HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Health New Zealand breaches the Code for delayed cancer diagnosis
23HDC00401

A report released by Deputy Commissioner Dr Vanessa Caldwell has found Health New Zealand breached the Code of Health and Disability Services Consumers' Rights (the Code) for a significant delay in a woman's cancer diagnosis.

The woman, known to be at high risk for liver cancer due to a liver disease, had undergone regular scans until 2019 when this surveillance was stopped. Two years later, she presented to the Emergency Department with nausea, upper back pain, and other symptoms. She was diagnosed with liver cancer and sadly passed away after receiving palliative care.

Dr Caldwell concluded that Health New Zealand's system was deficient for failing to continue the woman's liver ultrasound scans and failing to book an outpatient appointment with the gastroenterologist in a timely manner.

Health New Zealand had a duty to ensure that the services provided to the woman complied with legal, professional, ethical, and other relevant standards, Dr Caldwell said.

The woman did not receive coordinated services that ensured a continuation in her care. This failed to comply with Health and Disability Service Standards and breached the Code.

Dr Caldwell considered the most significant factor in the delay of the woman's cancer diagnosis was due to changes made to the radiology referral systems without the appropriate safety-nets being put in place to identify patients who were pre-scheduled for appointments.

"I am particularly concerned that when it was determined that surveillance ultrasound scans would require a new referral, there appears to have been no consideration as to how this might pose a risk to patients requiring new referrals for repeat scans to be generated, and no thought to develop a plan as to how to mitigate this," Dr Caldwell said.

Dr Caldwell did not consider it the sole responsibility of the referrer (the gastroenterologist) to make new referrals for all patients under surveillance.

"A system with safety-netting (eg, a message to GPs about the change) should have been in place to support him to do this."

Dr Caldwell was also concerned that the woman's six-monthly follow-up outpatient appointment with the gastroenterologist was not booked due to a process error in the Outpatients Appointment Office.

She said this was a missed opportunity to identify that the woman was overdue for her surveillance scan, and the recommended MRI follow-up could also have been actioned.

Dr Caldwell offered her sincere condolences to the woman's son and wider family and acknowledged the impact of the delayed diagnosis on the family.

Dr Caldwell made several recommendations for Health New Zealand, outlined in her report.

1 July 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

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For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709