Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Significant delays in post-operative treatment following TVT-O mesh surgery breaches the Code

21HDC02281

In a report published today, the Health and Disability Commissioner has found Taranaki District Health Board (now Te Whatu Ora|Health New Zealand Taranaki) breached the Code of Health and Disability Services Consumers’ Rights (the Code) in relation to its managment of postoperative complications developed by a patient following TVT-O mesh (vaginal mesh tape sling) surgery.

Deputy Health and Disability Commissioner Rose Wall found Taranaki District Health Board’s ongoing care and follow-up, post surgery, was inadequate.

For failing to provide services with reasonable care and skill, Taranaki District Health Board breached Right 4 of the Code, which gives consumers the right to services of an appropriate standard | Tautikanga.

The female patient at the centre of this report, experienced postoperative complications soon after the TVT-O mesh surgery was performed. She presented to the postoperative clinic at Taranaki Base Hospital six weeks after surgery with symptoms including pain, discomfort and haemorrhaging.

Despite reporting these symptoms, the woman endured significant complications over an extended close to five year period before revision surgery was eventually performed, and a more substantial attempt was made to remedy her situation and alleviate the adverse symptoms she had been reporting.

“The nature of her complications and the ongoing profound imposition they have had on her day-to-day life over this extended period cannot be overstated,” said Ms Wall.

An initial delay of over a year was attributed to a specialist temporarily leaving medical practice, resulting in a hiatus in the woman’s care.

“I consider this issue lies with Te Whatu Ora at a systemic level,” said Ms Wall. “If the specialist temporarily left medical practice, they needed to ensure that appropriate systems were in place to transfer the woman’s care to another specialist to action any plans in a timely manner.”

Ms Wall was unable to determine the cause of a second delay, of almost a year’s duration, between the referral to urogynaecology services at a tertiary centre and the woman being seen by that centre.

“Previously, this Office has raised concern about failures by public health services to action inter-hospital referrals and manage follow-up in a timely manner,” said Ms Wall.

“As stated in those cases, it is the responsibility of healthcare organisations to ensure that robust systems are in place to minimise the risk of errors occurring in the referral process and in arranging important follow-up.”

Ms Wall also made adverse comment about the care given by one of the specialists concerning the information provided to the woman about the risks of the TVT-O procedure.

Ms Wall said that, while the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) leaflet outlines that erosion of tape through the vaginal wall is the most reported mesh-specific complication, given that this was a substantial risk, it warranted a verbal discussion with the patient to allow her to consider the complications in more detail.

Ms Wall was also critical about that specialist’s recognition and response to the woman’s complications after being alerted to her symptoms when the woman was reviewed by the specialist’s registrar at the six week follow up consultation.

Ms Wall said that it would have been desirable for the specialist to have reviewed the woman personally at the six week follow up consultation but acknowledged that this is not an absolute requirement and that it may not always be practicable for the postoperative care of a patient to be managed by one practitioner alone.

Ms Wall recommended that both the specialist and Te Whatu Ora provide a written apology to the woman for the deficiencies in care outlined in the report.

Since the events, Te Whatu Ora has set up monthly multi-disciplinary meetings between the Urology and Gynaecology teams, to discuss and review all women referred with urinary incontinence issues. They have also recently established the New Zealand Female Pelvic Mesh service to support and care for women harmed by pelvic surgical mesh.

Ms Wall also noted changes in progress by Manatū Hauora| Ministry of Health (in leading the surgical mesh work programme with oversight and monitoring by the Surgical Mesh Roundtable), Medsafe, and RANZCOG, which should go some way in reducing harm from surgical mesh in the future.

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

For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 670