Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Surgical instrument left in a woman's abdomen

21HDC01479

Auckland District Health Board (DHB) (now Te Whatu Ora Te Toka Tumai Auckland) breached the Code of Health & Disability Services Consumer's Rights (the Code) when a surgical instrument was left in a woman's abdomen after a Caesarean section (C-section).

The woman experienced severe pains in her abdomen after a scheduled C-section at Auckland City Hospital. This led her to visit her GP several times, as well as the emergency department at the hospital, until the instrument was discovered on an abdominal CT scan.

An Alexis wound retractor (AWR) – a soft tubal instrument about the size of a dinner plate, used for holding open a surgical wound – was removed from her abdomen 18 months after her C-section.

Health and Disability Commissioner Morag McDowell found Auckland DHB in breach of Right 4(1) of the Code which gives every consumer the right to have services provided with reasonable care and skill.

"As set out in my report, the care fell significantly below the appropriate standard in this case and resulted in a prolonged period of distress for the woman," Ms McDowell said. "Systems should have been in place to prevent this from occurring."

Auckland DHB told HDC the process for ensuring all surgical tools are accounted for following surgery is set out in its Count Policy. However, at the time of the surgery, AWRs were not included as part of the Count Policy.

Ms McDowell found Auckland DHB's Count Policy provided insufficient guidance to enable staff to determine which instruments should be included in the count, instead relying on them to apply their own interpretation of what instruments were "at risk of being retained", which led to a culture and practice where AWRs were excluded from the count.

She was also critical of Auckland DHB's inconsistent messaging surrounding the expectations of staff reviewing the Count Policy, particularly as, at the time of the woman's surgery, the surgeons involved had not read the Count Policy.

In a 2018 case Auckland DHB was found in breach of the Code for the retention of a swab in another patient's abdomen. A recommendation from that breach was for Auckland DHB to mandate all surgical staff read the Count Policy and ensure they keep

up-to-date with any changes. Ms McDowell said she was disappointed this recommendation was not implemented after the earlier breach.

She recommended the DHB/Te Whatu Ora Te Toka Tumai Auckland write to the woman to apologise and offer the opportunity to meet face-to-face, facilitated by Te Whatu Ora's Pasifika health services.

She also recommended Auckland DHB/ Te Whatu Ora Te Toka Tumai Auckland confirm the directive to include AWRs as part of the surgical count has been sent to all perioperative staff.

Te Whatu Ora Te Toka Tumai Auckland was also referred to the Director of Proceedings to determine whether further proceedings should be taken.

4 September 2023

ENDS

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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