HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Poor response by hospital for terminally ill cancer patient requiring care

Complaint background

1. On 21 June 2023, a complaint was received from Mrs A about the care provided to her mother, Mrs B, by Health New Zealand | Te Whatu Ora Te Toka Tumai Auckland (Health NZ Te Toka Tumai).

2. In her complaint, Mrs A explained that Mrs B (aged 65 at the time) was terminally ill[1] with leukaemia[2] and was sadly at the end stage of her life. She was planning to visit family in Auckland to say her goodbyes, and the Haematology[3]/Oncology team at another tertiary hospital (the tertiary haematology team) made plans for her to receive care at Auckland City Hospital during this trip.

3. During the journey to Auckland, Mrs B became very unwell, and Mrs A contacted the tertiary haematology team to discuss her concerns. She was advised to wait until the appointment with the Auckland haematology team where Mrs B could be reviewed.

4. On 6 June 2023, on arrival at Auckland City Hospital's Haematology Day Stay, Mrs A stated that staff initially appeared unaware of Mrs B's planned appointment and said she was not in their system. However, this was resolved and a bed space provided. Mrs A said she raised her concerns with staff that Mrs B's health had been declining in the days leading up to the appointment and asked for her vital signs to be checked. Mrs A stated that staff declined to do this and said they could only do what was stated on the referral form from the tertiary haematology team.

5. Mrs B's bloods were eventually taken. Mrs A is a registered nurse herself, and she noted that she considered the results to indicate that Mrs B was in moderate kidney failure and significantly fluid overloaded. At this stage, Mrs A asked whether a doctor could review Mrs B. Mrs A states that staff told her that because Mrs B was not one of their 'Auckland patients' they could not do this and said how busy they were. Mrs A stated that staff repeated this 'multiple times throughout the day'.

6. Given this response from staff, Mrs A checked Mrs B's vital signs herself, which she recorded as temperature 39°C,[4] tachycardia,[5] and oxygen saturation 86% at rest on 2L oxygen.[6] Because of her ongoing concerns, Mrs A contacted a hospice doctor in the tertiary centre, who asked to be contacted by a doctor from the Auckland haematology team immediately. Mrs A states that staff were reluctant to facilitate this, requesting a rationale, and stating

[1] With a prognosis of weeks to short months.
[2] A type of blood cancer.
[3] A branch of medicine that focuses on the diagnosis, treatment and research of cancer.
[4] 38.3°C is considered fever level (Normal Body Temperature: Babies, Kids, Adults).
[5] Increased heart rate.
[6] In most people, a healthy blood oxygen level is 95–100%.

Names have been removed (except Health New Zealand | Te Whatu Ora Te Toka Tumai Auckland) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

that the doctor was 'extremely busy'. Eventually, the Haematology registrar at Auckland City Hospital made the call.

7. Mrs B was then seen by the Haematology registrar, and subsequent clinical records confirm that a full assessment was completed for drowsiness and her creatinine was noted to be '150, reportedly in the tertiary region it was 66'.[7] Mrs B's clinical records note the registrar's summary of findings as '[query] oliguric[8] renal impairment of unclear cause. As a result, likely opiate[9] accumulation' and treatment was provided.[10] Clinical records noted that, after her blood transfusion,[11] Mrs B's temperature spiked at 38.1 degrees, blood and urine cultures were taken, she was prescribed intravenous antibiotics, and she was advised to return to the tertiary region.[12]

8. Mrs A told HDC that, as a nurse, she was aware that if a patient presented to her from anywhere in the country, it was her duty of care to clinically assess them and put interventions in place to help them; she said that if she had not advocated strongly for her mother, she would not have received the required treatment and care she should have. Mrs A also stated that Health NZ was supposed to be a streamlined health system across the country, and the actions of staff within Auckland's haematology team in refusing to appropriately assess her mother were not consistent with the collaborative approach that Health NZ intended to offer.

9. Sadly, Mrs B died in late June 2022.

Information gathered

10. Health NZ Te Toka Tumai told HDC it wished to give its 'sincerest condolences to the family of Mrs B on their loss.'

11. In its response to HDC, Health NZ Te Toka Tumai apologised for the poor experiences of Mrs B and Mrs A. It acknowledged that the way they were welcomed did not give life to their organisational values of haere mai, manaaki, tūhono, and angamua.

12. Health NZ Te Toka Tumai acknowledged that unnecessary stress was caused by this experience and the impact it would have had on their overall trip. It also acknowledged that Health NZ is one united service and that this has been communicated to staff.

13. Health NZ Te Toka Tumai stated that, at the time there was no national Health NZ electronic health record. As such, it was unable to view Mrs A's full clinical details from the tertiary

[7] As reported by the Palliative Medicine team from the hospice in the tertiary region in a telephone call with the registrar.
[8] Low urine output.
[9] Drugs used to treat pain.
[10] Summarised in Health NZ's response as 'Furosemide [diuretic medication] and change analgesia to OxyNorm [to relieve moderate to severe pain when other forms of treatment have not been effective] and encourage regular paracetamol.'
[11] Noted in the clinical records that a '1 unit platelet' had been transfused.
[12] 'as medically unwell and fragmented care may be of further detriment. Also risk of ongoing deterioration making travel back to tertiary region difficult.'

region. It acknowledged that there is 'still work to be done to implement a seamless system nationally.'

14. Although staff were following instructions from the tertiary region referral, Health NZ Te Toka Tumai acknowledged that 'they should have shown more compassion and respect to Mrs B, who was travelling away from home', adding:

> 'An initial assessment should have been completed with observations to ascertain a baseline, a medical review requested due to [Mrs B's] clinical deterioration and a transfer to the emergency department.'

Changes made since events

15. Health NZ Te Toka Tumai stated that, in recognition that the welcome was poor for Mrs B, it has rolled out the 'Kia Ora Programme' (the programme) across all the cancer and blood units. Health NZ Te Toka Tumai stated:

> 'This programme will work towards embedding six foundational values providing a framework for how we can better serve patients and whānau and unite us all in the pursuit of te ora (wellbeing). Effective communication skills in order to connect and create relationships are our first skill in a journey of education and training that focuses on a warm mana-enhancing welcome and respectful connection.'

16. Health NZ Te Toka Tumai also stated it 'commit[s] to continuous reflection and improving our practice through values-based care, with an emphasis on providing everyone (no matter where they reside) a warm welcome into our services.'

17. Health NZ Te Toka Tumai told HDC that a 10-year Digital Investment Strategy had been developed and was progressing through Cabinet to set 'the foundation for whole-of-system sharing of clinical information with the right social licence and patient choice at its core.' However, in the meantime, it was focusing on 'simplifying the landscape and using available regional systems to enable consistent intra-regional sharing and as much cross-regional connectivity as current technology, funding, and governance arrangements allow.'

18. Health NZ Te Toka Tumai confirmed that interim measures would be put in place for patients seeking medical appointments across regions to ensure a consistent clinical baseline is established before their visit. This includes that all 'clinical requests and handovers must be conducted on a Specialist Medical Officer (SMO) to SMO basis.' Health NZ outlined what the required clinical documentation would include.[13]

[13] 'the referral letter for the appointment or treatment, a comprehensive clinical summary, the three most recent clinic letters, the four most recent sets of full blood results, nursing notes from previous treatments, any diagnostic results completed within the past four weeks, infectious status, the most current shared goals of care, next of kin, advanced care plans and any other information deemed necessary by the accepting SMO.'

Responses to provisional decision

Mrs A

19. Mrs A was given an opportunity to respond to the 'Complaint background', 'Information gathered', and 'Changes made since events' sections of the provisional opinion, but she provided no comments to HDC.

Health NZ

20. Health NZ was provided with the opportunity to respond to the provisional opinion and stated:

> 'we would like to give our sincerest condolences to the family of Mrs B on their loss.'

21. Health NZ also acknowledged that the way Mrs B and Mrs A were welcomed into the service 'did not align with our values of *Haere mai, Manaaki, Tūhono, and Angamua.'*

Ministry of Health

22. In response to a recommendation made in the provisional opinion regarding the request for an update on the progress of the 10-year digital strategy towards a nationally accessible patient information system, the Ministry of Health confirmed that Health NZ are to deliver a 10-year Digital Investment Plan (DIP) that covers all planned future digital investment. The Health DIP was announced by the Minister of Health on 25 November 2025.

Decision

23. At the time of this incident, Health NZ had been established for almost a year. One of the objectives of the health reforms and the nationalisation of the system was to achieve equity of access and to ensure that 'everyone gets the right healthcare, where and when they need it.'[14] For Mrs B, this did not occur.

24. I acknowledge that many aspects of the administrative functions of the organisation were still under development in 2023, and systems for coordinating care between districts were not fully established.

25. However, Auckland City Hospital did not appear to have an adequate system in place to ensure that Mrs B's full clinical details were available for review at her appointment. It appears that the only information readily available to staff was the referral letter from the tertiary hospital, which should have been sufficient to alert staff to undertake the necessary initial assessment, medical review, and transfer.

26. Further to this, the nursing staff's repeated refusal to escalate Mrs B's care because she was not an Auckland resident is deeply concerning in terms of clinical care. It was not in alignment with the aims of the nationalised service, and it was lacking in compassion and respect.

[14] How our health system is changing / E panoni ana tō tātou hātepe hauora – Health New Zealand | Te Whatu Ora

27. It appears that several staff were involved in Mrs B's care, and the deficiencies appear to reflect mainly systems issues, although I also consider that individual staff did not act with professionalism.

28. I consider that, cumulatively, these deficiencies amount to a breach of Right 4(1) of the Code, which states that every consumer has the right to have services provided with reasonable skill and care.

29. Health NZ Te Toka Tumai accepted this proposed finding.

30. As such, I find that Health NZ Te Toka Tumai breached Right 4(1) of the Code in the lack of care it provided to Mrs B on 6 June 2023.

Recommendations

31. I recommend that Health NZ Te Toka Tumai:

    a. Provide a written apology to Mrs B's family for the breaches of care outlined in this decision. The apology is to be sent to HDC within three weeks of the date of this report for forwarding to Mrs B's family.

    b. Confirm when the implementation of the 'Kia Ora Programme' was rolled out across all the cancer and blood units. Provide evidence of implementation by providing a copy of the programme to HDC within three months of the date of this report.

    c. Provide HDC with a summary of the feedback and evaluation collated at the end of each skill-based session for the 'Kia Ora Programme' within the Haematology Department at Auckland City Hospital for a period of three months. The purpose of this is to assess the participants' experiences and perceptions and whether they feel Health NZ Te Toka Tumai's foundational values of effective communication are being met. The summary of feedback is to be provided to HDC within six months of the date of this report.

    d. Use this report as a basis for developing education/training on the organisational values for staff (including using it in its induction materials for new staff) within the Haematology team at Auckland City Hospital. Provide evidence confirming the content of the training and attendance records for current staff to HDC within three months of the date of this report.

32. I recommend that Health NZ National Office:

    a. Provide HDC with an update regarding the progress of the 10-year Health DIP towards a nationally accessible patient information system. The update is to be provided to HDC within six months of the date of this report.

Follow-up actions

33. A copy of this report will be sent to Health NZ Te Toka Tumai, Health NZ's National Office, and the Ministry of Health.

34. A copy of this report with details identifying the parties removed, except Health NZ Te Toka Tumai, and the Ministry of Health will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner