HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Health New Zealand | Te Whatu Ora Waitaha Canterbury breaches Code for failures in management of man's renal care

21HDC02367

The Deputy Health and Disability Commissioner has found Canterbury DHB (CDHB) (now Health New Zealand | Te Whatu Ora Waitaha Canterbury) breached the Code of Health and Disability Services Consumers' Rights for failing to provide services of an appropriate standard.

Deborah James said CDHB had not provided timely and competent services and had not properly disclosed its error, or actively engaged with the man about a plan for his care, once the error was identified.

The man had been under the care of Vascular services at Christchurch Hospital for annual surveillance of kidneys and spleen artery aneurysms since 2010. He was diagnosed with renal cancer and had his left kidney removed in November 2021. The breach centres on three missed opportunities for the earlier detection of the man's cancer.

The first missed opportunity followed a CT angiogram in March 2019 when the Vascular service referred the man to Nephrology to investigate a renal cyst. This was not actioned. The second was in December 2019 when there was a failure, at the time of an ultrasound, to recognise the earlier missed follow up. An anomoly was also found, but it did not meet the threshold required for further investigation at the time, Health NZ said. Ms James considered that given the anomoly, it was another missed opportunity and would have been good practice to have recommended further investigation. A third opportunity was missed when a recommendation to further investigate a renal lesion was not actioned in January 2021.

Ms James said the Vascular Surgery service further failed to apologise to the man, or inform him of how the incident would be managed, or about the complaint process.

"I consider that CDHB failed to provide Mr A with timely and competent services in March 2019, December 2019 and January 2021... 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 him about his plan for care once the error was identified. In addition, CHDB's Open Discosure policy was not clear about who was to provide the disclosure [about the errors] and whose responsibility it was to ensure that open disclosure was provided."

Since the events Health NZ Waitaha | Canterbury has formally apologised to the man, and put in place several changes including an electronic referrral system and

updating vascular surveillance protocols to include, as a threshold for referral, “any other anomoly/ unexpected change to appearance.”

It has also transitioned over 85% of its patients off multiple databases onto a single wait list model which highlights when next steps in the care pathway have not been completed. Additionally, the Vascular surveillance pathway is under review and a quality and patient safety improvment facilitator is working on process improvments. Its Open Disclosure Policy is also being reviewed and updated.

Deborah James acknowledged the changes. She further recommended Health NZ Waitaha | Canterbury provide the man with confirmation of his recorded details and copies of letters he said he never received. She also recommended a meeting with a doctor involved in the man’s care, and asked to be provided with evidence of the system improvements made since the events, including audits, across the range of areas noted in the report that manage the patient pathway.

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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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