Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner (Case 21HDC02335)

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Introduction

1. This report discusses the care provided to Mr A by Health New Zealand|Te Whatu Ora (Health NZ).[1]

2. The report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

3. The following issue was identified for investigation:

- *Whether Health New Zealand|Te Whatu Ora provided Mr A with an appropriate standard of care from April to December 2021 (inclusive).*

4. The following parties were directly involved in the investigation:

Mr A	Consumer
Ms B	Consumer's daughter/complainant

[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.

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Health NZ Te Tai Tokerau[2]	District healthcare provider
Health NZ Te Toka Tumai[3]	District healthcare provider

5. Further information was received from:

Radiology service	Medical diagnostic imaging service
Medical centre	
Dr C	General practitioner (GP)
Dr D	Vascular surgeon
RN E	Registered nurse (RN)/nurse specialist
Dr F	Vascular surgeon

Background

Introduction

6. This Office received a complaint from Ms B about the care provided to her father, Mr A. On 15 June 2021, a significant incidental finding was discovered on a scan, which showed that Mr A had a mass in his kidney. However, Mr A was not informed about his cancer diagnosis until 28 September 2021, and his plan for treatment was not actioned in the interval. Ms B expressed concern about the delay taken in communicating the cancer diagnosis.

Timeline of events

7. On 30 April 2021, Mr A presented to his medical centre following an ABPI,[4] which had shown no blood flow to his legs. Mr A was assessed by GP Dr C, who recorded that Mr A had a two-week history of resting claudication pain[5] in his left leg and intermittent pain while walking, and that the ABPI had shown a poor reading. Ms B said that the intermittent claudication had started 2–3 years previously and was worsening progressively, and Mr A had delayed seeing the GP.

8. Dr C provided a working diagnosis of peripheral vascular disease[6] with an ischaemic foot (restriction of blood flow to the foot). Dr C then completed an urgent electronic referral for an outpatient vascular review 'due to symptoms and vascular compromise of foot'. The referral was acknowledged by Health NZ Te Tai Tokerau on the same day (30 April).

9. Health NZ Te Tai Tokerau said that the radiology appointment waiting lists are managed electronically on 'Karisma[7] via modality waiting lists'. Health NZ Te Tai Tokerau's policy titled 'Electronic referrals' (dated June 2022) states that triage of referrals should be completed within five working days of receipt and that the referring clinician is responsible for following

[2] Formerly known as Northland District Health Board.
[3] Formerly known as Auckland District Health Board.
[4] Ankle brachial pulse index. A non-invasive method of assessing peripheral arterial perfusion in the lower limbs.
[5] Pain when walking or moving the arms, caused by poor blood flow.
[6] Narrowing of blood vessels, which reduces blood flow to the limbs.
[7] The radiology information system (RIS) used to manage workflows and reporting.

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up on any requests or recommendations from the triaging service. However, the referral was not triaged until 6 May 2021 (six days later). Mr A was scheduled for an appointment on 18 May 2021.

Vascular outpatient appointment and referral for scan — 18 May 2021

10. On 18 May 2021 Mr A presented to Health NZ Te Tai Tokerau's vascular outpatient clinic at Whangārei Hospital and was reviewed by visiting vascular surgeon[8] Dr D.

11. Dr D completed an assessment for peripheral arterial disease. That day, Dr D requested an urgent scan — a magnetic resonance angiography (MRA)[9] from the aorta to the legs, with a timeframe that was marked '[two] weeks'. However, Health NZ Te Toka Tumai's adverse event report[10] (AER) stated that the indication for the scan was for a routine vascular examination to assess for peripheral vascular disease. Dr D also wrote to Dr C on 31 May 2021 and advised her of the plan for the MRA scan and his assessment findings.

MRA scan on 30 May 2021 and incidental finding

12. The referral for MRA was accepted and triaged on 19 May 2021, and the scan was completed on 30 May 2021 at Health NZ Te Tai Tokerau. The imaging was sent to a radiology service[11] for reporting.

13. The MRA scan was reported by the radiology service on 15 June 2021. The report showed a mass on the kidney (an incidental finding), as well as a left external iliac occlusion (blockage of the iliac artery, which brings blood to the legs), left common femoral stenotic disease (narrowing of the femoral artery), and a left popliteal occlusion (blockage of the popliteal artery). The report stated that the kidney mass was suspicious for a renal cell carcinoma and warranted dedicated workup if it had not been assessed previously, and also stated that the significant findings were notified to the referring site via the agreed pathway.

14. Health NZ Te Tai Tokerau said that there had been a delay in the reporting of Mr A's MRA scan because it remained on its reporting list until 10 June 2021, when it was sent to the radiology service. Although Dr D's request for the MRA was marked as 'urgent', Health NZ Te Tai Tokerau said that Mr A's MRA was not reported as urgent because he was not on the cancer treatment pathway. Health NZ Te Tai Tokerau stated that 'though many scans are deemed urgent, due to the department being understaffed from a Radiologist point of view, not all scans can be reported in this manner'. However, it noted that Mr A's MRA was still completed within the allocated timeframe (two weeks) for urgent MRA requests.

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[8] Vascular surgery services at Health NZ Te Tai Tokerau are provided by Health NZ Te Toka Tumai under contract. Health NZ Te Toka Tumai provides a regional service through locally delivered clinics and, as of 2021, Health NZ Te Toka Tumai serviced 40 clinics. All radiology results in the Northern region are on a single database and clinical services are provided by rotating clinicians.

[9] An MRI scan that examines the blood vessels using a contrast injection.

[10] Dated 16 October 2023.

[11] Health NZ Te Tai Tokerau said that the radiology service generates an average of 9,600 reports per quarter for Health NZ Te Tai Tokerau.

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15. The radiology service alerted Health NZ Te Tai Tokerau to the significant findings by email on 15 June 2021 and instructed it to notify Mr A’s treating clinician. This alert was not accompanied by a telephone call to Health NZ. The radiology service’s policy titled ‘Significant and Unexpected Findings’ [12] states that any unexpected findings, such as ‘unexpected tumour — e.g. renal cancer’ must be notified by a telephone call.

16. In contrast, the radiology service told HDC that this policy applies primarily to ‘STAT urgency studies’, and it relies on the treating hospital to alert the radiology service of studies the hospital deems clinically urgent for ‘STAT urgency reporting’. The radiology service noted that the policy also states that significant findings identified in routine cases are notified by the reporting radiologist to the Operations Coordinators for communication to the client. The radiology service advised that the study in question (MRA) was a routine urgency study, and while it did have a significant finding, this was communicated by email, because this was ‘the agreed method and addressee elected by the … site in question’.

17. In a further statement to HDC, the radiology service said that this policy is designed to be used in conjunction with various internal policies and, when viewed in isolation, it is remiss of the context. The radiology service provided copies of a telephone note from a call with Health NZ in 2018, and Meeting Minutes from 2024, which showed that Health NZ had asked the radiology service to communicate all routine significant findings by email, except for the urgent requests made by the Emergency Department (ED). It also provided evidence of a telephone note from a phone call with Health NZ in 2019 to discuss and clarify a disclaimer that had been added to Health NZ Te Tai Tokerau emails requesting that referrers not be contacted about abnormal or incidental findings and to direct these to the PACS office, which was different to or conflicted with their requirements at the time.

18. The AER stated that this reporting timeframe was acceptable and within the procedural timeframes for non-urgent routine vascular investigations. However, the AER also stated that a ‘pain point’ in Mr A’s patient journey included that this report was not followed up by a telephone call. On a similar note, Health NZ Te Tai Tokerau said that the MRA was ‘reported by off-site contractor therefore did not have the usual process of a [tele]phone call to the referrer for an unexpected significant finding’.

Actions taken on incidental finding — 16 June 2021 onwards

19. The radiology service’s email of 15 June 2021 (noting the significant MRA findings) was acknowledged by Health NZ Te Tai Tokerau’s Radiology Department administration staff on 16 June. The administrator also forwarded the radiology service’s email to Dr D on 16 June and informed him that the MRA report had been added to the alerts folder and to check the report, noting a potential significant or unexpected finding. The MRA report was also uploaded to Health NZ’s Éclair system and was assigned to Dr D on the same day.

[12] This policy was not dated, but the radiology service advised this Office that the policy is reviewed annually by the medical leadership council and that recommendations are drawn from the Royal Australian and New Zealand College of Radiologists. It provided a version of the policy that was noted to be in effect in 2021.

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20. Health NZ Te Tai Tokerau's policy titled 'Principles of Care Transfer between Secondary and Primary Care' (dated August 2021) states that the person who orders an investigation has the responsibility to view and action the results. The policy also states that if a doctor is copied into a test result and this returns a clinically significant result, then the doctor has a responsibility to act on the result even if they were not the requestor. A clinician who is unable to review results in a timely manner must make appropriate cover arrangements within their organisation.

21. There is no record of Dr D acknowledging the administrator's email of 16 June. He told HDC that he cannot recall whether this occurred, due to the passage of time and the inability to store emails (due to a lack of storage capacity) and other restrictions on the computer system.

22. The AER stated that the GP was also provided with a copy of the incidental finding via Healthlink[13] at this time, but it was not an expectation for the GP to bear responsibility or accountability for these results. Instead, copying of results to the GP was considered to serve as a 'backup safety system'.

23. On 21 June 2021, the MRA report was viewed by Dr D for the first time, and he requested that Mr A's case be discussed at the regional vascular multidisciplinary meeting (MDM) at Health NZ Te Toka Tumai. Vascular surgeon Dr F said that it was within Health NZ Te Toka Tumai's usual practice to review imaging results during the weekly MDM. The MDM is attended by various multidisciplinary specialists, and the purpose is to collectively review and deliberate on the optimal course of action for the patient's care.

24. Dr F said that the vascular nurse specialist, RN E, coordinates the cases for discussion at these meetings, dictates responses, and arranges follow-up under Dr F's supervision. Dr F stated that any dictated letters are then reviewed and signed off by him.

25. The MDM for Mr A's case was held on 28 June 2021. Following the MDM, RN E prepared a clinic letter to Dr C (which also appeared to serve as a case note for the MDM), which stated:

> '[Mr A] has a Vascular Outpatient Clinic appointment this week with [Dr F] in Whangārei [Hospital] where the findings of this scan will be discussed with him, and a referral will need to be made to Urology services for further follow-up of the mass on his right kidney. [Mr A] will also need to have a renal CT scan booked.'

26. Dr F confirmed that he approved this letter.

Vascular outpatient appointment — 2 July 2021

27. Mr A's next outpatient vascular appointment occurred on 2 July 2021, when he was seen by Dr F. The clinic letter recorded that Dr F explained to Mr A that the MRA showed 'left

[13] The AER said that Dr C was provided with the copy of the MRA result on 16 June 2021.

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external iliac occlusion, left common femoral stenotic disease and a left popliteal occlusion', but the incidental finding of a mass in the kidney was not noted to have been explained.

28. Dr F told HDC that he had reviewed Mr A's case notes from the MDM thoroughly, and he acknowledged that discussing the abnormal incidental finding of the kidney mass with Mr A was an integral part of the plan during the appointment on 2 July. Dr F said that unfortunately, he was primarily focused on the vascular findings and the need for surgery, and in this process, he overlooked discussing the incidental findings. Dr F expressed his sincere apologies for this.

29. Following the appointment on 2 July, Dr F completed a booking for Mr A to receive vascular surgery to treat his occlusion and stenosis.

30. A referral to the urology service and a booking for a renal CT scan (the plan outlined in the clinic letter from 28 June 2021) was not made at this time.

Follow-up by GP on relevant referrals — August–September 2021

31. On 24 August 2021, Dr C completed a referral to Health NZ Te Tai Tokerau's renal services. Dr C wrote:

> '[D]id vascular refer to renal for mass on right upper pole kidney that was picked up when they were scanning him for planning for vascular surgery? It's just not clear if this occurred or not.'

32. Health NZ Te Tai Tokerau responded a few hours later, stating that Mr A had not been referred to renal services and noting that a referral to urology services had been mentioned in the MDM case note and would be the appropriate service, but that such a referral was not in the system.

33. On 25 August 2021, Dr C contacted the vascular service for follow-up, noting that there was no referral to the urology service in the system despite the vascular service having stated that this would occur in June, and requesting that this be processed. An internal Health NZ Te Tai Tokerau clinician completed the referral to the urology service that day and stated the priority as 'Urgent: High suspicion of cancer'.

34. On 30 August 2021, a urologist completed a referral for an outpatient CT scan with priority listed as 'urgent' and the timeframe stated as 'ASAP'.

35. The referral for the CT scan was triaged on 31 August. The CT scan was completed on 4 September and reported on 10 September 2021. The urologist said that the CT scan showed a large right renal tumour, probable metastatic disease (spread of cancer) to his lungs, a mass in the left adrenal gland, and possible invasion of the liver by tumour.

36. The CT scan results were also copied to Dr C, and on 10 September Dr C reviewed the CT scan report and documented in her clinical notes: 'CT scan has shown [renal cancer] in one kidney with likely lung [metastasis].'

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37. On 13 September 2021, the urologist reviewed the CT scan and recorded in the notes:

> 'I recently received a copy of your CT scan which was done to assess your kidneys. This does show that you have a mass involving your right kidney and there are some small nodules in your lung as well. I will see you in the clinic to discuss this further with you.'

38. However, it does not appear that this message was communicated to Mr A.

39. On 28 September 2021, Mr A received a letter advising of a urology outpatient clinic appointment in three weeks' time. Mr A was unsure of the reason for this, and he visited Dr C for an explanation. Dr C provided Mr A with a copy of his CT scan results and explained that when 'the vascular team had done scans to work him up for his vascular treatment the scan ha[d] discovered a tumour in his right kidney'. This was the first communication to Mr A regarding his cancer.

Subsequent events

40. Following the cancer diagnosis, Mr A required a nephrectomy (removal of a kidney). Mr A was discharged on 11 November 2021 and referred to the medical oncology service to discuss the options of adjuvant treatment for his metastatic cancer. He commenced treatment in early December 2021.

41. The AER stated that as part of the review, a Health NZ Te Toka Tumai staff member engaged with Mr A and shared his experience and concerns regarding the delay in communication of his cancer diagnosis. Mr A had emphasised the importance of prompt reporting, referrals, and maintaining updated medical records.

42. The key finding of the AER was that there was a delay in notification to the patient about the incidental finding of a renal mass and subsequent referral for further investigation and management. The recommendation of the AER was for the vascular service to review its existing system for managing significant non-vascular pathologies to ensure reliable and timely patient notification and referral for further investigation.

Further information

43. Health NZ Te Tai Tokerau stated that following the abnormal MRA finding, there was a delay of three months before Mr A was referred for further evaluation, and a four-month delay before Mr A was informed that he had cancer in his kidney. Health NZ said that this did not meet the standards it strives for, and it unreservedly apologises to Mr A for the distress this caused him and his family.

System for input of results at time of events

44. The AER also noted that while the radiology service input Mr A's MRA results into the Karisma radiology system, Health NZ Te Tai Tokerau's radiology data capturer had to manually transfer the results to the regional clinical portal (RCP) for medical team review.

45. The results were not automatically visible in the RCP, prompting the data capturer to issue a discrepancy notification via email simultaneously with the manual entry of results. The

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discrepancy notification functioned as an alert, informing the referring service of a potential inconsistency or discrepancy in the report findings, signifying that the report had been captured in the RCP.

46. Health NZ Te Tai Tokerau has since updated its process (see 'changes made' below).

Responses to provisional opinion

Health NZ Te Toka Tumai

47. Health NZ Te Toka Tumai was provided with a copy of the provisional report and given an opportunity to comment. Comments have been incorporated throughout the report where relevant.

Health NZ Te Tai Tokerau

48. Health NZ Te Tai Tokerau was provided with a copy of the provisional decision and given an opportunity to comment. Health NZ Te Tai Tokerau concurred with Health NZ Te Toka Tumai's response to HDC. Other comments have been incorporated throughout the report where relevant.

Radiology service

49. The radiology service was provided with a copy of the provisional decision and given an opportunity to comment. Comments have been incorporated throughout the report where relevant. The radiology service stated that it was saddened to hear of the delay in communication of the findings and acknowledged Mr A's experience and concerns.

Ms B

50. Ms B was provided with a copy of the 'information gathered' section of the provisional report and given an opportunity to comment on this section. Her comments have been incorporated throughout the report where relevant.

Opinion: Introduction

51. On 30 May 2021, Mr A underwent an MRA at Health NZ Te Tai Tokerau to check for peripheral vascular disease, following complaints of leg pain. The MRA scan showed a significant incidental finding of a tumour on Mr A's right kidney. This was reported by the radiology service to Health NZ Te Toka Tumai on 15 June 2021. A plan was made to inform Mr A of this finding during the vascular outpatient clinic appointment with Dr F on 2 July 2021, but this did not happen.

52. Mr A became aware of his diagnosis only on 28 September 2021 (four months after the MRA scan) when he received an unexpected letter from the urology clinic. This meant that there was also a delay in Mr A being referred for further evaluation in the interval and until his GP followed this up.

53. I wish to convey my sympathies to Mr A for his cancer diagnosis and the stress he has endured. The delays were clearly an avoidable situation, and this case has highlighted the importance of timely communication and follow-up of test results.

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Opinion: Health New Zealand|Te Whatu Ora — breach

54. As a healthcare provider, Health NZ is responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code).

55. At the time of the events, vascular services within the Health NZ Te Tai Tokerau region were contracted out to Health NZ Te Toka Tumai, which provided outreach services to Health NZ Te Tai Tokerau through outpatient clinics at Whangārei Hospital. The vascular clinics are managed on a rotating basis by all vascular surgeons at Health NZ Te Toka Tumai.

56. I have carefully considered all the information on file and have identified three main issues with Health NZ's care, as set out below.

Communication of Mr A's MRA scan results

57. Mr A's MRA scan result was not communicated to him in a timely manner.

58. The standard premise, as stated in Health NZ's policy, is that the referrer — in this case, Dr D — is responsible for completing follow-up of test results and keeping the patient informed. However, each case is unique to its own circumstances. In this case, the task of informing Mr A of his MRA results was delegated to Dr F (which I have addressed separately below) following a discussion during the MDM on 28 June 2021. Clinicians often work in teams, and shift working is common; therefore, it is not uncommon nor unreasonable to delegate tasks to other clinicians.

59. RN E documented the plan that Dr F was to inform Mr A of the renal mass during the 2 July 2021 appointment. However, this did not occur because Dr F overlooked discussing the renal mass as he was focused on the vascular abnormalities. The vascular abnormalities were indeed Mr A's presenting problem and the reason for his imaging and outpatient appointment arranged by the vascular team.

60. Dr F's clinical note following the 2 July 2021 appointment also appeared focused on the vascular abnormalities and did not confirm whether he had discussed the renal mass with Mr A. In a proactive system, a lead clinician with whom the patient has had previous contact and built rapport would proactively follow up to check that any outstanding tasks had been completed as part of the patient journey.

61. As this Office has highlighted previously, the clinical system works under complex conditions, and this system complexity combined with human factors means that sometimes, despite a provider's best efforts, an error will occur.[14] Human factors simply reflect that humans are fallible and, in my view, no single individual in this case acted in a way to cause harm. While Dr F did have some responsibility for informing Mr A of his test result, it must be noted that the system is prone to error, and therefore should have redundancy built in to ameliorate this risk.

[14] 19HDC01900 — available on www.hdc.org.nz.

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62. Other than sending the result to the GP, there did not appear to be any other measures to ensure that Mr A was informed of his result. Further, the GP was operating under the agreed principles of care transfer between secondary and primary care, and the AER confirmed that this was not the GP's responsibility. It is noted that the GP was also specifically advised that this finding would be discussed with Mr A at his vascular outpatient appointment.

63. As RN E had documented clearly that Dr F was to communicate the incidental findings to Mr A, it would also not be unreasonable for all subsequent providers caring for Mr A after 2 July to assume that this had been done and not to have communicated the finding to Mr A themselves.

64. I consider that Health NZ would benefit from adding a patient-centred step within its processes, whereby patients are empowered to actively follow up on their test/scan results. It is widely accepted that the enablement of patients to become active partners in their care leads to increased patient and provider satisfaction, as well as improved health outcomes.[15] Fostering active participation from patients can also increase adherence to clinical pathways and reduce chances of errors. I address this further under the recommendations section below.

65. Health NZ submitted that the development of a process for patients to follow up on their results would be incompatible with a recently released policy titled 'Transfer of Care and Test Results Responsibility', where it advised that follow-up of results remains the responsibility of the requestor.

66. I thank Health NZ for bringing this policy to my attention; however, I disagree with its submission that my suggestion would be incompatible with the national policy. This step would not alleviate the responsibility of the referrer from following up, but rather provides an additional safety net to ensure that patients are informed of their test results in a timely manner.

Failure to complete urology referral and follow-up of referral

67. In addition to the finding of the renal mass not being communicated to Mr A, it is noted that a urology referral and renal CT scan was not completed by Health NZ, as planned during the MDM.

68. While this plan was documented by RN E in the clinic letter dated 28 June 2021, it is not clear who was responsible for this action. Although Dr F admitted to overlooking the plan to communicate the renal mass, neither Dr F nor Health NZ stated who was responsible for completing and following up with the urology referral and renal CT scan. It is not clear whether this was the responsibility of Dr F, RN E, Dr D (as the ordering clinician and who had

[15] Hickmann, E., Richter, P. & Schlieter, H. (2022). All together now — patient engagement, patient empowerment, and associated terms in personal healthcare. Retrieved from: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-08501-5#citeas

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arranged for discussion at the MDM), or another staff member of the vascular service or MDM.

69. This meant that a urology referral was not completed by Health NZ, nor was it followed up to see that it had been completed, leading to delays in Mr A receiving a urology assessment. As noted above, had a lead clinician been delegated to oversee Mr A's care, then this may not have occurred.

70. I am concerned about the oversight of tasks that arise from MDM discussions. While the role of the multidisciplinary team is to determine the most suitable treatment plan for patients, it also needs robust processes to oversee that the plan has been followed through. As recommended by Manatū Hauora|the Ministry of Health,[16] best practice as part of an MDM involves a process to check whether recommendations developed during MDMs are carried out, and there must be a clear line of responsibility as to who is responsible for these recommendations, particularly in circumstances where continuity of care can be impacted. In this case, and as noted above, it is unclear whether RN E was responsible for follow-up on these tasks, as the coordinator for the MDM.

71. Fortunately, the clinic letter dated 28 June 2021 was copied to Dr C, which acted as an additional safeguard, causing Dr C to follow up with Mr A's plan in August 2021, even though Dr C did not hold responsibility for the plan. Nevertheless, I remain concerned that the urology referral and arrangement of the renal CT scan was overlooked by Health NZ.

Agreement with radiology service for communication of test results

72. Mr A's scan was reported offsite by the radiology service on 15 June 2021, and Health NZ was alerted to the significant incidental finding by way of email communication. The radiology service stated that email communication was the agreed method for discussing the results of any routine studies, and Mr A's scan was routine. The radiology service pointed to its relevant policy, which stated that for significant findings on routine studies, these are notified to the Operations Coordinators for communication to the client, as opposed to significant findings on urgent studies, which are also notified via telephone call. In a further statement, the radiology service said that this policy is designed to be used in conjunction with other internal policies, rather than in isolation. It provided supporting evidence that showed that the agreement between the radiology service and Health NZ confirmed that all routine significant findings are to be emailed except for urgent ED requests.

73. Health NZ told HDC that because the radiology service was an offsite contractor, it did not have the usual process of a telephone call to the referrer for an unexpected significant finding. However, as discussed above, this appeared to be an expectation communicated to the radiology service by Health NZ. In addition, I note that the AER highlighted the lack of a telephone call as a 'pain point', but it did not follow up with any actions to address this.

[16] Ministry of Health. 2012. Guidance for implementing high-quality multidisciplinary meetings. https://www.health.govt.nz/publication/guidance-implementing-high-quality-multidisciplinary-meetings.

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74. The renal mass in the MRA was a significant incidental finding, and it is well understood that email communications are not a reliable way to communicate urgent findings. Therefore, I am concerned that this was not addressed or reviewed as part of the AER, particularly as the radiology service completes many radiology reports for Health NZ Te Toka Tumai (up to 9,600 reports per quarter). Accordingly, I suggest that Health NZ review its agreement with the radiology service for communicating significant findings.

Conclusion

75. Individually, some of the deficiencies in the care provided to Mr A may appear minor, but cumulatively they led to a poor overall standard of care for Mr A. In my view, there were several missed opportunities to advise Mr A of the results of his scan, but clinicians were understandably operating on the assumption that he had been advised as per the letter on file. The follow-up from his GP, Dr C, three months later could be seen as mitigation for the failure of the initial follow-up action. However, this occurred too late in light of the seriousness of the findings. Several contributing factors led to the delay in Mr A being advised of these results, including the lack of attention to this by Dr F, the absence of a patient-centred process and a lead coordinating clinician, poor oversight of MDM tasks, and the absence of a clear escalation pathway with the radiology service. I therefore find that Health NZ did not provide services with reasonable care and skill, in accordance with Right 4(1) of the Code. This meant that Mr A was not advised of the incidental finding on his MRA scan result in a timely manner. Accordingly, I find that Health NZ also breached Right 6(1)[17] of the Code.

Opinion: Dr F — adverse comment

76. The incidental finding on Mr A's MRA scan was not communicated in a timely manner.

77. The responsibility of informing Mr A of this incidental finding was delegated to Dr F. There was a clear plan in place to discuss this at the 2 July 2021 appointment, and Dr F acknowledged that discussing the abnormal incidental finding of the kidney mass with Mr A was to be an integral part of the appointment. However, Dr F did not communicate the incidental finding to Mr A. Dr F said that he overlooked the plan to discuss the renal mass and had focused on the vascular findings within the MRA report. Dr F apologised for the oversight and for the distress caused to Mr A.

78. Although Dr F did not provide an explanation as to how he may have overlooked the plan to discuss the incidental finding, there is no evidence to suggest that the oversight was intentional or malicious. I acknowledge that Mr A's presenting problem and reason for being assessed was his vascular issues. Nevertheless, I consider that Dr F needed to take extra care to ensure that the MDM plan was followed on this occasion. A kidney mass is a critical finding that needs to be communicated to consumers promptly, to ensure that they have sufficient time to process the finding and make a decision about any interventions.

[17] The right to be fully informed.

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Therefore, I make recommendations for Dr F below, to reduce the reoccurrence of this oversight.

Opinion: Radiology service — other comment

79. As a healthcare provider, the radiology service is responsible for providing services in accordance with the Code. This includes the responsibility to ensure that reporting of any scans is completed and communicated in an adequate and timely manner.

80. As stated above, Mr A's scan was reported offsite by the radiology service on 15 June 2021 and sent to Health NZ electronically. The significant findings were then alerted to Health NZ's administrator by email correspondence.

81. The radiology service's policy titled 'Significant and Unexpected Findings' explicitly states that any unexpected findings, such as an 'unexpected tumour — e.g. renal cancer' should be notified by a telephone call, although it also states that in the case of routine studies, these are notified to the radiology service's Operations Coordinators for communication to the client, in this case Health NZ Te Tai Tokerau. The radiology service stated that email communication was the agreed method with Health NZ for discussing the results of any routine studies with significant findings, and Mr A's scan was routine. The radiology service provided supporting evidence for this, and, in this case, I am satisfied that it followed the agreement in place with Health NZ.

Changes made since events

82. Health NZ Te Tai Tokerau said that with the advent of Health NZ as a single employer across New Zealand, it anticipates alignment of credentialling and policies to make movement of senior medical officers (SMOs) across districts seamless. It advised that all results in the Northern region are on a single database and are sent for e-sign-off by visiting clinicians as they would for internal SMOs.

83. Health NZ said that a lead coordinating clinician is formally planned if/when a regional vascular surgery structure is to be implemented for the Northern Region.

84. The radiology service now inputs results into the Karisma radiology system, and the results are automatically transferred to the Éclair component of the radiology clinical portal. They are then queued for acknowledgement and sign-off, eliminating the need for manual entry by Health NZ Te Tai Tokerau's data capturer and the issuance of a discrepancy notification.[18]

85. The radiology service said that this complaint has initiated an internal discussion within its global medical leadership team on the radiology service's approach to alerting client sites of new cancers and other related significant or unexpected findings.

[18] This system change was outlined in Health NZ Te Toka Tumai's AER.

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Recommendations

86. I recommend that Health NZ Te Toka Tumai and Te Tai Tokerau:

a) Provide HDC with an update on the recommendations made in Health NZ Te Toka Tumai's AER, in particular:

— confirm the changes made to the vascular service's existing system for managing significant non-vascular pathologies to ensure reliable and timely patient notification and referral for further investigation;

— confirm the implementation of the updated system and audit the timeliness of patient notification and referral for investigation and/or to the relevant clinical service by the MDM for significant non-vascular pathologies for the 12-month period prior to implementation and 12 months after implementation of changes to the system; and

— provide HDC with the outcome report with any corrective actions to be implemented, within 18 months of the date of this report.

b) Consider developing a process for ensuring that patients are informed that they need to follow up on their results with their GP or check their patient portal if they are not advised of results within two weeks by either their referring clinic/team or their GP. An update on the development of this process is to be provided to HDC within three months of the date of this report.

c) Consider appointing a 'lead clinician' for patients accessing Health NZ Te Tai Tokerau's and Health NZ Te Toka Tumai's vascular services, as part of its planned regional vascular surgery structure. An update on the development of this process is to be provided to HDC within three months of the date of this report.

d) Provide a written apology to Mr A for the deficiencies in care identified within this report. The written apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

e) Consider developing a process for ensuring that all tasks that arise for non-vascular care from MDMs are tracked on an action log. As part of this process, there should be clear lines of responsibility relating to who should follow up and close the actions. An update on the development of this process is to be provided to HDC within three months of the date of this report.

f) Review its memorandum of understanding with the radiology service for communication of significant and unexpected findings to determine how significant incidental findings are to be notified to Health NZ. A summary of this review is to be provided to HDC within three months of the date of this report.

87. I recommend that Dr F reflect on his practice of reviewing clinical documentation, particularly tasks to be undertaken during outpatient appointments, and provide a written report on his reflections and the changes to practice he has instigated as a result of this case, within three months of the date of this report.

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Follow-up actions

88. A copy of this report with details identifying the parties removed, except Health NZ, Health NZ Te Tai Tokerau district, Health NZ Te Toka Tumai district, and Whangārei Hospital, will be sent to Te Aho o Te Kahu | Cancer Control Agency, and will be published on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Health NZ, Health NZ Te Tai Tokerau district, Health NZ Te Toka Tumai district, and Whangārei Hospital) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.