Office of the HEALTH OMBUDSMAN

Listen. Respond. Resolve.

Complaint about treatment provided by Robina Hospital

Executive summary

Background

On 12 March 2015, I received a complaint from a patient about the standard of care that she received at Robina Hospital in March 2014.

The patient raised concerns that Robina Hospital's emergency department had failed to identify a suspicious mass on her left lung following a chest x-ray that had been arranged when she presented in March 2014 with severe abdominal pain. The patient alleged that there was a seven-month delay in the diagnosis and treatment of her confirmed lung cancer.

The scope of my investigation was to determine whether:

1. the treating medical practitioner at Robina Hospital failed to diagnose the patient's condition following the chest x-ray
2. there were systemic issues in relation to x-ray review at Robina Hospital that required rectification
3. there was any unsatisfactory professional performance on the part of any individual health service provider in relation to the failure to review the patient's x-ray and diagnose and report on her diagnosis.

This complaint was dealt with as an individual matter. However, it is related to the long standing radiology backlog, reported in 2014, which had a significant impact on the services provided by the Gold Coast Hospital and Health Service (HHS). My office has been involved in a separate investigation into the systemic issues regarding the backlog of radiology reporting at the Gold Coast HHS.

Summary of findings

Issue	Findings
Whether the treating medical practitioner at Robina Hospital failed to diagnose the patient's condition resulting from a chest x-ray taken in March 2014.	A failure to diagnose the patient's condition of lung cancer has been substantiated.
Whether there were systemic issues in relation to x-ray review at Robina Hospital that require rectification.	Systemic issues in relation to review and reporting of plain film x-rays in the Gold Coast HHS were substantiated. An external review was initiated by the Director-General of the Department of Health, resulting in 31 recommendations for Gold Coast HHS and Health Support Queensland. The review indicated that the current management initiatives of the medical imaging reform project, if sustained, should ensure that under-reporting of images does not occur again. I commenced a systemic investigation into these initiatives following the external review.

Issue	Findings
Whether there was any unsatisfactory professional performance on the part of any individual health service providers in relation to the failure to review the patient's x-ray and diagnose and report her condition.	A failure by the doctor to recognise the mass located on the patient's left lung has been substantiated. There is no evidence to indicate that the doctor sought confirmation of the diagnosis or plan for discharge with a senior doctor. The hospital submission acknowledged these issues. The doctor's performance has been referred to the Australian Health Practitioner Regulation Agency (AHPRA) for consideration by the Medical Board of Australia.

Conclusions

I have considered the outcome of the investigation undertaken by Robina Hospital resulting in an RCA report and the external review by the Department of Health.

To satisfy me that the health and safety of the public is protected in the future, and to determine whether the lessons learned from this incident and actions undertaken have effectively mitigated the risks, I consulted with Robina Hospital regarding the findings of my report and advised Gold Coast HHS of my decision to refer the doctor to AHPRA under section 91 of the *Health Ombudsman Act 2013* (the Act).

My decision in relation to this matter is to take *no further action* in relation to this investigation in accordance with section 44(iv) of the Act as I reasonably consider the complaint has been resolved. My systemic investigation into the medical imaging reform project will be reported separately.

Leon Atkinson-MacEwen
Health Ombudsman

13 October 2016

Please note: on 12 January 2018 information in this report was redacted and the amended report approved by the Acting Health Ombudsman Andrew Brown.