Otolaryngologist, Dr B

Southern District Health Board

A Report by the

Health and Disability Commissioner

(Case 16HDC01980)

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Executive summary

1. On 30 December 2014, Ms A had an appointment with an otolaryngologist/head and neck surgeon, Dr B, for significant right-sided sensorineural hearing loss. Dr B referred Ms A for a magnetic resonance imaging (MRI) scan.

2. The MRI scan was performed on 13 May 2015 and the written report (available electronically that day) states that a vestibular schwannoma[1] was seen. No action was taken in respect of the results at that time, and it was not noted that the MRI report results were still "unacknowledged" in the electronic system until nine months later. On 29 February 2016, the MRI results were identified as part of a project to address the clinical risk of unacknowledged results.

3. That day, Dr B was alerted to the unacknowledged result, and he arranged for Ms A to be seen by a head and neck surgeon. Ms A was seen by the head and neck surgeon on 17 May 2016; this was the first time she was made aware of the MRI scan result. She subsequently underwent surgical removal of the tumour.

4. At the time of these events at Southern District Health Board (SDHB), there was both an electronic and a paper-based results system. Dr B routinely used the paper-based system. While access logs show that he viewed the report on 14 May 2015, Dr B cannot recall this and confirmed that he did not receive a paper copy of Ms A's result, and accordingly did not action it. While the result was available to be seen in the electronic system, until September 2015, there was no requirement that clinicians at SDHB acknowledged test results in the electronic system.

Findings

5. The Commissioner was critical of Dr B that there was a delay in follow-up being arranged in a timely manner after Ms A's MRI of 13 May 2015, and that Ms A was not advised of the results at that time. However, he did not consider this to be solely attributable to Dr B.

6. As the MRI result, and an explanation for the delay in advising Ms A of it and arranging follow-up, was not conveyed to Ms A by Dr B once he was alerted to it on 29 February 2016, the Commissioner found that Dr B breached Right 6(1) of the Code.[2]

7. The Commissioner considered that the lack of a clear, effective, and formalised system within SDHB for the reporting and following up of test results meant that this result was not appropriately acknowledged, actioned, and communicated to Ms A by Dr B in May 2015. In addition, before September 2015 there was no process at SDHB to ensure that reports or results did not go unacknowledged by clinicians for any length of time. When such a policy was implemented in September 2015, the failure to send out a weekly compliance summary report to Dr B after the implementation of the new policy in September 2015 contributed to the result not being picked up between September 2015 and February 2016. For these

[1] A vestibular schwannoma is a benign tumour of the balance nerve, and presents with hearing loss from either pressure on the hearing nerve, or compression of the artery that supplies the hearing nerve.
[2] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …" This includes information about the results of tests.

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reasons, the Commissioner found that SDHB did not provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.[3]

Recommendations

8. The Commissioner recommended that SDHB provide HDC with a copy of its most recent audit of its new electronic system in relation to acknowledgement of electronic laboratory/radiology results, and that SDHB and Dr B provide written apologies to Ms A.

Complaint and investigation

9. The Commissioner received a complaint from Ms A about the services provided to her by Southern District Health Board (SDHB).

10. The following issues were identified for investigation:

- *Whether Southern District Health Board provided Ms A with care of an appropriate standard.*
- *Whether Dr B provided Ms A with care of an appropriate standard.*

11. The parties directly referred to in the investigation report are:

Ms A	Consumer
Southern DHB	Provider
Dr B	Otolaryngologist/head and neck surgeon
General practitioner (GP)	
Dr C	Otorhinolaryngologist/head and neck surgeon
Dr D	Neurosurgeon

12. Independent expert advice was obtained from an otolaryngologist, Dr Cathy Ferguson (**Appendix A**).

Information gathered during investigation

Introduction

13. On 22 September 2014, Ms A (then aged 45 years) was referred by her GP to the DHB Ear Nose and Throat (ENT) outpatients clinic, as Ms A was suffering from asymmetrical hearing loss and tinnitus.[4]

[3] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[4] A sensation of noise (as a ringing or roaring) that is caused by a bodily condition.

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14. On 30 December 2014, Ms A had an appointment with an otolaryngologist/head and neck surgeon, Dr B.

15. Dr B stated that Ms A had significant right-sided sensorineural hearing loss, and normal left-sided hearing. Dr B said that he discussed with Ms A his recommendation for a magnetic resonance imaging (MRI) scan to ensure that her hearing loss would not require further therapy, and told her that she would be notified if the scan required follow-up. Dr B referred Ms A for an MRI scan of the internal auditory canals.

16. The MRI scan was performed on 13 May 2015, and a radiologist issued the written report electronically at 4.53pm. The report states that a large right vestibular schwannoma[5] was seen and would be causing the clinical symptoms. The report also states:

> "The intracanalicular component reaches laterally to the cochlea, the internal canal appears not widened. The overall width of both components is measured at 19mm. The larger extracanalicular component has dimensions of 11mm (mediolateral) x 13mm (anterior-posterior) x 14mm (superior-inferior)."

17. No action was taken in respect of the MRI results at that time, and it was not noted that the MRI report was still "unacknowledged" in the electronic system until February 2016 — nine months later (discussed further below).

Result viewing process

18. SDHB told HDC that although test results have been available electronically since 2007, until October 2015 clinicians largely relied on paper copies of results.

19. SDHB said that, at the time of this event, the radiologist would approve (issue) the final report, and it would be distributed to the clinical intranet automatically. Within seconds, the report would be available for the referring clinician to view on the clinical intranet. SDHB advised that there was a memo system within the clinical intranet that informed clinicians that there were results to view/acknowledge, but this required the clinicians to log in to the clinical intranet to see the memo.

20. Dr B stated that at the time of these events, his routine was to receive printed copies of the scan reports and arrange for follow-up or a return visit via the department secretary as necessary. Dr B said that his only explanation for the delay in arranging follow-up is that the paper tracking system, on which they relied routinely, failed in some way.

21. SDHB explained that the paper tracking system worked by simultaneously adding the final report to a printing queue when it was approved by the radiologist. The print queue is run daily at 4pm. Printing is sorted manually and distributed to the referrer by internal or external mail. SDHB stated that it cannot determine with certainty that the report was printed. However, if it was, it would have been printed on 14 May 2015, then placed in the internal mail, then delivered to the relevant department's post box on Friday, 15 May 2015.

22. Dr B explained that, for him, the paper tracking system involved the departmental secretary collecting the results and passing them to him in the form of paper notes in a folder asking

[5] A vestibular schwannoma is a benign tumour of the balance nerve, and presents with hearing loss from either pressure on the hearing nerve, or compression of the artery that supplies the hearing nerve.

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for his action. In response to the provisional opinion, Dr B confirmed that he did not receive a paper copy of Ms A's results. He said that had he received the paper copy, he would have followed up the results with Ms A immediately.

23. Dr B stated that in May 2015 he did not use the clinical intranet in his clinical practice, and he was not aware of any system of notification that results were available electronically.

24. SDHB stated that access logs show that Dr B viewed the report at 8.15am on 14 May 2015; however, Dr B said that he does not recall this. In response to the provisional opinion, Dr B said that there is a possibility that he clicked on the results but did not read them.

25. Outside of the paper system described above and the clinical intranet, at the time of these events there was no other system to alert clinicians that a result was available.

Electronic acknowledgement patient safety project

26. In June 2015, SDHB commenced the "electronic acknowledgement patient safety project" to address the clinical risk of unacknowledged radiology and laboratory results. SDHB noted that in 2007, the former entities of SDHB and Otago DHB had introduced new information technology software, but that the efforts to ensure an efficient, systematic, and controlled process for acknowledging results had not been completely successful, and the majority of staff worked with parallel paper-based reporting.

27. The planned outcomes of the project included having all clinical staff using the clinical intranet to view, act upon, and record acknowledgement of results, having policies aligned across the district, controlling the numbers of unacknowledged results, and ensuring follow-up of all abnormal results.

Acknowledgement of report and follow-up

28. On 29 February 2016, RN E identified Ms A's unacknowledged May 2015 MRI scan result as part of this project. RN E emailed Dr B to advise him of the result. Prior to this, Dr B had not had the outstanding unacknowledged result brought to his attention.

29. Dr B advised that it was only then that he became aware that he had not seen Ms A's MRI results. On the same day, Dr B responded to RN E that he would look into the results. Dr B stated:

> "At that time, I reviewed the old notes, examined the image on the MRI and saw that a vestibular schwannoma was detected. In most cases, this is a slow growing, benign tumour and urgent treatment is not required."

30. Dr B made arrangements for follow-up of the vestibular schwannoma by way of a clinic visit for Ms A to a head and neck surgeon, Dr C. Dr B stated that this was made on a non-urgent basis, with an expectation for a repeat MRI to be done approximately a year after the first study. Dr B said that he expected Ms A to be seen by Dr C in his next clinic, which was on 16 March 2016.

31. Handwritten on the file copy of the MRI result provided to HDC is "? Follow-up" and "Routine visit with [Dr C]".

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32. SDHB told HDC that Dr C visits only bi-monthly. The March clinic was fully booked and, as the request was for a routine visit, Ms A was booked into the May clinic.

33. Ms A was seen in clinic by Dr C on 17 May 2016. Ms A told HDC that this was the first time she was made aware of the first MRI scan result indicating that she had a tumour. Dr C arranged another MRI scan and apologised for the delay in follow-up.

34. The MRI scan was performed on 26 May 2016 and showed that the vestibular schwannoma had grown. The report states: "Axial dimensions are 21mm … x 15mm compared to 13 x 11 mm on the previous study." Dr C stated that this is a greater rate of growth than is usually encountered with vestibular schwannoma (1 to 2mm per annum if growth occurs).

35. Dr C saw Ms A again on 3 June 2016. He discussed the MRI result with her, and that surgical excision would be an appropriate treatment option.

36. Ms A was then seen in the Neurosurgical Outpatient Clinic on 21 June 2016 by a consultant neurosurgeon, Dr D. Dr D stated that different treatment options were discussed, including radiation treatment and surgery, but that surgery was preferred.

37. On 1 July 2016, Ms A underwent surgical removal of the tumour by Dr D and an ear, nose and throat (ENT) surgeon.

38. RN E stated that following further review of this case, and noting that surgery had taken place on 1 July 2016, he acknowledged the result on the clinical intranet on 14 July 2016. RN E had delegated authority to acknowledge abnormal results where they had been noted in clinical documentation or where follow-up had been instigated.

Further information

Ms A

39. Ms A is now permanently deaf in her right ear, her balance is affected, and she experiences headaches. She is concerned that this is as a result of the delayed surgery.

Dr B

40. Dr B stated that on 17 November 2015 he attended training on the use of the clinical intranet, and that following the session he habitually signed off items on the clinical intranet once or twice per week. He said he only received training on how to use the clinical intranet at this time. Dr B said that until this time he had not been informed or advised that it was mandatory to acknowledge results via the clinical intranet. As discussed further below, SDHB did not have in place any specific policies regarding responsibilities for result follow-up until these were introduced in September 2015, following which training on the new policies was undertaken. Dr B said that the clinical intranet review process was poorly designed and cumbersome, and many senior medical officers continued to use the paper system until late 2015.

41. Dr B stated that the volume of results held in the clinical intranet inbox may have contributed to him not having seen the report when it was delivered in May 2015, as he started using the clinical intranet regularly six months later.

42. Dr B also stated:

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"Until this case, I have never thought it best to discuss important diagnoses over the phone and have considered that personal discussion in the office is preferable as it facilitates open two-way communication and notification/action is not urgent. My usual practice was to contact the patient for follow-up and then to allow [Dr C] to have this discussion with the patient as the MRI results would be referred to him for specialist review. Since receiving this complaint, my practice is to notify patients with such diagnosis by a phone call or letter indicating the diagnosis and informing them that they will be seen for follow-up where further treatment options will be explained to them. Despite the awkward discussion over the phone, this may remove some of the surprise of receiving the diagnosis later in person."

43. In response to the provisional opinion, Dr B said that he felt that contacting Ms A so long after the MRI and discussing the diagnosis over the telephone would have been quite unexpected and caused her stress, and he did not want to appear insensitive. Dr B said that he was also reassured that the tumour was small rather than large. However, Dr B accepts that he should have contacted Ms A to explain why the results had not been communicated to her in May 2015.

Dr C

44. Dr C stated that for someone with vestibular schwannoma, usually he would expect an appointment to be made within two to three months. He said that this is a slow growing benign tumour and usually treatment is not urgent. He stated that the size of Ms A's vestibular schwannoma, when detected in May 2015, was such that an urgent appointment would not have been required, but he would have expected her to be seen in this timeframe.

45. Dr C stated that if Ms A had been able to elect to have surgery earlier, the outcome would have been the same as she experienced, but treatment would have occurred earlier. That is, there would be no hearing in her right ear, and in the early postoperative period her balance would have been worse. Dr C stated that the degree of increased balance disturbance experienced by patients following surgical removal of vestibular schwannoma varies between individuals, and cannot be predicted easily before surgery.

46. Dr C told HDC that in May 2015, there would have been three potential management options for Ms A's vestibular schwannoma: observation without intervention, radiotherapy, and surgical removal.

SDHB

47. SDHB stated that Dr D opined that the delay in the surgery had no impact on the outcome, and that after her surgery Ms A would have been deaf irrespective of the timing of the surgery, as the auditory (hearing nerve) is always removed. In surgical treatment of vestibular schwannoma, removing the auditory nerve with the surgery is the best guarantee for total removal of the tumour.

48. SDHB stated that at the time of these events, there were no specific policies in place regarding responsibilities for result follow-up. In September 2015, policies for electronic acknowledgement of results were introduced. The Electronic Acknowledgement Policy

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(District)[6] specifies that all results must be acknowledged electronically. The Electronic Acknowledgement Guidelines (District)[7] states:

> "The organisation is responsible for ensuring there is a reliable process to notify SMOs of the test results for their patients. Currently this is done using the clinical intranet unacknowledged work lists.
>
> Every week a compliance summary report will be circulated to all SMOs to inform them of their outstanding unacknowledged results."

49. These policies were replaced in September 2016 when SDHB changed to a different electronic medical record system. SDHB said that internal referrers now receive all results electronically via the new electronic medical record system.

50. SDHB stated that the electronic acknowledgement project completed its objectives, and ongoing auditing is in place for the new electronic medical record system.

51. SDHB conducted a serious adverse event review for this event. It found that the MRI result was transmitted electronically and is recorded as having been viewed, but there is no record of the hard copy being received or actioned at that time. SDHB stated that this occurred during a period before mandatory electronic acknowledgement was established and reliance on hard copy was still routine practice. The review recommended that GPs be advised in letters from the specialist clinic as to whether to expect results of special investigations.

52. SDHB stated that the wait time from the initial appointment with Dr B to the first MRI scan (five and a half months) was longer than expected, but was due to then long waiting lists for complex scanning at the DHB for non-urgent requests.

Responses to the provisional opinion

53. In response to the "information gathered", Ms A advised that SDHB's lack of protocol has affected her everyday life, and that she has struggled to get assistance since these events.

54. In response to the provisional opinion, SDHB said that it accepts that there is an unexplained follow-up of the results of the MRI. It stated that this is in part due to the duplication of systems for reporting results, without an inbuilt fail-safe to prevent failure of clinician notification and subsequent action. SDHB's chief executive stated: "On behalf of all concerned, I would like to express sincere apologies to [Ms A] for our failings leading to a delay in treatment of her acoustic tumour…"

55. Dr B provided a response to the provisional opinion. Where appropriate, his comments have been incorporated into the "information gathered" section above.

[6] Issued 30 September 2015.
[7] Issued 30 September 2015.

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Opinion: Dr B — breach

Delay in follow-up — adverse comment

56. Dr B ordered a non-urgent MRI scan for Ms A in late December 2014. This was performed on 13 May 2015, and the written report was issued to the clinical intranet that afternoon. SDHB stated that access logs show that Dr B viewed the report at 8.15am on 14 May 2015; however, Dr B does not recall this. Dr B stated that he did not use the clinical intranet in his clinical practice in May 2015, and that he first became aware that he had not seen Ms A's MRI result on 29 February 2016, at which time he arranged a follow-up appointment with Dr C. Dr B said that his only explanation for the delay was that the paper tracking system that he relied on routinely failed in some way, and stated that he did not receive a copy of the paper report.

57. While the access logs show that Dr B viewed the report on 14 May 2015, the report was not "acknowledged" by Dr B at that time, and the extent to which he viewed the report and saw the result is unclear. In response to the provisional opinion, Dr B stated that there is a possibility that he clicked on the results but did not read them. Given that no timely action was taken as a result of the MRI report, I accept Dr B's explanation that it is likely that the paper-based system failed in this case. The paper-based system relied on the result being printed, collected from the printer and manually sorted, put in the internal mail, delivered to the department's post box, sorted by the department's secretary, then put in a folder for Dr B's attention. There were multiple opportunities during this process when the result could have been "lost", and therefore not brought to Dr B's attention. Accordingly, the absence of the paper-based result being available to him the following day meant that follow-up was not arranged in a timely manner at that time.

58. My expert advisor, otolaryngologist Dr Cathy Ferguson, advised:

> "The time taken and process involved and follow-up of 13 May MRI scan results is a departure from standards of care although I would consider this to be a mild to moderate departure."

59. As this Office has stated previously, doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal test results. The primary responsibility for following up abnormal test results rests with the clinician who ordered the tests. Dr B held this responsibility in Ms A's case. I am critical that after accessing the report in the clinical intranet on 14 May 2015, Dr B either did not review the report properly in the clinical intranet or, if he did review the report properly, failed both to inform Ms A, and to arrange timely follow-up. Having considered Dr B's response to the provisional opinion, I accept the most likely scenario is that he clicked on the results but did not read them. I am also critical that he did not notice the result in the clinical intranet when he started using it regularly in November 2015. However, I consider that there were numerous mitigating circumstances in this case, including:

a) There was a five-and-a-half month wait between Dr B ordering the MRI scan, and it being performed.

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b) The MRI was reported on at a time when SDHB did not have in place specific policies regarding responsibilities for result follow-up, particularly in the clinical intranet system.

c) The MRI was reported on at a time when there were both electronic and paper results systems being used in conjunction, and many senior medical officers relied on the paper system. Dr B told HDC that it was not his clinical practice to use the clinical intranet at the time, and his routine was to receive paper copies of scan results.

d) It was not mandatory to acknowledge results on the clinical intranet at the time of these events.

e) The paper results system appears to have failed.

f) The policy introduced in September 2015 stated that every week a compliance summary report would be circulated to senior medical officers to inform them of their outstanding unacknowledged results. This did not occur in relation to Ms A's MRI result, and so the result was not brought to Dr B's attention until February 2016.

60. I am guided by Dr Ferguson's advice. While I am critical of Dr B that there was a delay in follow-up being arranged in a timely manner after Ms A's MRI of 13 May 2015, and that Ms A was not advised of the results at that time, I do not consider this to be solely attributable to Dr B, for the mitigating reasons outlined above. Overall, having considered all the circumstances, I am of the view that the delay in follow-up being arranged was primarily a result of a lack of a clear, effective, and formalised system within SDHB.

Failure to provide information — breach

61. On 29 February 2016, Dr B was alerted to the fact that the 13 May 2015 MRI scan report was unacknowledged. Dr B then took steps to arrange a follow-up appointment for Ms A. Ms A stated that she was not aware of the result of the MRI scan until 17 May 2016, when she had the appointment with Dr C.

62. Dr B explained that he thought it best never to discuss important diagnoses over the telephone, and preferred this to occur in an office setting. Dr B told HDC that he expected Ms A to be seen in Dr C's next clinic on 16 March 2016. However, as this clinic was full, Ms A was booked into the May clinic.

63. Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …" This includes information about the results of tests. In my view, a reasonable consumer in Ms A's circumstances, including the particular symptoms she had been experiencing, would expect to receive an MRI scan result showing that a vestibular schwannoma had been identified. I also consider that after a nine-month delay, a reasonable consumer in those circumstances would want to receive those results as soon as possible, and to be provided with an explanation of the reason for the delay in receiving them and follow-up action being taken.

64. Despite Dr B expecting Ms A to be seen in just over two weeks' time, I consider that he should have contacted Ms A directly to inform her that she had a vestibular schwannoma once he was alerted to the MRI report being unacknowledged on 29 February 2016. This was particularly important given that the result had been unacknowledged for nine months,

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the MRI scan was an investigation that Dr B had ordered, and Dr B could not know whether Ms A would be seen in March without checking that. I also consider that he should have explained to her the reason for the delay in advising her of the result and in arranging follow-up. I note that Dr B accepts that he should have contacted Ms A to explain why the results had not been communicated to her in May 2015. While I acknowledge Dr B's explanation regarding why he did not do this, I do not think it was appropriate or fair for Dr B to leave the discussion of this result to Dr C, and that Dr C was left to apologise to Ms A for the delay in follow-up. I also note that there is no reason that the discussion of the results had to occur by telephone if this was Dr B's primary concern.

65. As the MRI result, and an explanation for the delay in advising Ms A of it and arranging follow-up, was not conveyed to Ms A by Dr B once he was alerted to it on 29 February 2016, I find that Dr B breached Right 6(1) of the Code.

Opinion: Southern District Health Board — breach

66. District health boards are responsible for the operation of the services they provide, and can be held responsible for any service failures.

67. As set out above, Dr B ordered a non-urgent MRI scan for Ms A in late December 2014. This was performed on 13 May 2015, and the written report was issued to the clinical intranet that afternoon. SDHB stated that access logs show that Dr B viewed the report at 8.15am on 14 May 2015; however, Dr B does not recall this. Dr B stated that he did not use the clinical intranet in his clinical practice in May 2015, and that he first became aware that he had not seen Ms A's MRI result on 29 February 2016, at which time he arranged a follow-up appointment with Dr C. Dr B said that his only explanation for the delay is that the paper tracking system he relied on routinely failed in some way.

68. I accept Dr B's explanation that it is likely that the paper-based system failed in this case. The paper-based system relied on the result being printed, collected from the printer and manually sorted, put in the internal mail, delivered to the department's post box, sorted by the department's secretary, then put in a folder for Dr B's attention. There were multiple opportunities during this process when the result could have been "lost", and therefore not brought to Dr B's attention.

69. Although the electronic version of the report was available on the clinical intranet, the MRI was reported on at a time when both the electronic and paper results systems were being used in conjunction, and SDHB has accepted that many senior medical officers relied on the paper system only. Further, at the time that the MRI was reported, SDHB did not have in place specific policies regarding responsibilities for result follow-up, particularly in the clinical intranet system. It was not mandatory to acknowledge results in the clinical intranet until a policy stating this was introduced in September 2015, and Dr B told HDC that he was not made aware of this new requirement until a training session in November 2015.

70. The September 2015 policy also stated that every week a compliance summary report would be circulated to senior medical officers to inform them of their outstanding

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unacknowledged results. Dr B was not informed of the unacknowledged result until 29 February 2016 and, prior to this time, Dr B had not had the outstanding unacknowledged result brought to his attention, as should have occurred in accordance with the new policy.

71. My expert advisor, otolaryngologist Dr Cathy Ferguson, advised:

> "The time taken and process involved and follow-up of 13 May MRI scan results is a departure from standards of care although I would consider this to be a mild to moderate departure."

72. Dr Ferguson also stated:

> "I understand from the policy that unacknowledged results are to be reported on a weekly basis, but it does not appear that this happened in this particular case. If this practice was adhered to, then the delay would have been avoided."

73. I am guided by Dr Ferguson's advice. While I acknowledge that the electronic result from the 13 May 2015 scan was available on the clinical intranet system immediately for review by Dr B, SDHB did not have any formalised systems or processes in place around the follow-up of test results at that time. In particular, the electronic system was operating concurrently with the paper tracking system, and there were no requirements around the acknowledgement of test results. Dr B told HDC that he routinely relied on the paper tracking system, and it seems that this was still customary practice in May 2015. As above, in this instance the paper tracking system appears to have failed and, in this circumstance, there was no other system outside of the clinical intranet to alert clinicians that a result was available.

74. As I have stated previously, district health boards have a responsibility to have in place clear, effective, and formalised systems for the reporting and following up of test results,[8] to enable their staff to action the results appropriately. I consider that the lack of a clear, effective, and formalised system within SDHB for the reporting and following up of test results at this time meant that this result was not appropriately acknowledged, actioned, and communicated to Ms A by Dr B in May 2015. In addition, before September 2015 there was no process at SDHB to ensure that reports or results did not go unacknowledged by clinicians for any length of time. When such a policy was implemented in September 2015, the failure to send out a weekly compliance summary report to Dr B after the implementation of the new policy in September 2015 contributed to the result not being picked up between September 2015 and February 2016. Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill." For these reasons, I find that SDHB did not provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Other comment

75. I acknowledge that following these events SDHB undertook significant work with the electronic acknowledgement patient safety project, and that all internal referrers now receive results electronically.

[8] Case 15HDC01204, available at www.hdc.org.nz.

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Recommendations

76. I recommend that within three months of the date of this opinion, SDHB provide HDC with a copy of its most recent audit of the electronic medical record system in relation to acknowledgement of electronic laboratory/radiology results. This should include the audit findings and details of corrective actions taken in the event of any adverse findings.

77. I recommend that SDHB provide a written apology to Ms A. This should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms A.

78. I recommend that Dr B provide a written apology to Ms A. This should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms A.

Follow-up actions

79. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Southern District Health Board, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name in covering correspondence.

80. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Southern District Health Board, will be sent to HQSC and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from otolaryngologist Dr Cathy Ferguson:

"I have been asked to provide an opinion to the Commissioner on case 16/01980 and I have read and agreed to follow the Commissioner's guidelines for independent advisors.

I hold an MB ChB from Otago University and I am a Fellow of the Royal Australasian College of Surgeons in Otolaryngology, Head & Neck Surgery. I have been practicing as an otolaryngologist head and neck surgeon in all aspects of Otolaryngology since 1991.

I have been asked to provide an opinion about the care provided to [Ms A]; in particular reference to the standard and appropriateness of care provided to [Ms A] by [Dr B], the standard and appropriateness of the care provided by the Southern DHB, the adequacy of relevant policies, procedures, and management systems in relation to test result acknowledgement in place at Southern DHB and any other clinical matters that I consider relevant.

I have reviewed the following documents:

- Letter of complaint, dated [date].
- Initial Southern DHB response dated 31 January 2017 including an initial letter from [Dr B] dated 11 January 2017 and input from [Dr C], dated 6 January 2017.
- Southern DHB response to notification, dated 24 August 2017 and appendices.
- Response to notification from [Dr B], dated 25 August 2017.
- Southern DHB adverse event report, signed off 30 October 2017.
- Southern DHB clinical records for [Ms A].

I do not think there was any missing information.

In September 2017, [Ms A] was referred by her GP to her local DHB for a specialist appointment due to issues with hearing loss and tinnitus. She had an appointment with [Dr B] on 30 December 2014. He referred her for an MRI scan of the internal auditory canals.

On 13 May 2015, the MRI scan was performed and reported. There was a delay in the hard copy and electronic version of the results of the MRI being received or followed up by [Dr B] and this was not noted until February 2016 at which point she was referred for follow-up to [Dr C]. [Ms A] was seen by [Dr C] on 18 May 2016 and a further MRI scan was performed on 31 May 2016. She underwent surgical removal of this tumour on 31 July 2016. She has no hearing in her right ear now and has been unable to return to work.

Names have been removed (except Southern DHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I have been asked to comment on the standard and appropriateness of care provided to [Ms A] by [Dr B]. The initial decision by [Dr B] in December 2014 to obtain an audiogram and order an MRI was completely appropriate and conforms to accepted practice. However, the time taken and process involved and follow-up of 13 May MRI scan results is a departure from standards of care although I would consider this to be a mild to moderate departure. I consider it would be viewed by my peers as such, but it is certainly not a severe departure as I do not think the final outcome to [Ms A] has been affected by this delay.

It appears that there were some procedures in place to prevent a similar recurrence in future, but that these procedures were not strictly adhered to. My interpretation of the Southern DHB procedure in relation to the signing of her results, while carefully described in the documentation, does not seem to have taken place. I understand from the policy that unacknowledged results are to be reported on a weekly basis, but it does not appear that this happened in this particular case. If this practice was adhered to, then the delay would have been avoided.

The MRI on 13 May 2015 describes a 'large tumour' with a 19mm dimension and the extracanalicular portion described as 11 x 13mm. The literature that I have reviewed varies in description of size but in general small tumours are described as less than 15mm or some reports less than 20mm. Medium tumours are described as between either 1.5 to 2.5cm or 2 to 4cm and large tumours are described as greater than 2.5cm in some reports and greater than 4cm in other reports. At any event, this particular tumour would either be small or medium and certainly not a large tumour."

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