Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

# A Decision by the Deputy Health and Disability Commissioner

## (Case 21HDC02367)


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## Introduction

1. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mr A by Health New Zealand Te Whatu Ora.

3. Mr A had been under the care of the Vascular Surgery service at Christchurch Hospital (Canterbury District Health Board (CDHB)[1]) for annual ultrasound surveillance of renal[2] and splenic[3] artery aneurysms[4] since 2010. In March 2019 the Vascular service referred Mr A to the Nephrology[5] service for further investigation of a renal cyst, but this referral was not actioned. Further, in January 2021 an ultrasound report recommended further investigation of a 'complex [renal] lesion', but this recommendation was not actioned. Following identification of the missed January 2021 recommendation, in September 2021, Mr A was diagnosed with renal cancer.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Health New Zealand|Te Whatu Ora. All references in this report to CDHB now refer to Health New Zealand|Te Whatu Ora Waitaha Canterbury.
[2] Relating to the kidneys.
[3] Relating to the spleen.
[4] A bulging, weakened area in the wall of an artery.
[5] Internal medicine specialty relating to the study, diagnosis, and treatment of the kidneys.




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4. The following issue was identified for investigation:

- *Whether Health New Zealand I Te Whatu Ora Waitaha Canterbury provided Mr A with an appropriate standard of care in 2019 and 2021.*

5. The parties directly involved in the investigation were:

| | |
|---|---|
| Mr A | Consumer/complainant |
| Health New Zealand│Te Whatu Ora Waitaha Canterbury | District healthcare provider |

6. Further information was also received from a medical centre.

## Events leading up to complaint

### November 2018 ultrasound

7. In November 2018, Mr A, in his sixties at the time, had an ultrasound of his splenic and renal arteries. The ultrasound was performed as part of an annual surveillance programme that had been in place since 2010, when a computerised tomography (CT)[6] scan showed bilateral renal artery aneurysms, a splenic artery aneurysm, and multiple renal cysts, including a left-sided complex renal cyst consistent with a Bosniak II cyst.[7] Follow-up imaging to review the left-sided Bosniak II cyst was taken in 2011 and 2012, each time showing that there had been no change. Following review in 2012, the urology consultant advised Mr A's GP:

> 'I don't think that further ultrasound [for the complex renal cyst] is necessary. However, I see [Mr A] is on regular follow up for his renal artery aneurysm and ultrasound of the complex cyst could be incorporated in that. I haven't arranged follow up from our side but would be happy to see him back should the situation change.'

8. The November 2018 ultrasound report identified that the right renal artery aneurysm had grown and 'may therefore require intervention'. The findings of Mr A's November 2018 ultrasound were discussed at a Vascular multidisciplinary meeting (MDM) in January 2019. CT angiography[8] was requested to investigate the right renal artery aneurysm.

### March 2019 Nephrology referral

9. On 14 March 2019 a CT angiogram was performed. The CT angiography report noted that Mr A's renal artery aneurysms appeared stable when compared with a previous CT in 2011.

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[6] CT uses X-rays to make detailed pictures of structures inside the body.

[7] The Bosniak classification system is used by radiologists and urologists for assessing renal cysts. The classification system ranges from Bosniak I (benign simple cyst) to Bosniak IV (clearly malignant mass). Bosniak II indicates a 'minimally complex' benign cyst. While Bosniak II cysts are characterised as benign, the rate of malignancy of cysts classified as Bosniak II is around 0–6%.

[8] CT angiography uses a CT scanner and an injection of dye into the blood vessels to help diagnose and evaluate blood vessel disease or related conditions, such as aneurysms or blockages.



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However, the report also identified '[a] couple of arterially enhancing areas … at the base of the mid [renal] pole cyst'.

10. The results of Mr A's March 2019 CT angiography were discussed at the Vascular MDM later that month. It was decided to continue with annual surveillance of Mr A's splenic and renal aneurysms, and to refer Mr A to the Nephrology service for assessment of the left kidney lesion. That day, Dr B, a vascular surgeon, wrote a letter to Mr A's general practice to advise of this plan. The letter was copied to Mr A, but Mr A told HDC that it was never received.

11. On 26 March 2019, Dr B also wrote a referral letter to the Nephrology service, stating: '[Mr A] has a suspicious cyst/lump on the kidney on the left side which needs to be reviewed. I would be grateful for your opinion and review of his CT abdomen.' The referral letter was copied to Mr A, but again Mr A said that it was never received.

12. The referral to the Nephrology service was not actioned.

13. Health New Zealand|Te Whatu Ora (Health NZ) told HDC that at the time of events the system for internal referrals was paper based. Health NZ stated that despite evidence that a paper-based referral was generated by the Vascular service and intended for the Nephrology service, there is no evidence that the referral was received by the Nephrology service.

14. The Clinical Director of Christchurch Hospital's Vascular service stated:

> 'It is [not] clear why [the 26 March 2019] referral ended up un-actioned, and with the benefit of hindsight the referral probably should have been sent to urology.
>
> At the time, Te Whatu Ora did not have a formal system for ensuring internal referrals (between services within the organisation) were successfully received and actioned by the receiving team.'

15. Health NZ told HDC that at this time, it was not appreciated that '[Mr A] had been seen by Urology some years previously for the cyst and discharged from that service. The referral to Nephrology was a correct plan without this prior knowledge.'

16. The Clinical Director of Christchurch Hospital's Nephrology service explained that all referrals received by the Nephrology service are entered into the service's database, Proton. For paper-based referrals, the booking clerk generates a record in Proton that is then completed by the triaging clinician. The clinical director stated that on occasion the Nephrology service 'get[s] a few referrals for urology accidentally'. On those occasions, it would be recorded on Proton that the referral was transferred to the correct department and the paper referral would then be physically delivered to the Urology Department.



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17. Regarding Mr A's referral, the Clinical Director of the Nephrology service stated:

> 'There's no record on Proton of [Mr A], which indicates the document was not received. This process is fairly robust as the doctor and the secretary both have actions that depend on each other, so we check up on each other. These paper referrals are a known source of risk.'

**December 2019 ultrasound**

18. Mr A had an ultrasound as part of the annual surveillance programme of his renal artery aneurysms and splenic artery aneurysm. The findings were compared against the November 2018 ultrasound and March 2019 CT angiography. The findings of the December 2019 ultrasound report included:

> 'Complex lesion [left] upper-mid pole anteriorly containing heterogenous echoes but no internal vascularity … There is also a further complex area seen posteriorly in the [left] upper pole region but again this was difficult to assess …'

19. The December 2019 ultrasound report concluded: 'Stable vascular appearances, of the known splenic and bilateral renal aneurysms, to previous imaging. Bilateral renal cysts, some complex, as detailed [in the report].' The report did not make any recommendations for follow-up.

20. Health NZ told HDC that as the December 2019 ultrasound showed no change from the November 2018 ultrasound, it did not meet the threshold for referral to the Vascular MDM. Further, Health NZ stated that where there had been no change in annual surveillance results it was not standard practice or policy to advise a patient or their GP.

21. A letter dated 23 January 2020 from Dr B to the medical centre documents that the December 2019 ultrasound was reviewed at the Vascular MDM on 31 December 2019. Dr B's January 2020 letter advises that Mr A's ultrasound and CT had been reviewed and that '[a]ll aneurysms are threshold and there is no indication for further intervention'. A repeat ultrasound was to be undertaken in one year's time.

**January 2021 ultrasound**

22. On 12 January 2021, Mr A's annual surveillance ultrasound was performed. The report noted Dr B as the referring physician and concluded (emphasis added):

> 'Stable vascular appearances of the known splenic and bilateral renal aneurysms. Multiple bilateral renal cysts again noted. *A complex lesion in the upper-mid left renal pole anteriorly shows some internal vascularity and should be assessed in further detail using CT or contrast enhanced ultrasound*.'

23. These findings were not communicated to Mr A or his GP and the recommendation for follow-up investigations was not actioned. While the electronic results were available to the referrer, Dr B did not state whether he saw these results. Health NZ told HDC that 'the referrer or the ultrasound scan is responsible for reviewing and signing off results'. However,



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Dr B advised that surveillance scans were reviewed by the nurse and triaged so that abnormal scans were brought to the Vascular MDM for discussion.

*CDHB 'Radiology Critical/Actionable Results Notification Policy'*

24. The January 2021 ultrasound was read by a radiologist, who told HDC that 'the finding on the ultrasound fell into the expected (as distinct from unexpected) category as it had already been identified on previous US and CT scans'. The radiologist stated that an expected finding does not require any communication with the referrer other than the electronic report.

25. Health NZ provided a copy of CDHB's 'Radiology Critical/Actionable Results Notification Policy' (the 'Radiology actionable results' policy) applicable in 2021. The purpose of the policy is to clarify the communication processes that the Radiology service will use in relation to an imaging study that has new/unexpected findings that could result in mortality or significant morbidity.

26. The Radiology actionable results policy defines three levels of 'critical finding or results' and pathways for communication. Level 3 results are defined as:

> '[A]ny new/unexpected findings on an imaging study that suggest conditions that could result in significant morbidity if not appropriately treated, but are not immediately life-threatening.'

27. The policy includes examples of level 3 results, including 'a solid renal mass'. The policy states that level 3 results must be notified to the referring clinician/team within three days and that communication will be via the distribution of a paper report or, where enabled, via electronic systems. The policy states that no other communication is required of the Radiology Department, and referring clinicians will be responsible for establishing and managing processes related to the results.

*CDHB Vascular surveillance protocol*

28. Health NZ provided a copy of CDHB's 'Protocol for aneurysm surveillance' (the 'surveillance protocol') applicable from 2007–2023. The protocol sets out threshold diameters for when aneurysms may require intervention.

29. The surveillance protocol provides that scan results are to be reviewed by the nurse on receipt of the clinical review list and the patient's details, and scan results will be added to the Radiology list if the threshold is met or there is indication for vascular review by a consultant. If the patient is below the threshold, this information will be given to the surveillance clerk, who will add it to the appropriate surveillance database for a further follow-up surveillance scan at the appropriate time.

30. The surveillance protocol does not discuss management of non-vascular incidental abnormal findings.

31. Health NZ told HDC that the January 2021 ultrasound findings did not meet the Vascular surveillance protocol threshold for referral to the Vascular Radiology MDM, but as the



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ultrasound findings identified an 'anomaly', good practice would have been to refer the case to the next Vascular Radiology MDM for review. This did not occur, and Health NZ said that the reason for this is unclear.

32. Health NZ stated that it was Dr B's responsibility, as the referrer of the January 2021 ultrasound scan, to review, sign off, and communicate abnormal results to the GP and patient, and to make internal referrals to other departments or request further investigations if required. Health NZ described two ways in which abnormal results are considered and actioned by the referring vascular surgeon:

> 'The most common is that the results will be reviewed in [an MDM]. The second way is that the Vascular surgeon directly reviews and actions the results as part of signing off the scan. At the relevant time there was no protocol or policy which identified the appropriate process when it was a non-vascular issue.'

33. Health NZ stated: '[Dr B] has advised that his process was reliant on scans being reviewed and triaged so that abnormal scans were put on the Vascular Radiology [MDM] list.'

34. Dr B stated:

> '[Mr A's] scan should have been added to the MDM list under my name. However, [Mr A's] scan never made it to the MDM list and I have discussed the reason for that with our administrator. Unfortunately, we are unable to explain why [Mr A's] scan was not brought forward to the MDM.'

*MDM list process*

35. Health NZ stated that each week a list is made of the patients to be reviewed at the MDM. This list is a shared document and, at the time of these events, 'it was updated by staff within the Vascular Surgery service as part of their role and within their scope of practice'.

36. Health NZ stated that the number of people with access to the MDM list is 'problematic and creates a risk of error'. It noted that multiple health practitioners are involved in the assessment of whether a patient requires review, and the MDM list does not track additions and removals to the list 'in an identifiable way'.

37. RN D ordered Mr A's surveillance ultrasound that was performed in January 2021. RN D acknowledged that the January 2021 scan report recommended follow-up investigations and stated that it is difficult to know why this did not occur. She noted that several people have access to make changes to the MDM list, and stated:

> 'It may have been thought that as [Mr A] had already had a CT in March 2019 and been referred to another service that the lesion was already being managed. However, our standard practice would be to re-refer based on the recommendation of the radiologist.'



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38. RN D said that following receipt of the January 2021 report she ordered a further surveillance scan for one year's time in accordance with the Vascular surveillance protocol, as Mr A's aneurysms were stable.

*Communication with GPs*

39. Health NZ stated that all vascular surveillance ultrasound scans are ordered electronically by the senior Vascular nurses, who have delegated authority by the Vascular Surgery service and are guided by the Vascular Surgery surveillance protocol.

40. Health NZ said that when the scan is ordered, the patient's GP's details appear automatically on the form and the referrer can tick a box that states: 'Copy to GP.' If this box is ticked, the GP will then receive the scan report to the address the GP has registered in the system, in the same way they would if they were the referrer. Health NZ said that if there is no GP recorded for a patient in the system, the 'Copy to GP' box will not be available.

41. The radiologist also confirmed that the Radiology Department's practice is to copy the report to the patient's GP only if this has been requested by the referrer, and the referrer is responsible for the discussion of the result with the patient, as '[the referrer is] aware of the clinical situation that guides the interpretation of the report'.

42. Health NZ noted that Mr A changed his registered GP practice sometime between 2015 and 2018. It stated that CDHB transitioned to the patient management system South Island Patient Information Care System (SI PICS) in 2018, and it is possible to view only system changes that have been made in the previous 12 months. Health NZ stated that it is therefore not possible to identify what changes may have been made to Mr A's recorded GP between 2015 and 2018. However, Health NZ noted that Mr A's GP was not copied into any ultrasound scans from 2019 to 2022, and 'this could possibly indicate that there was no GP recorded in the system during this time', and therefore it would not have been an option for the nurse to request the scan results be copied to Mr A's GP.

43. RN D stated:

> 'I tick the box requiring the scan to be copied to the GP on every scan I order. I only do not do this if there is no GP recorded in the [the system] which means I am unable to tick "copy to GP" when ordering the scan … For the 2023 scan, requested on 14 January 2022, [Mr A's] GP was listed, and I was able to tick this box. Given the scan was not copied to the GP three years in a row [2019, 2021, and 2022], this indicates to me that there was no GP recorded in [the system] at this time.'

44. Mr A told HDC that each time he attended a hospital appointment he was asked to confirm that his information and contact details, including his GP, were correct. Mr A stated that he knows this, because 'they never pronounce [his] doctors names properly. Both [Dr F] and now [the new doctor]'.

45. Mr A's medical centre patient records show that he was registered with the medical centre on 14 January 2013. His previous GP, Dr C, told HDC that Mr A was under the care of Dr E



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from 2013 until June 2018. In June 2018 Mr A's care was transferred from Dr E to Dr C, but he remained registered at the medical centre.

46. Dr B stated that when diagnostic tests are discussed at the MDMs, it is not routine practice to send a copy of the ultrasound report to the GP. Instead, a letter stating the finding of the scan and the recommended plan is sent to the patient and their GP. Dr B also noted that GPs have access to their patient's records and investigations via HealthOne.[9]

47. Dr C told HDC:

> 'By way of background, [HealthOne] is a web-based shared care record repository which both primary care and secondary care can access to check what information is available from other clinicians about an individual patient. However, it requires knowledge that a particular investigation has been done for the clinician to go looking for the result.'

*Transfer of care framework*

48. Dr C referred to a document titled 'Principles and practicalities of transfer of care between secondary and primary care in the Canterbury Health System' (Transfer of Care Framework). The framework was developed in December 2019. The framework outlines the principles and practical aspects of transfer of care between secondary and primary care, to mitigate the clinical risk that lack of clarity regarding transfer of care poses to patients.

49. The Transfer of Care Framework states as a 'fundamental principle' that the requesting clinician holds primary responsibility for follow-up of the results of medical investigations and tests. Further, it states that any clinician who is copied into a result has residual responsibility for acting on clinically significant results, and notes that this creates duplicate work for clinicians who are copied into results without handover of clinical responsibility or context. For this reason, the framework emphasises that results should not be copied to any other clinician routinely at the time of request. This ensures that ongoing responsibility lies unambiguously with the requester, unless handover of responsibility is clearly requested in writing and with 'closed loop communications'.

50. Under the heading 'Responsibility for test results', the Transfer of Care Framework states that hospital doctors are responsible for following up the results of all tests and referrals initiated as part of the reason for specialist consultation, unless an explicit and documented handover has been agreed and has occurred. This includes results of outpatient radiology investigations.

51. Under the heading 'How hospital teams can contact [GP] teams', the Transfer of Care Framework states that HealthOne holds the details of a patient's correct current enrolled GP, and that this may vary from the information recorded in Health Connect South (HCS), SI PICS, and written notes, 'all of which are unreliable sources of the enrolled GP'. The framework states that if the GP in HealthOne is different from that recorded elsewhere,

[9] HealthOne is a secure web-based patient management system that enables primary and secondary healthcare providers to share and access patient information.



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administration staff should be advised so that they can update the details in SI PICS, which will in turn update HCS.

**September 2021 — identification of missed results**

*Medical centre recall*

52. Dr C told HDC that when she took over Mr A's care in 2018 she created an annual recall for his vascular surveillance ultrasound in the medical centre's patient management system, MedTech. She stated that she noted on the recall that Mr A was under the care of the Vascular clinic for this. Dr C also stated: 'The vascular clinic letter implied that responsibility for recall lay with them, but it is not uncommon to add a matching recall to primary care notes for my own information.'

53. Dr C stated that the MedTech recall created in 2018 appears to have been updated to December 2019 after Dr B wrote to the medical centre in March 2019 to advise that Mr A's CT had shown that his renal artery aneurysms were in a stable condition and that the plan was to continue with annual surveillance. Dr C noted that Mr A was recalled as planned in December 2019 and Dr B wrote to the medical centre in January 2020 confirming that the results had been reviewed and the plan was for further surveillance in one year's time. Dr C stated that it appears that the medical centre's MedTech recall was not updated at this time. In March 2021, Mr A's care was transferred to another GP at the medical centre.

54. Dr C told HDC that the medical centre's recall protocol at the time of events involved practice nurses printing lists of upcoming recalls each month for each GP to assess and action. She stated that as the recall for Mr A's annual vascular ultrasound was set to 2019 and had not been updated, it would not have come up on monthly recall lists in 2021. Dr C said that historic recalls were reviewed periodically as well, but she cannot recall whether there was a list of historic recalls to review over this time.

*Identification of missed results*

55. On 15 September 2021, Mr A contacted the medical centre for a repeat prescription, which was arranged by Dr F (GP registrar). Whilst doing so, Dr F checked Mr A's 'recalls' in MedTech and saw that he had been due for an ultrasound follow-up of his known aneurysms but there were no ultrasound results on the medical centre's system.

56. Dr F checked HealthOne and found the January 2021 ultrasound report. She told HDC:

> 'I saw an ultrasound report from 12 January 2021 which showed an incidental finding of a new kidney lesion suspicious for malignancy. I could not see any documentation that the results had been discussed with [Mr A] or further tests had been ordered.'

57. Following discussion with Mr A that day, Dr F requested a CT scan. She also sent a referral to the Christchurch Hospital Vascular service outlining her concerns about the January 2021 ultrasound findings not being relayed to Mr A, and the delay in follow-up investigations.

58. As a result of Dr F's referral, Mr A's January 2021 ultrasound results were discussed at the Vascular Radiology MDM on 17 September 2021. That day, Dr B wrote a referral to the



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Urology service requesting review of Mr A's January 2021 ultrasound and noting that this 'showed he does have a lesion over the left kidney and another lesion on the right kidney'. The referral was copied to Mr A and Dr F.

59. The Clinical Director of the Vascular service stated: 'Again, there was no formal mechanism to ensure that such written referrals are successfully delivered and actioned by the receiving team.'

**September 2021 CT scan**

60. A CT scan performed on 27 September 2021 showed a 35mm by 27mm left upper pole renal lesion consistent with a renal cell carcinoma.

61. On 28 September 2021, Dr F discussed the CT results with Mr A and sent a referral to the CDHB Urology service for further management. Dr F also wrote to the Vascular service that day requesting that a formal apology be sent to Mr A for the delay in diagnosis and treatment of his cancer, and that procedures be reviewed to ensure that this did not happen again. Health NZ told HDC that the Vascular Surgery Clinical Director communicated with Dr F on 28 September 2021 indicating that this incident would be investigated, and the findings shared. Health NZ acknowledged that the Vascular Surgery service omitted at this time to apologise or inform Mr A of the incident management and complaint process as well as the plan going forward.

*CDHB Open Disclosure policy*

62. Health NZ told HDC that as Dr F had apologised to Mr A for the delay in diagnosis, this demonstrated '"open disclosure" at the point of discovery'. On the other hand, Health NZ also stated that the failure to apologise in a timely manner and communicate the plan forward was not in line with CDHB's Open Disclosure policy in place at the time of events.

63. Health NZ provided a copy of CDHB's Open Disclosure policy applicable in 2021. The policy requires staff to participate in open communication with patients and their whānau whenever a patient in the care of Health NZ has been exposed to possible harm resulting from a system error that affected that patient's care, or when a patient has suffered harm while receiving health care.

64. The policy outlines the expected elements of open disclosure, including:

- **Acknowledgement:** All events must be acknowledged to the patient[10] as soon as possible (preferably within 24 hours) after the event is identified.
- **Openness, timeliness, and clarity of communication:** Information about an event that causes harm must be given to the patient in a timely, open, and honest manner.
- **Apology:** The patient must receive an honest and genuine apology for any harm as soon as possible (ideally within 24 hours) after the event is identified.

[10] And/or their support person.



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- **Recognition of the reasonable expectations of patients:** The patient may reasonably expect to be fully informed of the facts surrounding the event and the consequences of any harm; treated with empathy, respect, and consideration and to be provided with such support as is necessary in a manner appropriate to their needs; and fully informed as to the outcome of any investigation undertaken together with any changes instituted as a result of that investigation.
- **Ongoing Care:** Any required further management or rehabilitation must be planned in discussion with the patient in order to ensure that they are fully informed of, and in agreement with, any proposed ongoing care.

**Urology care and surgical treatment**

65. There is conflicting information about what Mr A was told regarding the plan for his care after he was referred to the Urology service on 28 September 2021 for review of the 27 September 2021 CT scan results.

66. In his complaint to HDC, Mr A noted his concern that despite the delays in diagnosis, following referral to the Urology service he was placed in the 'general clinic pool' with a two-month wait to see a urologist. Mr A stated that his wife contacted CDHB about this, after which his priority was expedited, and he received an appointment for 11 October 2021.

67. On the other hand, CDHB provided a letter addressed to Mr A, shown to have been generated on 29 September 2021, which advised: 'You have been added to our clinic waiting list and will receive an appointment by 4 October 2021.' In response to Mr A's complaint, Health NZ told HDC that the term 'general clinic pool' refers to a model of service in which the urologists 'work as a team' rather than using a 'named clinician model', so that patients can be seen by different urologists.

68. Mr A told HDC that he did not receive a letter from CDHB dated 29 September 2021. He said that on 4 October 2021, after his wife spoke with CDHB, it agreed to make an earlier appointment for him. Subsequently, he received a letter dated 4 October 2021, advising him that he had an appointment on 11 October 2021.

69. Mr A's CT results were discussed at the Urology Radiology MDM on 12 October 2021. Surgical removal of the left kidney was recommended, with continued surveillance of the right lesion. Mr A was seen in the Urology outpatient clinic on 13 October 2021. The CT results and MDM recommendation were discussed, and Mr A decided to proceed with surgical treatment.

70. On 19 October 2021 Mr A underwent a staging chest X-ray, which showed no evidence of metastatic disease.



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71. On 18 November 2021 Mr A underwent surgery to remove his left kidney. Histopathology[11] of the tumour confirmed a diagnosis of clear cell renal cell carcinoma, stage pT1a.[12]

**Further information**

72. Mr A expressed his concern that he had 'slipped through the cracks' at the medical centre and Christchurch Hospital and stated that the delays he experienced have caused him and his family 'huge upset and distress'.

73. In November 2022 Health NZ generated an apology to Mr A, in which it acknowledged that the March 2019 referral had not been actioned and the findings and recommendations of the January 2021 ultrasound report had not been followed up. Health NZ noted that a further annual surveillance scan was requested following Mr A's January 2021 ultrasound scan and acknowledged that this was another missed opportunity for the March 2019 referral to have been followed up and for the recommendations in the January 2021 report to have been actioned.

74. HDC received a copy of this apology, and it has been forwarded to Mr A in finalising this report.

## Opinion: Health New Zealand | Te Whatu Ora Waitaha Canterbury — breach

75. I acknowledge the distress experienced by Mr A and his family as a result of the omissions in care discussed in this report, and I thank him for bringing his concerns to the attention of this Office.

76. Under Right 4(2) of the Code of Health and Disability Services Consumer's Rights (the Code), CDHB had a duty to ensure that the services Mr A received at Christchurch Hospital complied with legal, professional, ethical, and other relevant standards.

77. CDHB was required to comply with the Health and Disability Services Standards 2008 (HDS Standards).[13] The HDS Standards are designed to establish safe and reasonable levels of services for consumers, and to reduce the risk to consumers from those services. This necessitated having robust policies/procedures and safety-netting in place that were followed by CDHB staff consistently.

78. For the reasons discussed below, I consider that CDHB failed to provide Mr A with services that complied with relevant standards, including the HDS Standards. Accordingly, I find CDHB in breach of Right 4(2) of the Code.

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[11] The microscopic study and diagnosis of diseased tissues and cells.
[12] The size of a tumour is described in four stages (T1–T4). Pathological (p) stage T1a means that on examination of the specimen the tumour is less than 4cm across and is completely inside the kidney (no growth into nearby tissues or veins).
[13] NZS 8134.0:2008 and NZS 8134.1:2008.



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**Management of scan results**

79. In March 2019 Dr B wrote a referral to the Nephrology service requesting review of a left renal 'suspicious lump/cyst' that had been identified on Mr A's recent CT scan. This referral was not actioned, and it appears that it may not have been received by the Nephrology service. The Vascular service did not identify that the referral had not been actioned and, as a result, it was never followed up. In my view, this was the first missed opportunity for earlier detection of Mr A's renal cancer.

80. Health NZ stated that at the time, CDHB did not have a formal system for ensuring that internal referrals were received and actioned. Further, the Nephrology service's Clinical Director stated that internal paper-based referrals were a 'known source of risk'.

81. In addition, at the time of the December 2019 ultrasound, it was not recognised that the March 2019 referral had not been actioned. I consider this to be the second missed opportunity for earlier detection of Mr A's renal cancer.

82. In January 2021, almost two years after the lost March 2019 referral, the Vascular service failed to action the recommendation in Mr A's surveillance ultrasound report for further investigation of the left complex renal lesion. Health NZ stated that as the vascular appearances were stable, the scan did not meet the threshold for referral to the Vascular Radiology MDM, but that as the ultrasound findings identified an 'anomaly', it would have been 'good practice' to have done so. The Vascular surveillance protocol did not provide guidance for recommended management of non-vascular incidental abnormal findings. Health NZ was not able to explain why Mr A was not added to the Vascular Radiology MDM list, or whether he had perhaps been added and subsequently removed. I consider this to be the third missed opportunity for earlier detection of Mr A's renal cancer.

83. I accept that, as the referring clinician, Dr B was responsible both for ensuring that the March 2019 referral had been received by the intended department and for reviewing the January 2021 scan results and actioning any recommended follow-up. However, on review of the information gathered I consider that Dr B's failures in this regard are attributable to CDHB at an organisational level.

84. I am critical that in March 2019, despite the paper-based system for internal referrals being a 'known source of risk', CDHB did not have robust policies and procedures in place to ensure that it was able to identify when referrals had not been received or actioned by the intended referee department. I consider that this contributed to the unacceptable situation of Mr A's referral for assessment of his left kidney lesion not being actioned.

85. Further, I am critical that in January 2021 CDHB's Vascular surveillance protocol did not provide guidance for the management of incidental findings of non-vascular abnormalities. I consider that this created room for uncertainty about the responsibility for review and follow-up of such abnormalities, which in turn created a risk that this would not occur as needed. I also find it very concerning that CDHB had no way of tracking the addition or removal of patients from the Vascular Radiology MDM. By Health NZ's own



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acknowledgement, CDHB's process for managing the MDM list was 'problematic and create[d] risk of error'.

86. I acknowledge that it was Dr B's responsibility to review and action the January 2021 ultrasound report and that he could have done this without Mr A being added to the MDM list. It is not apparent whether Dr B did review the January 2021 ultrasound report. However, as Health NZ stated, the most common way for results to be reviewed was in the MDM. In my view, it is unsurprising that Dr B's process had become reliant on the process of scans being triaged by the nurse and added to the MDM list. In these circumstances it was essential for CDHB to have a robust system in place for managing the MDM list, and I am critical that it did not.

87. I hold CDHB accountable for achieving quality outcomes and for minimising risk to patients. Standard 3.3 of the HDS Standards requires that healthcare providers ensure that '[c]onsumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes/goals'. The criteria required to achieve this outcome include the organisation ensuring that '[e]ach stage of service provision … is provided within time frames that safely meet the needs of the consumer' (Criteria 3.3.3) and '[t]he service is coordinated in a manner that promotes continuity in service delivery …' (Criteria 3.3.4).

88. For the reasons discussed above, I consider that CDHB failed to provide Mr A with timely and competent services in March 2019, December 2019, and January 2021 and, accordingly, did not meet the HDS Standards on those occasions.

**Open disclosure**

89. On 17 September 2021, Dr F notified the CDHB Vascular service that the abnormal findings on Mr A's January 2021 ultrasound had not been followed up. On 28 September 2021 she requested that CDHB formally apologise to Mr A for the delay in diagnosis and treatment of his kidney cancer.

90. Health NZ acknowledged that the Vascular service did not at this time apologise or inform Mr A of the incident management and complaint process or the plan for his care going forward, as required by CDHB's Open Disclosure policy. CDHB did not offer Mr A an apology or explanation for the omission until November 2022, after he had complained to HDC.

91. It is not clear when CDHB became aware that the March 2019 referral had not been actioned. This matter is not mentioned in Mr A's complaint to HDC, and it appears that he may not have been aware of this issue when he made the complaint. The error regarding the March 2019 referral was addressed in CDHB's November 2022 apology letter to Mr A. There is no evidence that Mr A had been made aware of this previously.

92. Standard 2.4 of the HDS Standards requires that 'all adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers … in an open manner'. The criteria required to achieve this outcome include the organisation ensuring that such events are 'addressed in an open manner through an open disclosure policy'



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(Criteria 2.4.4). Further, Standard 1.9 of the HDS Standards requires that service providers 'communicate effectively with consumers and provide an environment conducive to effective communication'. The criteria required to achieve this outcome include the organisation ensuring that '[c]onsumers have a right to full and frank information and open disclosure from service providers'.

93. CDHB's Open Disclosure policy was discussed in a previous opinion (20HDC0013[14] published August 2023) in relation to care provided by CDHB to another consumer in 2019. The opinion stated:

> 'I note that although the Te Whatu Ora open disclosure policy does require timely disclosure of harm to a patient, there is a lack of clarity about who is to provide the disclosure, and whose responsibility it is to ensure that open disclosure is provided.'

94. In that case, there was a failure by several clinicians in two different departments to inform the consumer that a radiology report had not been actioned, resulting in a delayed diagnosis of lung cancer. It was found that the failure to inform the consumer of the error in a timely manner was attributable to systemic issues at Health NZ Waitaha Canterbury, including the lack of clarity in the Open Disclosure policy.

95. In this case, after being notified on 15 September 2021 of the error in relation to the January 2021 ultrasound report, on 17 September 2021 Dr B made a referral to the Urology service for review; on 28 September 2021 the Clinical Director of the Vascular service advised Dr F that the matter would be investigated; and on 13 October 2021 Mr A attended a Urology clinic appointment to discuss his diagnosis and recommended treatment. I am critical that none of these clinicians appear to have acknowledged or apologised to Mr A for the January 2021 error, and that CDHB did not offer Mr A an apology until November 2022, after he had raised his concerns with HDC. As was found in case 20HDC00132, again I consider that these failures and delays are attributable to systemic issues at Health NZ Waitaha Canterbury, including the lack of clarity in the Open Disclosure policy about who is responsible for ensuring that open disclosure is provided.

*Timing of follow-up care*

96. There is conflicting evidence about what Mr A was told regarding the plan for his care after the CT scan on 27 September 2021 showed renal cell carcinoma.

97. In his complaint, Mr A stated that initially he was placed in the Urology 'general clinic pool' with an expected wait time of two months for an appointment, and that his priority was expedited after his wife contacted CDHB. On the other hand, the evidence from CDHB shows that Mr A was advised on 29 September 2021 that he could expect to receive an appointment by 4 October 2021. Mr A was seen in the Urology outpatient clinic on 13 October 2021, the day after his CT scan results were discussed at the Urology MDM.

[14] https://www.hdc.org.nz/decisions/search-decisions/2023/20hdc00132/



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98. While I am unable to resolve these conflicts, I note that CDHB's Open Disclosure policy required CDHB to discuss with Mr A the proposed plan of care going forward and seek his agreement. In my view, this discussion should have occurred as soon as possible after CDHB was notified on 17 September 2021 that the Vascular service had failed to follow up on the January 2021 scan findings. I do not consider that it was sufficient for the CDHB Vascular service simply to refer Mr A's results to the Urology service without a timely discussion with Mr A about the proposed plan of care going forward. Further, I note that if such a timely discussion had taken place, Mr A would have had the opportunity to discuss his prioritisation by the Urology service as part of the management plan, and his concern about being added to the 'general clinic pool' may have been avoided.

**Conclusion**

99. As outlined above, I consider that CDHB failed to provide Mr A with timely and competent services in March 2019, December 2019, and January 2021 and, accordingly, did not meet Standard 3.3 of the HDS Standards on those occasions.

100. Further, I am critical that CDHB failed to provide Mr A with open disclosure about the January 2021 error and did not engage in a timely discussion with Mr A about his plan for care once the error had been identified. In addition, CDHB's Open Disclosure policy was not clear about who was to provide the disclosure and whose responsibility it was to ensure that open disclosure was provided. Accordingly, I consider that CDHB failed to provide services in accordance with Standards 1.9 and 2.4 of the HDS Standards.

101. On this basis, I find that CDHB failed to provide Mr A with services that complied with legal, professional, ethical, and other relevant standards, and, accordingly, breached Right 4(2) of the Code.

**Communication with GP — other comment**

102. CDHB did not copy or communicate the findings of the January 2021 ultrasound to Mr A's GP.

103. The Canterbury Transfer of Care Framework 2019 emphasises that results should not be copied to any other clinician routinely at the time of request to ensure that ongoing responsibility lies unambiguously with the requester.

104. RN D stated that it is her usual practice to select 'Copy to GP' when ordering scans unless this is not available because the patient's GP details are not recorded in the system. It is not clear whether Mr A's GP details were on record in January 2021. In any case, based on the guidance in the Transfer of Care Framework, I am not critical that CDHB did not arrange for the January 2021 ultrasound report to be copied to Mr A's GP at the time of the request. However, I intend to ask Health NZ Waitaha Canterbury to communicate with staff the expectations and guidance in the Transfer of Care Framework regarding when and how results should be copied or communicated to primary healthcare providers.



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105. Dr B stated that when diagnostic tests are discussed at an MDM it is not routine practice to copy the ultrasound report to the patient's GP, but a letter will be sent to the GP stating the finding of the scan and the recommended plan. With reference to the Transfer of Care Framework, in my view this would have been the appropriate method and time for the January 2021 scan results and management plan to be communicated to Mr A and his GP. Unfortunately, this did not occur because the results were never discussed at the MDM. I have already outlined my criticism in this regard.

106. Dr B also noted that the scan report is available to GPs on HealthOne, while Dr C noted that this requires the GP to know about the investigation in the first place. For the avoidance of doubt, I do not consider the availability of scan reports on HealthOne to be sufficient 'communication' of results between the requesting clinician and the patient's GP.

## Opinion: Medical centre — other comment

107. Mr A's complaint noted that he had 'slipped through the cracks' at the medical centre as the annual recall set by Dr C for his surveillance ultrasounds had been missed.

108. It is regrettable that the medical centre's recall had not been updated since 2019. This resulted in a missed opportunity for the medical centre to identify that the January 2021 ultrasound findings had not been followed up or communicated to Mr A.

109. However, on review of the information from CDHB and the medical centre, and the guidance in the Canterbury Transfer of Care Framework, it is clear that it was not the responsibility of Mr A's GPs at the medical centre to ensure that the annual surveillance ultrasounds took place or that results were communicated and followed up appropriately. Mr A's annual surveillance programme was being managed under the care of CDHB's vascular clinic, as Dr C had noted in the recall. As stated by Dr C, the recall was added as a corresponding recall in the primary care notes 'for [her] own information'. I accept that this practice can serve as a useful safety-net and note that if the recall reminder had prompted the medical centre regarding Mr A's 2021 ultrasound, I would have expected the medical centre to have followed up this with CDHB. However, in the circumstances that occurred, I am not critical that the medical centre did not identify until September 2021 that the January 2021 results had not been followed up.

110. I note that the medical centre has since reviewed and initiated changes to its recall system (discussed below) to minimise the risk of historic recalls being 'overlooked'. I am reassured by this and consider it appropriate.

## Changes made since events

111. In October 2022 the medical centre undertook an incident review regarding the unactioned January 2021 ultrasound results. As a result of the review, the medical centre reviewed its recall process, which identified 'a flaw in the system that allowed incomplete historic recalls for a retiring GP to be overlooked'. The medical centre initiated a new system design with the following key objectives:



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a) Alerting of historic incomplete items, including those for staff who have left.

b) Streamlining the processes to be simpler and consistent, and bringing current records into that new model.

c) Training resources for new staff and registrars.

d) Minimising the impact of the recall process on GP time.

e) Consideration towards removing recalls involving testing and services being arranged by the hospital or specialist, over which the GP has no authority or control, in line with the Canterbury Transfer of Care Framework.

f) Development of SQLs,[15] queries, and other data-oriented tools to support the new process and quickly identify potential items of concern.

112. Health NZ Waitaha Canterbury outlined several actions and changes that have been made since the events of this complaint:

a) In November 2022 Health NZ provided HDC with a written apology to Mr A for the failures identified regarding the March 2019 referral and January 2021 ultrasound report.

b) In October 2022 an electronic system for internal referrals to outpatient services was implemented, which has replaced letters and other paper-based forms of referral. Internal referrals now arrive in the same triage queue and are triaged using the same process as external referrals received.

c) In 2023 the Vascular surveillance protocol was updated to include as a threshold for referral for MDM/consultant review 'any other anomaly/unexpected change in appearance'. A copy of this updated policy has been provided to HDC.

d) Prior to 2020, all information for Vascular patients relating to uncompleted tests and surveillance tests were solely kept on multiple databases by the service and updated manually. The SI PICS Vascular service's waiting list model has now been updated to enable the system to highlight when next steps in the care pathway have not been completed, eg, if MDM review or a test has not been completed. Tailored reports are now able to be generated to enable closer monitoring. Health NZ stated that newly identified surveillance patients and over 85% of existing patients have been transitioned to this wait list entry in SI PICS. Health NZ said that this requires a manual update and an ongoing investment in time by the administration staff, which has been identified as a priority.

e) Beginning in 2022, there has been ongoing review to streamline the MDM referral process, as the pathways for referral to the MDM and other patient pathways considered by the Vascular surgeons outside of MDM 'can be quite complicated and there can be overlapping lines of responsibilities'.

[15] Structured query language (computer language used to manage data).



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f) Work is being done to further identify roles and responsibilities for the MDM preparation and surveillance patient database.

g) The Vascular surveillance pathway is under review with the support of a production analysist and the Quality and Patient Safety Improvement facilitator to work with the service to improve processes to reduce error and increase efficiency. Changes have been made to the 'uncompleted tests' pathway to automate the process and increase accuracy and efficiency.

h) Health NZ acknowledged that copying of results is not a transfer of care and results should not be copied routinely. Accordingly, Health NZ advised that the Vascular Surgery service intended to review its practice on this and in future ensure that there is an agreement with GPs around the copy rule as per the Transfer of Care Framework.

i) In September 2023 Health NZ advised of its intention to raise this case for discussion at the Vascular Surgery service's Morbidity & Mortality meeting and for the Vascular Surgery service to ensure that this case is presented at a Clinical Medical Education session, alongside a teaching on open disclosure and safety first management system.

j) The Open Disclosure policy is being reviewed and updated. I note that in Opinion 20HDC00132 it was recommended that Health NZ Waitaha Canterbury '[p]rovide an update to HDC on the urgent review of its open disclosure policy, and in particular how it is to be updated to prevent a future failure such as that identified in [that] report, and who has responsibility to disclose harm to the patient'. Health NZ Waitaha Canterbury confirmed that this was updated in November 2023. It provided a copy to HDC and advised that it has strengthened its Open Disclosure policy to 'make it clear under the acknowledgement section that if harm is identified retrospectively then this must be disclosed by those who identify this and also to let the team know if this occurred under a different team (or service).

k) All clinicians involved in this case have reflected on these events, and Dr B has offered to meet with Mr A and his family should they wish to.

## Recommendations

113. In light of the changes made, I recommend that Health NZ Waitaha Canterbury:

a) Provide Mr A with confirmation of his recorded contact details on the SI PICS, within three weeks of the date of this report.

b) Provide Mr A with copies of the letters that he states were never received, within three weeks of the date of this report:

i. Dr B to Mr A's GP — March 2019

ii. Dr B to the Nephrology service — 26 March 2019

iii. Health NZ (CDHB) letter to Mr A — 29 September 2021.



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c) Arrange for Dr B to meet with Mr A. Evidence confirming the completion of the meeting details (for example, attendance records and summary of discussion) is to be provided to HDC within three months of the date of this report.

d) Evaluate the effectiveness of the updated electronic system for internal referrals by conducting an audit of a sample of internal referrals over a six-month period and report how many, if any, referrals were missed/unactioned. A report with the outcome of the audit and any corrective actions to be implemented is to be provided to HDC within three months of the date of this report.

e) Provide HDC with an update on the transition of existing patients to the SI PICS Vascular service's waiting list model. This is to be provided within three months of the date of this report.

f) Evaluate the effectiveness of the updated system for the SI PICS waiting list model by conducting an audit of a sample of waitlisted patients over a six-month period and report how many, if any, 'next steps' in the care pathway were missed/unactioned. A report with the outcome of the audit and any corrective actions to be implemented is to be provided to HDC within three months of the date of this report.

g) Provide HDC with an update, within six months of the date of this report, on the review to streamline the MDM referral process and identify roles and responsibilities for the MDM preparation and surveillance patient database, as well as any changes made or intended to be made as a result of this review.

h) Provide HDC with an update, within six months of the date of this report, of the review of the Vascular surveillance pathway and any changes made or intended to be made as a result of this review.

i) Confirm that the Vascular service has reviewed its practice with respect to routine copying of imaging results to GPs to align with the guidance in the Transfer of Care Framework and confirm that this has been communicated to relevant staff. Confirmation/evidence of this is to be provided to HDC within one month of the date of this report.

j) Confirm that an anonymised version of this case has been discussed at the Vascular Surgery service's Morbidity & Mortality meeting. Evidence (for example, meeting agenda or minutes) is to be provided to HDC within one month of the date of this report.

k) Confirm that an anonymised version of this case has been presented at a Clinical Medical Education session for wider education. The case study presentation should detail the actions/decisions taken, the results of these actions/decisions, and the appropriate course that should have been taken to arrive at a more desirable outcome. Evidence confirming the content of the presentation (for example, presentation material) and delivery (for example, attendance records) is to be provided to HDC within three months of the date of this report.

l) Confirm that an open disclosure education topic has been delivered at a Clinical Medical Education session. Evidence confirming the content of the presentation (for example,



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presentation material) and delivery (for example, attendance records) is to be provided to HDC within three months of the date of this report.

114. I recommend that the medical centre provide HDC with a copy of its updated recall process within one month of the date of this report.

## Follow-up actions

115. A copy of this report with details identifying the parties removed, except Health NZ Waitaha Canterbury and Christchurch Hospital, will be sent to Te Aho o Te Kahu|Cancer Control Agency and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.



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