Delay in woman being told about her diagnosis of meningioma

Complaint background

1. On 18 June 2024, Mrs B submitted a complaint to the Health and Disability Commissioner (HDC) raising concerns about an approximately four-month delay in being told about her diagnosis of meningioma (a tumour arising from meningeal tissue in the brain) by a specialist outpatient department at Health New Zealand | Te Whatu Ora – Te Matau a Māui Hawke's Bay (Health NZ).

2. Mrs B explained that she was only told of her meningioma diagnosis during a routine follow-up appointment with the specialist outpatient department, where it became apparent that there had been an oversight in communicating her diagnosis to her.

3. Mrs B described her concern that she had fallen through the cracks of the system and the impact the delay in communication of her diagnosis has had on her.

Scope of investigation

4. The following issue was investigated:

   - *Whether Health New Zealand | Te Whatu Ora provided Mrs B with an appropriate standard of care between 22 January 2024 and 17 June 2024 inclusive.*

Background

5. On 22 January 2024, an optometrist referred Mrs B to a specialist outpatient department at Health NZ as she had a sixth nerve palsy (a condition where the nerve controlling outward eye movement is damaged) with a background of viral illness.

6. On 26 January 2024, the referral was triaged as urgent by an allied health specialist, Ms C, and an appointment was made for Mrs B to see Ms C on 16 February 2024.

7. On 16 February 2024, Mrs B attended the planned specialist appointment. Ms C had concerns regarding the sixth nerve palsy in Mrs B's right eye, with symptoms of double vision (diplopia). Ms C asked Dr A, the locum acute specialist registrar, to see Mrs B in the acute clinic that day.

8. Dr A assessed Mrs B then ordered routine blood tests and a diagnostic magnetic resonance imaging (MRI) scan. He requested that the MRI scan be completed within the next two weeks and a follow-up appointment be made for after it had been completed.

9. Mrs B had the blood tests on 19 February 2024 and the MRI scan on 28 February 2024. On 2 March 2024, a radiologist reported the MRI results as indicating a 'high suspicion of meningioma'.

10. On 28 April 2024, having had no contact from the specialist department or an appointment for her MRI follow-up, Mrs B contacted the department and spoke to Ms C.

11. Ms C stated that she was unable to provide the findings of the MRI to Mrs B because this was outside of her scope as an allied health specialist. However, she said she would follow this up and expected someone to contact Mrs B. Ms C escalated the situation to a registrar later the same day.

12. On 29 April 2024, specialist registrar Dr D reviewed the MRI, consulted with the on-call neurosurgery registrar at a tertiary hospital over the phone, and sent an urgent referral to the Neurosurgery department at the tertiary hospital. There was no communication with Mrs B at this time about her results, the referral, or any follow-up appointments.

13. On 17 June 2024, during a routine appointment with Ms C, it became apparent that Mrs B was unaware of the diagnosis of meningioma or the referral that had been made to the Neurosurgery department. Ms C advised Mrs B of the results and referral.

14. On 25 June 2024, Mrs B's case was discussed at the neurosurgery multidisciplinary meeting, and she was referred to the tertiary oncology clinic for aggressive treatment of the meningioma.

Serious adverse event review and follow-up actions

15. In its first response to HDC about Mrs B's complaint, Health NZ identified several factors that led to the failure to inform Mrs B of her results and the failure to organise follow-up of her results. Health NZ subsequently provided HDC with a copy of their serious adverse event review (SAER), which confirmed how the delays had occurred. The factors included:

- Mrs B was moved from Ms C's specialist clinic to the acute clinic to be reviewed. This was not highlighted to the clinic bookers and so was not captured in the electronic booking system. This meant the request from Dr A for a follow-up appointment to be booked two weeks after the MRI was not actioned.

- When Dr A completed the blood test request form and the electronic order for the MRI, he named the specialist team (rather than an individual) as the ordering provider on the blood forms and allied health specialist Ms C as the referrer on the MRI form. This was because he was working in the acute clinic in a locum capacity and so would potentially not be available to follow up on the results. As it is beyond Ms C's scope of practice to request an MRI, she should not have been named as the member of staff to receive and check for the results. Expected practice would have been for the blood and MRI results and follow-up to be assigned to a senior doctor in the specialist team.

- The radiologist reporting the MRI result on 2 March 2024 did not flag the results to Ms C or the specialist Senior Medical Officer (SMO). The Radiology department explained that there is no hard rule for flagging this particular kind of finding with the referrer and that, in this circumstance, the Radiologist would expect that the requester would read the result and act accordingly.

- On 29 April 2024, Dr D did not contact Mrs B to communicate her findings and discuss her action plan and referral to the tertiary hospital neurosurgery department. Standard

practice would be for Dr D to contact Mrs B and invite her for a face-to-face consultation with the specialist SMO to discuss her diagnosis and the required treatment plan.

16. The SAER made the following recommendations:

- Educate the specialist department staff to use the appropriate phrases when alerting the booking staff about urgent clinical priority patients (completed).
- Develop a comprehensive orientation programme for substantive and locum clinicians, which includes guidance on the management of test requests (completed).
- Ensure that the generic results inbox in the clinical portal is monitored regularly and results are signed off (policy development in progress).

17. In addition, Health NZ advised that the clinical nurse coordinator now works with the booking staff to ensure that patients receive their appointments when due.

Decision

18. I acknowledge the distress the delay in communication of the meningioma diagnosis caused Mrs B, and I appreciate her bringing her concerns to this Office with a view to improving services to prevent a similar event happening to another consumer.

19. Health NZ had knowledge of the high suspicion of meningioma from Mrs B's MRI scan result of 2 March 2024, yet Mrs B was not informed about this result until 17 June 2024. Right 6(1)(f) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including the results of tests. However, it was three and a half months before Mrs B was advised of her results. In my view, especially given the significance of the diagnosis and the need for ongoing treatment, the failure of Health NZ to provide this information in a timely manner amounts to a breach of Right 6(1)(f) of the Code.

20. In addition, the locum acute specialist registrar, Dr A, requested a follow-up appointment to be booked for two weeks after Mrs B's MRI scan, but this was not booked. Such an appointment would have provided an opportunity for a specialist department clinician to discuss the results of the MRI scan with Mrs B and inform her of and prepare her for her treatment plan, but this opportunity was missed. I am therefore satisfied that services were not provided to Mrs B with reasonable care and skill and that Health NZ breached Right 4(1) of the Code.[1]

21. The information I have reviewed, including Health NZ's responses and the SAER, confirm that system factors contributed to the delay in communication of the MRI scan result to Mrs B and the failure to book the follow-up appointment after the MRI scan. These factors included administrative oversights and a lack of knowledge for some clinicians of appropriate systems to ensure the appropriate ordering and assignation of tests, follow-up,

[1] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

and communication. Given the systemic factors and that there were failings by several clinicians, it is appropriate that responsibility for these failings rest with Health NZ.

22. I note that Health NZ has accepted the proposed breach findings.

Recommendations

23. When this complaint was brought to the attention of HDC, I wrote to the Chief Executive of Health NZ expressing concern that Mrs B's experience occurred in the context of significant workforce shortages in the Hawke's Bay specialist outpatient service – noting the vacancies for the head of department and for senior and training doctors. Administrative bookers were also understaffed. Locum cover was available but, in part (as discussed above), contributed to the care delivery issues. I requested information about the support of Hawke's Bay's specialist outpatient service.

24. Health NZ have since provided an update to HDC on the current staffing levels of the specialist department and noted that there are no nursing vacancies, four of five registrar positions are filled, and a head of department has been appointed. I am satisfied that Health NZ has addressed the workforce constraints that were current at the time of these events.

25. I acknowledge the system improvements made by Health NZ since this event. I recommend that Health NZ – Te Matau a Māui Hawke's Bay:

- Provide a written apology to Mrs B for the breaches of Rights 4(1) and 6(1)(f) as identified in my investigation. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B.

- Provide HDC with a copy of the orientation handbook now in use to guide locum staff in the management of test requests, within six months of the date of this report.

- Provide HDC with a copy of the policy guidance regarding monitoring and signing off of results in the generic results inbox in the clinical portal, within six months of the date of this report.

Follow-up actions

26. A copy of this report will be sent to Health NZ National Office.

27. A copy of this report with details identifying the parties removed, except Health NZ – Te Matau a Māui Hawke's Bay, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner