Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Te Whatu Ora Waikato breaches Code for failures in management of X-ray results

20HDC01571

The Deputy Health and Disability Commissioner has found Waikato District Health Board (now Te Whatu Ora Waikato) breached Right 6(1) of the Code of Health and Disability Services Consumers' Rights for failing to provide critical information to a consumer about her test results.

Dr Vanessa Caldwell said the organisation failed to inform the consumer, and her medical centre, of a chest X-ray result that recommended further cross-sectional imaging.

Later the woman was admitted to a public hospital and diagnosed with metastasised cancer in her lungs, lymph nodes, liver, and bones. Sadly, she passed away a few weeks later.

Months earlier the woman had visited a GP to check a lump on her neck. The doctor referred the woman for an ultrasound which identified abnormal lymph nodes. A subsequent chest X-ray also noted abnormalities. The doctor advised the woman to have another chest X-ray in six weeks as, at the time, the woman's lump had shrunk, and her cough had improved. The GP set a task reminder for a repeat chest X-ray but did not follow this up.

The woman returned to her GP four days later due to upper back pain. The doctor, concerned the pain could indicate metastasised cancer in the bone, discussed her concerns with an oncologist registrar at the public hospital.

Five days later the woman was admitted to the emergency department of a public hospital with pain in her back, lower chest and abdomen, nausea, reduced appetite and urination.

Although a chest X-ray taken at that time was interpreted as indicating a lung nodule that had not changed, the actual X ray report, issued seven days later showed nodules in both lungs and cross-sectional imaging was recommended. Neither the medical centre nor the woman was alerted to the recommendations in the report.

Several months later the woman was re-admitted to ED where she was diagnosed with advanced cancer.

Dr Vanessa Caldwell extended her sympathies to the woman's whānau, saying while an earlier diagnosis may not have altered the course of the disease, it would have given the woman more time to contribute to a more meaningful management plan of her illness.

“Te Whatu Ora had a responsibility to inform Ms A of the abnormal result that had been reported and the recommendation for further imaging.

“In addition, Te Whatu Ora should have either arranged the further scan, or explicitly communicated to the medical centre that this additional imaging had been recommended. This omission was a further factor that contributed to the delay in diagnosis…I do not accept that Ms A should have been expected to follow up the repeat chest X-ray herself, as suggested by Te Whatu Ora.”

Dr Caldwell also made adverse comment about Te Whatu Ora Waikato regarding when the woman was first admitted to the ED, saying, given an unclear diagnosis following the chest X- ray, the woman should have been seen by a senior clinician. However, she acknowledged the systemic issues emergency departments face and the steps taken by Te Whatu Ora in the time since to increase staffing ratios of senior medical officers and registered nurses for ED. Te Whatu Ora also continues to recruit radiologists, and has increased film reporting capacity.

Dr Caldwell also made adverse comment about the GP for failing to follow up a task reminder for a repeat chest X-ray. “I consider that this oversight was one factor that contributed to the delay in Ms A’s diagnosis, and do not accept that providing safety netting advice to have the repeat chest X-ray was sufficient.”

Dr Caldwell recommended the doctor and Te Whatu Ora Waikato provide written apologies for the deficiencies identified in her report. She also recommended Te Whatu Ora Waikato review its electronic results policy and provide ED staff training on the updated policy.

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Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's 'Latest Decisions'.

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 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

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