a timely way, Peter's life might have been saved. As I have said in another inquest, whilst consideration of that issue will inevitably involve an element of speculation, I believe that s 3BA of the Act does oblige me to attempt to answer that question.[20]

83. The passages extracted above [18] suggest that had the dissection been identified at the time of his admission to Calvary, then statistically Peter stood a good chance of surviving for a period after any remedial surgery was undertaken. Given he survived for a period of time after the initial dissection, it is more likely that the initial dissection was more limited in size. The evidence from the autopsy suggests that the walls of the aorta were not otherwise seriously compromised. The level of atherosclerotic disease within the aorta was moderately advanced but age appropriate. Peter's heart was enlarged.

[20] Section 3BA of the Act provides that as far as is practicable, the objects of the Act must, for an inquest into a person's death, be carried out in a way that recognises that the family and friends of a deceased person have an interest in having all reasonable questions about the circumstances of the person's death answered.

This may or may not have serious immediate consequences in respect of his life expectancy. The fact that the aortic valve ring was dilated may suggest that consideration would have been given to its replacement during surgery. This would add to the seriousness of the surgery and increased the scope of complications arising. Peter was older and the hypertension he suffered would have had to be controlled at the time of surgery and afterwards.

84. In light of these factors, I conclude that if there had been timely treatment of the aortic dissection, there were very reasonable prospects of saving Peter's life. I am unable to say what his long-term prognosis may have been.

85. Peter's family have also asked whether, notwithstanding the error made by Dr CD, there was sufficient evidence to suggest that aortic dissection should have specifically been diagnosed or a cardiac cause of his symptoms identified.[21]

86. Looking at the matter retrospectively, there was, as noted above [80], symptomology consistent with the aortic dissection that Peter suffered. Aortic dissection was one of the conditions initially suspected. Clotting was suspected and a request was made of Dr CD for a review of the CT in light of that issue. However, the mistake originally made in reading the scans was not identified.

87. Given the error made in reading the CT scan and the inconsistency in how some of these symptoms presented, it was not unreasonable for clinicians to look for alternative diagnoses. It is noted that differential diagnoses and planned diagnostic tests (notably the echocardiogram request) were circling back towards possible cardiac causes of his symptoms at the time of Peter's death. As noted earlier, access to a troponin result on 22 August 2021 may or may not have caused surgical intervention prior to Peter's collapse.

Matters of Public Safety

88. Dr CD's failure to correctly interpret the CT scan taken at the time of Peter's admission contributed to the cause of Peter's death. There appears to have been an acceptable level of communication between Dr CD and treating clinicians, and a follow up re-examination of the CT scan was requested, but with a focus that did not compel checking of the initial reporting's accuracy.

89. In and of itself, the mistake made by Dr CD does not suggest that a matter of general public safety arises. However, the letter of 14 March 2025 indicated that within CHS there

[21] Ms Evans was provided with the opportunity to comment on the provisional findings. Ms Evans reiterated that the neurology team should have involved a "cardiac specialist to assist with forming a view regarding Peter's treatment".

is no formal policy governing when a peer review of a radiology report occurs. Nor was the Court provided with any indication that peer review procedures within CHS are such as to generate a statistically valid profile of the accuracy of image reporting. Out of hours imaging is provided by a contracted provider. Their policies in respect of peer review are apparently unknown to the Territory although peer review reports are provided by that provider to NCH and TCH.

90. It is unclear from the evidence whether it was appropriate for the report of Dr CD to be subject to peer review or not. Expressed generally, there is no guidance in existence within CHS as to when peer review should be undertaken.

91. Peer review in radiology is crucial for quality assurance and is claimed by the Royal Australian and New Zealand College of Radiologists to be a central feature of its various quality and standards initiatives.

92. It is recommended that CHS develop and publish guidance as to peer review systems and procedures for imaging services provided within CHS and by private providers providing such 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 TCH and NCH.

Postscript

93. I express my sincere condolences to Peter's family for the loss of a much-loved husband and father. I acknowledge the additional stress caused by the longevity of coronial proceedings and thank Julia in particular for her patience and guidance in my inquest.

I certify that the preceding ninety-three [93] numbered paragraphs are a true copy of the Reasons for Findings of his Honour Coroner Archer.

Associate: Lucy James

Date: 9 April 2025