HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Health New Zealand breaches the Code for management of post-menopausal bleeding

20HDC00531

In a report published today, Deputy Commissioner Dr Vanessa Caldwell found Northland District Health Board (now Health New Zealand |Te Whatu Ora Te Tai Tokerau) breached the Code of Health and Disability Services Consumers' Rights (the Code) for the care of a woman in her fifties.

The woman experienced post-menopausal bleeding over five years. Despite multiple referrals to Health New Zealand, and many investigations, no plan was put in place to address the woman's symptoms, and surgery was not offered as a viable treatment option at two critical junctures.

An MRI scan was finally undertaken when the woman presented with abdominal pain. The scan confirmed stage four ovarian cancer and the woman passed away a few months later.

The woman's recurrent presentations should have triggered re-evaluation and consideration of treatment options, including a hysterectomy and/or hormonal therapy. Opportunities to perform imaging, which may have resulted in an earlier diagnosis, were also missed.

"I am critical of the failure by multiple clinicians to consider the causes of the woman's symptoms critically, manage the post-menopausal bleeding appropriately, and undertake necessary imaging in the form of pelvic ultrasounds and/or CT scans," said Dr Caldwell.

The failures in care by Health New Zealand amounted to a breach of the woman's right to receive services of an appropriate standard and her right to be provided with information regarding treatment options.

"The missed opportunities to provide treatment information are attributable to multiple clinicians, and signify a failure at an organisational level, for which Health New Zealand is responsible," Dr Caldwell said.

Dr Caldwell made an adverse comment about the continuity of care and a comment about cultural considerations.

"In my view, offering support only at the start and end of care is not a culturally responsive or appropriate approach, especially given the woman's long-standing engagement with the healthcare system," she said.

Dr Caldwell reminded Health New Zealand of the need for the service to be culturally appropriate and to be mindful of the timing of offering support throughout a patient's journey.

Since the event, Health New Zealand has made a number of changes, outlined in the report. Dr Caldwell made several further recommendations for improvement.

Dr Caldwell offered her sincere condolences to the woman's whānau for their loss and acknowledged that the matter continues to cause them significant distress.

10 June 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).

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