HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delayed diagnosis of colorectal cancer

1. On 19 March 2025, the Health and Disability Commissioner (HDC) received a complaint from Mr B about the care he received from Health New Zealand | Te Whatu Ora Southern (Health NZ). The complaint concerns the delayed diagnosis of colorectal cancer (cancer in the colon and/or rectum). I was very sorry to hear of Mr B's diagnosis and acknowledge the profound impact this has had on him and his whānau.

Information gathered

Referral to gastroenterology service – 2 October 2023

2. Mr B, aged 56 years at the time, presented to his general practitioner (GP), Dr A, on 2 October 2023 with occasional rectal bleeding over the previous three to four months and low-grade anaemia[1] (without evidence of iron deficiency). Mr B's symptoms also included urinary retention and poor urinary stream. Mr B was seen by the Urology Department at Dunedin Hospital in September 2023 and was waiting to undergo transurethral resection of the prostate (TURP – a surgical procedure to remove parts of the prostate).

3. Following this appointment, Dr A referred Mr B to Health NZ's gastroenterology outpatient service at Dunedin Hospital for investigation, noting the above symptoms and that a previous digital rectal examination (a physical examination of the lower rectum and anus) had been normal. No change in bowel habits, weight loss, or other red flag symptoms such as reduced appetite or tenesmus[2] were mentioned in the referral letter. Health NZ completed an adverse event report (AER) into Mr B's care following his diagnosis, which noted that this referral was appropriate, as Mr B did not meet the criteria for a direct access colonoscopy.[3] The AER also noted that there was no set criteria or checklist on the GP referral documentation and that the referral relied on free-text comments.

4. The gastroenterology service declined the referral on 4 October 2023 because it considered the bleeding to be 'outlet bleeding',[4] which often settles spontaneously. The AER noted that outlet bleeding without a change in bowel habit in a person aged over 50 years does not require a colonoscopy, unless benign (not cancerous) causes of bleeding have been excluded, which was not done in this case. However, the AER also stated that more clarity in the symptom description within the referral may have resulted in a different path and that the gastroenterology service could have sought this clarity from Dr A before declining the referral.

[1] Mr B's haemoglobin level was 121g/L (normal range is 130–180g/L).
[2] The sensation of incomplete bowel evacuation and the sensation of needing to go again.
[3] A programme that allows patients to schedule a screening colonoscopy without a pre-procedure visit.
[4] Bright red blood that is visible on toilet paper or in the toilet bowl, typically after or during a bowel movement. The AER noted that the phrases relating to unexplained bleeding and outlet bleeding within HealthPathways (a resource available to GPs) were inconsistent.

5. Subsequently, Dr A was advised to refer Mr B to the general surgical team for a sigmoidoscopy[5] if symptoms persisted. The AER found that this suggestion to refer to general surgery was appropriate. However, the AER also noted that the gastroenterology service could have referred Mr B directly to the general surgical service, which would have shortened the delay in receiving a diagnosis by at least eight weeks.

Referral to general surgical service – 14 December 2023

6. On 14 December 2023, Mr B re-presented to his GP with ongoing intermittent 'rectal bleeding – [quite] a bit ''coming out''' which was described as 'red water in pan … bowels [quite] loose'. Dr A completed a physical examination, including a digital rectal examination, and noted that Mr B's bowel movements had changed. The digital rectal examination was normal.

7. Later that day, Dr A referred Mr B to the general surgical service at Dunedin Hospital for an assessment of his symptoms (outlined above). The referral also stated that Mr B's weight remained unchanged, that his bleeding was ongoing two and a half months after the original referral to the gastroenterology service, and that he had gradually worsening anaemia, but that several digital rectal examinations had been normal.

8. The general surgical service accepted the referral with the following comments: '[p]robably outlet bleeding but anaemic [sic] and age requires sigmoidoscopy at least'. The AER notes a delay of six working days to triage this referral. Mr B was then triaged as 'semi-urgent' for a sigmoidoscopy. The AER notes that, at this stage, Mr B would have also met the criteria for direct access colonoscopy and that the referral could have been directed back to colonoscopy triage but that the option to continue with an assessment by the general surgical service was also appropriate.

9. The AER notes that the first specialist assessment (FSA) by the general surgical service should have occurred within 56 working days of 14 December 2023 (by 11 March 2024) because the referral was triaged as 'semi-urgent'. However, the AER states that an administrator incorrectly set the 'treat-by date' to 16 June 2024 using a 120-working-day timeframe. At this time, the administration process was taking longer than usual because Health NZ was transitioning to a new patient management system.

10. In addition to the incorrect 'treat-by date', the AER also noted a mismatch between the capacity of and demand for the colorectal clinic, which resulted in difficulties in allocating timely appointments for FSAs. The annual capacity of the clinic is limited to 400 new FSAs. However, as of 7 March 2025, 196 new patients were waiting for an FSA (equating to six months of full-time work) and 517 patients were waiting for follow-up appointments, with the follow-up appointments limiting capacity for new assessments. The AER notes that patients triaged as 'semi-urgent' may wait up to 14 times longer for an FSA than the recommended six-week wait time set by the Ministry of Health. The AER found that the mismatch between the capacity and demand was not mitigated sufficiently to limit potential harm to patients such as Mr B, who were waiting longer than clinically appropriate. In

[5] A procedure used to examine the sigmoid colon and rectum using a flexible tube.

addition, the AER states that there was no regular systematic monitoring of the FSA waitlist for those at possible risk of significant pathology (a medical condition, such as cancer).

11. It is relevant to note that updated figures relating to the waitlist were provided to this investigation in October 2025; they showed a reduction of FSA patients on the colorectal list to 142. There were 579 FSA patients overall on the general waitlist at this time.

Further referral to general surgical service – 25 June 2024

12. While Mr B was waiting for a sigmoidoscopy, his GP noticed that his kidney function had deteriorated. His creatinine[6] levels had risen from the 70s in 2023 to 125umol/L in May 2024.[7] Subsequently, Mr B was referred to the nephrology service for a review and expediting of the TURP procedure. The nephrology service referred Mr B for an ultrasound scan and CT scan of the kidneys to investigate possible causes of the kidney impairment. The ultrasound scan showed a pelvicalyceal dilation, which indicates an underlying problem affecting kidney function. A CT scan on 20 June 2024 showed a rectosigmoid tumour, regional lymphadenopathy (swelling of the lymph nodes), and probable spread of tumours to the liver and that the cancer was blocking Mr B's right kidney and urinary tract.

13. Subsequently, the nephrology service completed a further referral to the general surgical service on 25 June 2024, noting the findings of the CT scan. The referral was triaged as urgent. This resulted in a second referral to the general surgical service and a new waitlist being generated in the system; a new FSA date was set for 18 July 2024. The AER found that the original referral from 14 December 2023 should have been updated rather than a second referral created.

14. Mr B underwent a colonoscopy on 4 July 2024 and was reviewed by a general surgeon on 18 July 2024, that is, 144 working days after referral for an FSA and a delay of 88 working days. At this stage, Mr B had stage 4 colorectal cancer, indicating that the cancer had grown through the outer layer of the rectum and invaded nearby tissues, and the prognosis was poor. The AER found that Mr B had experienced significant delays in the diagnosis of colorectal cancer.

15. Mr B and Health NZ were provided with the opportunity to comment on the provisional report. Health NZ's comments have been incorporated into this report where relevant. Mr B said his diagnosis has placed a great strain on him and his family but that he has accepted his condition and that he does not wish to see this happen to anyone else.

Decision: Health NZ – breach

16. Health NZ's comprehensive AER included demonstrated systemic issues that contributed to the delay in the diagnosis of Mr B's cancer (also indicated by the timeline), and Health NZ has acknowledged that the diagnosis of Mr B's cancer was significantly delayed. Therefore, I proposed to Health NZ that HDC find it in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) by way of adopting the findings of the AER, which Health NZ accepted. I am pleased that Health NZ has agreed with this approach.

[6] A waste product excreted by the kidneys. High levels can indicate kidney disease or damage.
[7] Normal creatinine levels are 50–110umol/L.

17. Right 4(1) of the Code states that '[e]very consumer has the right to have services provided with reasonable care and skill.' The issue for me to determine is whether Mr B's cancer diagnosis was delayed and, if so, whether the circumstances in which the delay occurred were reasonable.

18. As highlighted in Health NZ's AER, there were significant delays in the diagnosis of Mr B's colorectal cancer, and several system-level issues contributed to this delay. These issues included the incorrect timeframe being used to set the 'treat-by date' for the sigmoidoscopy and general surgical review, the duplication of the referral to the general surgical service, the lack of systematic monitoring of the general surgical FSA waitlist and, most importantly, the significant mismatch between the capacity of and demand for the colorectal clinic. Other systemic issues also contributed to the delays in Mr B's case: the re-routing of Mr B's gastroenterology referral to his GP rather than directly to the general surgery team and the failure to seek clarity from Dr A about the initial gastroenterology referral before declining it.

19. I have carefully read through the AER, and I agree with the findings (that are supported by other evidence provided to my investigation). It is highly concerning to learn that, around the time of Mr B's care, semi-urgent patients were waiting up to 14 times longer to be seen by the general surgical service for an FSA than the recommended six weeks. This is unacceptable, and I conclude that, as a result, Mr B did not receive timely and appropriate care, amounting to a breach of Right 4(1) of the Code.

Changes made

20. Health NZ has already made significant changes to its processes and systems in an effort to avoid similar circumstances arising in the future:

    a) The gastroenterology service now seeks additional information from the referring clinician or the patient if outlet-type bleeding is not clearly identified during the triage process.

    b) A dedicated consultant is now undertaking monthly colorectal clinics and is seeing patients who are semi-urgent/routine and patients who have been waiting for a long time to be seen, focusing on reducing the number of these patients.

    c) Since 12 June 2025, an extra weekly clinic has been held, with a general surgeon focusing on rectal bleeding.

21. In addition, Health NZ plans to make, and is implementing, the following changes since completing its AER in August 2025:

    a) review the HealthPathways guidelines to ensure definitions of unexplained bleeding and outlet bleeding are clear, that the pathways differentiate between general surgical service and gastroenterology outpatient requests for direct access colonoscopy, and that guidance on communication to primary care is included. Health NZ has advised that information has been provided to the National HealthPathways Team to allow it to consider this proposal;

b) implement a process during triage in the gastroenterology service that will allow for direct transfer of referrals to the general surgical service;

c) undertake a review of the primary care referral process to the gastroenterology service to improve standardisation, ensure consistency, and enhance patient safety in the referrals process to secondary care;

d) consider the request for a referral dedicated to outlet-type bleeding to ensure alarm symptoms are mandated as part of the referral template;

e) review the establishment of a rapid access sigmoidoscopy clinic for those in higher-risk groups with outlet-type bleeding and develop a business case to build sustainable ongoing progress, including capacity;

f) map the work process for the administration team that books general surgical referrals to identify inefficiencies and risk. As part of this, Health NZ will amend the standard operating procedure to improve identification of outlet-type bleeding.

Recommendations and follow-up actions

22. I acknowledge the significant changes Health NZ is undertaking and planning to make. In addition, I recommend that Health New Zealand | Te Whatu Ora Southern:

a) provide a further update on the recommendations outlined in its AER (see paragraph 21a) to f)) within six months of the date of this report;

b) provide an update on the wait times for general surgical FSAs within six months of the date of this report.

23. Health NZ has confirmed that it accepts the above recommendations.

24. A copy of this report with details identifying the parties removed, except Health New Zealand | Te Whatu Ora Southern, will be sent to the Cancer Control Agency and the Ministry of Health and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner