HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Tissue disposed of incorrectly after hysterectomy

Background

1. Mrs A was seen regularly by the gynaecology service at Wairarapa Hospital (Health New Zealand | Te Whatu Ora Wairarapa (Health NZ)) between November 2022 and December 2023.

2. On 30 June 2023, Mrs A underwent a clinical investigation that showed the presence of uterine fibroids. It was noted that, despite taking medication (oral progestin) daily, Mrs A continued to have significant cramping, even with mild bleeding. During this appointment, different surgical treatment options were discussed, including a hysterectomy.[1] A plan was made to follow up with Mrs A in two to four weeks' time to see how she would like to proceed.

3. During her follow-up appointment on 27 July 2023, Mrs A agreed to proceed with a hysterectomy, and the potential risks and benefits of this were discussed. A surgical consent form for a total laparoscopic hysterectomy with bilateral salpingectomy (removal of her fallopian tubes) was completed at this appointment. The consent form stated that Mrs A consented to her tissue (uterus, fallopian tubes, and fibroids) being sent to the laboratory for testing but that she then wanted her tissue returned to her.

4. On 28 November 2023, Mrs A was seen at the pre-admission clinic. She filled in a Return of Tissue form, which stated that her husband would collect her tissue from the laboratory. The form was completed in triplicate, with one copy being given to Mrs A, one copy to remain in Mrs A's clinical records, and the other to accompany her tissue to the laboratory.

5. On 9 December 2023, Mrs A had a phone conversation to finalise her surgical plan and discuss the surgery, the healing process, and the recovery time. On 19 December 2023, Mrs A underwent a hysterectomy at Wairarapa Hospital and was discharged home on 21 December 2023.

6. Mrs A told the Health and Disability Commissioner (HDC) that during her post-surgery follow-up appointment, she enquired about her tissue and when it would be returned to her. However, staff were unable to provide her with an answer, and Mrs A recalls a nurse saying that she would look into it. After waiting a further two weeks, Mrs A followed up with Wairarapa Hospital and the Onsite Hospital Laboratory and was told that her tissue had been destroyed. Mrs A was deeply distressed by this news, and she told HDC that she is still trying to process what happened and how it occurred.

7. Health NZ stated that after Mrs A's surgery, her tissue was sent to the laboratory with 'return of tissue' indicated on the laboratory request form, as per Health NZ's usual tissue

[1] Surgical removal of the uterus.

return process. Health NZ told HDC that Mrs A had completed the Return of Tissue form correctly, which is the other requirement of the tissue return process. However, for some unknown reason, the laboratory copy of Mrs A's Return of Tissue form was not located within her records.

8. The usual process for signalling that a patient would like their tissue to be returned is for a Return of Tissue form to accompany the laboratory request form and tissue when it is sent to the laboratory for testing. Health NZ explained that the laboratory request form did clearly indicate 'return of tissue to patient' but the absence of a Return of Tissue form meant that, unfortunately, Mrs A's tissue was destroyed in error.

9. Following these events, a department-level review was undertaken by the Laboratory Manager and Planned Services Manager. Health NZ identified that, at the time, there was no process whereby the handover of the patient tissue request was documented and acknowledged by laboratory staff. Following the departmental review, Health NZ developed a revised 'Human Tissue — Management and Handling Protocol', which has been implemented hospital-wide.

10. Health NZ has offered Mrs A both verbal and written apologies for this error and offered the opportunity to contribute her experience to a shared learnings document.

Response to provisional decision

11. All parties were given the opportunity to comment on my provisional decision. Health NZ accepted my provisional decision and proposed recommendations.

12. Mrs A has not provided any comments on my provisional decision.

Decision Health NZ — breach

13. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. Upholding a consumer's right to have their tissue returned when requested is a part of providing services with reasonable care and skill. In Mrs A's case, this did not occur.

14. Right 7(9) of the Code states that every consumer has the right to make a decision about the return or disposal of any body parts removed through a healthcare procedure. In preparation for her hysterectomy, Mrs A was offered a choice about the return of her tissue and chose for it to be returned to her. Her choice was documented clearly in her clinical records, she filled in the required Return of Tissue Form, and her laboratory request form clearly indicated 'return of tissue to patient'. However, despite this documentation, Mrs A's tissue was destroyed instead of being returned to her, which was a systems failure.

15. Wairarapa Hospital acknowledged that these events fall below its expectations of care, as Mrs A had made it clear at her preoperative appointment that she wished to have her tissue returned. I agree with this assessment.

16. For the reasons outlined above, I therefore find Health NZ in breach of Right 4(1) of the Code. Put simply, Mrs A's tissue should have been returned to her as part of providing services of an appropriate standard.

Recommendations and follow-up action

17. I acknowledge the thorough review done by Health NZ Wairarapa and the significant remedial actions taken to minimise the risk of similar events occurring in future. I am also aware of another complaint to HDC concerning the improper return of a consumer's uterus (or in ao Māori, whare tangata[2]), involving another Health NZ district.

18. In this context, I recommend that Heath NZ Wairarapa:

a) Share the revised Human Tissue — Management and Handling Protocol with other Health NZ districts, with a view to supporting those districts to strengthen their tissue return protocols.

b) Undertake an audit of the revised Human Tissue — Management and Handling Protocol to determine the degree of compliance with patients' return of tissue requests. A summary of the findings is to be provided to HDC within six months of the date of this report.

c) Consider updating the Human Tissue — Management and Handling Protocol to require documented confirmation that the tissue return form has been provided to the laboratory with the tissue and advise HDC on steps taken in this respect within three months of the date of this report.

19. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

[2] 'Whare tangata' literally translates to 'house' (whare) of people or humanity (ira tangata). It encompasses the sexual and reproductive functions of wāhine as one of many sources of strength and sacredness. Whare tangata has its own mana and is considered tapu (sacred). Whare tangata refers to the maternal body, including the uterus, cervix, fallopian tubes, ovaries, and vaginal canal.