HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Combination of failures led to woman's delayed terminal cancer diagnosis

Introduction and complaint

1. This investigation concerned the care provided to Mrs A by Health New Zealand | Te Whatu Ora Whanganui (Health NZ). Mrs A initially presented to Health NZ in Month1 2021 and in Month3 2022 was diagnosed with terminal endometrial cancer. Sadly, Mrs A passed away four months later.

2. Mr A (Mrs A's husband) raised concerns with the Health and Disability Commissioner (HDC) about the care provided to Mrs A, including failure to assess her on first admission, failure to follow up in an outpatient setting, and failure to act on a radiology report indicating further review was required. Very sadly, Mr A passed away during this investigation.

3. I express my sympathy and heartfelt condolences to Mrs A's family for their loss. Noting the loss of both Mrs and Mr A, who brought the original complaint so 'that this does not happen to another person,' it is commendable that their son and daughter continued with the complaint to ensure 'no other family has to go through what we've been through.'

4. Under Rights 4(1) and 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code), Health NZ had an obligation to provide services with reasonable care and skill and to ensure that care was provided in a manner that minimised the potential harm to, and optimised the quality of life of, Mrs A.

5. Having reviewed all the information, I consider that Mrs A experienced a series of systemic failures in her care, and I find Health NZ in Breach of Rights 4(1) and 4(4), as outlined in the remainder of this report.

Recommendations

6. Noting that Mrs A's family felt Health NZ's initial apology was 'meaningless,' I recommend that Health NZ provide a fulsome written apology to Mrs A's family acknowledging the failures identified in this report. Health NZ may wish to consider including an update on the changes it has made since the events and any work it is planning to undertake. The written apology is to be provided to HDC within three weeks of the date of this report for forwarding to Mrs A's family.

7. In addition, I recommend:

   a) Health NZ conduct audits to assess compliance with the following:

      i) sign-off on radiology reports occurs within 24 hours, unless impacted by public holidays or weekends

      ii) discharge requirements are clearly outlined in patient notes

Names have been removed (except Health New Zealand | Te Whatu Ora Whanganui and the expert advisors on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name. Relevant days and months are referred to as Day1-Day4 and Month1–Month5 to protect privacy.

iii) follow-up appointments are scheduled within the time requested on the discharge summary, noting they will be subject to clinical triage and may be re-prioritised based on service demand and patient need

iv) follow-up instructions have been met in the time requested in the referral section of the discharge summary

v) general practitioner (GP) information (where known and provided by a patient) is listed on the discharge summary.

A copy of these reports, along with any corrective actions/improvements, is to be provided to HDC within 6 months of the date of this report.

b) Provide a copy of the new process introduced to demonstrate that results requested by locums/departing staff are being diverted to an appropriate head of department and evidence that training has taken place around this for staff concerned. Evidence of the education/training occurring in the form of education/training material and staff attendance records is to be provided to HDC within three months of the date of this report.

c) Confirm what steps have been taken to ensure that registrars discuss all admissions with the relevant consultant gynaecologist/specialist on duty to ensure relevant checks and medical reviews of a patient with an unusual/concerning presentation (such as that of Mrs A) take place before discharge. This information is to be provided to HDC within three months of the date of this report.

d) Provide an update on recruitment to address the understaffing problem. This information is to be provided to HDC within three months of the date of this report.

e) Provide a copy of the 'National Policy – Transfer of Care and Test Results Responsibility' that is in place. This information is to be provided to HDC within three months of the date of this report.

Background

8. On the evening of Day1 Month1 2021, Mrs A was taken to the Emergency Department (ED) of Whanganui Hospital (the hospital) after fainting and hitting her head in her bathroom at home. In the days leading up to her visit to hospital, Mrs A had been experiencing diarrhoea, vomiting, and heavy vaginal bleeding.

9. Mrs A was seen by the ED Registrar and the clinical records noted menstruation being 'unusual in a 61-year-old female.' The ED Registrar discussed Mrs A's case with the on-call Obstetrician and Gynaecologist Registrar after which Mrs A was accepted for admission. There are no notes on file regarding this consultation. The primary diagnosis was

'Symptomatic anaemia secondary to menorrhagia'[1] with a plan for the ward that included reviewing Mrs A's blood results the following morning and an outpatient referral on discharge for 'follow-up of changing menstruation with possible endometrial biopsy.'

10. There are two conflicting discharge summaries. The first discharge summary notes from the ED to the ward, dated Day1 Month1 and completed by the ED Registrar, state that Mrs A 'did not require a referral to any other Service at present.' It included a section 'Advice to GP,' which left the ongoing care of Mrs A with the GP, with 'no specific recommendations' and asked for the discharge summary to be sent to the GP. However, Mrs A's GP is identified as 'Unknown' in the documentation.

11. The second discharge summary is dated Day2 Month1 and is a separate discharge summary record of Mrs A's discharge from the ED to the ward. This summary documents the names of her GP and GP practice and notes that Mrs A is 'for admission to surgical under [gynaecology].'

12. On Day2 Month1, Mrs A was seen by Dr B, Junior House Officer, and subsequently discharged from hospital as a routine discharge. The discharge plan does not include information on Mrs A's GP, despite indicating that ongoing care of Mrs A was expected to be with the GP. Under 'Advice to GP,' there were 'no specific recommendations' despite the discharge plan outlining that an ultrasound scan (USS) order had been placed and that a referral had been made to the gynaecology outpatient clinic for follow-up.

13. Records indicate that the USS was booked; however, the outpatient referral was not actioned, and Mrs A was not booked for follow-up. Additionally, Mrs A's GP was not sent a copy of any of the discharge summaries.

14. On page four of the Summary Discharge from hospital under the section 'SendToGP' it states 'No.' Again, Mrs A's GP is documented as 'Unknown.' The discharge plan was signed only by Dr B. Dr B's discharge summary recorded Dr C, locum Obstetrics and Gynaecology Senior Medical Officer (SMO), as the responsible clinician and Mrs A's primary diagnosis as 'Anaemia secondary to heavy PV bleeding; Dehydration secondary to gastroenteritis.'[2]

15. Dr C told HDC that, although he was on duty at the hospital over the weekend of Mrs A's stay, and his name is referenced on the discharge summary completed by Dr B as the responsible clinician, he did not see Mrs A while she was in hospital. Dr C told HDC that there was 'no record in the notes that [he] was ever informed of Mrs A's admission and nor did [he] have any memory of having been informed.' Dr C told HDC that his usual practice would be to see all women who are admitted and needing medical review once he is made aware of their admission. Health NZ told HDC that its usual process was for the responsible clinician

[1] Symptomatic anaemia means the patient is experiencing symptoms related to the blood being deficient in red blood cells, haemoglobin, or total volume. Secondary to menorrhagia means the anaemia is caused by abnormally heavy menstrual flow.
[2] Meaning 'anaemia caused by heavy bleeding from the vagina (PV) and dehydration caused by intestinal (gut) infection.'

to be advised of admissions and for a management plan to be established. It appears that this did not occur.

16. Mrs A was subsequently discharged without having been reviewed by an SMO. Health NZ told HDC that it had no explanation for this.

17. On Day3 Month1, Mrs A attended the Gynaecology Outpatient Department and had an USS of her pelvic area, reported on the next day by Dr D. Dr D told HDC that the history provided to him on the electronic order was of 'Symptomatic anaemia secondary to heavy PV bleeding at 61 years of age.' The radiology report noted multiple concerns,[3] including an abnormal left ovary, that it was a 'Complex ultrasound for interpretation,' and that he recommended an urgent gynaecology review.

18. The radiology report was sent back to the 'responsible clinician', Dr C. However, by this stage, Dr C was no longer working at the hospital and so the report remained as 'sent' but not received/signed. Health NZ told HDC that, at the time, no policy was in place to ensure radiology reports requested by locum clinicians were accepted or reviewed in a timely manner.

19. Health NZ told HDC that Mrs A's GP did not receive a copy of Dr D's report and that no gynaecological review occurred and no outpatient appointment was arranged despite the results, Dr D's recommendations, and the referrals outlined on the discharge summary of Day2 Month1.

20. On Day1 Month3 2022, Mrs A visited her GP because of swelling in her lower left leg and back pain. Mrs A was urgently referred to the Gynaecology Outpatient Department for probable malignancy, with mention of the postmenopausal bleeding, anaemia, querying an abnormal ovary from previous USS (information from Mrs A), the swollen left leg, and pelvic obstruction. An urgent USS of Mrs A's lower leg was also arranged for the following day.

21. On Day2 Month3, a USS on Mrs A's lower left leg at the hospital identified a 'non-occlusive thrombus [a blood clot that partially blocks a vein] within the left common femoral [of or relating to the femur or thigh] and femoral veins, with further below knee DVT [deep vein thrombosis].' A referral was made to the Gynaecology service for Mrs A to be seen urgently within two weeks because of a high suspicion of cancer.

22. On Day3 Month3, Mrs A was seen at the Gynaecology Outpatient Clinic by a separate Obstetrician and Gynaecologist. The clinical records noted that Mrs A's last menstrual period had been two years previously but she had been having 'postmenopausal bleeding for the past year.' They also noted that the USS on Day3 Month1 2021 had found a 'complex left

[3] An abnormal left ovary enlarged in size (20.9ml compared with her left, which was 13.1ml). In his comments, Dr D noted, 'Poor differentiation between myometrium [the muscular outer layer of the uterus] and endometrium [lining of the uterus]. I am uncertain whether there is a subserosal fibroid [non-cancerous growth on the outside of the uterus] measuring 43 x 36 x 29mm or whether it is a hyperplastic endometrium [abnormally thick uterus lining] measuring 30mm thick. Increased vascularity [more blood vessels than normal] noted in the cervix.'

ovarian mass.' Mrs A underwent a vaginal speculum (cervical smear) examination, which identified a 2cm polyp outside of her cervix, which was removed by surgery and sent for testing. An urgent computed tomography (CT) scan of Mrs A's chest, abdomen, and pelvis was ordered. The possibility of ovarian malignancy was discussed with Mr and Mrs A.

23. The CT scan results showed that Mrs A had a 5cm endometrial mass, a 7cm ovarian lesion, and a 6cm mass on the left iliopsoas[4] to the front of the sacroiliac joint (a large mass inside the uterus that extended to the cervical canal). The left ovary was solid (68 × 45 × 53mm) and notably increased from the Day3 Month1 2021 USS. There were also enlarged lymph nodes on the pelvic side wall.

24. On Day4 Month3 2022, Mrs A was called and advised of the histology and the findings from the CT scan and biopsy, which showed a serious carcinoma and malignancy with possible metastases. Mrs A was advised that her case would be discussed in the Gynae-Oncology multidisciplinary meeting at the hospital on Day1 Month4 and that she would be called after that.

25. On Day2 Month4, Mrs A was contacted and advised that she had an endometrium malignant primary cancer that had spread to her ovary and invaded the iliopsoas muscle and that she would be referred for palliative care and chemotherapy. Sadly, Mrs A passed away a few months later, surrounded by her family.

Further information

Health NZ Critical Systems Analysis (CSA)

26. Health NZ conducted a CSA to review what happened; this was completed in Month5 2022 and identified the following issues.

- No medical review was conducted.
- Clinical documentation was inaccurate and incomplete.
- Information about whether follow-up was required was conflicting.
- Discharge paperwork was incomplete.
- The USS report was neither sighted nor signed.
- The USS was not followed up with gynaecology review.
- The GP was not sent a copy of her discharge summary or USS report.

27. In a letter to Mr A dated early August 2023, Health NZ acknowledged that there had been 'a failing of the system that supports clinical care in so much as there were several human errors by different individuals at play here.' Health NZ also recognised that, due to the delays, 'an earlier diagnosis may have made a difference in terms of spread of the malignancy.'

[4] The iliopsoas is a muscle that connects the spine and the lower limbs.

Dr C

28. Dr C told HDC that he was deeply sorry to learn what had happened to Mrs A and offered his sincere condolences to her family.

Dr B

29. In his statement to HDC, Dr B expressed his sincere condolences to Mrs A's family.

30. Dr B told HDC that he was on the after-hours roster at the hospital on Day1/Day2 Month1 2021 but that the passage of time meant he had no recollection of any discussion with Dr C, although it was possible he did. Dr B was also unable to comment on the discrepancies in the discharge follow-up documented in the discharge summary and the other form and believed it would have been what Dr C requested. Dr B also told HDC it was usual practice for junior medical staff to complete and sign discharge paperwork on behalf of SMOs and not typical for SMOs to sign discharge paperwork.

ACC information

31. An ACC Treatment Injury claim was made and expert advice obtained. Dr E, Obstetrics and Gynaecology specialist, considered that the treatment provided to Mrs A in Month1 2021 was neither reasonable nor appropriate. Dr E stated that 'Bleeding heavy enough to cause symptomatic anaemia in a 61-year-old is very unusual, and a malignant cause is the most likely explanation.'

32. Dr E also considered that there was a lack of gynaecology review and examination on Day2 Month1, lack of gynaecology clinic follow-up, possible under-reporting of the findings of the USS scan on Day3 Month1, and a lack of gynaecology sign-off of the abnormal scan report. Dr E stated that these failures resulted in a delay in diagnosis of Mrs A's endometrial cancer, and she believed it likely that Mrs A could have been treated surgically at an early stage.

Mrs A's family

33. Mrs A's family consider that if an earlier diagnosis had occurred in Month1 2021 when the USS was taken, there was a high chance that Mrs A could have had surgery in Month1/Month2 and a much better chance of survival and a good life after chemotherapy. Mrs A's family told HDC that the written apology offered by Health NZ lacked empathy and was unacceptable. The apology stated, 'We apologise that the request from the locum consultant for a follow-up appointment was overlooked.'

34. Mr and Mrs A's son (on behalf of their family) also told HDC that he watched his father's mental health deteriorate in the aftermath of his mother's eventual diagnosis up until his passing and explained that seeing their mother's premature death from cancer has affected them all as a family.

Expert advice

35. To assist in my assessment of this complaint, I sought independent expert advice as follows.

Radiology care and reporting

36. Dr Ben Wilson, Consultant Radiologist, carried out a blind review of Mrs A's USS of Day3 Month1 and reviewed the radiology report from Dr D (Appendix A). Dr Wilson advised that Dr D's report was of an appropriate standard aside from using two incorrect words. Dr Wilson advised that Dr D gave appropriate advice in recommending gynaecology review and confirmed that it is not the responsibility of the radiologist to follow up on recommendations made in the report.

37. However, Dr Wilson advised that the follow-up process at the hospital was unclear and that the timeframe of four months for Mrs A to be seen after the report would not be regarded as satisfactory.

Gynaecology care provided on Day1 and Day2 Month1 and follow-up/referral process

38. Dr Guy Gudex provided specialist gynaecology advice (Appendix B). Dr Gudex advised that the admission and care in the ED was appropriate, as was the discharge plan by Dr B, which included referral to the gynaecology service and a request for a pelvic USS.

39. However, Dr Gudex advised that he would have expected the on-call specialist, Dr C, to be informed of Mrs A's admission given her dramatic anaemia as a postmenopausal woman. Dr Gudex found the following departures from accepted practice:

- **Severe departure** – failing to organise a follow-up appointment for Mrs A.
- **Severe departure** – failing to have a process in place for radiology results requested by locum doctors to be reviewed and signed in a timely manner.

40. In his further advice to HDC, Dr Gudex found it unusual that there was no written record of medical admission by the gynaecology registrar or house surgeon and that the nursing notes do not mention a medical review of Mrs A, which would often be recorded.

Responses to provisional decision

41. Mrs A's family were given an opportunity to comment on relevant sections of the provisional decision and stated that, as a family, it was important to them that long-term improvements have been made by Health NZ.

42. Health NZ was given an opportunity to comment on the provisional decision and confirmed it accepted the Deputy Commissioner's provisional decision.

Decision

Health NZ – breach

43. Under Rights 4(1) and 4(4) of the Code, Health NZ had an obligation to provide services with reasonable care and skill and to ensure that care was provided in a manner that minimised the potential harm to, and optimised the quality of life of, Mrs A.

44. Having reviewed all the information in this case, including that of the independent experts, I consider that Mrs A experienced a series of systemic failures in her care. I acknowledge that several changes and improvements to address the multiple systems failures have since

been initiated by Health NZ. However, I note that the experts and Health NZ itself recognise that an earlier diagnosis is likely to have resulted in a different outcome for Mrs A and her family. I have sent Health NZ the full comments from Mr and Mrs A's son on behalf of Mrs A's family for it to consider when responding to my recommendations.

45. I consider many opportunities for Mrs A's diagnosis to have been made earlier were missed, as follows.

Failure to assess her on first admission

46. I note that a decision was made on Day1 Month1 for Mrs A to be admitted to gynaecology. However, Health NZ has provided no evidence that an SMO was contacted or advised of Mrs A's admission despite her concerning presentation and that this was standard practice. Health NZ has provided no explanation for why this did not occur, though I note the conflicting discharge summaries, which would have likely led to confusion about who should (or not) be seeing Mrs A. I find this unacceptable, especially as this was a missed opportunity to provide appropriate health care to Mrs A. Further, no clinical notes regarding discussions between clinicians are on file, and these could have been a point of reference given the conflicting discharge summaries.

Failure to follow up in an outpatient setting

47. As outlined above, the discharge summaries were confusing, with only one of the two indicating that Mrs A's GP should be sent a copy. Even though Mrs A's GP was listed on the Day2 Month1 discharge summary for her admission to the ward, her GP and GP location are listed as 'unknown' on the discharge plan, which meant her GP did not receive the information. The discharge summaries are also conflicting about the recommendations, with one stating 'no specific recommendations' and the other appropriately referencing Mrs A being referred for the USS and to Gynaecology. Given that the purpose would have been to include Mrs A's GP as part of a safety-netting process, this oversight was another missed opportunity for Mrs A's GP to follow up on the recommendations made, and I am critical of this.

48. I am also critical that Dr C was the only doctor listed on Mrs A's records, including being listed as the responsible clinician, which meant that any further information/results would be re-routed to him and not the gynaecology service or her GP. Knowing there was no system in place to route locum follow-up information, this lack of alternative detail created an unacceptable risk and meant the information was lost and not followed up.

49. I note that information and actions in relation to the recommendations made were incomplete, with some information included on the discharge summary that a USS and outpatient appointment should occur. However, Health NZ told HDC that this was in the incorrect section, where 'it might not have been seen.' Although the USS was booked, the outpatient appointment was not, and Dr Gudex stated that it would be standard practice for the discharging doctor to arrange the outpatient follow-up and that this was a **severe departure** if it was not arranged. I agree with Dr Gudex and am extremely concerned this did not happen; I consider this to be an overall system failure that created a further missed opportunity for appropriate care for Mrs A.

50. In my view, additional opportunities were missed when Mrs A presented to outpatients for the USS. No process was in place to identify that she had not been booked for an outpatient clinic appointment as mentioned in the discharge notes or to identify that no appointment had been booked for a review of her USS results.

Failure to act on a radiology report indicating further review was required

51. I note that Health NZ failed to have a policy in place for the receipt and acceptance/actions of radiology reports requested by locums. Dr Gudex states that this is a **severe departure** from standard practice. I agree with Dr Gudex and consider that this created an unacceptable risk that no follow-up would occur for Mrs A.

Poor clinical documentation

52. I note that various clinicians failed to document discussions that took place during Mrs A's care. As I have stated in paragraph 46, not only would it have been a useful reference at the time, given the confusing discharge summaries, it has also made it difficult for me to understand what happened, and I am critical of this. However, I note that Health NZ – Whanganui has now provided further training for staff on timely, accurate documentation, and I recommend this continues.

53. I consider that all these issues arose because Health NZ's systems and oversight were inadequate and appropriate policy was lacking.

54. As a result of these inadequacies, Mrs A was 'lost in the system' at a critical point in her health care journey and consequently received a delayed diagnosis of cancer, at which stage she was terminal. I am of the view that the multiple failure points meant Mrs A did not receive care of an appropriate standard, and the care did not minimise the potential harm to her or optimise her quality of life. Accordingly, I find Health NZ in breach of Rights 4(1) and 4(4) of the Code.

Dr B – educational comment

55. I accept Dr Gudex's advice that Dr B's discharge plan for Mrs A to be referred for a USS and to the gynaecology service was adequate. However, I am critical that Dr B did not identify Mrs A's GP on the discharge plan and that he provided incorrect information around 'no recommendations made,' which contributed to the failure to send a copy of the discharge notes to Mrs A's GP. I also note that Dr Gudex outlined that it would be expected for the discharging doctor to schedule the outpatient appointment, and I am critical this did not occur. However, as I have acknowledged as part of my decision, I recognise that Health NZ did not have a clear process in place for this. I recommend that Dr B ensures he carries out appropriate reviews of the discharge summaries he completes to ensure they are cross-checked and contain accurate and all necessary information.

Changes made since events

Health NZ

56. Health NZ confirmed the following actions had taken place as a result of the CSA findings:

- An audit of receipt and confirmation of radiology results showed a small percentage of delays in acknowledging reports within 24 hours. A data steward responsible for monitoring unacknowledged results and informing SMOs when these are not acknowledged and addressed was appointed.
- In mid-2022, a memo was sent to staff about the importance of checking the referral section of any discharge summary and that a GP for every patient is listed. An audit to assess follow-up appointments noted in patients' discharge summaries showed that 100% of follow-up appointments had been scheduled within the time requested on the discharge summary.
- A request was made that all heads of departments include all locums in their results sign-off filter to ensure all patients' results are followed up appropriately. A new process was introduced where a list of locums and departing staff is provided to the information technology team weekly to identify any departing locums and ensure results are diverted to the appropriate head of department. Drop-in sessions with the data and digital team were arranged for SMOs to ensure they are familiar and comfortable with using the result management aspects of their patient management system.
- The Chief Medical Officer sent a reminder to medical staff about the importance of timely, accurate documentation in clinical inpatient notes. This was also discussed at a medical meeting in mid-2022, and a further memo was sent to medical staff in Month2 2022 about ensuring that discharge requirements are clearly and appropriately outlined in the patient notes and discharge summaries. It was also discussed extensively at several senior medical staff meetings in mid-2022, 18 May 2023, 19 April 2023, and 20 June 2023; a Clinical Board meeting on 26 July 2023; and at the June 2023 Mortality and Morbidity meeting with senior medical staff.

57. Health NZ – Whanganui also confirmed that a 'National Policy – Transfer of Care and Test Results Responsibility' is now in place.

58. Health NZ – Whanganui also told HDC that it was recruiting to get a 'satisfactory complement of medical staff.'

Follow-up actions

59. A copy of the sections of this report that relate to Health NZ – Whanganui will be sent to Health NZ's National Office and the Ministry of Health.

60. A copy of this report with details identifying the parties removed (including references to specific dates), except Health NZ – Whanganui and my expert advisors on this case, will be sent to Te Aho o Te Kahu | Cancer Control Agency and placed on the HDC website, www.hdc.org.nz, for educational purposes.

61. Taking account of the multiple severe departures in the system of care in this case, which impacted on the outcome for Mrs A, Health NZ – Whanganui will be referred to the Director of Proceedings in accordance with s 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from Dr Ben Wilson, Consultant Radiologist, dated 28 February 2025.

'Independent clinical advice to Health and Disability Commissioner

Complaint:	**Mrs [A] /Dr [D]**
Our ref:	**C23HDC00114**
Independent advisor:	**Dr Ben Wilson**

I have been asked to provide clinical advice to HDC on case number **C23HDC00114**. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved	B Sc(Hons) 1987 MB ChB 1992 (Otago) FRANZCR 2004. I am a consultant Radiologist at Dunedin Hospital and have been since 2004. I am the Clinical Director of the Radiology Service and am a general radiologist, reporting a wide variety of radiology examinations and performing procedures. I regularly report ultrasound studies and in particular pelvic ultrasound studies. I take part in the regional gynaecology-oncology MDM [multidisciplinary meeting] as the backup radiologist if the primary radiologist is unavailable.
Documents provided by HDC	1. [Mr A]'s complaint to HDC – 16 January 2023 2. Complete radiology referral and report of [Dr D] – Day3 Month1 2021 3. [Dr D]'s response to HDC – 1 May 2023 4. Health New Zealand – Whanganui Critical System analysis – […] 2022 5. Critical results policy
Referral instructions from HDC	1. Whether [Dr D]'s assessment/report was of an appropriate standard. Please consider: a. Whether the findings of the USS were 'more serious' than that reported by [Dr D] (and if so, how). b. [Dr D]'s inclusion of 'a thickened endometrium measuring 30mm or a subserosal fibroid measuring up to 43mm' and whether this impacted on any recommendations

	2. Whether the findings of the USS warranted urgent action per the 'critical results policy.' Please comment on: a. [Dr D]'s statement that 'possible malignancy' on the USS was an expected finding (and therefore did not meet criteria for urgent referral). b. Whether [Mrs A]'s USS results would be considered 'urgent abnormal findings.' c. The adequacy of the critical results policy. 3. Any other matters in this case that you consider warrant comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	

Question 1: Whether [Dr D]'s assessment/report was of an appropriate standard. Please consider: **a. Whether the findings of the USS were 'more serious' than that reported by [Dr D] (and if so, how).** **b. [Dr D]'s inclusion of 'a thickened endometrium measing 30mm or a subserosal fibroid measuring up to 43mm' and whether this impacted on any recommendations.**	
List any sources of information reviewed other than the documents provided by HDC:	No sources of information other than those provided by the HDC.
Advisor's opinion:	My opinion is that [Dr D]'s report was of an appropriate standard. Leaving aside two incorrect words, ("subserosal" for "submucosal" and the word "without" for "whether" in the body of the report), the report in my opinion has commented on the major abnormalities even though the exact nature of these is not completely clear on this one examination. That is, [Dr D] has highlighted a thickened endometrium or a submucosal fibroid, although I think the latter is less likely on this imaging. In addition, he has commented on an abnormal appearance of the left ovary. From my experience reporting pelvic ultrasound, it is not unusual that the exact pathology cannot be determined from an initial ultrasound examination, and further imaging is often needed (CT and/or MRI) to clarify appearances further.

	The summary sentences at the end of the report "Complex ultrasound for interpretation. Gynaecology review recommended" are appropriate, and [Dr D] has acted safely in this situation. In doing so, [Dr D] has reported a degree of diagnostic uncertainty and has made a recommendation that gynaecology review should be sought. This is appropriate advice to give in the report.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From a radiology reporting perspective, my opinion is that an appropriate standard of care has been met. What is less clear to me is the follow-up process that exists at Whanganui Hospital in situations like this. Once the recommendation for gynaecology review [by] [Dr D], it is not clear from the documentation I have been provided as to how that referral is to occur. [Dr D] states in his letter that the findings did not meet the threshold for the critical findings system that exists, and I believe he makes a reasonable statement in this regard. The referrer for the US examination initially was Dr [C], but it is not clear to me what role [Dr C] plays at Whanganui Hospital or whether they acknowledged the report in the Whanganui Hospital patient management system. The timeline and process that occurred from the time of the report being issued to the time of the regional gynaecology-oncology meeting (Day1 Month4 2022) has been redacted in the documentation provided to me. This [means] it is unclear to me how the report eventually came to be acknowledged and then acted upon.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	My opinion is that there is no departure from an appropriate standard of care from a radiology reporting point of view. In the absence of further information about how the report was finally acted on, it is difficult to comment on as to departures from standards for clinical care. However, I note the patient's husband, [Mr A], states that [Mrs A] was seen in the gynaecology clinic on Day3 Month3 […], which is four months after the report was issued. This to me is an excessive time to be seen in clinic for such concerning findings.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	At a radiology level, I believe my peers would agree with me that the report was adequate and the recommendations safe. I believe that the time frame to be seen following the report being issued would not be regarded as satisfactory, but as I have no information regarding referral processes or resources available at Whanganui Hospital, this cannot be commented on further.

Please outline any factors that may limit your assessment of the events.	Noted above. The referral process from the time of issuing of the report to [Mrs A] being seen is not available.
Recommendations for improvement that may help to prevent a similar occurrence in future.	From a radiology perspective, the report was timely, the findings appropriately made (even though the exact diagnosis is not clear, which of itself is not uncommon in pelvic ultrasound), and the recommendations are appropriate. Management of the findings beyond that is out of scope from a radiology perspective.

Question 2: Whether the findings of the USS warranted urgent action per the 'critical results policy.' Please comment on: **a. [Dr D]'s statement that 'possible malignancy' on the USS was an expected finding (and therefore did not meet criteria for urgent referral).** **b. Whether [Mrs A]'s USS results would be considered 'urgent abnormal findings'** **c. The adequacy of the critical results policy.**	
List any sources of information reviewed other than the documents provided by HDC	No sources of information other than those provided by the HDC.
Advisor's opinion	The Critical Results Policy document provided to me states that "urgent abnormal or unexpected radiology findings should be flagged a critical result …" In this case, the referral details for the US were "Symptomatic anaemia secondary to heavy PV bleeding at 61 yoa. Prior to OP apptmt please." My interpretation of this request in this clinical scenario is that the referrer expects that the ultrasound will find an abnormality, which may or may not be malignant. While the findings of the examination are important, they are not "urgent abnormal or unexpected radiology findings." While very important findings, they did not pose an immediate risk to life, nor were they unexpected. Additionally, the referral makes note of an OP (outpatient) appointment, which suggests that one has been made or will be made in order to follow up on the US findings.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	As above.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	I believe there was no departure from the standard of care in management of the ultrasound findings by [Dr D], in relation to the policy in place at Whanganui Hospital at the time.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I have not discussed this with any of my peers, but – based on my experience and with knowledge of the pathways in place at the time – they would concur with my findings.
Please outline any factors that may limit your assessment of the events.	None
Recommendations for improvement that may help to prevent a similar occurrence in future.	None

Question 3: Any other matters in this case that you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	No sources of information other than those provided by the HDC.
Advisor's opinion:	No further matters raised by me.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or	

• Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.	
Signature:	BKJ Wilson
Name:	Dr Ben Wilson
Date of Advice:	28 February 2025

Appendix B: Independent clinical advice to the Commissioner

The following independent advice was obtained from Dr Guy Gudex, Specialist Gynaecologist, dated 18 January 2025 and 19 February 2025.

'**Independent clinical advice to Health and Disability Commissioner**

Complaint:	**[Mrs A] /Health NZ – Whanganui**
Our ref:	**C23HDC00114**
Independent advisor:	**Dr Guy Gudex**

I have been asked to provide clinical advice to HDC on case number **C23HDC00114.** I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved	FRANZCOG CREI. Specialist gynaecologist for over 30 years
Documents provided by HDC	1. [Mr A]'s complaint 2. Clinical records of admission and discharge [Day1–Day2 Month1 2021] 3. Radiology referral and report 4. Health NZ response to HDC 5. [Dr C] response to HDC 6. [Dr D] (radiology) response to HDC 7. Health NZ process for referrals 8. Policy on critical results
Referral instructions from HDC	Please review the enclosed documentation that relates to the care provided to [Mrs A] by Health NZ Whanganui and advise: 1. Whether [Mrs A] had appropriate medical review and care during her admission to hospital on [Day1] and [Day2 Month1] 2021. In your response please consider: a. Individual/systemic issues b. Medical review, assessment and recording c. Discharge process, paperwork and sign out d. Follow-up/referral process

	2. Whether the standard of documentation and actions taken following discharge on [Day2 Month1] 2021 were appropriate, including systems in place for ensuring continuity of care. In your response, please consider: a. Individual/systemic issues b. Responsibility for follow-up/actioning referrals where locum doctors are involved c. Responsibility for actioning gynaecological review after the ultrasound report where locum doctors are involved 3. Any other matters you wish to comment on

Factual summary of clinical care provided complaint

Brief summary of clinical events:	[Mrs A] was admitted to Whanganui ED in [Month1] 2021 with a history of fainting at home and was found to be anaemic with a history of two days' postmenopausal bleeding (PMB). She was discharged the following day with a plan for urgent pelvic ultrasound and gynaecology outpatient review. The ultrasound was performed 10 days later and was reported as showing changes of concern given the history of PMB particularly. The outpatient appointment review was not organised or followed up, and the patient subsequently attended her GP in [Month3] 2022. The GP noted the scan report and organised urgent gynaecology assessment. A stage 4 adenocarcinoma was diagnosed, and – after palliative treatment – [Mrs A] died in […] 2022.

Question 1: Whether [Mrs A] had appropriate medical review and care during her admission to hospital on [Day1] and [Day2 Month1] 2021. In your response, please consider: **a. Individual/systemic issues** **b. Medical review, assessment and recording** **c. Discharge process, paperwork and sign out** **d. Follow-up/referral process**	
List any sources of information reviewed other than the documents provided by HDC	
Advisor's opinion	I have reviewed the documents sent to me.

	The admission and care in ED were appropriate, with referral to the gynaecology service. I have not been sent a copy of any inpatient notes from gynaecology and can therefore see no evidence that a vaginal speculum examination was performed by the gynaecology team. It would be usual practice to do that, and I note that a speculum examination in [Month3] 2022 did show a cervical polyp that was malignant. The discharge plan was appropriate, with a pelvic ultrasound requested within 12 days of discharge and for subsequent follow-up in gynaecology outpatients. It appears that a copy of the discharge summary was given to the patient on discharge, and presumably instructions were given to her verbally regarding planned follow-up. It appears that the on-call specialist gynaecologist (a locum, [Dr C]) was not informed of the admission and discharge of [Mrs A]. The assessment and plan were formulated by a gynaecology registrar, and this would be accepted practice for management of this presentation, but I would expect the on-call specialist to be informed of the admission given the dramatic anaemia in a postmenopausal woman. I presume that standard practice would be for the on-call Saturday specialist to do a ward round to review overnight acute admissions. I have reviewed the Discharge Summary prepared by Dr [B]. Under "Radiology Appointments," the ultrasound scan referral status is recorded as "Placed" with the responsible clinician [Dr C]. The section listed "Booked clinic appointment" states "there are no items on display." Under the section "Referrals," it states "OP clinic Gynaecology within 2 weeks." Send to GP section is listed as "No." Under advice to GP — "please make an appointment for this patient to be seen within 14 days following discharge." A separate document "Process for ERMS Referrals" outlines that electronic referral was introduced in [Month2] 2022. It appears from these documents that, although the ultrasound could be requested electronically by the discharge

	doctor, the outpatient referral may not have been able to have been, but I would expect that that would still be the responsibility of the gynaecology service rather than expecting the GP to organise that. It would be helpful if Whanganui Hospital could confirm what was the normal process for organising outpatient follow-up on discharge and asking [Dr B] what his understanding was at the time of the process.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The care at the time of admission was to an expected standard with an appropriate plan to investigate further with ultrasound. I would like to know if a vaginal examination was performed at the time of assessment in hospital in [Month1] 2021 by the gynaecology registrar with a smear as that would be standard practice.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	It is not clear from the notes provided what the normal process was for scheduling a follow-up appointment in outpatients. It would not be expected practice to make that the responsibility of the GP. It would be a severe departure if the hospital service had not organised a follow-up appointment for a patient where there was a high suspicion for malignancy.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would expect that the outpatient appointment would be scheduled by the discharging doctor.
Please outline any factors that may limit your assessment of the events.	I do not have documents outlining the presumed paper process for internal referral for follow-up.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Ensure patients are informed they should contact the service if an expected appointment has not been made.

Question 2: Whether the standard of documentation and actions taken following discharge on [Day2 Month1] 2021 were appropriate, including systems in place for ensuring continuity of care. In your response please consider: **a. Individual/systemic issues** **b. Responsibility for follow-up/actioning referrals where locum doctors are involved** **c. Responsibility for actioning gynaecological review after the ultrasound report where locum doctors are involved.**	
List any sources of information reviewed other than the documents provided by HDC	
Advisor's opinion	I note that [Dr C] was listed as the referring clinician for radiology — a copy of the scan report was to go to him as noted in "electronic order for radiology" Cc [Dr C] (76892 Cc Doc HCP WDHB (73907)). It is not clear from the information what process was in place to ensure results were seen if the requesting doctor was a locum, as in this case. I note the scan report remained unsigned (not seen). I note the ultrasound report was abnormal, with possible endometrial thickening and an enlarged ovary. I would not expect the radiologist to contact the referrer directly at the time of reporting, and it would be reasonable for the radiologist to rely on the report being seen by the referrer/gynaecology department and that follow-up had been organised. I note the "Critical Results Policy" document. In his letter of response, I note that [Dr D] refers to the comment by [Dr E] regarding the urgency of the report and immediate notification of the result. As stated above, I agree with [Dr D] that that would not be usual practice in public or private practice.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	It would be standard practice for the department to have a process for ensuring radiology and blood/histology reports requested by a locum be signed in a timely manner. It is not clear whether the locum has remote access to later access these results.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure	It would be a severe departure if there was no process in place at Whanganui Hospital for radiology results requested by locum doctors to be reviewed and signed in a timely manner.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed as a severe departure if there was no process.
Please outline any factors that may limit your assessment of the events.	I have not seen documents related to the policy and work process for signing of reports requested by locum doctors.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Ensure there is a robust policy that locum doctors and departments are aware of.

Question 3: Any other matters you wish to comment on	
List any sources of information reviewed other than the documents provided by HDC	
Advisor's opinion	N/A
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or	

• Severe departure	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	
By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.	
Signature:	
Name: Dr Guy Gudex	
Date of Advice: 18 January 2025	

Auckland Gynaecology Group

19/02/2025

[…]

Senior Investigator | Kaitūhura Matua

Office of the Health and Disability Commissioner | Te Toihau Hauora, Hauātanga

RE: Further opinion sought | [Mrs A] C23HDC00114

Thank you for your request for review of new information and further comments.

The new information has not changed my previous opinion. I note the response from [Dr B], including that he does not recall this case, understandably. As an on-call junior doctor on a weekend, he was probably covering most of the surgical specialties, including gynaecology, and his only involvement in this case may have been to complete the discharge as requested, presumably by the nursing staff, and a registrar might complete the admission after assessing the patient if they knew that the house surgeon was busy, for instance.

I remain of the view that the radiologist who reported the outpatient ultrasound would not have been expected to contact the referrer or referring department directly by escalating, as the ultrasound findings were not unexpected in a patient presenting with significant postmenopausal bleeding and malignancy was an important, expected part of the differential diagnosis.

2.

a. I would expect it would be normal practice for a vaginal examination to have been performed by the gynaecology registrar. I would not expect a house surgeon to have those skills necessarily, particularly if they had not completed a three- or six-month gynaecology attachment. A speculum examination would have allowed the taking of a cervical smear, and although this appeared to be an endometrial cancer, there was a large malignant polyp seen at the cervical entrance several months later, and a smear may have shown atypical or malignant cells when reported a couple of weeks later.

b. It is very unusual that there is no written record of medical admission by the gynaecology registrar or house surgeon, and I wonder if there was a paper record and it has been misplaced from the notes as it is a quite unusual circumstance. I do note, however, that the nursing notes do not mention that review had been completed by the medical staff, and this often would be recorded.

I cannot see that the gynaecology registrar, […] has provided a response for her recollections of this case, and I do note on the Medical Council website that she has a current practising certificate, and so she may be able to provide that if requested.

c. I note there was no policy in place for sign off on reports requested by locums. This is probably a common oversight in many hospitals. What is important is a system that flags electronically unsigned

results (radiology/laboratory/histology/cytology) after 4 weeks with an allocated resource to follow those up.

3.

I note the Critical Systems analysis and recommendations dated […] 2022.

They seem appropriate and address several of the issues identified.

No comment was made in the analysis of the apparent omission by the admitting registrar to perform a vaginal examination.

It is possible the patient declined a vaginal examination, but without any medical record in the progress notes it is not possible to comment further on that.

One observation to make is that it is good practice to inform patients verbally and in writing that they should contact the service provider if they have not had results communicated or appointments organised within three to four weeks.

It is possible that the patient assumed the scan was normal and that there was no urgency to be seen for review.

It was recommended that radiology reports be signed off as followed up within 24 hours and that this would be audited.

It would be useful to know if this audit is ongoing – perhaps monthly?

4. Further comment

As is often the case, several omissions or failures are required for an adverse event to occur. In this case, they included the opportunity to vaginally examine and take a smear, no outpatient appointment booked as planned, ultrasound report not signed or sighted, GP not sent a copy of discharge summary, and – finally – patient not being aware to follow-up herself the lack of contact.

I would suggest the gynaecology registrar on duty be asked for a response/comment if that has not already occurred.

Kind Regards,

[-Signed by:

Dr Guy Gudex

Gynaecologist and Fertility Specialist

FRANZCOG CREI