HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delays in communicating a scan result

21HDC02335

A report released today by Deputy Health and Disability Commissioner Dr Vanessa Caldwell has found Health New Zealand | Te Whatu Ora Te Tai Tokerau (Health NZ) breached the Code of Health and Disability Services Consumers Rights (the Code) for delays in communicating a scan result.

Following complaints of leg pain, a man underwent a Magnetic Resonance Angiography (MRA) at Whangarei Hospital. The MRA showed a significant incidental finding of a tumour on the man's right kidney, however, there was a four-month delay before the man was informed of the finding, which came in the form of an unexpected letter from the urology clinic. Following his diagnosis, the man required a nephrectomy (removal of the kidney) and commenced treatment for metastatic cancer.

Dr Caldwell said, "several contributing factors led to the unacceptable delay in this person being advised of the results". She found Health NZ breached the Code for not providing an appropriate standard of care and for failing to provide full information.

The breaches resulted from the MRA scan results not being communicated to the man in a timely manner and both the urology referral and booking of a renal CT scan were overlooked. Dr Caldwell said she was concerned about the oversight of tasks that arise from the multidisciplinary team meeting (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, and people are assigned the tasks to be responsible for actioning" she said.

The HDC also found there was a lack of agreement with the radiology service for the communication of test results. Health NZ was alerted to the incidental finding by email. However, Dr Caldwell said the renal mass in the MRA was a significant incidental finding and it is well understood that email communications, on their own, are not a reliable way to communicate urgent findings.

Dr Caldwell said what while some of the deficiencies may appear minor individually, cumulatively they led to a poor standard of overall care.

Since the events, Health NZ and the radiology service have made several changes. Dr Caldwell outlined further recommendations in her report, including that Health NZ provide HDC with an update on the recommendations for improvements made in their adverse event report.

29 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%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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