HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Department of Corrections breaches Code in management of man's specialist referrals

20HDC01779

The Deputy Health and Disability Commissioner has found Corrections in breach of the Code for not following up on referrals, resulting in unacceptable delays in specialist care for a man who became profoundly deaf in one ear.

Dr Vanessa Caldwell said, in a report released today, that Corrections did not provide an appropriate standard of care after finding that Mr A's referral was not sent for specialist follow up and nor was it followed up with the service for a further five months.

"This complaint highlights the importance of having adequate processes in place for the management and follow-up of external specialist referrals," she said.

A Corrections doctor noted the man was experiencing dizziness, decreased hearing and ringing in his left ear, and that he would refer his patient to an ORL service at a public hospital.

However, there was no record in the man's medical notes of the referral being sent to the hospital and Health New Zealand said its Otorhinolaryngology service had no record of the referral. As the referral was not recorded in the Corrections patient system to prompt reminders, no one was aware the referral had not been actioned.

The man continued to experience symptoms, including increasing deafness in his left ear. He sent several requests to see health services and was becoming increasingly worried about the lack of progress and information about his referrals. Medical clinic notes recorded his complaints.

Several months later, a nurse noted that the man had no hearing in his left ear and was still waiting to see a specialist. An urgent referral was made noting the man's new and ongoing symptoms.

The notes of the specialist appointment said an audiogram showed the man had profound hearing loss in his left ear and some in his right. An MRI was arranged which showed no evidence of a tumour. However, this information was not given to the man, or the prison's health centre.

After the man's lawyer intervened, the prison doctor received the MRI results and advised the man that there was no evidence of a tumour and the man received an apology from the Corrections health centre manager on behalf of Corrections.

Corrections advised HDC that it had made several changes since the incidents which are outlined in the report. Dr Caldwell's recommendations for Corrections included providing her with evidence of improvements resulting from a new electronic referral system, an update of a new paperless patient administration system and for Corrections to review the guidance given for doctors in responding to patient health requests.

* Otorhinolaryngologist – specialist in medical and surgical treatment of ear, nose and throat conditions.

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Editor's notes

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

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

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

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

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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