Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Error in colostomy surgery breaches the Code

21HDC00322

The Deputy Health and Disability Commissioner has found a consultant general surgeon breached the Code of Health and Disability Services Consumers' Rights (the Code).

The breach concerns the care of a man with a spinal fracture who was partially tetraplegic and had difficulties with bowel care. The surgeon performed a laparoscopic end colostomy which diverts one end of the colon through an opening in the abdominal wall. The surgeon mistakenly formed the stoma (end of the bowel) at the wrong end, which led to bowel obstruction, and required additional hospital care and treatment.

According to the independent advisor consulted during this investigation, the formation of an end colostomy in patients with bowel dysfunction after spinal injury is a well-recognised procedure, and wrong end stoma formation is a significant technical error. Dr Vanessa Caldwell agreed that the incorrect formation of the colostomy was a departure from accepted practice.

Dr Caldwell found the surgeon breached Right 4(1) of the Code for not providing services with reasonable care and skill.

Following the surgery in a private hospital, the man was then admitted to a public hospital after developing postoperative complications. While Dr Caldwell noted there were delays in the follow-up treatment she was not critical of this, as the issues were multi-factorial, including that wrong end stoma is rare.

Dr Caldwell acknowledged that, in addition to providing a written apology to the man and his family for the breach of the Code, the surgeon has taken a number of actions to improve his practice, including:

- Converting to open, rather than laparoscopic surgery, if there is any doubt about the correct end of the colon being made into a stoma.
- Placing his camera and operating ports on the contralateral side of the abdomen from where the stoma is being formed, and using a cut-down technique under direct vision, while performing laparoscopic colostomy.
- Remaining vigilant for the possibility of wrong end colostomy (and other complications).

- Reviewing the discharge plan with the patient (and family if necessary) and nursing staff (including the stoma nurses) daily to ensure that timing of the discharge is safe and appropriate.

The private hospital also made several changes to practice.

14 August 2023

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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