(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 51**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 019/2021
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**KLAUS PLATZ**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms SJ Eyre, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms BL Klippel, Member

REPRESENTATION:
Mr G Robins, Acting Director of Proceedings
Mr M McClelland QC for defendant

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

DATE OF DECISION: **25 November 2021**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v Platz* [2021] NZHRRT 51. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 30 April 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 30 April 2021;

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

[2.3] Memorandum of plaintiff in support of permanent order prohibiting publication of name and identifying details of aggrieved person dated 29 October 2021.

[3] In the Consent Memorandum dated 30 April 2021 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; and
>
> 2(b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter (Mr A (deceased)).

[4] Having considered 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 having considered the submissions of counsel for the plaintiff as to name suppression.

[6] The Tribunal may order non-publication of the name and identifying details in accordance with s 107(3)(b) of the Human Rights Act 1993, if the Tribunal is satisfied that it is desirable to do so.

[7] To determine this, the Tribunal must consider whether there is material before the Tribunal to show specific adverse consequences sufficient to justify an exception to the fundamental rule of open justice. The Tribunal must also consider whether an order is reasonably necessary to secure the "proper administration of justice" in proceedings before it and does no more than is necessary to achieve that (see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 at [66] (*Waxman*)).

[8] Open justice is an essential legal principle. It was described in *Waxman* at [56] where the Tribunal cited *Erceg v Erceg* [2016] NZSC 135, as follows:

> [2] The principle of open justice is fundamental to the common law system of civil and criminal justice. It is a principle of constitutional importance and has been described as "an almost priceless inheritance". The principle's underlying rationale is that transparency of court proceedings maintains public confidence in the administration of justice by guarding against arbitrariness or partiality, and suspicion of arbitrariness or partiality, on the part of courts. Open

> justice "imposes a certain self-discipline on all who are engaged in the adjudicatory process – parties, witnesses, counsel, Court officers and Judges". The principle means not only that judicial proceedings should be held in open court, accessible by the public, but also that media representatives should be free to provide fair and accurate reports of what occurs in court. Given the reality that few members of the public will be able to attend particular hearings, the media carry an important responsibility in this respect. The courts have confirmed these propositions on many occasions, often in stirring language. [Footnote citations omitted]

[9] The resolution of this claim arises from the death of Mr A and the acceptance by Dr Platz that he failed to provide Mr A with services with reasonable care and skill. As Mr A is deceased, it was not possible to seek his opinion on suppression of his name and identifying details.

[10] Mr A's adult children share his name and have already been through the lengthy and stressful process, after his death, of taking this complaint through the Health and Disability Commissioner's complaints process, leading up to this decision. Publishing Mr A's name and other identifying details along with the very detailed Agreed Summary of Facts would have the specific adverse consequence of causing Mr A's family significant further distress if this information was in the public arena.

[11] It was also submitted by counsel that as Mr A is not a party to this proceeding but was simply a consumer of the services provided by Dr Platz, there is no public interest in knowing Mr A's name or his identifying details.

[12] The Tribunal considers the principle of open justice can be maintained by the publication of the Tribunal's decision and the detailed Agreed Summary of Facts with Mr A's name and identifying details redacted. Accordingly, the Tribunal is satisfied that it is desirable to prohibit publication of Mr A's name and identifying details.

DECISION

[13] The decision of the Tribunal is that:

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

[13.2] 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. There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms SJ Eyre	**Dr SJ Hickey MNZM**	**Ms BL Klippel**
Deputy Chairperson	**Member**	**Member**

"A"

This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 25 November 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**, designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **DR KLAUS PLATZ**, of Hamilton, Medical Practitioner

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 "Mr A" (deceased). At all material times Mr A was a consumer of health services.

3. The defendant in these proceedings is Dr Klaus Platz ("Dr Platz"). At all material times Dr Platz was a Senior Medical Officer ("SMO"), General Surgery, at Thames Hospital, was a health care provider within the meaning of s 3 of the Act, and was providing health services to Mr A within the meaning of s 2 of the Act.

4. In March 2017 Mr A's daughter, Ms A, complained to the Health and Disability Commissioner ("HDC") about the services provided to Mr A by Dr Platz.

5. In February 2020 the Deputy HDC (appointed under s 9 of the Act) finalised his opinion that Dr Platz had breached Mr A's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred Dr Platz to the plaintiff.

Background

6. In 2016 Mr A, aged 84 years, was living on his own in his own home. He was independent with his cares and still driving. He had a history of atrial

fibrillation,[1] hypertension,[2] and previous asbestos exposure, and was an ex-smoker. Previously he had undergone an open cholecystectomy.[3]

Discovery of abdominal mass

7. On 5 April 2016 Mr A's general practitioner referred Mr A for a chest x-ray at Thames Hospital due to him experiencing slight shortness of breath when walking up hills or stairs. The x-ray showed suspicious opacity in his right upper lung.[4] On 7 April 2016 Mr A was referred to Waikato Hospital's Respiratory Clinic for review.

8. On 22 April 2016 Mr A had a CT scan[5] of his chest and upper abdomen at Thames Hospital, which revealed a suspicious growth in his right lung, and a large heterogenous[6] abdominal mass below the pancreas and related to small bowel loops.[7]

9. On 26 April 2016 Mr A had an appointment at Waikato Hospital's Respiratory Clinic. Ms A also attended the appointment with her father. Mr A reported having had slight shortness of breath over the previous few months when walking up hills or stairs, but no shortness of breath at night, and no cough or chest pain. He had not had any recent weight loss.

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[1] An irregular, often rapid heart rate.
[2] High blood pressure.
[3] Surgical removal of the gallbladder.
[4] A lung opacity is a non-specific term describing an area in the chest x-ray which appears whiter than it should be.
[5] A computed tomography (CT) scan is a medical imaging technique that uses computer-processed combinations of multiple x-ray measurements taken from different angles to produce tomographic images of the body.
[6] Diverse in character or content.
[7] The small bowel (or small intestines) is a tubular structure within the abdominal cavity which aids digestion. It is divided into three different parts: the duodenum (the first and shortest part), the jejunum (the middle section), then the ileum.

10. To investigate further, on 4 May 2016 Mr A had a bronchoscopy and bronchial brushing and washing of his right upper lung lobe.[8] The collections were negative for tumour cells.

11. On 10 May 2016 Mr A had a further CT scan of his abdomen and pelvis at Thames Hospital.

12. On 11 May 2016 the Waikato Hospital Respiratory Multidisciplinary Membership ("MDM") Conference (also referred to as "the Chest Conference")[9] discussed Mr A's case. A Waikato Hospital radiologist present at the Chest Conference verbally reported on the 10 May CT scan, pending the formal report on the scan from Thames Hospital. Review of Mr A's CT showed the lung lesion in the right upper lobe was indeterminate and not definitive of a mass lesion, so the Chest Conference suggested further imaging of the chest in three months' time.[10] However, the further CT of Mr A's abdomen identified significant mesenteric lymphadenopathy[11] that was suspicious in appearance and required further biopsy. The Chest Conference agreed further investigation was needed and recommended Mr A be referred to the general surgical team for consideration of a laparoscopic core biopsy[12] of the mesenteric lymphadenopathy.

Referral to general surgical team

[8] Examination of the airways using a bronchoscope (a thin, tube-like instrument with a light and lens for viewing) and collection of cells for histological examination.
[9] The Chest Conference was attended by representatives from several disciplines (including respiratory physicians, a radiologist, a pathologist, oncologists, cardiothoracic surgeons, clinical cancer nurse specialists, etc) from Waikato Hospital and other hospitals around New Zealand. MDMs are regular meetings involving health professionals with expertise in a range of different specialities and are run according to Ministry of Health guidelines and standards.
[10] The autopsy report confirmed subsequently that Mr A's lungs were normal with no evidence of disease, infection, or tumour.
[11] Disease or inflammation of the lymph nodes affecting the mesentery. The mesentery is a membrane that connects the bowel (intestines) to the abdominal wall through which most abdominal organs are attached to the abdominal wall and supplied with blood, lymph vessels and nerves.
[12] Using a needle to obtain a small sample of tissue, using a laparoscope. The laparoscope is inserted through a small incision in the abdominal wall and allows a surgeon to see inside the body without open surgery.

13. On 12 May 2016 Mr A and his daughter met with a respiratory registrar and a lung cancer clinical nurse specialist at Waikato Hospital's Respiratory Clinic, to discuss the results of the Chest Conference. The respiratory registrar told Mr A that his abdominal CT scan showed widespread mesenteric lymphadenopathy, and the consensus of the Chest Conference was to pursue a histological diagnosis[13] by obtaining a biopsy of the mesenteric lymph nodes. The respiratory registrar told Mr A that this would not be accessible via an ultrasound or CT-guided biopsy[14] by radiologists but would require a referral to the general surgical team for laparoscopic core biopsy. Ms A asked the respiratory registrar about the possibility of having a PET-CT scan[15] as a less invasive test, and the respiratory registrar confirmed "at present the consensus at Chest Conference was that we needed to get a histological diagnosis in the first instance if possible". Mr A understood that the differential diagnosis of the lymphadenopathy included malignancy.

14. Ms A recalls the respiratory registrar advised that the CT scan showed a lot of enlarged lymph nodes in her father's abdomen which were suspicious for cancer and that a referral to general surgery was needed to biopsy the lymph nodes laparoscopically. This advice is also recorded in the lung cancer clinical nurse specialist's clinical notes.

15. On 12 May 2016, the respiratory registrar sent a referral letter (the "referral letter") to the General Surgery Team at Waikato Hospital. The referral letter outlined Mr A's background and stated that the Chest Conference felt Mr A's chest lesion "is actually indeterminate and is not clearly a mass lesion". It also noted that Mr A's bronchoscopy results were negative for tumour cells. However, the referral letter stated that a further abdominal CT had found "widespread mediastinal mesenteric lymphadenopathy which is suspicious

[13] Based on microscopic study of a tissue sample.
[14] Use of imaging to determine exact placement of a needle when performing a biopsy.
[15] A Positron Emission Tomography (PET) scan is an imaging test which uses small amounts of a radioactive drug (tracer) to help diagnose, locate and assess a disease.

for a malignant process." The letter stated that the Chest Conference felt Mr A required "possible laparoscopic core biopsy of his mesenteric lymphadenopathy as this would not be accessible under CT or ultrasound guidance by the radiologist. Therefore we would be grateful of your review of Mr A's case and assistance with gaining a histological diagnosis of his mesenteric lymphadenopathy please." The referral letter did not specify the exact location of the nodal mass requiring biopsy. In order to triage the referral appropriately the exact location of the required biopsy should have been checked prior to the referral.

16. The referral letter also noted that Mr A reported a change in bowel habit and had been admitted to Thames Hospital at the beginning of April with ongoing diarrhoea, having previously had a history of constipation requiring regular laxatives for several years.

17. On 13 May 2016 the referral letter was received by Waikato District Health Board's ("WDHB") Referral Coordination Centre ("RCC"). Mr A was allocated an urgent First Speciality Assessment ("FSA") consultation with a general surgeon at Thames Hospital, as he lived in the Thames area. At the time of these events, it was standard practice for WDHB's RCC to send consumers who lived in the Thames/Coromandel area to Thames Hospital to be seen by either Thames Hospital general surgeons or visiting surgeons from Waikato Hospital. Dr Platz advised HDC he expected that as the referral was made to the General Surgery Team at Waikato Hospital, it would have been triaged by a Waikato Hospital surgeon first. He advised that if he had been notified that it was a non-reviewed referral, he would have returned it to the General Surgery Team as the Chest Conference had anticipated.

18. WDHB advised HDC that Thames and Waikato Hospitals are part of the same DHB and do not work in isolation. The referral, triage, and decision-making process is standard practice for the DHB. All surgeons are familiar

with the general environment, capabilities and limitations of the Thames surgical service and surgical teams are in frequent contact.

19. Dr Platz received a copy of the referral (date stamped by WDHB's RCC on 13 May 2016) and hand-wrote instructions on the referral that Mr A be booked within two weeks. Under Dr Platz's instructions are the words: "Booked 2/6/16".

20. At the time Dr Platz received the referral and first reviewed Mr A's CT scans, he had been employed as a SMO, General Surgery, at Thames Hospital for about nine days. Prior to that Dr Platz was employed by WDHB from 12 December 2011 to 31 January 2014 initially as a Senior Surgical Registrar at Waikato Hospital. This role involved being on call and regularly taking referrals from Thames Hospital, together with attending MDMs where Thames cases were reviewed. In December 2012 Dr Platz was engaged by the DHB as a locum consultant in general surgery for Waikato Hospital, Hamilton, Whanganui, Thames and Masterton.

21. On 13 May 2016 the formal report of Mr A's 10 May CT scan was provided by the Thames Hospital radiologist. The report findings included a "large heterogenous mass measuring up to 7x6x8cm identified with close relation to small bowel loops. The differentials include GIST[16] and lymphoma.[17]" The impression was a "large mesenteric root[18] mass, histological confirmation recommended."

22. On 19 May 2016 Dr Platz reviewed Mr A's CT scans.

FSA by Dr Platz on 2 June 2016

[16] Gastro-intestinal stromal tumours.
[17] Cancer of the lymphatic system.
[18] The mesenteric root is a section of the small intestines located centrally in the abdominal cavity.

23. On 2 June 2016 Mr A and his daughter met with Dr Platz at Thames Hospital for Mr A's FSA. Mr A had just turned 85 years of age.

24. In his reporting letter to Mr A's GP and WDHB's respiratory team, Dr Platz noted that on examination, Mr A's abdomen was soft, non-tender, and there was no guarding or peritonism.[19] He stated that Mr A had had a normal bowel motion that morning, had no kidney or bladder symptoms and there was no palpable mass in his abdomen.

25. Dr Platz subsequently advised HDC that he also examined Mr A for further tumour deposits in his neck, axilla,[20] and inguinal region,[21] and the findings were negative. However, Dr Platz did not record having performed such examination in the clinical notes.

26. In his reporting letter Dr Platz stated that Mr A had been "diagnosed with a lung lesion in his right upper chest". Dr Platz noted that review of Mr A's abdominal CT scan on 10 May revealed in addition a large intra-abdominal mass between the aorta[22] and his superior mesenteric artery ("SMA").[23] Dr Platz noted the Chest Conference had "asked us to get some histology samples from this mesenteric mass prior to the initiation of oncological treatment."

27. However, the referral letter clearly stated that the lung lesion was negative for tumour cells, and that the Chest Conference considered it was indeterminate and was not clearly a mass lesion. The letter stated that the widespread mediastinal mesenteric lymphadenopathy was suspicious for

[19] Localised inflammation of the lining of the abdominal cavity.
[20] Armpit.
[21] Groin.
[22] The abdominal aorta is the largest artery in the abdominal cavity (beginning at the level of the diaphragm) and supplies blood to much of the abdominal cavity.
[23] The SMA is a major artery of the abdomen arising from the abdominal aorta and supplying arterial blood to the organs of the midgut.

malignant process but did not state that Mr A was about to start oncological treatment.

28. WDHB advised HDC that MDMs provide a recommendation based on the available information but that the primary clinician must then consider the appropriateness of the recommendation. The following factors should be considered at the initial FSA consultation of any patient being considered for surgical intervention:

    - The patient's age and current level of function;
    - The patient's co-morbidities;
    - The risk of the procedure versus the expected benefit;
    - The expertise and experience of the assessing surgeon;
    - The suitability of surgery at the local facility;
    - Whether transfer to tertiary care or a specialist centre should be considered; and
    - Whether non-operative or palliative management may be more appropriate.

29. Dr Platz's reporting letter stated: "We had a long discussion about [the findings of the Chest Conference] and in the end we all concluded to go ahead with a diagnostic laparoscopy +/- proceed. [Mr A] is aware of the most common side effects of this procedure like bleeding, infection, bowel damage, damage to other organs, conversion to an open operation and he is happy to proceed."

30. During the FSA Mr A signed a consent form which stated "diagnostic laparoscopy +/- proceed". Ms A advised HDC that she and her father understood from their discussion with Dr Platz that "+/-proceed" referred to the possibility of having to change from laparoscopic to open surgery if needed for access. The consent form did not record Dr Platz having discussed with Mr A the benefits and risks of any available alternative treatments.

31. Mr A and his daughter came away from the FSA feeling confused that the information provided by Dr Platz was different to what they had been told

by the respiratory registrar. Dr Platz told Mr A and Ms A that he had been asked to "biopsy the bugger" in Mr A's abdomen which was "related to his lung cancer". Ms A questioned Dr Platz about this as they understood the bronchoscopy results were negative for cancer cells, and that the abdominal biopsy would be of enlarged lymph nodes. Ms A recalls Dr Platz reiterated that the CT scan showed a "10cm mass", not lymph nodes, and advised them that biopsy was the only option to identify a diagnosis. Dr Platz recalls he advised that the mass, until proven otherwise, could be a malignancy which could be related to Mr A's lung condition or a secondary tumour unrelated to it. Dr Platz advised them that the tumour was close to main arteries and could be difficult to get at. Ms A asked Dr Platz if her father could get the biopsy done at Waikato Hospital so that her father could stay with her while he recovered. She recalls Dr Platz advised that this would mean a wait of at least another three months. Dr Platz does not recall notifying any specific time frame. Mr A agreed to have the biopsy done in Thames Hospital. Dr Platz did not record Ms A's request for the biopsy to be performed at Waikato Hospital, or his response.

32. Mr A advised Dr Platz he did not want any treatment or intervention that would reduce his quality of life, as he currently felt well and was doing all the things he wanted to do. Mr A also told Dr Platz that he did not want any heroic measures if things did not go well during the biopsy; he did not want his life prolonged if he would have no quality of life. Dr Platz did not record Mr A's requests in the clinical notes.

33. Following the FSA, Ms A contacted the lung cancer clinical nurse specialist to clarify whether Mr A had lung cancer, and whether the abdominal CT scan showed a tumour. The nurse sought clarification from the respiratory registrar who confirmed that Mr A did not have a diagnosis of lung cancer, hence the planned follow-up scan in three months, and that the referral to

general surgery was to review Mr A for possible biopsy of his mesenteric lymph nodes. Mr A and Ms A felt reassured by this clarification.

34. On 8 June 2016 the Thames Hospital radiologist amended the 13 May CT report, with the findings noted as: "mesenteric root likely lymph node conglomerate[24] measuring up to 7cm by 6cm by 8cm identified with further mesenteric lymph nodes in the vicinity measuring up to 19mm."

35. On 9 June 2016 Dr Platz reviewed Mr A's amended CT report and his CT scans.

36. On 15 June 2016 Mr A's blood tests showed mild anaemia.

37. On 16 June 2016 Mr A signed an anaesthetic consent form which identified the procedure as: "General Anaesthetic for laparoscopic biopsy of mesenteric mass." Mr A was assessed overall as an intermediate anaesthetic risk given his age and co-morbidities and was given a "green" status to proceed with surgery.

Mr A's first operation on 4 July 2016

38. The clinical notes record that the first surgery commenced at 9.57am and stopped at 12.03pm.

39. In his operation report Dr Platz recorded that: "We were asked by the Chest Conference in Waikato whether we were able to provide histology samples for Mr A who is known to have a primary lung malignancy with a large metastatic abdominal mesentery mass between Aorta and SMA. It is a retroperitoneal[25] position and at least 7x6x8cms in size. …" Dr Platz also

[24] Consisting of a number of different and distinct parts grouped together.
[25] The retroperitoneum is the space in the abdominal cavity behind the peritoneum. The peritoneum is the thin, transparent membrane that lines the walls of the abdominal cavity. It is one continuous sheet forming two layers. The outer layer is attached to the abdominal wall and the pelvic walls. The inner layer is wrapped around most of the intra-abdominal organs for protection and supports many of the abdominal organs and their blood vessels. Intraperitoneal is the space wrapped in the inner layer of peritoneum and which contains structures like the stomach and intestines.

referred to the collection of tissue samples "prior to oncology treatment" and "necessary to start chemotherapy".

40. As noted above, Mr A did not have a diagnosed lung malignancy and there is no reference anywhere in Mr A's clinical notes to him starting oncological treatment for anything.

41. Dr Platz recorded that the initial approach was laparoscopic, and that multiple adhesions between the omentum[26] and the anterior abdominal wall, which had resulted from the open cholecystectomy 35 years earlier, were released. His operation report also stated:

> "[T]he intensive search for superficial tissue sample was negative; I was forced to lift the omentum and part of the small bowel upwards to get to the bigger mesentery mass between aorta and mesenteric artery."

42. Dr Platz recorded that he made a longitudinal incision of 5cm over the mass and separated the retroperitoneal tissue, and:

> "After 2–3cm deep incision I could not get down to the presumed abdominal mass and due to the poor visibility and deepness I decided to convert this operation to an open procedure and reopening his old midline incision between xiphoid[27] and umbilicus."

43. Dr Platz recorded that the open incision reached deep down into the retroperitoneum to a tumour mass, which looked black and dark blue and more fluid than solid. Dr Platz removed this tumour mass leaving the rest of the tumour alone. His operation report stated:

> "It had an intact capsule around it and so I decided not to incise this intact capsule in order not to spill liquid tumour masses into the abdomen. The

[26] A sheet of fatty tissue that is covered by peritoneum.
[27] The lower part of the breastbone.

incision was extended to around 8cm and the soft tissue mass with an intact capsule was easily retrieved."

44. The operation report recorded that there was complete haemostasis,[28] and the postoperative instructions included that Mr A could be discharged the following day.

45. About two hours after Mr A was transferred to the Post-Anaesthesia Care Unit the recovery nurse advised Dr Platz that Mr A was clammy and showed signs of having an intra-abdominal bleed. Mr A's blood pressure was unstable and a complete blood count showed that Mr A's haemoglobin level had dropped from 125 to 95. Mr A was returned to the theatre and a second operation was undertaken.

Second operation

46. The clinical notes record that Mr A's second operation commenced at 3.15pm and finished at 6.04pm. Dr Platz was assisted in the operation by another surgeon.

47. Upon opening Mr A's abdomen, Dr Platz found it to be filled with blood. Dr Platz removed the blood clots and performed an initial washout, and Mr A's abdomen was packed with swabs in order to isolate the bleeding source. Dr Platz inspected the different quadrants of Mr A's abdomen for a source of the bleeding, and when none was found he inspected the original enucleation[29] site at the lower pole of the tumour mass and found diffuse bleeding out of the tumour bed cavity.

48. In addition, Dr Platz discovered bleeding from the third part of the duodenum into the proximal jejunum. He repaired the duodenal laceration, and performed a duodenal-jejunal bypass. Parts of the upper tumour mass

[28] Stoppage of bleeding.
[29] Removal of whole tumor or encapsulated parts of a tumour.

were removed and sent for histology. Dr Platz also observed a blue discolouration of the distal small bowel which he left alone for later revision. In his operation report Dr Platz also recorded finding tumour infiltration of the third and fourth part of the duodenum. Mr A was administered ten units of blood during the second operation.

49. During the second operation Dr Platz contacted the on-call consultant surgeon at Waikato Hospital who agreed Mr A should be transferred to Waikato Hospital.

50. At about 3.45pm Waikato Hospital's intensive care unit ("ICU") was contacted by Thames Hospital to request retrieval of Mr A for post-operative ICU or High Dependency Unit care. The ICU consultant asked to be updated with progress during the operation.

51. At about 5.45pm the consultant anaesthetist at Thames Hospital contacted Waikato ICU's SMO to advise that the second operation was coming to a close, Dr Platz believed the bleeding was controlled as well as was possible, and that Mr A had required transfusion of multiple units of red blood cells and plasma. The anaesthetist advised that Mr A was still critically unwell with complications of haemorrhagic shock and a major transfusion. The ICU SMO dispatched a retrieval team with three units of cryoprecipitate[30] and one unit of platelets as Thames Hospital did not store platelets or blood products to manage coagulopathy.

52. After the insertion of two drains, the abdomen was closed and Mr A was left in the operating theatre for further observation. Mr A was also administered another 15 units of blood within 39 minutes of completion of the second operation.

[30] A frozen blood product prepared from blood plasma, rich in clotting factors, which are proteins that can reduce or stop bleeding.

53. After the second operation Dr Platz spoke to Ms A and her brother, advising that Mr A had lost a significant amount of blood, that his situation was barely survivable, and that they were transferring Mr A to Waikato Hospital's ICU by helicopter once he had stabilised. Ms A and her brother were allowed to see their father in the operating theatre. In light of Mr A's request to Dr Platz for no intervention or heroic measures to be taken to prolong his life if it was clear he was not going to survive or would have little or no quality of life, Mr A's children told Dr Platz that he should let their father go.

54. A retrieval team from Waikato ICU arrived at Thames Hospital about 7.30pm to transfer Mr A, however Mr A was still very unstable with a high noradrenaline infusion[31] and sudden large losses of blood from the surgical drains. Mr A was unsafe to transport in that condition. The retrieval team was also concerned that the weather was closing in which could make a return flight to Hamilton impossible.

55. At about 8.15pm, having consulted the accepting surgeon at Waikato Hospital, Waikato ICU's SMO advised Dr Platz that Mr A was too unstable to transport, and that Dr Platz should re-operate to attempt to stabilise Mr A by packing the abdomen, for urgent transport to Waikato ICU.

Third operation

56. At 8.25pm Dr Platz returned Mr A to theatre. Again, he was assisted by another surgeon. The operation took 22 minutes and was completed at around 8.47pm. Dr Platz performed a wash out and packed the abdomen with five swabs.

57. At about 8.30pm, on their way to Waikato Hospital, Mr A's children were advised that their father had been taken back into surgery a third time.

[31] To support Mr A's blood pressure.

58. At 9.15pm the retrieval team contacted the ICU SMO to advise that the re-operation was complete and Mr A's abdomen packed.

59. Mr A was administered another eight units of blood during the procedure. When he was transferred to the transport trolley he became more haemodynamically unstable,[32] requiring significant blood pressure support, and was administered further blood.

60. Mr A arrived at Waikato's ICU at around 10.20pm. The surgeons and ICU specialists at Waikato Hospital decided that further surgical intervention for Mr A's continued bleeding was inappropriate. They transfused further blood products, however Mr A continued to deteriorate. A family meeting took place when Mr A's children arrived at Waikato Hospital, and the ICU SMO advised that survival was extremely unlikely due to ongoing bleeding and multi-organ failure. Mr A's children agreed to stop further intervention and allowed Mr A to pass away at 12.35am on 5 July 2016.

[32] Unstable blood pressure.

Post-events

61. The histology report of the removed tumour (dated 14 July 2016) identified "portions of small bowel wall with features of a large well differentiated[33] neuroendocrine tumour[34] (carcinoid[35] tumour) abutting[36] and extending out from the muscularis propria[37] of the duodenum.[38] Lymphovascular space invasion[39] is also seen. The tumour also appears well vascularised,[40] congested[41] and haemorrhagic.[42] The tumour abuts and forms the tissue edges in places."

62. The autopsy report (dated 24 July 2016) stated that Mr A's cause of death was uncontrollable blood loss as a complication of surgery, and that the site of bleeding was unable to be identified but was in the region of the mesenteric root and the inferior vena cava.[43] The report stated that there was haematoma[44] about the mesentery root and inferior vena cava region and there was no vessel wall defect identified. The report noted:

> "[T]he Waikato Hospital histology report of the resected tissue shows features of a neuroendocrine tumour that is malignant with evidence of lymph node spread. Interestingly this tumour was noted to be very vascular."

63. In August 2016 the General Surgery Morbidity and Mortality Meeting at Waikato Hospital identified as an issue, the decision to have the surgery at Thames Hospital (noting that mesenteric biopsy is not always a straight

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[33] A tumour which closely resembles the structure of the tissue it started with. The cells and tissue look like normal cells and tissues.
[34] A tumour that arises from cells of the endocrine (hormonal) and nervous systems.
[35] A slow growing tumour.
[36] Adjoining or bordering.
[37] Muscular layer.
[38] The first part of the small intestine.
[39] Invasion of cancer to the blood vessels or lymphatics.
[40] Has several blood vessels.
[41] Abnormally full of blood.
[42] Accompanied by abnormal bleeding.
[43] A large vein that carries deoxygenated blood from the lower and middle body to the heart.
[44] A collection of blood outside of blood vessels due to either trauma or disease.

forward procedure) and suggested that, going forward, such biopsies should be discussed at a MDM involving a surgeon at Waikato Hospital with potentially all to be done at Waikato Hospital.

64. Since these events, WDHB has moved to central triaging, with all surgical referrals being triaged by two general surgeons based at Waikato Hospital, to allow greater standardisation of management, and potentially easier access to opinions by interventional radiologists[45] and collegial opinions.

Expert advice

65. Dr Elizabeth Dennett, a Consultant General and Colorectal Surgeon and Associate Professor of Surgery, provided independent expert advice to the HDC in relation to Dr Platz's care of Mr A. Dr Dennett is also an examiner in General Surgery for the Fellowship exams of the Royal Australasian College of Surgeons.

66. Dr Dennett advised that there were multiple points of failure in this case and that Mr A died from a catastrophic haemorrhage following an unnecessary operation in a small hospital that was not designed or supported for the surgery that Dr Platz performed.

67. In summary, Dr Dennett identified Dr Platz's failures as his:

    (i) Inadequate pre-operative work-up and planning for the laparoscopic biopsy of a retroperitoneal mass;

    (ii) Decision to operate in a small and unsupported hospital, and to not abandon the first operation when he could not find any superficial intra-peritoneal mass to biopsy, and before the situation became irretrievable;

[45] Interventionalist radiology is a subspecialty of radiology which utilises minimally invasive imaging.

(iii) Decision not to confine the second operation to a damage-control laparotomy[46] to ensure Mr A had proper abdominal packing and was stabilised for transfer to Waikato Hospital, rather Dr Platz performed a long and unnecessary procedure during which Mr A continued to deteriorate.

Inadequate pre-operative work-up and planning

68. Dr Dennett advised that there were multiple differential diagnoses for Dr Platz to have considered, including lymphoma,[47] neuro-endocrine tumour,[48] or duodenal tumour.

69. In light of these possibilities, Dr Platz failed to undertake a number of tests prior to surgery, some of which only involved performing blood tests. In terms of duodenal tumour, Dr Dennett advised:

> "[T]he third part of the duodenum is (on the CT) intimately associated with the mass, in many coronal views[49] it is impossible to separate them. Based on the CT images an upper GI [Gastro-Intestinal] endoscopy +/- endoscopic ultrasound[50] should have been undertaken. Dr Platz as the operating surgeon should have reviewed all of the images of the CT scan and seen this, if he wasn't sure given the position of the mass he should have reviewed all the images with a radiologist."

70. Dr Dennett advised that a diagnosis may have been possible before any biopsy and may have completely avoided the need for a tissue diagnosis. She

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[46] A surgical incision into the abdominal cavity.
[47] Cancer of the lymphatic system (the disease-fighting network).
[48] A tumour that arises from cells of the endocrine (hormonal) and nervous systems. (As it transpired, this is what Mr A's abdominal mass was).
[49] In terms of imaging, the coronal or frontal plane is any vertical plane that divides the body into belly and back sections. One of three main planes of the body used to describe the location of body parts in relation to each other.
[50] Endoscopy is an internal examination using an endoscope – a long, soft, flexible tube with a camera and light. Endoscopic ultrasound (EUS) is a minimally invasive procedure to assess GI and lung diseases. A special endoscope uses high-frequency sound waves to produce detailed images of the lining and walls of digestive tract and chest, and nearby organs, and lymph nodes. Practitioners can also use fine-needle aspiration (FNA) to take a tissue sample, guided by the endoscope.

stated that it was a moderate departure from good practice for Dr Platz not to consider any differential diagnoses to aid his decision-making.

71. Dr Dennett advised that the CT scan showed the SMA was stretched over the top of the mass, the anatomy of some of the most important vessels in the abdomen was distorted, and other important vessels could not be seen. She stated that an appropriate work-up for surgery should have included angiography[51] to map out the important vessels accurately and to help to make a decision about the best approach to the mass for a biopsy. She advised:

> "The lack of any work-up/further investigation particularly endoscopy (best practice with ultrasound) and angiography would be viewed poorly by my peers. It is a substantial departure from good practice."

72. Dr Dennett advised that it is clear from Mr A's CT scan that the third part of the duodenum cannot be separated from the mass, the mass is heterogenous suggesting necrosis,[52] and it is in the retroperitoneum. She stated that if Dr Platz had read the scan correctly before he operated, he would have been aware that the tumour was highly vascular, contained necrotic components, and was inseparable from the duodenum. She said that if Dr Platz was not able to read the scan, he should have gone over it with a radiologist.

73. Dr Dennett advised that had the operation been to obtain a biopsy of an easily accessible intraperitoneal mass, there would have been no reason for it not to be performed at Thames Hospital. However, she considered that Dr Platz should never have undertaken this particular operation at Thames Hospital, as it was a major procedure in a critical area that usually is operated on only by surgeons with specialist training. She stated that there was no support in case of a complication (for example blood products and ICU), Mr A was not

[51] An imaging test that uses x-rays to view the body's blood vessels.
[52] The death of cells in living tissue.

worked up adequately prior to the surgery, and the anatomy was not fully appreciated.

First operation

74. Dr Dennett advised that knowing the mass was in the retroperitoneum and that Thames Hospital was not adequately supported for major surgery, Dr Platz should have abandoned the operation when the search for a superficial tissue sample failed.

75. Dr Dennett advised that in his operation note, Dr Platz's description of his approach to the retroperitoneal mass contains very little detail about what he actually did and how the major vessels were identified and protected. Similarly, there is a lack of information for the open part of the operation.

76. Dr Dennett advised that there never should have been a conversion to an open operation because the attempt at the laparoscopic dissection of the retroperitoneum should never have been undertaken. Dr Platz converted as attempts at laparoscopic dissection failed. However, Dr Dennett stated that Dr Platz had forced himself into the position of converting to open surgery. From his operation note it would have been negligent to abandon the operation after the laparoscopic attempt, without first checking for any injury or damage following the deep dissection into the retroperitoneum under poor visibility.

77. Further, Dr Dennett advised that the reason for surgery was never to remove a highly vascular tumour from the retroperitoneum; this was an intra-operative decision of Dr Platz.

78. Dr Dennett also advised that Dr Platz's postoperative instructions were poor. Given that Mr A had undergone major intra-abdominal surgery, it would have been impossible for him to be ready for discharge the following day.

Second operation

79. Mr A was taken back to theatre due to bleeding. He was unstable by this point and was underway with a massive blood transfusion. Dr Dennett advised that the second operation should have been a damage control laparotomy only, with appropriate abdominal packing to temporarily stabilise Mr A for retrieval. Her view was that time was wasted that should have been used to get Mr A to Waikato Hospital.

80. Mr A was taken back to theatre and his whole abdomen was inspected for a source of bleeding before the original operating site was inspected. Dr Dennett stated that in the absence of any trauma, the obvious source was going to be the operative site.

81. During the second operation, Dr Platz found a laceration in the duodenum, which he repaired. Dr Dennett considered that was appropriate to prevent any contamination, even in a damage control laparotomy. However, this was followed by a duodenal-jejunal bypass which, Dr Dennett advised, extended the operating time unnecessarily. The tumour bed should have been packed and nothing more.

82. In his operation note Dr Platz suggested the duodenal laceration may have been caused by infiltration of the tumour. Dr Dennett stated that the laceration was due to the first operation, irrespective of whether or not the duodenum was involved with the tumour. She advised that the finding of a duodenal laceration in light of Dr Platz's claim that the tumour was encapsulated, and his failure to recognise the duodenal injury, amounted to a substantial departure from good practice.

83. During the second operation Dr Platz noted a bluish discolouration of the distal small bowel, which he left. Dr Dennett advised that this was an appropriate decision. However, Dr Platz's operation note stated that this was

probably also mediated by tumour infiltration. Dr Dennett advised that if the discolouration had been due to tumour infiltration, it should have been noted at the first operation. She said:

> "I know of no pathophysiological process involving tumour that would have led to [the] small bowel looking bluish when it was normal looking only a few hours earlier except for ischaemia i.e. the blood supply had been compromised. Dr Platz was looking at ischaemic bowel and the post mortem report confirms this. It is of concern that he could not recognise this …"

84. Dr Dennett advised that the long second operation and the failure to treat it as damage control was a moderate departure from good practice. She also advised that Dr Platz's under-appreciation of the gravity of the situation was a substantial departure from good practice.

Third operation

85. Dr Dennett advised that the steps taken during the third operation were what should have been done during the second, and that by the time of the third operation, it was too late.

Breach of Right 4(1) of the Code

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

87. Dr Platz has accepted that he should not have operated on Mr A at Thames Hospital and that the operation should have been abandoned when his search for a superficial tissue sample failed.

88. Dr Platz has acknowledged the tragic outcome for Mr A and his family from his clinical handling of Mr A in June and July 2016. He has accepted that he made a number of incorrect assumptions and judgements, and that he should

have sought more information and collegial support instead of concluding that gaining a histological sample in a laparoscopic/open operation would be the appropriate way. He acknowledges that he missed an important opportunity to fully appreciate Mr A's age and clinical symptoms, the limited resources at Thames Hospital, and Mr A's desire for the least intervention possible. He takes full responsibility for his actions. Dr Platz has accepted there were steps that he should have taken that he did not and he sincerely regrets the decisions he made on that day.

89. Dr Platz accepts that in this case he breached Right 4(1) of the Code, and has provided a written apology to Mr A's family.

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Greg Robins
Acting Director of Proceedings

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

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By or on behalf of Dr Klaus Platz
Date: