(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF THE AGGRIEVED PERSON

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2021] NZHRRT 44**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 056/2021
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**TUI MEDICAL LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms J Foster, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms SB Isaacs, Member

REPRESENTATION:
Mr G Robins, Acting Director of Proceedings
Mr D McGill and Ms S Britz for defendant

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **20 September 2021**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v Tui Medical Ltd* [2021] NZHRRT 44. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 31 August 2021.

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

[2.1] A Consent Memorandum dated 10 August 2021;

[2.2] An Agreed Summary of Facts, a copy of which is annexed and marked 'A'.

[3] In the Consent Memorandum the parties request that the Tribunal exercises its jurisdiction and issues:

> 2. (a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) (by failing to provide services to the aggrieved person with reasonable care and skill); Right 4(5) (by failing to ensure co-operation among providers to ensure quality and continuity of services); and Right 6(1)(f) (by failing to ensure the aggrieved person received information that a reasonable consumer in her circumstances would expect to receive, in particular the results of tests);
>
> (b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter (Mrs A).

[4] Having perused the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2(a) of the Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person as sought in paragraph 2(b) of the Consent Memorandum.

DECISION

[6] The decision of the Tribunal is that:

[6.1] A declaration is to be made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of:

[6.1.1] Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill;

[6.1.2] Right 4(5) by failing to ensure co-operation among providers to ensure quality and continuity of services; and

[6.1.3] Right 6(1)(f) by failing to ensure the aggrieved person received information that a reasonable consumer in her circumstances would expect to receive, in particular the results of tests.

[6.2] A final order is made prohibiting publication of the name and of any other details which might lead to the identification of the aggrieved person (Mrs A). There

is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms J Foster	**Dr SJ Hickey MNZM**	**Ms SB Isaacs**
Deputy Chairperson	**Member**	**Member**

'A'

This is the Agreed Summary of Facts marked with the letter 'A' and referred to in the annexed decision of the Tribunal delivered on 20 September 2021

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT /21

UNDER	Section 50 of the Health and Disability Commissioner Act 1994
BETWEEN	**THE DIRECTOR OF PROCEEDINGS**
	Plaintiff
AND	**TUI MEDICAL LIMITED**
	Defendant

[REDACTED] AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Greg Robins – Acting Director of Proceedings

[REDACTED] AGREED SUMMARY OF FACTS

INTRODUCTION

1. The plaintiff is the Director of Proceedings exercising statutory functions under sections 15 and 49 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The aggrieved person in these proceedings is Mrs A. At all material times Mrs A was a consumer of health services.

3. The defendant, Tui Medical Limited (trading as Tui Medical), is an incorporated company having its registered office at 67 Seddon Road, Frankton, Hamilton 3204, New Zealand.

4. At the time of the events in question, the defendant comprised a group of six medical clinics (five in Hamilton and one in Huntly), offering six general practice ("GP") services and two drop-in centres for urgent care services. The defendant employed 30 FTE clinicians, servicing an enrolled population of about 40,000 people. The drop-in centres catered to both casual and enrolled patients.

5. At all material times the defendant was a health care provider within the meaning of s 3 of the Act, and was providing health services to Mrs A within the meaning of s 2 of the Act.

6. In October 2018 Mrs A complained to the Health and Disability Commissioner about services provided to her by the defendant.

7. In August 2020 the Health and Disability Commissioner (appointed under s 9 of the Act) finalised his opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Service Consumers'

Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

BACKGROUND

8. Between 2014 and 2017 Mrs A had several consultations with a number of providers at Tui Medical about ongoing urinary symptoms. Mrs A was treated with antibiotics, despite her urine tests showing no infection and blood in her urine.[1] Ms A was not referred for a specialist review of her symptoms until more than three years after her initial consultation, at which stage a cystology[2] revealed tumours in her bladder, and she was diagnosed with urothelial bladder cancer.[3]

Consultations regarding urinary symptoms

2014-2015 consultations

9. On 2 July 2014 Mrs A, aged 76 years, presented to her GP (Dr E) with flank pain[4] and dysuria[5] that worsened as the day progressed. The plan was to test a mid-stream urine ("MSU") sample[6] and treat Mrs A with nitrofurantoin.[7] The urine test showed no evidence of an infection.

10. On 23 July 2014 Mrs A consulted a different GP (Dr F) who recorded that Mrs A was complaining of dysuria. The GP recorded a possible diagnosis of atrophic vaginitis[8] and urinary tract infection ("UTI") as part of the differential diagnosis. Mrs A was given a back-pocket prescription for nitrofurantoin in case her MSU showed a UTI. Mrs A's MSU was negative for infection, but a high vaginal swab ("HVS"),[9]

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[1] Haematuria.
[2] An endoscopy procedure to examine the urinary bladder via the urethra using a cystoscope.
[3] Cancer that most often begins in the cells that line the bladder (urothelial cells).
[4] Discomfort in the upper abdomen or back and sides.
[5] Pain, discomfort, or burning when urinating.
[6] A specimen of urine to be examined for micro-organisms.
[7] An antibiotic.
[8] Inflammation of the vaginal walls as a result of tissue thinning caused by low oestrogen levels. Symptoms may include pain with sex, vaginal itchiness or dryness, and an urge to urinate or burning with urination.
[9] To test for infection.

showed features consistent with bacterial vaginitis.[10] Mrs A was sent a prescription for metronidazole.[11] No follow-up plan was recorded.

11. On 20 August 2014 Mrs A again consulted Dr F for pain in her right knee and thigh. She also reported discomfort passing urine but no frequency.[12] A repeat MSU and a HVS were taken. The urine test showed no infection. The HVS again showed features consistent with bacterial vaginitis. Mrs A was sent a prescription for metronidazole. No follow-up plan was recorded.

12. On 19 November 2014 Mrs A presented to a different GP (Dr G) with a sore throat, fever, and discomfort while passing urine. A dipstick test[13] revealed red blood cells and increased protein[14] in the urine. Mrs A's blood pressure was elevated at 169/96mmHg. The GP prescribed co-trimoxazole[15] for five days and arranged for a MSU, and blood tests to assess Mrs A's renal function. The blood tests were normal. The MSU was recorded as normal. The GP did not arrange to follow-up Mrs A further.

13. On 8 April 2015 Mrs A presented again with dysuria and urinary frequency and was seen by GP Dr H. This was her fifth presentation of recurring urinary symptoms in nine months. No MSU was taken, but a dipstick test showed blood and leucocytes (white cells). Dr H suspected a UTI and prescribed nitrofurantoin and advised Mrs A to trial Ovestin cream.[16] No follow-up plan was recorded.

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[10] Inflammation of the vagina.
[11] An antibiotic.
[12] The need to urinate frequently.
[13] A chemical strip that changes colour to show the level of certain substances in the urine.
[14] An abnormal amount of protein in the urine may be a sign of kidney disease.
[15] An antibiotic.
[16] A hormone replacement cream used to relieve menopausal symptoms of vaginal dryness or irritation.

2016 consultations

14. On 29 July 2016 Mrs A saw GP Dr B, who recorded that Mrs A was complaining of urinary frequency, dysuria, and left flank pain, and was feeling cold and weak. Dr B conducted a urine dipstick test, which was positive for blood and leucocytes. A MSU showed no bacteria, borderline red blood cells, and insignificant pyuria.[17] Dr B diagnosed a UTI and prescribed trimethoprim.[18] She advised Mrs A to keep up her fluid intake, and to return if she deteriorated or had any concerns or problems.

15. On 4 August 2016 Mrs A again saw Dr B, who noted that Mrs A was experiencing pain on passing urine, and that the previous day her urine had been brown in colour. Dr B recorded that a urine dipstick was positive for leucocytes, and that there was "large blood". She considered that Mrs A could have an ongoing UTI and prescribed nitrofurantoin. Another MSU test showed no infection, but indicated a significant number of red and white blood cells in the urine. Dr B did not follow up on the abnormal MSU result.

16. On 29 November 2016 Mrs A saw Dr B again for repeat medications. Mrs A also told Dr B that for months she had been urinating three times each night, and that her urine was no longer pink but urinating was sometimes uncomfortable, and Ural sachets[19] had helped. Dr B prescribed Mrs A Ural sachets as required. Dr B did not undertake a dipstick urinalysis or MSU at this consultation, and did not make a follow-up plan.

[17] Pus in the urine.
[18] An antibiotic.
[19] A powder used to reduce the acidity of urine to provide relief from burning symptoms when passing urine.

2017 consultations

17. Dr B saw Mrs A again on 20 February 2017 regarding a left leg and heel injury sustained in March 2016. The clinical notes do not refer to presentation of urinary symptoms but a MSU was also undertaken, which showed red and white blood cells but no infection. A telephone text message was sent to Mrs A to say the results were normal. However, while there was no growth, there was significant haematuria and pyuria present. Dr B told HDC she did not realise there were a lot of red cells in Mrs A's urine until she looked at the results again when she saw Mrs A in August 2017.

18. On 19 April 2017 Mrs A saw GP Dr C, having experienced urinary frequency and dysuria, nocturia,[20] and blood in her urine. Dr C recorded that Mrs A had recurrent urinary symptoms usually without a positive MSU test result. A repeat MSU was taken, and Mrs A was given more Ural sachets.

19. The MSU results were received the following day and showed a large number of white cells, red cells, and no infection. This was the third MSU over eight months that had returned a negative culture but had shown persistent haematuria. Dr C called Mrs A to explain the results, and told her that it was unusual to have so many white and red blood cells in the urine, and that a UTI was possible but that once a UTI had been treated, all the red cells should have cleared. Dr C said that Mrs A agreed to a course of antibiotics and then a repeat MSU in two to three weeks' time to ensure that the red blood cells had cleared.

20. On 2 May 2017 Mrs A saw a nurse practitioner at an urgent care/drop-in clinic reporting dysuria and cloudy red-tinged urine. Mrs A said that she was urinating four to five times overnight and passing good amounts of

urine. The nurse practitioner recorded her impression that Mrs A had a UTI and/or a vaginal infection, with a differential diagnosis of atrophic vaginitis. Mrs A was prescribed nitrofurantoin and given further Ural sachets. A MSU and a HVS were sent to the laboratory for testing. The nurse practitioner encouraged Mrs A to follow up with her usual GP for continuity of care. The nurse practitioner documented that if no infection was found, the symptoms would require further investigation, including an internal examination to check for vaginal atrophy.

21. The nurse practitioner recorded in the clinical notes that the results of the MSU and HVS would be texted to Mrs A when available. Later on the same day, the nurse practitioner recorded the HVS was normal and the MSU had no growth. There is no entry in the clinical records recording that Mrs A was contacted regarding her results after the 2 May 2017 consultation, or any further follow-up by clinical staff at Tui Medical. 2 May 2017 was the last day on which the nurse practitioner worked at Tui Medical for several months, because she had a sudden and significant family emergency. The nurse practitioner told HDC that she did not recall asking a colleague to review Mrs A's results and action them while she was away, and she believed that management would organise that for her.

22. The defendant's Result Notification Policy at the time stated that all incoming laboratory results were to be seen and actioned by the staff member who requested them, or a designated deputy. When a clinician went on leave, a designated team member was nominated to cover his/her patient load, including management of patient results. The policy did not state who had the responsibility to arrange the designated deputy. However, the job description for the defendant's Clinical

[20] Excessive urination at night.

Operations Manager stated that the role included ensuring all cover arrangements were made and any short notice changes handled in accordance with organisational priorities, and the Clinical Operations Manager would act as point of contact and control for roster changes.

23. On 7 June 2017 Mrs A requested a repeat prescription for Ural sachets and other regular medications. These were prescribed by a provider who had not been involved in Mrs A's care previously.

24. On 28 August 2017 Mrs A saw Dr B again, for her repeat medications. Mrs A told Dr B that she took Ural sachets four times per day, every day, otherwise she had blood-stained urine and burning pain when passing urine. A MSU sample was obtained. Mrs A told Dr B that she had been experiencing nocturia three to five times per night, but no urinary incontinence,[21] for more than a year. On 29 August 2017, Dr B sent a referral to the DHB Urology service.

25. On 8 September 2017 the MSU results showed: "LEU [leucocytes] ++ blood large +++." On the same day, Mrs A was seen for an urgent care consultation. The records note her presenting complaint as haematuria and increased frequency of urination, and that all her urine tests had been negative and she had been referred to a urologist and was waiting for an appointment.

26. On 6 November 2017 a cystoscopy revealed multiple bladder lesions.[22] Mrs A was referred to the gynaecology team at the DHB, and subsequently was diagnosed with urothelial bladder cancer.

27. Mrs A had surgery to remove the tumours on 4 December 2017, and again in January 2018. Subsequently, she underwent surgery to remove

[21] The involuntary leakage of urine.
[22] Tumours.

her bladder, uterus, and lymph nodes, followed by a course of chemotherapy. Mrs A has now completed all scheduled treatments and is being monitored for any return of the cancer.

Impact on Mrs A

28. At the time of her surgery Mrs A was aged 79. The impact of living without her bladder and the effects of chemotherapy have left her weaker and unable to live the active life she did before. She had been a fit person who looked after the house and garden, and was full time carer for her husband who was disabled. After her surgery she was not as strong as before, and felt no longer able to continue to care for him at home. She now has a urostomy bag[23] which must be changed twice a week and is painful, and a night bag changed one a week. She has to wear loose clothing to hide the bag and has lost her hair and some hearing.

EXPERT ADVICE

29. Both Dr David Maplesden (HDC's in-house GP expert) and a GP expert for ACC advised that over at least a year (from April 2014) there were numerous missed opportunities for earlier diagnosis of Mrs A's bladder malignancy. From November 2014 Mrs A had persistent micro haematuria[24] on urinalysis and she was having recurrent urinary symptoms (frequency and dysuria) with no laboratory confirmation of urinary tract infection. Her symptoms were sufficient to raise concern about the possibility of another significant illness i.e. kidney disease.

30. Given Mrs A's age, her symptoms, and the presence of haematuria without infection, guidelines[25] recommended further investigation,

[23] A bag used to collect urine.
[24] Blood in the urine visible only under a microscope.
[25] For example, the experts refer to the Best Practice Advocacy Centre New Zealand (BPAC) Guidelines 'Interpreting urine dipstick tests in adults": A reference guide for primary care' (June 2013)

specifically urinary tract imaging and specialist referral for urological assessment and cystoscopy. The experts advised that by November 2014 there were already sufficient grounds to initiate further investigations and arrangements should have been put in place to ensure follow up of test results. There was no follow up, which was a significant failure of care.

31. An oncology expert for ACC advised that Mrs A's symptoms were consistent with significant tumour in the bladder disrupting normal functions, and it was reasonable to attribute all her bladder symptoms from April 2014 onwards to her progressive cancer. The oncologist advised that treatment in 2014 or 2015 would, in all probability, have been relatively simple and tolerable for a well 79 year old. However, in 2018 Mrs A had radical surgery which was extensive for a 79 year old and left her with a permanent urostomy bag and less than certain survival future.

DEFENDANT'S RESPONSE TO COMPLAINT

32. In its responses to HDC, the defendant accepted "there is no question" that if Mrs A had been referred for a cystoscopy before 6 November 2017, her prognosis would have been "infinitely better and she would have been spared the morbidity she is currently going through." The defendant has acknowledged that the various doctors who saw Mrs A "did not do her justice in picking up her condition sooner", and has acknowledged the number of lost opportunities where Mrs A's condition was missed. The defendant also acknowledged Mrs A's pain and suffering, stating that as individuals and as a group they let her down.

33. As a result of these events, the defendant has implemented the following changes:

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https://bpac.org.nz/bt/2013/june/docs/BT19-pages-10-21.pdf, and public hospital urology referral guidelines.

a. A document outlining the new NICE[26] guidelines on urinary tract infections was sent to all medical and nursing practitioners at Tui Medical, and the guidelines were discussed at multiple peer review meetings.
b. Tui Medical has been separated into Urgent Care and General Practice, to allow better continuity of care.
c. More appointment slots have been made available, including same-day appointments and general practice appointments, to allow for better continuity of care.
d. Patients have been educated that Urgent Care and General Practice are two different services, and patients are encouraged to see their GP as regularly as possible, and to use Urgent Care only for urgent matters.
e. Patients are made aware that when they see an Urgent Care practitioner, they should catch up with their regular practitioner for ongoing follow-up.
f. Urgent Care doctors wear scrubs so that patients know that this is a different service.
g. Urgent Care notes are made using a different colour from regular notes.
h. At the end of each consultation, there is a mandatory classification to show whether it was a General Practice or an Urgent Care consultation.
i. All Urgent Care patients are triaged before a consultation and asked whether it is their first presentation for the condition.
j. Both Urgent Care and General Practice have regular peer reviews and audits of notes.
k. Urgent Care doctors are encouraged to follow up any investigations they have requested and liaise with the GP if there is anything that warrants further follow-up.
l. A Clinical Advisory Group has been formed to oversee all complaints.
m. Tui Medical has employed a social worker and an occupational therapist.
n. Tui Medical utilises an induction document that outlines each doctor's tasks with regard to handling patient results, responsibility for the management of patient care, and policies and protocols.
o. Tui Medical has improved its result notification policy to address cover arrangements for absences, especially short notice absences.

BREACH OF THE CODE

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

35. Right 6(1)(f) states: "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."

[26] National Institute for Health and Care Excellence.

36. Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

37. The defendant acknowledges it failed to provide appropriate care to Mrs A as follows:

    a. The standard of care at various consultations about urinary symptoms from November 2014 to August 2017 was poor. Mrs A's care was hindered by the failure of multiple doctors to review her clinical history adequately and to apply critical thinking, and, as a result, there were lost opportunities to identify the need to refer Mrs A for renal tract imaging and/or urology review.
    b. The defendant did not have a clear policy for the review of test results when the staff concerned went on leave at short notice. As a result, the defendant failed to oversee the assignment of test results cover when the nurse practitioner was unexpectedly absent from work.
    c. Mrs A was not informed of her test results following the consultation on 2 May 2017.

38. Accordingly, the defendant accepts it breached Right 4(1) and Right 6(1)(f) of the Code. In addition, the defendant accepts it breached Right 4(5) of the Code as the practitioners involved failed to co-operate effectively with one another to ensure that Mrs A received quality and continuity of services.

_____

Greg Robins
Acting Director of Proceedings

Date:

I, , agree that the facts set out in this Summary of Facts are true and correct.

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For or on behalf of the defendant

Date: