RADIOGRAPHERS BOARD
放 射 技 師 管 理 委 員 會

DISCIPLINARY INQUIRY
SUPPLEMENTARY MEDICAL PROFESSIONS ORDINANCE, CAP. 359

Date of Inquiry： 23 May 2024 (Thu) and 24 May 2024 (Fri)

Respondents： Mr CHAN Wan-fai Kelvin, Registered Part I Radiographer (Diagnostic) (Registration No.: RD101559) and [redacted] Registered Part I Radiographer (Diagnostic) (Registration No.: [redacted])

Charges against the respondent

The charges as extracted from the Notice of Inquiry sent to the Respondents on 24 December 2019 are as follows:-

> "That on or about 4 July 2018, you, being a radiographer registered in Part I of the register (Category: Diagnostic), disregarded and/or neglected your professional responsibility towards [redacted] ("the Patient"), in that you inappropriately conducted the diagnostic barium enema examination on the Patient which resulted in or contributed to severe injury to the Patient, and that in relation to the facts alleged, you have been guilty of misconduct in a professional aspect."

Decision of the Radiographers Board

In the present inquiry, the Secretary is represented by Legal Officer. There are two respondents, Mr CHAN Wan-fai Kelvin and [redacted] Both of them are radiographers registered in Part I of the register (Category: Diagnostic). Mr Kelvin CHAN is absent from the entire hearing. The Board is satisfied that the notice of inquiry has been served on him and proceeds with the inquiry in his absence. [redacted] is represented by counsel.

Legal Officer called two witnesses to testify, the first one being the Patient's son and

the second being an expert witness, [redacted]. [redacted] gave evidence himself. His counsel also called his current direct supervisor, [redacted], to give evidence. While Mr Kelvin CHAN was absent from the entire hearing, he submitted to the Board two emails dated 12 July 2019 and 21 May 2024 respectively giving his account of the incident.

Findings of facts

Having considered the evidence in the present case, the Board made the following findings of facts. The Patient was arranged to have a barium enema examination at Queen Elizabeth Hospital ("QEH") on 4 July 2018. She was 79 years old at that time. The examination was conducted by the two respondents in the present case together with a radiologist. Mr Kelvin CHAN was the one who inserted the enema tube into the Patient's body and the radiologist acted as chaperon. Mr Kelvin CHAN inserted the tube wrongly into the Patient's vagina instead of her anus. The mistake was not discovered until later in the examination.

There are conflicting evidence between the two respondents as to whether the patient was moving when Mr Kelvin CHAN inserted the enema tube. [redacted] gave oral evidence that he was in the control room making preparation and did not notice that the Patient was uncooperative. He also said that he did not remember seeing the patient moving while Mr Kelvin CHAN was inserting the tube. He stated that Mr Kelvin CHAN did not ask for any assistance when inserting the tube. On the other hand, Mr Kelvin CHAN stated in his earlier email that the Patient had "moved" while he was inserting the tube, and in his later email that the Patient "was moving vigorously during the process". Mr Kelvin CHAN did not state that he had ever sought any assistance during the process. It is against common sense that he did not seek any assistance if the Patient was moving vigorously. The Board rejects his evidence that the Patient was moving vigorously and finds that the Patient was largely cooperative during the insertion process.

After inserting the enema tube, Mr Kelvin CHAN received verbal confirmation from the Patient that the tube was inside her rectum and applied adhesive tapes to the Patient's buttocks to secure the tube. He then inflated the retention cuff (or balloon) of the enema tube to avoid leakage of barium during the examination. While the balloon was being inflated, the Patient expressed that she felt discomfort. Mr Kelvin CHAN comforted her by explaining that it was common for inflation of balloon to cause discomfort. He obtained verbal confirmation from the Patient again that the enema tube was inside her rectum. The examination continued with Mr Kelvin CHAN and

the radiologist standing at the foot side of the couch facing the monitor and [redacted] standing at the head side of the couch to assist the movement of the Patient. [redacted] was not able to see the image in the monitor from his position.

As to what happened in the examination afterwards, the Board accepts [redacted]'s evidence as follows. Shortly after the infusion of barium had started, the Radiologist and Mr Kelvin CHAN found that barium was accumulated instead of moving along the Patient's bowel. The radiologist tilted the couch to increase the infusion pressure, but barium was still accumulating. [redacted] walked over to look at the monitor and realized that something had gone wrong. He then removed the adhesive tapes on the Patient's buttocks to check the position of the enema tube and discovered that the tube was wrongly inserted into the vagina. He immediately told the radiologist and Mr Kelvin CHAN. The infusion was stopped and the tube was withdrawn from the Patient. No bleeding was discovered at that time.

The radiologist instructed the two respondents to resume the examination, but shortly thereafter active bleeding from the Patient was noted and the radiologist aborted the examination. As a result of the incident, the Patient was admitted for emergency treatment and was discharged on 24 July 2018.

QEH did not issue any Standard Operation Procedures ("SOP") for barium enema examination until after the incident.

Regarding the experience of the two respondents, Mr Kelvin CHAN had over 5 years of experience as a radiographer at the time of the incident. According to the evidence of [redacted], it was estimated that Mr Kelvin CHAN had conducted barium enema examinations for around 600 times prior to the incident. The Board considers this estimation reasonable. On the other hand, [redacted] has worked as a radiographer since [redacted] and the Board accepts his evidence that by the time of the incident, he had performed not less than 2 000 times of barium enema examination.

The Board also accepts the following evidence from [redacted] as to what happened in the morning before the examination in question was conducted on the Patient. He testified that he and Mr Kelvin CHAN had conducted a water soluble contrast enema examination on another female patient. The examination required the insertion of a foley catheter into the rectum of the patient. Such procedure was completed by Mr Kelvin CHAN without any problem and [redacted] acted as a chaperon.

Meaning of "unprofessional conduct"

According to the Code of Practice issued by the Board, a radiographer is guilty of "unprofessional conduct" when he does something or omits to do something which in the opinion of his professional colleagues of good repute and competency, might be reasonably regarded as disgraceful, dishonourable, or negligent or which falls below that standard of competency that such a colleague might regard as reasonable, having regard to the radiographer's stage of experience.

Case against Mr Kelvin CHAN

At the time of the incident, Mr Kelvin CHAN had more than five years of post-qualification experience and should have performed barium enema examination for not less than 600 times. The Board considers that Mr Kelvin CHAN has clearly fallen below the standard of competency reasonably expected of him in that he failed to properly insert the enema tube into the anus of the Patient. He should have visually inspected the position of the tube instead of simply seeking verbal confirmation from the 79-year-old Patient. Furthermore, he should have sought assistance from [redacted] or the radiologist if he considered that there was any difficulty in inserting the tube. For the reasons above, the Board finds that Mr Kelvin CHAN is guilty as charged.

Case against [redacted]

It is undisputable that given his seniority, [redacted] was the radiographer in charge when the examination was conducted on the Patient. He admitted that he should be responsible for overseeing the examination and ensuring that the examination was conducted smoothly. No SOP was issued by QEH at the time of the incident. The Board accepts that there was, at that time, no general guideline that the radiographer in charge must visually inspect the position of the enema tube after it has been inserted by another radiographer. Indeed, according to the SOP issued by QEH after the incident, it should be the radiologist who should visually inspect the position of the enema tube before adhesive tape is applied.

In the present case, both Mr Kelvin CHAN and [redacted] are radiographers registered in Part I of the register (Category: Diagnostic). At the time of the incident, Mr Kelvin CHAN possessed substantial knowledge and experience in conducting barium enema examination and should be reasonably expected to know how to insert an enema tube. [redacted] had personally witnessed Mr Kelvin CHAN insert

a catheter into the anus of another female patient without any problem shortly before they conducted the examination in question. Furthermore, Mr Kelvin CHAN did not seek any assistance when he inserted the enema tube into the Patient's body. The Board considers that in the circumstances of the present case, there should be no reason for [redacted] to suspect that Mr Kelvin CHAN could not properly insert the enema tube into the Patient's body. The Board does not consider that it is reasonable to expect [redacted] to visually inspect the position of the tube after Mr Kelvin CHAN inserted it.

The Board accepts that it is common for patients to complain of pain or discomfort during a barium enema examination. [redacted] gave oral evidence, and the Board accepts, that the Patient did not say there was severe pain, nor did she appear to be in grave pain. The Board does not consider that it is reasonable to expect [redacted] to visually inspect the position of the tube after hearing the Patient's complaints of discomfort or pain.

Accordingly, the Board finds that [redacted] is not guilty of the charge.

Sentence

Having considered all the relevant circumstances of the present case and the written representations of Mr Kelvin CHAN in his two emails, the Board orders that subject to any appeal which must be lodged within one month after the date of service of the order of the Board, Mr Kelvin CHAN shall be removed from the register for a period of six months and such order shall be published in the Hong Kong Government Gazette.

(Dr Kitty HSE Mei-yin, JP)
Chairman, Radiographers Board
24 May 2024