Auckland District Health Board

A Report by the

Health and Disability Commissioner

(Case 07HDC19869)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Mrs A	Complainant/Consumer's wife
Dr B	Consumer's General Practitioner
Dr C	Ophthalmologist
Dr D	Ophthalmologist
Northland District Health Board	Provider
Auckland District Health Board	Provider

Complaint and investigation

On 12 November 2007, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by Auckland District Health Board to her husband, Mr A. The following issue was identified for investigation:

- *The adequacy of the ophthalmology referral systems operating at Auckland District Health Board in July 2006 to February 2007 in relation to Mr A — including the information provided regarding referral and waiting times.*

An investigation was commenced on 7 March 2008. Independent expert advice was obtained from Allan Cumming, a healthcare quality improvement expert, and from Dr Kenneth Tarr, a consultant ophthalmologist.

Information gathered during investigation

Background
Mr A suffered a significant left eye injury during his childhood and was hospitalised for a period. Thereafter, Mr A did not experience further problems with his left eye until he was an adult.

While driving home on 27 September 2004, Mr A (aged 44) noticed a shadow over his left eye. On 29 September 2004, he saw his GP, Dr B, who documented "dark curtain has increased in size". Dr B queried retinal detachment and referred Mr A to Whangarei Base Hospital (Whangarei Hospital). Mr A was reviewed at Whangarei Hospital later that day, and referred to the Greenlane Clinical Centre (Auckland DHB's Ophthalmology Department) where he underwent a retinal detachment

Names have been removed (except Auckland DHB, Greenlane Clinical Centre, Northland DHB, Whangarei Hospital) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

operation including vitrectomy[1] that evening. In July 2006, Mr A had a cataract extraction and removal of silicone oil and residual liquids in his left eye. Both procedures were performed by ophthalmologist Dr D. Thereafter, Mr A was referred back to Whangarei Hospital for follow-up.

Referral in August 2006

On 11 August 2006, Mr A (aged 46) was reviewed by Whangarei Hospital's ophthalmologist, Dr C, who suspected that Mr A had a recurrent retinal detachment and referred him back to the Greenlane Clinical Centre for further care. Dr C requested that Mr A be reviewed in a timely manner. The referral was addressed to the "vitreoretinal surgeons", and was faxed directly to Auckland DHB's Ophthalmology Department because of its urgent nature. The referral was also posted. However, Dr B (Mr A's GP) was not sent a copy of the referral.

According to a handwritten note (dated 11 August 2006) on the letter of referral, the referral was documented with Dr D, and arrangements were to be made for Mr A to be seen at the next available outpatient clinic on 23 August 2006. Regrettably, Auckland DHB's Ophthalmology Department misfiled the referral and Dr D's note was never actioned. (The cause of the misfiling has not been identified.)

Ten days later (21 August 2006), Mr A informed Dr B that he had not heard from Auckland DHB's Ophthalmology Department regarding an appointment. Dr B stated:

> "… I then contacted the ophthalmology nurse specialist at Whangarei Hospital, having not received a copy of [Dr C's] referral letter at that stage. I requested that [the ophthalmology nurse] check with [Auckland DHB's Ophthalmology Department] that they had received the referral letter, and that they sent an appointment. …"

Following Dr B's call, Whangarei Hospital's Ophthalmology Department contacted Auckland DHB's Ophthalmology Department, which confirmed that it had received the referral, and would be contacting Mr A. It appears that following this telephone call, Whangarei Hospital's Ophthalmology Department did not communicate further with Auckland DHB's Ophthalmology Department regarding the referral. A week later, Dr B contacted Whangarei Hospital's ophthalmology nurse again. She informed Dr B of the details of her telephone call to the Auckland department, including the fact that they would be contacting Mr A. However, there was no communication from Auckland DHB's Ophthalmology Department to Mr A to acknowledge receipt of the referral and to provide an approximate time frame for the appointment.

[1] Removal of the whole or part of the vitreous humour (transparent jelly-like material that fills the chamber behind the lens of the eye). Vitrectomy is often necessary in surgery to repair a detached retina.

Care in February 2007
Six months later, on 14 February 2007, Mr A complained to Dr B that he had not received any appointment from the Auckland department. Dr B contacted Auckland DHB's Ophthalmology Department and requested an urgent appointment on Mr A's behalf.

On 21 February 2007, Mr A was reviewed by Dr D, who noted that Mr A's retinal detachment was complete and that corrective surgery was not an option. In his report to Dr C, Dr D stated:

> "When I examined [Mr A's] eyes [on 21 February 2007] his visual acuity was 6/5 in the right and perception of light only in the left. He had a grossly inflamed eye with a total hyphema[2] and no view of the intraocular contents was possible. I performed a B scan ultrasound which clearly shows an open funnel retinal detachment which is fixed.
>
> In my opinion this is not surgically amenable to treatment and I have counselled [Mr A] accordingly. Because of his inflammation I have started him on Pred Forte 4x a day and Atropine 1% 4x a day and have asked him to take these drops until he is reviewed by an ophthalmologist again in Whangarei Base Hospital."

ACC
In late February 2007, a treatment injury claim was submitted to ACC. In a supporting statement to ACC, Dr D stated:

> "In my opinion … [Mr A] has undergone [treatment injury] due to a systems failure in accessing the appropriate medical treatment. In my opinion if [Mr A] had received timely attention following the letter of [Dr C] in August 2006 he may well have expected to have a better visual outcome."

On 13 September 2007, ACC accepted the claim as treatment injury on the basis of failure to provide treatment in a timely manner for a left retinal detachment, resulting in loss of left eye vision.

Subsequent events
On 27 April 2007, Mr A returned to see Dr C at Whangarei Hospital. Mr A stated that he was "still having trouble getting used to a monocular view" and was reassured "that his ability to judge distances, and parallel park, [would] settle down with time". The eye drops Dr D prescribed were effective in keeping Mr A's left eye comfortable and Dr C advised cutting down on them over time. A follow-up appointment was scheduled for August 2007.

[2] Haemorrhage within the anterior chamber of the eye.

During the review on 27 August 2007, Dr C recorded that Mr A's left eye was "chronically red" and he had "constant irritation". Dr C noted that Mr A was "very sensitive" to light even when wearing dark glasses. On examination, Dr C documented that Mr A's left eye felt "soft" and that there was "mild corneal thickening". Dr C advised Mr A that he could either continue using eye drops on his left eye or have it removed surgically (enucleation). Mr A opted for surgery.

On 8 November 2007, Dr C carried out the enucleation to remove Mr A's left eye. The surgery was uneventful. A month later, Mr A was referred to a maxillofacial prosthetist and underwent a successful ocular prosthesis to his left eye on 21 December 2007.

Northland DHB referral systems

Northland DHB defended the operation of its ophthalmology referral system in this case:

"1. We agree that it is generally desirable to include the name and contact details of the patient's GP in referral letters.

2. We agree that copies of referral letters should generally be given to patients and their GPs.

   All of the above practices are already often undertaken in our services. We will be recommending to clinicians and clerical staff that they become standard practice, although we have some concerns about the potential increase in clerical staff workloads, for which we may not have adequate resources. Recent improvements in our procedures for updating and noting information regarding the patient's GP at each patient visit will assist these processes.

3. We believe that we took reasonable steps to follow up the referral in this case, when the patient notified our service that no appointment had been received from ADHB. We do not consider that referrers have a duty of care to ensure that referrals have been received and acted upon, over and above taking reasonable steps to ensure that the referral has been conveyed by reliable means to the correct address. We do not have sufficient clerical resources to check on the receipt of all referrals sent elsewhere, the appointments made by the receiving agency, and the notifications sent by that agency regarding appointments made. In our view, it would not be reasonable to divert limited DHB resources from other tasks to do this, as the administrative burden would be significant and the gains questionable. A more appropriate and comprehensive solution would be the development of a single electronic health record and record management system in New Zealand, which could provide automatic electronic tracking of referrals and appointments together with the

> capacity for all health providers (including GPs and patients) to view the progress of referrals in the system and appointments made."

Auckland DHB referral receipt systems

Auckland DHB's process for managing referrals[3]
Auckland DHB has two separate processes for managing the referrals it receives. The Central Referrals Office (established in 2003) processes all non-urgent elective referrals sent to Auckland DHB. If referrals are marked urgent by the referring practitioner or if the party making the referral indicates that the patient needs to be seen in less than seven days, the referrals are sent directly to the service concerned for processing. The service is expected to review urgent referrals and to action them as required. Upon receiving an urgent referral, it is triaged by the clinician concerned, and the scheduler books the appointment according to the clinician's instructions. The scheduler then logs the referral into the system. In other words, urgent referrals are not logged by the Central Referrals Office and do not go through the same wait listing process for elective non-urgent referrals. Auckland DHB explained that "it is necessary for urgent referrals to be sent directly to the service for management, to avoid any delay in seeing the patient within the week (7 days or less)".

Changes made to prevent a recurrence
Auckland DHB has taken a number of steps to prevent an urgent ophthalmology referral going astray:

> "This issue has been discussed at the Ophthalmology Management meeting with the Clinical Director and the Service Manager. … [A]n email communication has been sent out to the consultants reiterating that all requests for appointments must be put in the designated box at all times and all documents must clearly indicate what needs to be done with them. Any document received from the consultants without clear instruction will be returned to their tray. … All staff in the Ophthalmology department are aware to bring any documents to the team support where there is uncertainty about what to do with the document and to investigate any loose documents. This will continue to be reinforced at Departmental meetings.
>
> It has been decided at the Ophthalmology Management meeting that a letter will be sent … to all potential referrers throughout the country advising them if they have sent a referral directly to one of the consultants in the department but

[3] Clarification provided by Auckland DHB in response to my provisional opinion of 29 July 2008. Auckland DHB had previously stated that its Central Referrals Office (CRO) processes all referrals regardless of whether they are sent directly to the CRO or to a particular consultant or department. Refer to Appendix A for the information Auckland DHB previously provided, on which Allan Cumming's expert advice (Appendix B) is based.

have not had any response back four weeks after the date of referral, to advise the Ophthalmology Department of the patient details, the Ophthalmology Department will then check the records and advise the referrer accordingly.

It has been decided that an audit of patient files will also be conducted to identify whether there are any other referrals filed in the patient charts without having been actioned. … Any action will be taken as necessary based on the findings of the audit. This audit will also help check that the referral processes are sound and being followed. The process and findings of this audit will be the subject of further discussion and meetings in the Ophthalmology Department to look [at] any key systems issues identified.

The Ophthalmology Department acknowledges that the open tray system used at present in the consultant room has a potential for documents to get misplaced.

The Ophthalmology Department has also identified that at the time [Mr A's] referral got misplaced, the label on the 'for appointments' tray was glued to the wall next to the tray and not on the tray itself. Because there are two other trays with labels placed on the wall alongside the appointment tray, there is a potential likelihood of documents being placed in the wrong tray if trays have moved.

The appointment tray in the consultant room has been replaced by a box clearly labelled 'for appointments only'. The Ophthalmology Department believes this will eliminate the chances of requests for appointments being misplaced which will prevent similar situations arising in the future.

…

… [T]he clinical records staff who manage filing into Ophthalmology records have also been advised to carefully check any correspondence before filing, and question any referrals that are sent to them for filing in the record.

These changes in administrative processes will help to reduce the likelihood of referrals not being actioned despite being received by the Ophthalmology Service. …"

Auckland DHB advised that its Ophthalmology Team Leader meets monthly with the Central Referrals Office Team Leader to "discuss and resolve any issues that may have arisen in the previous month".

Single entry point for referrals to Auckland DHB
In response to HDC's recommendation that Auckland DHB revise its referral receipt system from a multiple point entry to a single point entry system, Auckland DHB stated:

> "We will adopt this recommendation with regard to non-urgent Ophthalmology referrals. This will ensure that referrals are logged and can be tracked."

Auckland DHB acknowledged that the recommended changes have implications for both the Ophthalmology Department and other services across the DHB.

Electronic system for managing referrals
Auckland DHB outlined measures it is taking to move towards an electronic system for managing the referrals it receives:

> "… ADHB is involved in an ongoing regional ([Auckland] DHB, [Counties Manukau] DHB and [Waitemata] DHB) project to work towards an electronic medium for referrals management. This project is designed to deliver newly designed best practice referrals business processes and an electronic solution for the creation, submission and processing of patient referrals by primary to secondary and by secondary to secondary health care providers. The full solution will include standardised and automated electronic referral forms for the different specialty services, electronic data exchange between primary and secondary care providers plus electronic triaging, processing of referrals and decision support at the secondary care provider. This project is in the planning phase, and requires considerable consultation with all stakeholders in the Auckland region, including General Practitioners and other referrers.
>
> In the meantime, ADHB is currently working on an interim project to provide a standardised electronic GP referral form using the Medtech32 practice software (the software used by approximately 90% of ADHB's GP referrers). This system will provide an electronic referral form from the GP to the Central Referrals Office, from which point the current processes for triaging and appointment scheduling will apply. Please note that this solution is also reliant on the adoption of all potential GP referrers to the use of the standard template."

Explanation and apology
Auckland DHB explained what happened to Mr A as follows:

> "We are aware and remain concerned about the severe outcome [Mr A] has faced as a result of his appointment not being scheduled. Whilst ADHB considers the matters concerning the management of [Mr A's] referral to be serious and is working to rectify the systems problems identified, the use of the phrase 'beggars belief' could possibly be ambiguous or misleading. At present,

> most DHBs including ADHB use a paper based referral system where referrers write or fax their referral to ADHB. With this in mind, the likelihood of a systems error occurring could be variable at any one time and dependent on a number of factors. Such errors may also be compounded by human factor errors. Other hospitals in New Zealand are also at risk of this happening. We agree that ADHB's role is to minimise risk to the best of our capacity by having robust systems to help to prevent the mismanagement of referrals. We may as a DHB not be able to eliminate the risk completely. We note that the report highlights systems issues but the human factors component has not been addressed. Human factors may be the least understood in this particular case, but are worthy of mention."

Auckland DHB offered the following apology to Mr A:

> "… We sincerely apologise for this administrative error resulting in [Mr A] not receiving a timely appointment. … We are concerned about the severe outcome for [Mr A] given that the referral was not actioned as it did not go through our usual referral and waitlisting processes. We sympathise with [Mr and Mrs A] especially with the knowledge that [Mr A] had to have his eyeball removed in November 2007. We have put the above processes in place to try to minimise any similar event from occurring."

Auckland DHB comments

Auckland DHB made for the following comments on points mooted in my provisional opinion (see italics below):

> 1) *DHBs referring a patient must have systems to: a) ensure the referral is received; b) keep a record of appointments made by the receiving DHB; and c) take reasonable steps to follow up the referral if an appointment has not been made within a reasonable time.*
> While the proposal has obvious merits, as a general principle, it is both impractical and unreasonable. If this recommendation is applied consistently internal referrers, general practitioners and others should not only ensure that a referral is received and care of the patient accepted, but they must follow up to ensure that appropriate care (in the form of a timely appointment) has been given. Developing a system that tracks both referrals and the actions of another provider presents significant logistical problems. It also runs against the principle that one provider can, as a default, have trust and confidence in the quality of care of another provider. That trust and confidence must extend to administrative processes as much as clinical decision making as both are elements of the care provided. In theory double checking is a valuable safety principle, however it is simply not realistic to apply it in the manner suggested. There may be extenuating circumstances where it is necessary for a referrer to monitor the actual provisions of services by another agency. However, as a

general principle, we would suggest that a referring provider's obligation is to ensure that a referral has been received and care of the patient accepted.

2) *All letters between healthcare professionals should be routinely copied to the patient*.
In our view this comment should be reframed. As a generalisation it is unsustainable. Under the Code of Health and Disability Services Consumers' Rights providers have an obligation to communicate appropriately with patients. This does not translate into a global requirement to copy all correspondence to patients. In many cases, particularly around referral it is sensible and beneficial to copy letters and we support the Commissioner's encouragement to do so. However, even putting aside exceptional circumstances such as uncontactable or incompetent patients, there has to be consideration of all circumstances, the nature of the information communicated, alternative communication with the patient, privacy risk and so on. We would suggest that the Commissioner limit comment to the circumstances of this case or, alternatively, qualify this comment to acknowledge that there is discretion when deciding whether to copy letters to patients."

Ministry of Health comment

On being advised of this case and the problems it highlights in referrals between district health boards, Director-General of Health Stephen McKernan stated:

"I am concerned about the situation … and I agree with your view that inter-district health board (DHB) referrals should be managed consistently throughout the New Zealand health system. Current policy is that all elective referrals are acknowledged appropriately within 10 working days. I suggest that this policy should also be applied to inter-DHB referrals.

… [T]he Ministry of Health will raise this matter with the Chief Executive Officers and Chief Medical Officers of the DHBs to ensure that they are introducing this process."

Independent advice to Commissioner

Independent expert advice was obtained from:

- Allan Cumming, a healthcare quality improvement expert. Mr Cumming's advice is attached as Appendix B.

- Dr Kenneth Tarr, an ophthalmologist. Dr Tarr's advice is attached as Appendix C.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

…

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 6

Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

…

(c) Advice of the estimated time within which the services will be provided; …

Opinion: Breach — Auckland District Health Board

Overview

Mr A suffered a preventable injury — complete retinal detachment leading to the loss of eyesight in his left eye, and ultimately of the eye itself — because of a flawed referral system at Auckland District Health Board, which allowed his referral from Northland District Health Board to go into a "black hole" for six months. It must be of little comfort for Mr A to learn that this was due to a referral "systems problem" at Auckland DHB, that other district health boards had similar ophthalmology referral systems (with multiple entry points) in 2006, and that referring boards consider they have no duty of care to ensure that referrals have been received and acted upon, apart from checking that the referral has been conveyed by reliable means to the correct address.

What happened to Mr A was inexcusable. Although Auckland DHB finds the phrase "possibly … ambiguous or misleading", it does *beggar belief* that a patient with a serious, treatable health problem can be lost in a modern health system in this way.

It is not for HDC to prescribe the correct solution to these problems.[4] But it is my job to state the obvious: whatever referral system is operating between district health boards, it has to work for patients, who should have justified confidence that referrals will lead to action in sufficient time to treat preventable problems that the public system undertakes to treat.

Had appropriate safeguards been in place in this case, the misfiling of Mr A's referral at Auckland DHB would almost certainly have been detected and rectified, an appointment arranged, and timely treatment provided.

As the Director-General of Health acknowledges, the situation revealed by this case is of concern. It should be a wake-up call for all district health boards to improve their systems for handling inter-DHB referrals, so that patients are not lost in the system. Leadership at a national level will be essential for this to occur. Changes are clearly needed to referring and receiving practices if boards are to fulfil their duty of care for patients.

Duty of care — general principles

District health boards owe patients a duty of care in handling outpatient referrals, under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). This duty applies no less to referrals from other DHBs (inter-DHB referrals) than to referrals from GPs within the district. A specific aspect of the duty of care is the duty to co-operate with other providers to ensure continuity of care, under Right 4(5) of the Code.

[4] The suggestions made by my expert, Allan Cumming, seem a sensible way to improve the system design for receipt of ophthalmology referrals at Auckland DHB.

In meeting this duty of care, it would seem necessary for a referring district health board to: (1) copy all referrals to the patient and their general practitioner, and (2) have a system in place to ensure that a referral has been received (and follow it up in the absence of confirmation of receipt) and that care of the patient has been accepted by the receiving district health board.

Receiving district health boards owe referred patients a duty of care to: (1) acknowledge receipt of the referral, (2) prioritise it,[5] (3) arrange for patients to be seen in a timely fashion, in their assigned priority,[6] and (4) keep the patient and their GP informed whether, and if so when, the patient will be seen.

Duty of care of Auckland DHB

The Northland DHB referral of Mr A to Auckland DHB in August 2006 was sent by fax to the "vitreoretinal surgeons", and not to any particular ophthalmologist. It was not processed through the Central Referrals Office (CRO) because it was an urgent referral. On receipt of the faxed referral, a consultant ophthalmologist (Dr D) documented that Mr A was to be seen at the next available outpatient clinic on 23 August 2006. However, the referral was misfiled within the Ophthalmology Department, apparently due to an administrative error.

Auckland DHB operates two different processes for managing urgent and non-urgent referrals. Non-urgent referrals are handled by the CRO, while urgent referrals are sent directly to the service/department concerned without involving the CRO. This situation applied at the time of the events in question.

The separate system for handling urgent referrals is obviously prone to human error, which can result in potentially serious clinical consequences for the patient, as happened to Mr A. As noted by my systems advisor, Mr Cumming, the failure to involve the CRO removed "an essential check in the process". It also "prevented any subsequent misfiling or loss of the letter from being identified" since there were "no checks in place to follow up on unmade appointments". Although the specific failure was the misfiling of the referral, the underlying cause was "allowing multiple points of entry into the system without a process to return all referrals to the point where a record is made of their receipt".

Auckland DHB proposes to adopt a single entry point into the system (with the CRO logging all referrals before they are forwarded to the appropriate service/clinician), but only for non-urgent ophthalmology referrals. A separate system will continue to

[5] As noted in the Southland urology case 04HDC13909 (4 April 2006), prioritisation systems should be "fair, systematic, consistent, evidence-based and transparent" (citing "Statement on safe practice in an environment of resource limitation" (Medical Council of New Zealand, 2005)).

[6] As noted in the Southland urology case, district health boards have a duty to appropriately manage and monitor their waiting lists. See http://www.hdc.org.nz/files/hdc/opinions/04hdc13909urologist,dhb.pdf (4 April 2006), page 13.

operate for urgent referrals. This means the risk of urgent referrals going astray will continue.[7]

In this case, there was a missed opportunity for Auckland DHB to "catch" the error before it was too late. On the day the referral was faxed, Dr D prioritised the referral and an appointment was to be arranged for 23 August. This request was not actioned as it was misplaced — probably within the following few days. Ten days later, on 21 August, Mr A followed up the referral with his GP, who contacted Northland DHB. Northland DHB then contacted Auckland DHB. Auckland DHB confirmed that it had the referral at this point. However, no appointment eventuated despite this external check. The referral remained lost for six months.

I note Dr D's comment that Mr A "may well have expected a better visual outcome" had he received timely attention following Dr C's referral in August 2006. My expert ophthalmologist, Dr Kenneth Tarr, stated that "at this point in time, the surgery on [Mr A's] eye [was] very much at the end of the road for salvaging vision and even retaining the eye" and that a "recurrent retinal detachment after a vitrectomy needs urgent attention". Dr Tarr advised that the re-operation "should have been undertaken within a maximum period of two weeks" after Auckland DHB received the referral on 11 August 2006.

In my view, Auckland DHB missed the window of opportunity for the re-operation as it did not have an appropriate referral receipt system in place. Mr A was appropriately prioritised for an urgent appointment on 23 August 2006, but the appointment was not booked and did not happen. Auckland District Health Board failed to co-ordinate its ophthalmology services with those of Northland DHB in handling the referral. In these circumstances, Auckland DHB breached Rights 4(1) and 4(5) of the Code.

Information provided about the referral

Right 6(1) of the Code states that patients have the right to receive full information about their condition and treatment options, including advice about the estimated time within which services will be provided. As noted by my advisor, involving patients at all stages of the communication process provides a very reliable check in the system to correct errors and ensure communications do not go astray.

The Ministry of Health requires DHBs to appropriately acknowledge and process all referrals within 10 working days. In my view, a receiving DHB should acknowledge receipt of the referral, promptly notify the patient (with a copy to the patient's GP and to the referring DHB) of an approximate time frame for an appointment, and then

[7] As an aside, I am also concerned that it has taken Auckland DHB some time to clarify that it has two separate processes for managing urgent and non-urgent referrals. The apparent confusion even within Auckland DHB does not bode well for patients.

notify the patient (again, with a copy to the GP and referrer) of a specific appointment time.

Auckland DHB should have acknowledged receipt of the referral from Northland DHB and promptly notified Mr A (with a copy to Mr A's GP and to Northland DHB) of an approximate time frame for an appointment. This should have been followed by notification to Mr A (again, with a copy to the GP and Northland DHB) of a specific appointment time.

Instead, Auckland DHB only acknowledged receipt of the referral when Northland's Ophthalmology Department contacted the Auckland Ophthalmology Department 10 days after receiving the referral. Since the referral was then misfiled, no appointment was ever made.

In these circumstances, Auckland DHB failed to provide Mr A with adequate information about his referral and breached Right 6(1)(c) of the Code.

Other comment: Northland District Health Board

Northland DHB is not the focus of this investigation. However, the board that referred Mr A to Auckland DHB played an important role in the events that ensued.

A number of observations can be made in relation to the conduct of Northland DHB:

1) The letter of referral did not provide the name and contact details of Mr A's general practitioner, Dr B.

2) A copy of the letter of referral was not given to Mr A or Dr B.

3) Northland DHB did not have a system in place to track its referral of Mr A to Auckland DHB. When prompted by Dr B on 21 August 2006, the Northland Ophthalmology Department appropriately telephoned the Auckland Ophthalmology Department and confirmed that the referral had been received. That was good initial follow-up, and should have been adequate. However, Northland DHB undertook no further follow-up to check whether Mr A had actually received an appointment.

Northland DHB believes that it took "reasonable steps" to follow up the referral in this case, when notified that no appointment had been received from Auckland DHB. It submits that referrers do not have a duty of care to ensure that referrals have been received and acted upon, "over and above taking reasonable steps to ensure that the referral has been conveyed by reliable means to the correct address". Northland DHB cited its shortage of clerical resources, and the significant administrative burden of

following up referrals. It noted that "[t]here is no evidence that Northland DHB practices were any different from that of other New Zealand DHBs". The Ministry of Health confirmed that it imposes no requirement on district health boards to track the progress of referrals.

Auckland DHB made a persuasive submission on this point. It stated:

> "Developing a system that tracks both referrals and the actions of another provider presents significant logistical problems. It also runs against the principle that one provider can, as a default, have trust and confidence in the quality of care of another provider. That trust and confidence must extend to administrative processes as much as clinical decision making as both are elements of the care provided. In theory double checking is a valuable safety principle, however it is simply not realistic to apply it in the manner suggested. There may be extenuating circumstances where it is necessary for a referrer to monitor the actual provisions of services by another agency. However, as a general principle, we would suggest that a referring provider's obligation is to ensure that a referral has been received and care of the patient accepted."

I accept that it may be unduly onerous for a referring DHB to have a system in place to track and monitor referrals to another DHB. Such a system may only be achievable once New Zealand has an integrated electronic system for all DHB referrals. I fully endorse the statement by Northland DHB:

> "A more appropriate and comprehensive solution would be the development of a single electronic health record and record management system in New Zealand, which could provide automatic electronic tracking of referrals and appointments together with the capacity for all health providers (including GPs and patients) to view the progress of referrals in the system and appointments made."

However, referring district health boards do need to *ensure* that a referral has been received[8] (and take follow-up action in the absence of confirmation of receipt), and that the receiving board has accepted care of the patient.[9] I accept that Northland DHB did this by its phone call on 21 August 2006.

I also consider it essential that, wherever possible, referring DHBs provide the name and contact details of the patient's GP on the letter of referral. For most patients, their GP is the health care provider who is best placed to keep an overview of their care —

[8] Not merely "to ensure that the referral has been conveyed by reliable means to the correct address", as Northland DHB submitted.

[9] See also the discussion in a concurrent case, 07HDC20199 (3 October 2008).

even though the primary duty of care lies with the DHB that receives the referral. Northland DHB stated that this practice (ie, copying referral letters to patients and their GP) has been adopted and the DHB intends to make it a standard practice for all clinical and clerical staff.

I agree with Mr Cumming that, as a general rule, "all letters between healthcare professionals should be routinely copied to the patient". After all, it was Mr A's eyesight that was at risk, and he had the greatest investment in the referral not going astray and in receiving prompt treatment from Auckland DHB. As noted by Mr Cumming, "involving patients at all stages of the communication process provides a very valuable check in this system to correct errors and ensure communications do not go astray".

Mr A needed to be told very clearly by the Northland Ophthalmology Department that he needed urgent treatment to prevent the risk of loss of eyesight from his retinal detachment, and that he or his GP should follow up with the Auckland Ophthalmology Department if an appointment had not been received within 7 to 10 days. There is no evidence that Mr A received this information.

Recommendations

I recommend that Auckland District Health Board further review its referral receipt system in light of this report, and advise HDC of the outcome of its review by **31 January 2009**.

I recommend that Northland District Health Board review its referral system in light of this report, and advise HDC of the outcome of its review by **31 January 2009**.

I recommend that the Director-General of Health advise HDC, by **31 March 2009**, what systems are in place at all district health boards for inter-DHB referrals, to fix the problems highlighted by this case.

Follow-up actions

- A copy of this report, with details identifying the parties removed (other than the Greenlane Clinical Centre, Auckland District Health Board, Whangarei Hospital, Northland District Health Board and my experts), will be sent to the Minister of Health, the Quality Improvement Committee, the Health Information Strategy Action Committee, the Director-General of Health, the Royal Australian and New

Names have been removed (except Auckland DHB, Greenlane Clinical Centre, Northland DHB, Whangarei Hospital) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Zealand College of Ophthalmologists, the Royal NZ College of General Practitioners, and all district health boards, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Auckland DHB, Greenlane Clinical Centre, Northland DHB, Whangarei Hospital) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A

Information previously provided by Auckland DHB

Process for managing referrals[10]
Auckland DHB outlined its processes for handling referrals that enter the system in various ways as follows:

1. The usual process

> "The usual process regarding referrals sent to the Auckland District Health Board is that they are sent to the Central Referrals Office, where they are logged onto the database. Referrals are then sent to the relevant services for triaging by a consultant. Once triaged, referrals are then sent back to the Central Referrals Office to be waitlisted according to clinical priority. The Central Referrals Office monitors all referrals logged until they have been given a priority score from their service. This is then reflected in the relevant waitlist."

2. Referrals sent directly to the Ophthalmology Department

> "Despite the above process, at times referrals are still sent directly to the Ophthalmology Department.[11] However, these are forwarded to the Central Referrals Office to be logged and go through the usual process.[12] The Team Leader for Ophthalmology and Central Referrals Service believe there is a rigorous process in place to have all referrals logged and followed up appropriately, and therefore we have no explanation to why [Mr A's] referral[13] has not followed the usual process."

3. Referrals addressed to a particular consultant

> "… [I]f referrals are sent to a particular consultant, the consultant will triage the referral and put them in the tray 'for appointment' if appropriate. The team support empties the tray daily and send all appointment requests to the

[10] Auckland DHB clarified on 18 September 2008 that there are two separate processes for managing urgent and non-urgent referrals. Allan Cumming's advice (Appendix B) is based on the information set out in Appendix A, which was the information originally supplied by Auckland DHB between February and May 2008.
[11] Auckland DHB stated that up to 30% of referrals received for ophthalmology service are sent directly to the Ophthalmology Department.
[12] This applies only to referrals addressed to the Ophthalmology Department, not to a particular consultant.
[13] The referral from [Dr C] was addressed to the "vitreoretinal surgeons", not to a particular ophthalmologist.

scheduler. If an appointment is requested within 4 weeks the scheduler will process the referral, waitlist the patient and give an appointment within the 4-week time frame. If appointment is needed later than 4 weeks, the scheduler will send the referral to the CRO [Central Referrals Office] to follow the usual process."

Appendix B

Independent advice to Commissioner — Systems

The following expert advice was obtained from Allan Cumming, a healthcare quality improvement expert:

> "My name is Allan Cumming, and I am General Manager of the Quality Improvement Unit / *Te Pai Huanga* at Counties Manukau District Health Board. I have been asked to provide an opinion on case number 07/19869. I have read and agree to follow the Commissioner's *Guidelines for Independent Advisors* as provided to me.
>
> **My qualifications and experience**
>
> I have been a senior manager in the New Zealand Health Service, as well as the National Health Service in England and Wales, since 1996. From 1988 to 1996 I was manager of the Department of Ophthalmology at Dunedin Hospital. From 1996 to 1999 I was a senior manager in Dunedin Hospital, responsible for a portfolio of services including Ophthalmology. During that time I was also responsible for quality improvement training at Dunedin Hospital.
>
> From 1999 until 2001 I was Service Development Manager for the Huddersfield NHS Trust in West Yorkshire, England. In that post I had responsibility for the improvement of outpatient services, and was responsible for developing new ways of managing the outpatient referral process which were then extended across a number of NHS Trusts in England.
>
> From 2001 as Associate Director of *Innovations in Care* I was responsible for the Outpatient Improvement Programme across the NHS in Wales. I held the post of Associate Director in *Innovations in Care* and its successor organisation, the *National Leadership and Innovation Agency for Healthcare*, until August 2007. Other national programmes overseen by me included primary and secondary elective services improvement. I was also responsible for the development of national quality improvement training programmes. I have published, lectured and run workshops on outpatient process improvement in England, Wales, Scotland and Northern Ireland as well as New Zealand.
>
> **Purpose of this report**
>
> In complaint 07/19869 I have been asked to provide independent expert advice on Auckland District Health Board's processing and management of [Mr A's] ophthalmology referral, and on changes subsequently made to the referral system. I have been asked to comment on the following specific questions.

[At this point, Mr Cumming lists the six questions asked of him. These are outlined again further in the report.]

I have reviewed the materials supplied to me, as follows:

- Complaint email dated 12 November 2007.
- HDC letter of 11 December 2007 to Auckland DHB.
- Auckland DHB response dated 14 February 2008 to HDC.
- HDC letter of notification dated 7 March 2008 to ADHB.
- Auckland DHB response dated 23 April 2008 to HDC.
- [Mr A's] clinical records from Auckland DHB.
- Information from Northland DHB.
- Information from GP [Dr B].

I have also referred to the outpatient booking processes set out in chapter 3.3 of *A Guide to Good Practice (Elective Services)*, Cumming, A., National Leadership and Innovation Agency for Healthcare, Wales, 2005, as well as good practice on copying letters to patients set out in chapter 1 of *A Toolkit for Change*, Bird, D and Cumming, A. National Leadership and Innovation Agency for Healthcare, Wales, 2007.

Background

[At this point, Mr Cumming lists the précis of the background of the case which has been omitted for the sake of brevity. He noted that there were no disagreements of the facts by any of the parties involved.]

Responses to the specific questions posed by the Commissioner

1. *Please comment on the events that led to the misfiling of the referral dated 11 August 2006.*

   At the time of the referral on 11 August 2006 there were three distinct points of entry into the referral system for Ophthalmology at Auckland DHB.

   - The preferred point of entry, introduced in 2003 and advertised to GPs and other potential referrers, was for referral letters to be sent to the Central Referrals Office (CRO). On receipt these referrals were entered

onto the referrals management system before any other action was taken.

- The second point of entry into the referral process was for referrals to be addressed to the Ophthalmology Department directly. These referrals were immediately sent to the CRO for entry onto the referrals management system before any other action was taken.

- The third point of entry was for referrals to be addressed personally to a named ophthalmologist. In this third case, the referral was opened by the secretary and passed to the ophthalmologist without being entered onto the referrals management system. It was this third process which failed in this case.

The entry onto the referrals management system is an important check-point in this process. Once a letter is entered onto the system, wherever it physically ends up, there is always a record that it has been received, and is awaiting an appointment. The failure for the third group of letters to be entered onto the referrals management system before being passed to the ophthalmologist for prioritisation has removed an essential check in the process, and prevented any subsequent misfiling or loss of the letter from being identified.

Subsequent to the letter being prioritised by Dr D, it was placed into a tray of referrals to be sent to the clinic schedulers, who would then make an appointment or send the referral to the Central [Referrals] Office for processing. It is likely, although not certain, that in the case of [Mr A's] referral the referral letter was placed into the incorrect tray (one intended for filing), or removed from the correct tray and inadvertently mixed up with letters intended for filing. However it occurred, the result was that the letter was filed and no appointment was made. Because no entry existed on the referral management system, there was no check in place to follow up the unmade appointment.

2. *Please comment on the adequacy of Auckland DHB's process for managing ophthalmology referrals at that time.*

The process followed by the Ophthalmology Department at ADHB at the time of referral was similar to the process probably followed at other departments within the DHB, and at other District Health Boards. It is common that letters entering the process at points further along the process will continue through the process rather than being returned to the start of the process. This is an important failure of the referral system. When the paper copy of a letter or fax is the only record of a referral being received, there is always a risk that the paper copy will be lost. It may be misfiled as occurred in this case, or it may simply become attached to another file, fall

behind a desk, or even be mistakenly discarded. The entry onto the referrals management system, and regular audit of referrals entered but not closed (by having an appointment made or returned), is a fundamental check that letters are not lost. Irrespective of how the referral was misfiled, the key failure of the system in this case was allowing letters to proceed through the hospital process without a record being made on the referrals management system that it had been received.

Any system that does not make an electronic record of receipt of a referral as the first step in the referral process is at risk. Auckland DHB clearly recognised this risk in 2003 when they set up the Central [Referrals] Office as the single point of entry for referrals to ADHB. The failure in this case was allowing referrals not following the correct entry point to be handed to the consultant rather than being returned to the CRO first.

3. *(If not addressed above) Are there any systemic issues of concern that contributed to the misfiling of the ophthalmology referral?*

As noted, the systemic failure in this case was allowing referrals to proceed without being entered into the referrals management system. Allowing multiple points of entry into the system without a process to return all referrals to the point where a record is made of their receipt is the core failure of the process, although the specific failure in this case was the misfiling of the letter.

4. *Please comment on the changes that Auckland DHB have made since the events in question. In your view, have the issues of concern been adequately addressed?*

According to the letter dated 23 April 2008, several actions have been taken to prevent a recurrence of the problem that led to this failure.

a. A memo has been sent to staff by email reminding them of the process that should be followed; that referrals for appointment should be placed in the 'appointments' box.

b. Staff undertaking filing have been asked to check all filing to ensure no referrals have been sent for filing in error.

Reminders and exhortations to staff to follow established procedure and to take more care are unlikely to have any long-term effect.

c. The 'appointments' open tray has been replaced with a box to distinguish it from the other trays used for filing.

d. All non-appointment letters will be stamped or have 'filing' written on them. Letters with no such writing or stamp are to be returned to the consultant.

Physical changes to the location and 'look' of the box (to make it more obviously different to the filing basket) and to the letters (through use of a stamp for filing) will help prevent misfiling. However these solutions assume that the only way a letter could go astray is through misfiling; they address the specific problem identified in this complaint but not the underlying systemic issue of the letters failing to be logged.

e. A decision has been made that a letter will be sent to all potential referrers asking them to contact the Ophthalmology Department if they have not received confirmation that a referral has been received. There is no confirmation that this has occurred.

The establishment of external checks is an important safeguard. Providing mechanisms to ensure that referrals have been received and actioned is an important part of the process. However it should be noted that in the case of [Mr A], Northland DHB did follow up the referral ten days after it was sent, and were told that it had been received.

f. An audit of records will be undertaken to determine if this case was unique, or an indication of a more widespread problem.

Audit of historical files to identify the extent of the problem will not in itself lead to improvement.

None of these actions of themselves address the underlying system error that the process set out for dealing with referrals was not followed. The loss of the referral was a consequence of a process failure; retaining the faulty process while adding extra steps or checks is not the optimum solution.

There is a lack of clarity in the response from Auckland DHB relating to whether all referrals do go to the CRO in the first instance. In the letter to the Commissioner dated 14 February 2008, Auckland DHB state:

'Despite the above process, at times referrals are still sent directly to the Ophthalmology Department. However, these are forwarded to the Central Referrals Office to be logged and go through the usual process. The Team Leader for Ophthalmology and Central Referrals Service believe there is a rigorous process in place to have all referrals logged and followed up appropriately, and therefore we have no explanation to why this particular referral has not followed the usual process.'

In the letter dated 23 April 2008 a different process, the third entry point into the system via a direct letter to the consultant, is described as one of the normal processes. This contradicts the original statement.[14]

To have a robust system in place, a single point of entry into the system with immediate logging of referrals before they are forwarded to any staff is essential. This provides a check in case the letter is lost at any point in its journey around the hospital. The changes proposed by Auckland DHB do not address this problem. The changes proposed and implemented put additional scrutiny on part of the process which does not comply with the system, rather than ensuring that the system is followed in all cases.

Actions should be taken to ensure that all referrals, even those sent direct to a named consultant, are logged into the referrals management system upon arrival. Secretarial staff must comply with this process even when referrals are addressed to named consultants. While this may on occasion appear to delay the process (by sending the referral out of the department for logging), it is the only way that there can be confidence that referrals will not go missing.

5. *What issues does this case raise in relation to primary care referrals to secondary care? What steps should DHBs take to prevent referral patients from being 'lost in the system'?*
   While [Mr A's] referral was between Northland DHB and Auckland DHB, all the issues raised by this incident apply equally to referrals made into DHBs from primary care. There are some key principles that would make the referral system from any source more robust.

   a. As already described, all referrals from all sources should enter the system at a single point, and be logged immediately. Where referrals are received by mail or fax at locations other than a central referral office, they should on opening be forwarded by mail or fax to the Central Referrals Office. No referral should proceed to a later stage of the prioritisation or appointment process until its receipt has been logged.

   b. Forcing functions, such as providing GPs with addressed envelopes or addressed fax headers for referrals are options routinely used in hospitals in the United Kingdom. These forcing functions substantially reduce wrongly addressed referrals.

[14] Auckland District Health Board clarified in July 2008 that referrals addressed directly to a particular consultant are first assigned a clinical priority by the consultant, who decides whether an appointment should be allocated. If an appointment is required urgently (within a 4-week time frame), it is scheduled by the Ophthalmology Department. Referrals that are less urgent (not required within a 4-week time frame) are forwarded to the Central Referrals Office in accordance with the usual process.

c. When referrals are made by GPs or other District Health Boards, the referrer should have in place a system to ensure that the letter was received and actioned. This requires the referrer to keep a record of referrals made, and to keep a record of appointments made. It also requires the receiver of the referral to acknowledge receipt of the referral, and notify the referrer of the made appointment. Finally it requires the referrer to have a system to routinely check that there are no outstanding referrals. This system 'closes the loop' ensuring that faxes are not lost due to an error in entering the fax number, or that letters are not lost in the post. While in this case Northland DHB did check that the referral had been received, there was no check that it had been actioned and an appointment made. Such a feedback system entails additional copies of letters and communication, and may appear cumbersome. An alternative mandated in both England and Wales is that the patient becomes the central focus of the communication process, with all letters routinely copied to the patient (see below).

d. All letters between healthcare professionals should be routinely copied to the patient. If referral letters are copied to the patient, the person with the highest degree of involvement in the care process will have documented evidence of who the referral was to and when it was sent, placing them in a much better position to follow the referral up if no appointment is received. Involving patients at all stages of the communication process provides a very reliable check in the system to correct errors and ensure communications do not go astray. If letters from hospital staff to GPs are copied to the patient, the patient will know whether they should expect a further appointment, or whether they have been discharged. They will also know what information has been conveyed to the GP and whether it was accurate.

6. *Are there any aspects of the care provided by Auckland DHB that you consider warrant additional comment?*
I believe that the central issue in this case is one of system failure due to multiple processes, and poor adherence to agreed good practice as described above. There are no additional comments that I would wish to make at this time."

Appendix C

Independent advice to Commissioner — Ophthalmology

"Thank you for asking for my opinion in regard to a clinical outcome of a retinal detachment in a 46+ aged male patient.

May I first summarise the chronology of events in light of the updated clinical information as:

29th September 2004:	GP diagnosed a retinal detachment and referred to 1st ophthalmologist. Referred to a 2nd ophthalmologist who proceeded with a retinal detachment operation that included a vitrectomy and intra-ocular silicone oil.
6th October 2004:	Reviewed. Retina 'flat' i.e. attached as required.
20th October 2004:	Reviewed. Retina still 'flat'.
22nd December 2004:	Reviewed. Retina flat and cataract developing.
2005:	No clinical records available.
July 2006:	A left cataract operation with removal of silicone oil operation undertaken. Patient referred back to the 1st ophthalmologist.
26th July 2006:	Reviewed by 2nd ophthalmologist / hospital (VR unit) Anterior chamber reaction with heavy liquid, retina flat.
11th August 2006:	Reviewed by 1st Ophthalmologist. A recurrent retinal detachment diagnosed by 1st ophthalmologist and referred back to the 2nd ophthalmologist. Delays occurred in the referral process.
21st August 2006:	Patient contacted general practitioner as he had not heard from the 2nd ophthalmologist or hospital.

14th February 2007:	Patient again complained to his general practitioner that he had not received an appointment to see the 2nd ophthalmologist at the second hospital.
21st February 2007:	Patient was seen by the 2nd ophthalmologist and advised that the retinal detachment was now inoperable.
April 2007:	Patient reviewed by the 1st ophthalmologist.
August 2007:	Reviewed by the 1st ophthalmologist. The eye was chronically red, very sensitive to light and blind. A decision for removal of the eye was made.
November 2007:	The eye was removed.

OPINION

1st Consideration

It is apparent that the first retinal detachment operation included a vitrectomy with insertion of silicone oil. This is referred to in the clinical record subsequently including the operation date in July 2006, which indicates that there was silicone oil in the eye.

The use of silicone oil is a last resort effort to manage very difficult retinal detachments. At the initial presentation it would appear that the retinal detachment had many features that indicated a poor prognosis both in terms of regaining vision and in maintaining the retina in the normal position attached to the inside of the eye. I note that the retina remained attached 'flat' as required for about 21 months postoperatively. The initial eye care and retinal detachment operation were done appropriately and were successful.

2nd Consideration

I note the recurrent retinal detachment diagnosed in August 2006 occurred within a month of the cataract operation and removal of silicone oil.

There is always a high risk of the retinal detachment recurring after silicone oil is removed. The decision to remove silicone oil is always made balancing the long term disadvantages of silicone oil in the eye and the possibility of the detachment recurring when the silicone oil is removed. Postoperative care in this situation following removal of the silicone oil would be primarily focused on the security of the retina and it remaining in its appropriate attached

position. The vitreoretinal surgeon would understand that there was a highly likely possibility that the eye would need to be reviewed in regard to a retinal detachment and further surgery done urgently if the retinal detachment recurred.

At this point in time the surgery on the eye is very much at the end of the road for salvaging vision and even retaining the eye. If a further recurrence of a retinal detachment occurred following removal of silicone oil, and it was to be operated on again, it should have that operation within one or two weeks. Once an eye has had a vitrectomy, any subsequent retinal detachment will quickly become inoperable. Vitreo-retinal fibrosis occurs which is extensive scarring within the eye.

3rd Consideration
On the evidence presented to me above, it would appear that the patient waited from the 11th of August 2006 until the 21st of February 2007 to be seen in regard to the recurrent retinal detachment that occurred following removal of silicone oil.

YOUR QUESTIONS

1. What is the normal window of opportunity to treat a retinal detachment? In particular the question is directed to the referral of the 11th of August 2006.

2. What is the appropriate course of action/management in this case?

The appropriate urgency to undertake a retinal detachment surgery in an eye largely divides into the following groups:

1. A retinal detachment, often of recent onset, in which the macula is 'on'. The eye will have a good visual acuity because the macula is on but the macula is threatened by progression of a retinal detachment. The visual outcome is substantially better if the macula does not come off. Retinal detachment surgery would often be done within 24 hours and certainly within a few days in this situation. If the detachment is slowly progressive then the operation could wait up to two weeks maximum.

2. An uncomplicated retinal detachment where the macula has also detached. The macula is 'off'. The central vision will be poor. At presentation the central vision or visual acuity will take a long time to recover after the retinal detachment has been reattached. The visual acuity often does not return to entirely to normal. The repair of a retinal detachment in this situation can be delayed for up to a maximum of 3

or 4 weeks without reducing the success of the operation in reattaching the retina.

3. A retinal detachment that is complicated by the development of fibrosis, 'scarring', brings the retinal detachment into fixed folds. It crinkles the retinal detachment and makes it difficult if not impossible to reattach it to the inside of the eyeball. Fibrosis is often the final pathological process that occurs in and on the retina that leads to blindness in an eye from a retinal detachment. A blind eye in this condition will often go on to be inflamed, irritable and red requiring it to be removed. When there is limited fibrosis present on the retina then frequently a vitreoretinal surgeon will choose to use silicone oil to help stretch out the retina and attach it to the inside of the eyeball.

4. A retinal detachment that occurs after a previous operation, that includes a vitrectomy and insertion of silicone oil, requires urgent surgery within a few days if it is to be anatomically successful in reattaching the retina inside the eyeball.

Opinion in regard to Delay in Surgery

In regard to the first retinal detachment operation the care was appropriate and successful.

A recurrent retinal detachment was diagnosed on the 11th of August 2006. Given the past history of a retinal detachment operation that included a vitrectomy and the use of silicone oil, then urgent consideration should have been given to deciding whether a further retinal detachment operation was worth undertaking. In this situation it is highly likely that the eye would develop fibrosis on the retina leading to a poor outcome from surgery and to a situation that was inoperable. Fibrosis can develop very rapidly over a few days to a week. Recurrent retinal detachment after a vitrectomy needs urgent attention. A re-operation for the retinal detachment in this situation should have been undertaken within a maximum period of 2 weeks.

I would therefore place the window of opportunity for the 2nd operation following presentation on the 11th of August 2006 at 2 weeks.

It should be noted that 100% success in reattaching a detached retina is not possible anywhere. Silicone oil is reserved for the most difficult detachments and it would appear that the initial retinal detachment here was in that category. Silicone oil is frequently removed at a later date and the retina remains attached in the 'flat' position as desired.

It should also be noted that the subsequent clinical course of events after the eye was found to have an inoperable, retinal detachment, leading to the removal of the eye was appropriate eye care."