Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC02273)

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Ms A by optometrists Mr B and Ms C at the optometry clinic and considers concerns raised about the misdiagnosis of a right eye retinal detachment.

3. The following issues were identified for investigation:

- *Whether Mr B provided Ms A with an appropriate standard of care on 25 July 2018.*
- *Whether Ms C provided Ms A with an appropriate standard of care on 30 July 2018.*
- *Whether the optometry clinic provided Ms A with an appropriate standard of care in July 2018.*

4. The parties directly involved in the investigation were:

Ms A	Consumer
Mr B	Provider/optometrist
Ms C	Provider/optometrist
Optometry clinic	Group provider

Names have been removed (except the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. ACC's expert advisor, optometrist Mr D, is also mentioned in the report.

6. Further information was received from the ophthalmology clinic, the Optometrists and Dispensing Opticians Board, and the Accident Compensation Corporation.

7. Independent clinical advice was obtained from optometrist Mr Brett Hooker (Appendix A).

Background

Referral of complaint from ODOB to HDC

8. On 21 September 2021, the Optometrists and Dispensing Opticians Board|Te Poari o ngā Kaimātai Whatu me ngā Kaiwahakarato Mōhiti (ODOB) referred a complaint to HDC regarding the care provided to Ms A (aged in her seventies at the time of events) by optometrists Mr B and Ms C. The ODOB had received a 'Notification of Harm'[1] from the Accident Compensation Corporation|Te Kaporeihana Āwhina Hunga Whara (ACC) on 18 March 2019, which raised concerns that the examinations performed on Ms A by Mr B and Ms C on 25 and 30 July 2018 (respectively) were inadequate and failed to diagnose Ms A with a retinal detachment.[2]

9. I take this opportunity to extend my sympathies to Ms A for her diagnosis and acknowledge the severe impact this has had on her. Furthermore, I thank Ms A for the ODOB referral and for assisting with this complaint.

Presentations to the optometry clinic

21 September 2017

10. On 21 September 2017, Ms A attended the optometry clinic for a routine sight test and was seen by Ms C. Clinical notes show that Ms A had no previous ocular (vision-related) issues but reported experiencing the occasional floater.[3]

11. A comprehensive examination was conducted, including a visual field test[4] and an anterior eye examination with a slit lamp,[5] which Ms C stated 'did not reveal any significant abnormalities', although nuclear sclerotic cataracts[6] were reported in each eye. A dilated

[1] Section 284(2) of the Accident Compensation Act 2001 requires ACC to notify the authority responsible for patient safety in relation to treatment that causes a personal injury.
[2] Retinal detachment is an emergency situation in which the tissue at the back of the eye (the retina) pulls away from a layer of blood and vessels and can cause permanent vision loss if not treated quickly.
[3] Floaters are spots in vision that look like black or grey specks, strings, or cobwebs that drift across the eyes. Usually, floaters are caused when the vitreous (transparent gel that fills the space between the lens and retina) lifts up from the surface and pulls on the retina causing tension. Usually, floaters are harmless but can be symptoms of a torn or detached retina.
[4] A visual field test measures the area of vision, showing the amount of vision loss and the affected areas.
[5] A slit lamp microscope is used to examine the tear film (spread over the eye by a blink), which is usually irregular in patients with dry eye.
[6] A nuclear sclerotic cataract is a type of cataract (cloudy area in the lens of the eye) that develops in the nucleus, or central area of the eye's lens, and is the most common type of age-related cataract.

fundus examination (DFE)[7] was also undertaken, which showed '[c]lear [f]loaters' in both eyes but no signs of retinal tears, holes, or detachments. The right and left macula[8] were both noted as 'flat' (normal).[9] Ms A's vision was corrected to 6/6[10] (right and left eye), and she was prescribed reading glasses and asked to return for another full examination in two years' time.

25 July 2018

12. On 25 July 2018, Ms A again attended the optometry clinic and was seen by Mr B. Ms A told HDC that she had been experiencing 'dark blurred vision, with flashes and black floating spots' in her right eye. Clinical notes do not document any medical history, and Ms A told HDC that she is unable to recall whether she was asked about this.

13. Mr B told HDC that as Ms A had been seen for a full examination on 21 September 2017, he recommended a 'short supplementary examination' to check for any vision prescription change and 'a few specific tests to understand the cause of the slight blurring'.

14. Clinical notes show that Ms A's best corrected visual acuity was lower in her right eye (6/7.5) than her left (6/6). Mr B told HDC that when he was unable to improve Ms A's vision past 6/7.5, he decided to perform an anterior eye examination, which revealed mild nuclear sclerotic cataracts in both eyes, as well as conjunctival staining,[11] which Mr B stated was worse in the right eye.

15. The optometry clinic told HDC that Mr B performed a visual field test, which revealed superior defects in the right eye, but he 'did not record any diagnostic testing to assess the visual field defect'. The visual field test and/or its findings were not documented in the clinical notes.

16. Retinal (fundus) photographs[12] were also taken, which Mr B stated showed unremarkable maculae, although reference to the images and/or the results were not documented in the clinical notes. Mr B told HDC that as the fundus photographs were clear, he felt that the most likely cause of Ms A's slight vision drop in her right eye was a combination of her advancing cataracts and dry eye.

[7] Dilated fundus examination (DFE) is a diagnostic procedure that employs the use of pupil-dilating eyedrops to dilate (enlarge) the pupil, allowing the optometrist to obtain a better view of the fundus and to look for signs of eye disease, such as retinal detachment.
[8] The macula is the central portion of the retina, responsible for central vision. Abnormalities of the macula (such as macular degeneration or a macular hole) can indicate retinal detachment.
[9] The macula must lie flat against the back of the eye to work properly. When the macula wrinkles or bulges (known as macular pucker), the central vision is affected.
[10] A person with 6/6 visual acuity (also known as 20/20 vision) is the benchmark for what optometrists consider 'normal' vision. It means that a person can see what an average person can see on a Snellen Chart (visual acuity test) when they are standing 6 metres away.
[11] Conjunctival staining is an indicator of inflammatory dry eye.
[12] Retinal (or 'fundus') photographs record the condition of the interior surface of the eye (the fundus, made up of the retina, macula, optic disc, fovea, and posterior pole) in order to document eye diseases and conditions, including retinal degeneration and damage.

17. Mr B diagnosed Ms A with dry eye (although this is not documented in the clinical notes) and prescribed Systane® Balance lubricant eyedrops. Mr B stated that he told Ms A that she could expect a gradual improvement in her vision over the next few weeks with the use of the eyedrops, but to return to the optometry clinic sooner if her vision deteriorated, although this advice was not documented in the clinical notes.

30 July 2018

18. On 30 July 2018, Ms A returned to the optometry clinic and again was seen by Ms C. At this supplementary examination, Ms A reported no improvement after having used the prescribed eyedrops five times a day. In addition, clinical notes record that Ms A's right eye felt 'different to see than [her left eye] and a bit of stinging, can see a greeny film'. Again, no medical history was documented, and Ms A is unable to recall whether she was asked about this.

19. Clinical notes show that an anterior eye examination (which the optometry clinic stated included a dry eye and ocular surface assessment) was undertaken, which again recorded nuclear sclerotic cataracts and conjunctival staining in both eyes, as well as 'sl[ightly] irregular' tear films. Ms C stated that on examination, Ms A's anterior eye health was 'otherwise unremarkable'. In addition, clinical notes show that an Amsler Grid test[13] was performed, which reported 'no distortion', retinal photographs were obtained, but not commented on, and that Ms A had raised intraocular pressure (IOP).[14]

20. Ms A's best corrected visual acuity was again lower in her right eye (6/9) than her left eye (6/6), with the right eye vision slightly worse than five days previously. Ms C told HDC that given the reduction in Ms A's visual acuity, she decided to refer Ms A to a specialist for further assessment. Clinical notes document the referral for 'checks — IOP, Macula, cataract'. Ms A stated that she was told that the referral was due to her raised IOP and was classed as non-urgent.

21. A referral to the ophthalmology clinic was sent on 31 July 2018 for 'right eye issues'. The referral notes: '[Ms A] would feel better if you were to review and reassure that everything is within normal limits.' Ms C told HDC that the referral included details of Ms A's posterior ocular health, including optic nerve and macula findings, which she did not record in the clinical notes. The referral documents the macula findings on 30 July 2018 as 'flat' (normal).

Subsequent events

22. On 24 August 2018, Ms A was examined at the ophthalmology clinic by an ophthalmologist, who diagnosed 'a right inferior retinal detachment with a tear at 7 o'clock position'. The macula was noted as 'just off [very] shallow'. Ms A was scheduled for urgent surgery to repair the retinal detachment. However, ultimately the surgery was unsuccessful after two[15] attempts at repair, and unfortunately Ms A lost vision in her right eye.

[13] The Amsler Grid is a visual testing tool that can help detect early signs of retinal disease, such as macular degeneration, by showing where distortions are in the visual field.
[14] Fluid pressure of the eye.
[15] Ms A underwent retinal detachment surgery on 27 August 2018 and 4 October 2018.

Information provided by ACC

23. Following Ms A's unsuccessful retinal detachment surgery, a treatment injury claim was lodged with ACC for a 'delay in diagnosis [of a] detached retina'. ACC accepted the treatment injury claim and, as part of its assessment, sought external advice from optometrist Mr D. A copy of this report was provided to HDC by ACC.

24. Mr D's treatment injury advice states that there was no evidence that Ms A's eyes were examined internally at both the examinations on 25 and 30 July 2018, other than relying on the retinal photographs. Mr D advised ACC that as Ms A was over 60 years of age,[16] both Mr B and Ms C should have performed a DFE, and, given that Ms A's corrected vision on 30 July 2018 had deteriorated from five days previously (a sign indicating greater risk of finding eye disease), this should have further prompted a DFE. Mr D advised ACC that a DFE, which involved the physical inspection of the peripheral retina, would have given the optometrists the opportunity to discover the predisposing factors of retinal detachment that were reasonably likely to have been present at both visits.

25. Furthermore, Mr D stated in his advice that there was no record of any medical history taken at either of the examinations on 25 and 30 July 2018 and questioned the volume of clinical notes provided to him.[17] In addition, Mr D advised ACC that on 25 July 2018, 'critically, any internal eye exam notes dilated or not are not recorded' and although retinal photographs were taken, 'there is no comment on these'.

Information provided by ODOB

Mr B

26. The ODOB told HDC that following consideration of the ACC notification and other relevant information, Mr B was required to undergo a competence review. During this time, on 25 June 2020, the ODOB issued an order requiring Mr B to practise under supervision.[18]

27. On 30 October 2020, Mr B completed the competence review, which showed that he was not performing to an acceptable level. Therefore, on 23 December 2020, the ODOB imposed a further order for Mr B to undertake a competence programme, which commenced in February 2021, in addition to supervision for the duration of the programme.[19] The programme aimed to improve clinical knowledge in glaucoma,[20] gonioscopy,[21] binocular vision, peripheral retinal degeneration, and retinal detachment. In addition, the programme required Mr B to demonstrate proficiency with gonioscopy, improve record-keeping, and

[16] The ACC advice documents: 'Eye health institutions generally recommend comprehensive dilated eye exams starting at age 60 years.'
[17] The ACC advice documents: '[The optometry clinic] have assured ACC that the notes presented for [25 July 2018] are complete … We are told by [the optometry clinic] on questioning the volume of notes presented [for 30 July 2018] that this was a supplementary eye exam.'
[18] Pursuant to Section 39(2)(b)(ii) of the Health Practitioners Competence Assurance Act 2003.
[19] Pursuant to Section 38(1)(a) and (b) of the Health Practitioners Competence Assurance Act 2003.
[20] Glaucoma is a group of eye conditions that damage the optic nerve.
[21] Gonioscopy is an eye test that checks for signs of glaucoma.

undertake continued professional development (CPD). Mr B completed this programme in July 2022.

28. Mr B was required by the ODOB to undergo a follow-up competence review on 17 April 2023. On 12 June 2023, the ODOB found that Mr B met the required standard of competence and removed the conditions imposed on his scope of practice.

Ms C

29. The ODOB told HDC that following receipt of the ACC notification, Ms C was asked to complete a self-audit,[22] which was reviewed by the ODOB on 28 August 2019. The ODOB noted concerns in the self-audit material, and therefore Ms C was asked to provide additional cases to demonstrate her standard of practice, as well as a reflective statement on any changes made. After reviewing the additional information, the ODOB considered that the concerns from the initial self-audit had been addressed and decided to take no further action.

Further information

Ms A

30. Ms A told HDC that after both the appointments on 25 and 30 July 2018, her vision was not corrected, and she was 'just told on both occasions that [she] had a dry eye'. Ms A said that she has suffered blurred vision in her right eye as a result of these events, making it difficult to drive at night. Ms A stated:

> 'After the two operation[s] I suffered anxiety, often feeling dizzy. My right eye is constantly red and the drops that I am permanently on sting my eye. This means I can't wear eye makeup. I wish I had got a second opinion at another optometrist, but at the time trusted the medical professionals, this still plays on my mind, especially when my eye is all red and stinging an[d] know it will never get any better.'

Mr B

31. Mr B apologised to Ms A that she has lost vision in her right eye as a result of these events. He accepted that the standard of his note-taking was poor and recognised that his 'main clinical failing' was the decision not to carry out a full examination, including a DFE. Mr B stated:

> 'The reasons I chose not to go ahead with a full examination including dilation were: [Ms A] had been seen for a full examination including dilation only 10 months prior and was not due for her next full examination for another 14 months. Her symptoms were mild and the [visual acuity] drop was only slight. The fundus photos showed both maculaes were unremarkable and I felt that the cataracts and dry eye, which was worse in her right eye could account for the symptoms she was experiencing. I did not feel [Ms

[22] A self-audit reviews patient care against required ODOB standards to ensure that practitioners are working within their scope of practice and to assess practitioner competence: https://odob.health.nz/site/maintain-registration/recertification/self-audit.

A's] symptoms or her clinical results indicated that she was possibly undergoing or in obvious risk of developing a retinal detachment.'

Optometry clinic

32. The optometry clinic told HDC that Mr B did not recognise the need for further investigation based on the reduced vision in Ms A's right eye, as well as the defect apparent from the visual field test. The clinic also said that while a 'routine' referral was initiated by Ms C, 'unfortunately [it] was not provided with the correct urgency'.

33. Regarding both the examinations on 25 and 30 July 2018, the optometry clinic stated that a 'posterior assessment and further investigation, such as a [DFE], may have led to an earlier detection of a retinal abnormality in [Ms A's] right eye'.

Responses to provisional opinion

Ms A

34. Ms A was given an opportunity to respond to the information gathered during this investigation but had nothing further to add.

Mr B

35. Mr B was given the opportunity to respond to the provisional opinion. Mr B accepted the provisional findings and proposed recommendations.

Ms C

36. Ms C was given the opportunity to respond to the provisional opinion. Ms C accepted the provisional findings and proposed recommendations.

Optometry clinic

37. The optometry clinic was given the opportunity to respond to the provisional opinion. The optometry clinic recognised the 'awful ordeal' Ms A went through and sincerely hopes it never recurs. In addition, the optometry clinic thanked HDC for an in-depth investigation 'that hopefully will result in improvements'.

Optometry clinic

38. The optometry clinic was given the opportunity to respond to the provisional opinion, and it accepted the provisional findings and proposed recommendations.

Relevant standards and policies

39. The ODOB's Standards of Clinical Competence for Optometrists (2017) provides the following:[23]

- Task 3.1: 'Formulates an examination plan based on the patient history in order to obtain information necessary for diagnosis and management.'
- Task 3.2: 'Implements an examination plan that is progressively modified on the basis of findings.'

[23] Although the Standard is undated, ODOB has confirmed to HDC that this version applied in April 2017.

- Task 3.3.4(a): 'Assesses and evaluates the structure and health of the **components of the posterior segment** including but not limited to: retina, choroid, vitreous, blood vessels, optic nerve head, macula and fovea.' (Emphasis added.)
- Task 3.3.4(b): 'Uses and interprets results of tests including but not limited to: direct and indirect ophthalmoscopy, retinoscopy, photography, diagnostic pharmaceuticals, slit-lamp biomicroscopy and fundoscopy, visual acuity, colour vision tests, Amsler test, visual field assessment, photostress test, pupil reactions, auxiliary lenses for fundus viewing and optic nerve head assessment.'
- Task 4.1: 'Interprets and analyses examination findings and results in order to determine the nature and aetiology of conditions or diseases and to establish a diagnosis or differential diagnoses.'
- Task 5.9: 'Refers the patient to other professionals in a timely and appropriate manner.'
- Task 7.1.1: 'Promptly records all relevant information pertaining to the patient in a separate record and in a format which is understandable and useable by any optometrist and his/her colleagues (including such information as name and address of patient, name of examining practitioner, patient history, diagnoses, management strategies, summary of advice given to patient, photographic and video information for all consultations, dates and information relating to all patient contacts, timing of review, copies of referral letters and reports with the record).'

40. The clinic's Optometrists Communication and Record Keeping Policy (December 2016) provides the following:

- 'Case History/Reason for Visit … Information from case history is required for effective diagnosis and management of the patient.'
- 'Examination Procedure … Test and procedures are tailored to the patient's needs and findings … All testing results should be recorded … If there is no record in a particular tab/section — it is considered that this procedure or advice has not been provided.'
- Reference to the ODOB's Standards of Clinical Competence for Optometrists.

Opinion: Mr B — breach

41. As a healthcare provider, Mr B had an obligation under the Code of Health and Disability Services Consumers' Rights (the Code) to provide services of an appropriate standard. Furthermore, as a registered optometrist, Mr B had a responsibility to meet the Standards of Clinical Competence for Optometrists (the ODOB Standards) set out by the ODOB.

42. In considering whether Mr B provided services to Ms A with reasonable care and skill, I have drawn on the clinical advice provided to this Office by optometrist Mr Brett Hooker and have considered the advice provided to ACC by optometrist Mr D.

43. Although it is clear from the information gathered that Mr B was practising below the ODOB Standards, and I have found him in breach of the Code (the reasons for which are set out below), I acknowledge his admission of, and apology for, the substandard care provided,

alongside the extensive professional development undertaken, including completion of the ODOB's competency review. I find this to be appropriate remedial action.

Missed diagnosis of retinal detachment — breach

44. On 25 July 2018, Ms A was seen by Mr B, as she was experiencing blurred vision in her right eye. Mr B examined Ms A, diagnosed her with dry eye, and prescribed eyedrops. Subsequently, on 24 August 2018 Ms A was diagnosed with a right eye retinal detachment and required urgent surgery.

Retinal examination

45. Mr B decided to conduct a short, supplementary examination, focusing on a 'few specific tests' to investigate the cause of Ms A's blurred vision, rather than undertaking a full examination including a DFE. The optometry clinic stated that although an anterior eye examination and visual field test were performed, Mr B did not recognise the need for further investigation, which 'may have led to an earlier detection of a retinal abnormality in [Ms A's] right eye'. Mr B accepted that he should have undertaken a full examination, including a DFE, and stated that this was his 'main clinical failing'.

46. My independent clinical advisor, Mr Brett Hooker, considered that there was enough information in the presenting symptoms, retinal images, and visual field test to have raised suspicion of retinal detachment and, therefore, the consultation should have been modified to include a retinal examination, in line with accepted practice.

47. Mr Hooker advised that although a DFE was not needed to make a diagnosis of retinal detachment in this case, it would have made the diagnosis easier, and is the accepted level of practice based on the other findings. Regardless, Mr Hooker advised that the failure to perform a retinal examination, whether it be dilated or undilated, represents a significant departure from accepted practice.

48. Although ACC's advisor, Mr D, stated that a DFE should have been performed, given that Ms A was over 60 years of age, he also advised that an examination of the retina would have given Mr B the opportunity to discover the predisposing factors of retinal detachment, which were reasonably likely to have been present at this visit.

49. I accept Mr Hooker's advice and acknowledge that Mr D's ACC advice reinforces the advice that in this instance, a retinal examination should have been undertaken. Furthermore, I draw reference to Tasks 3.2 and 3.3.4(a) of the ODOB Standards, which outline that Mr B should have modified his examination plan to include an assessment and evaluation of the retina based on the findings (which is reinforced in the optometry clinic's Optometrists Communication and Record Keeping Policy[24]). I am therefore critical that Mr B failed to recognise the need to progressively modify his examination based on the findings and did not perform a retinal examination.

[24] 'Test and procedures are tailored to the patient's needs and findings.'

Retinal imaging and visual field test

50. As part of the examination, retinal photographs were taken, which Mr B stated showed unremarkable maculae, and a visual field test was performed, which the optometry clinic stated revealed superior defects in the right eye. It is noted that there is no comment on either of these in the clinical notes.

51. Mr B told HDC that as the fundus photographs were clear, he felt that the most likely cause of Ms A's slight vision drop in her right eye was due to a combination of her advancing cataracts and the dry eye. He stated that Ms A's symptoms and clinical results did not indicate 'that she was possibly undergoing or in obvious risk of developing a retinal detachment'.

52. Mr Hooker stated that examination of the retinal images show an inferior retinal detachment, and he confirmed that the visual field test revealed a superior visual field defect, which he said corresponds to an inferior retinal detachment. Mr Hooker advised that the failure to recognise the retinal detachment and the corresponding visual field defect was a significant departure from accepted practice; however, he advised that given that there are no comments in the clinical notes about the retinal images and/or visual field test, it is likely that Mr B did not review these, as opposed to failing to recognise the retinal detachment upon review, although he stated that this is 'certainly a possibility'.

53. In any event, Mr Hooker considers that Mr B failed to make a diagnosis of retinal detachment appropriately when there was enough information to do so — in particular, the recent onset of blurred, reduced vision, the visual field defect, and the retinal detachment visible on the retinal photographs.

54. I accept Mr Hooker's advice, and further add that under the ODOB Standards, ultimately Mr B had a responsibility to interpret and analyse the results of the photographs and visual field assessments in order to establish a diagnosis or differential diagnoses (as per Tasks 3.3.4(b) and 4.1 of the ODOB Standards). Therefore, in my view, regardless of whether Mr B reviewed the retinal images and/or visual field test, he still failed to recognise the retinal detachment from the retinal images and the corresponding visual field defect, for which I am critical.

Conclusion

55. Mr B failed to make an appropriate diagnosis of retinal detachment, as he did not perform a retinal examination (which would have informed the diagnosis) and failed to recognise retinal detachment from the retinal photographs and the corresponding visual field defect. As such, I find Mr B in breach of Right 4(1) of the Code.[25]

Documentation — breach

56. Task 7.1.1 of the ODOB Standards requires 'all relevant information pertaining to the patient' to be recorded, including patient history, diagnosis, advice given to patient, and photographic information.

[25] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

57. As noted above, Mr B performed a visual field test and retinal photographs were taken; however, there is no comment on either of these in the clinical notes. Mr Hooker highlighted the importance of optometrists commenting on such tests in the clinical notes to indicate that they have been reviewed (as outlined in paragraph 52).

58. Furthermore, although the reason for the visit is noted, there is no record of any medical history taken, and Ms A is unable to recall whether she was asked about this. Although Mr B diagnosed Ms A with dry eye and told her to return to the optometry clinic if her vision worsened, neither the diagnosis nor the advice to return is documented.

59. Mr Hooker advised that the clinical notes 'could be described as brief, at best' and said that there is a 'significant difference' between what is documented in the clinical notes and what is required under the ODOB Standards, which represents a moderate to significant departure from accepted clinical practice. It is noted that Mr D questioned whether the clinical notes presented for this examination were complete, and Mr B accepted that his standard of note-taking was poor.

60. I accept this advice and am critical that Mr B's documentation did not meet the requirements under the ODOB Standards. Accordingly, I find Mr B in breach of Right 4(2) of the Code for failing to fully document his assessment of Ms A.[26]

Opinion: Ms C — breach

61. At the time of these events, Ms C was a full-time optometrist at the optometry clinic and therefore also had obligations and responsibilities under the Code to provide services of an appropriate standard, and to meet the ODOB Standards of Clinical Competence for Optometrists.

Missed diagnosis of retinal detachment — breach

62. On 30 July 2018, Ms A returned to the optometry clinic and was seen by Ms C, as Ms A had experienced no improvement in her vision since her appointment with Mr B. On examination, Ms A's visual acuity had reduced since the appointment five days previously, and therefore Ms C referred Ms A to a specialist for further assessment. Subsequently, on 24 August 2018 Ms A was diagnosed with a right eye retinal detachment and required urgent surgery.

Retinal examination

63. The optometry clinic stated that although Ms C performed an anterior eye assessment and Amsler Grid test, a 'posterior assessment and further investigation, such as a [DFE], may have led to an earlier detection of a retinal abnormality in [Ms A's] right eye'.

64. Mr Hooker advised that there was enough information at this examination to have raised suspicion of retinal detachment and, therefore, a retinal examination should have been performed. He advised that the retinal examination would have been further enhanced by

[26] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

undertaking a DFE, which is the accepted level of practice, although he noted that it was not needed to make a diagnosis of retinal detachment in this case. Mr Hooker advised that Ms C failed to recognise the need to progressively modify her examination based on the information available and conduct a retinal examination, whether it be dilated or undilated, which was a significant departure from accepted practice.

65. Mr D advised ACC that the deterioration of Ms A's corrected vision from five days previously, alongside her age, should have prompted Ms C to perform a DFE. He said that examination of the retina would have given Ms C the opportunity to discover the predisposing factors of retinal detachment, which were reasonably likely to have been present at this visit.

66. I accept Mr Hooker's advice and acknowledge that Mr D's ACC advice reinforces that in this instance, a retinal examination should have been undertaken. I am therefore critical that Ms C failed to recognise the need to modify her examination based on the findings and did not perform a retinal examination, as required by Tasks 3.2 and 3.3.4(a) of the ODOB Standards, as well as the Optometrists Communication and Record Keeping Policy (the Policy).

Retinal imaging

67. As outlined in paragraph 19, retinal photographs were taken, although there is no comment on the photographs in the clinical notes.

68. Mr Hooker advised that Ms C failed to make a diagnosis of retinal detachment given that examination of the retinal images of the right eye show an inferior retinal detachment. Mr Hooker considers that the failure to recognise the retinal detachment was a significant departure from accepted practice; however, he advised that given that there are no comments in the clinical notes about the retinal images, it is likely that Ms C did not review these, as opposed to failing to recognise the retinal detachment upon review, although he stated that this is 'certainly a possibility'.

69. I accept Mr Hooker's advice, and add that under the ODOB Standards, ultimately Ms C had a responsibility to interpret and analyse the results of the photographs in order to establish a diagnosis (as per Tasks 3.3.4(b) and 4.1 of the ODOB Standards). Therefore, I am critical that regardless of whether or not Ms C reviewed the retinal images, she still failed to recognise the retinal detachment from the retinal images.

Conclusion

70. Ms C did not perform a retinal examination, which would have informed the diagnosis of retinal detachment, and did not recognise the retinal detachment apparent on the retinal photographs. Accordingly, for failing to make an appropriate diagnosis of retinal detachment, I find Ms C in breach of Right 4(1) of the Code.

Documentation — breach

71. Task 7.1.1 of the ODOB Standards requires 'all relevant information pertaining to the patient' to be recorded, including patient history and photographic information.

72. Although the reason for this visit is documented, including information about the previous appointment with Mr B, no medical history was documented, and Ms A is unable to recall

whether she was asked about this. In addition (and by her own admission), Ms C failed to record details of Ms A's posterior ocular health, including optic nerve and macula findings, in the clinical notes. Furthermore, as noted in paragraphs 67 and 68, although retinal photographs were obtained, there is no comment about these in the clinical notes, and Mr Hooker highlighted the importance of optometrists commenting on such tests in the clinical notes to indicate that they have been reviewed.

73. Mr Hooker advised that Ms C's clinical notes 'fall well short' of what is expected in the ODOB Standards, which represents a moderate to significant departure from accepted clinical practice. I accept this advice and am critical that Ms C's documentation did not meet the requirements under the ODOB Standards.

74. For failing to fully document her assessment of Ms A, I find Ms C in breach of Right 4(2) of the Code.

Untimely referral — adverse comment

75. Ms C told HDC that given the reduction in Ms A's visual acuity, she decided to refer Ms A to a specialist for further assessment. Clinical notes document the referral for 'checks — IOP, Macular, cataract'. The referral was sent to the ophthalmology clinic on the following day, 31 July 2018, and noted: '[Ms A] would feel better if you were to review and reassure that everything is within normal limits.' Ms A told HDC that the referral was classed as non-urgent, and the optometry clinic stated that the 'routine' referral was not provided with the correct urgency.

76. Mr Hooker advised that had a diagnosis of retinal detachment been made on 30 July 2018, then acute ophthalmic referral would have been the appropriate management.

77. While I accept Mr Hooker's advice, I note that a diagnosis of retinal detachment was not made, for which I have already found Ms C in breach of the Code. Although I acknowledge that Ms C referred Ms A to a specialist due to the reduction in her visual acuity, I am concerned that the referral was not provided with the correct urgency, as stated by the optometry clinic.

78. I draw reference to Task 5.9 of the ODOB Standards, which directs optometrists to refer patients in a timely and appropriate manner. I do not consider a routine referral timely and appropriate for a woman in her seventies who was re-presenting with reduced visual acuity from only five days prior, despite using eyedrops five times a day. In addition, Ms A presented with cataracts, conjunctival staining, and irregular tear films in both eyes, as well as raised IOP.

79. Irrespective of the detached retina diagnosis, I consider that the culmination of Ms A's presenting symptoms should have prompted a more urgent referral, and I am concerned that Ms C did not do so.

Opinion: Optometry clinic — adverse comment

80. As a healthcare provider, the optometry clinic is responsible for providing services in accordance with the Code.

81. As noted above, Mr B performed a visual field test on 25 July 2018 and retinal photographs were taken at both the appointments on 25 and 30 July 2018, although both the visual field test results and the retinal photographs were not commented on in the clinical notes at either of these appointments.

82. Mr Hooker advised that there is no record of who performed any of those tests, although he stated that '[t]hey were likely done by an ancillary staff member'. Furthermore, and as discussed above, he advised that given that there are no comments in the notes about the retinal photographs and/or visual field test, it is likely that both Mr B and Ms C did not review these.

83. Mr Hooker stated that '[i]t is apparent' that the optometry clinic uses a system of pre-testing in which preliminary tests are carried out by non-optometric staff members, which he advised is a common form of accepted optometry practice but is of 'no use' if the tests performed are not then reviewed by the optometrist. He further advised:

> 'While the staff members performing pre-testing are not qualified to, or expected to interpret the test results, it is common "safety net" practice for staff members to flag clearly abnormal results with the Optometrist. The visual field test on 25 July 2018 was clearly abnormal. The retinal image of the [right eye] on 30 July 2018 was clearly abnormal.'

84. Mr Hooker advised that the policy does not mention how pre-testing is integrated into patient care and places 'the onus of responsibility' with the optometrist, without any reference to the role that ancillary staff play. He advised that not having a safety-net procedure in place around pre-testing is a significant departure from accepted practice.

85. I have already determined that both Mr B and Ms C had a responsibility under the ODOB Standards to interpret and analyse the results of digital imaging and visual field assessments, and therefore regardless of whether they reviewed the retinal images and/or visual field test, ultimately they failed to recognise the retinal detachment. I do not believe that the failure by ancillary staff, who (as Mr Hooker advised) are not qualified or expected to interpret the test results, to flag the abnormalities to the optometrists lessens the optometrists' responsibility for reviewing and documenting the results themselves.

86. However, I agree with Mr Hooker that the role of ancillary staff and how pre-testing is integrated into patient care should be documented in the policy. While I am concerned that the process of pre-testing was not documented in the policy, it is still clear in the policy that the onus of responsibility lies with the optometrists, and I consider that the lack of review of results represents individual failings, and that this does not amount to a breach of the Code for the optometry clinic, although I will make appropriate recommendations below surrounding the integration of pre-testing in the policy.

Changes made since events

Mr B

87. Mr B told HDC that he has taken this complaint seriously and has undertaken the following steps to prevent this failure happening again, under guidance from the ODOB:

a) As of 17 May 2023, Mr B logged 52.25 'Continuing Education Points' in the past two years, where the requirement was for 38.55. Mr B stated that he is continuing to be proactive with his CPD.

b) Mr B completed five 'Problem Based Learning Papers' (PBL) to the satisfaction of the ODOB, which he stated has helped to improve his problem-solving skills through study and research.

c) Mr B has completed 43.5 hours of ophthalmology rounds with a supervising ophthalmologist, which he stated enabled him to draw from the ophthalmologist's experience and improve his confidence.

d) Mr B has had 14 in-practice sessions with a therapeutic optometrist, which he stated has 'helped to expand [his] knowledge in a hands-on, practical way', and has improved his methods/techniques (in particular, Binocular Indirect Ophthalmoscope[27] technique) and record-taking style.

e) Mr B told HDC that his weekly supervision meetings (required by the ODOB) have helped to expand his knowledge through discussing patient care.

f) Mr B has improved his note-taking and now ensures that his descriptions are more thorough, with all observations and discussions noted. He now takes a thorough history, including occupation and visual demands, with an aim to include as much information as possible, including a detailed management plan.

g) Mr B now undertakes full examinations for any patient who has noted changes to their vision, and he stated that he has become mindful about considering the differential diagnoses as he works through the examination.

h) Mr B now treats phorias[28] routinely and ensures that he records near visual acuities. Furthermore, he aims to do retinoscopy[29] on all patients and performs a 'pinhole' test[30] on patients with reduced visual acuity.

i) Mr B told HDC that he is now competent in his gonioscopy technique and has upskilled his knowledge with the Optical Coherence Tomography (OCT)[31] programme, which has improved his ability to interpret results.

[27] The binocular indirect ophthalmoscope (BIO) is a tool used to view the back of the eye (fundus).
[28] A phoria is a misalignment of the eyes so that their natural resting point is not perfectly aligned.
[29] Retinoscopy is a technique used to obtain an objective measurement of the refractive error of a patient's eyes.
[30] A test for visual acuity using an opaque disk with one or more small holes through it.
[31] An OCT is a non-invasive imaging test that uses light waves to take cross-sectional pictures of the retina.

j) Mr B also regularly attends the New Zealand Association of Optometrists (NZAO) peer discussion sessions, as well as other local seminars (held by industry organisations).

Ms C

88. Ms C told HDC that she has reflected on the care provided and has taken several steps to enhance her practice, including the following:

a) Independent research and reading regarding signs, symptoms, and management of retinal detachments.

b) Online CPD on retinal detachment management covering retinal pathology.

c) She attended a full-day in-clinic observation with an ophthalmologist immediately after the complaint was brought to her attention.

d) She attended workshops covering gonioscopy and OCT, including differential diagnosis and interpretation of OCT results.

89. Ms C stated that steps a)–d) above, alongside her regular CPD, have reinforced her understanding of the diagnosis and management of retinal detachments and the importance of DFEs to rule out differential diagnoses, as well as the importance of ensuring accurate and contemporaneous record-keeping for all tests she performs.

90. Ms C said that since the ODOB self-audit, she feels that she is 'a diligent optometrist' who listens to patients' concerns and always conducts a full history. Furthermore, she is 'pedantic' with patient records being up to date with any communication detailed on the record, visual field reports, and all letters attached to the patient file.

91. Ms C told HDC that the inclusion of the OCT in her practice has complemented her own examination of the retina and has enhanced her ability to pick up eye disease in its very early stages, as well as aiding her knowledge and learning with everyday findings.

92. Ms C stated that the optometry clinic now uses the iCare OCULO® referral system for sending electronic referrals to specialists with relevant clinical information and images needed for appropriate triage, and this allows for tracking of a patient's referral for a more efficient patient follow-up process.

93. Ms C told HDC that she has fostered good working relationships with local specialists, enabling the optometry clinic to reach out for advice at any time and, as a result, she has been able to provide more comprehensive care to her patients.

Optometry clinic

94. The following actions have been taken by the optometry clinic since these events:

a) Peer discussion meetings with the Director of the optometry clinic (at the time of the events), Mr B, and Ms C, where this case has been used as a case study to discuss related topics.

b) The Director of the optometry clinic (at the time of the events) and Ms C attended peer discussion sessions with optometrists, organised by the local branch of the NZAO.

c) The optometry clinic purchased an OCT machine, and a scan is now performed on each patient who attends an eye examination (at no extra charge), which provides optometrists with an extra level of granularity when assessing a patient's posterior ocular health. The optometry clinic told HDC that this technology enhances the existing diagnostic testing performed throughout an eye examination.

d) A morning meeting is held prior to the start of the clinic, where all optometrists are encouraged to engage in peer discussion and collaboration during each clinic to encourage engagement and collaboration amongst optometrists at the optometry clinic.

e) The optometry clinic has maintained strong relationships and connections (including actively co-managing patients) with local ophthalmologists.

Recommendations

95. I consider that Mr B has taken this matter seriously and undertaken several remedial actions to mitigate any recurrence of these events. Further to this, I recommend that Mr B:

a) Apologise to Ms A for the deficiencies identified in this report. The written apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Undertake an internal audit of 15 clinical files where retinal photographs and/or visual field tests have been obtained to examine his standards of clinical documentation against the ODOB standards. Mr B is to report back to HDC on the results of this audit within three months of the date of this report.

96. I recommend that Ms C:

a) Apologise to Ms A for the deficiencies identified in this report. The written apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Undertake an internal audit of 15 clinical files where retinal photographs have been obtained to examine her standards of clinical documentation against the ODOB standards and report back to HDC on the results of this audit within three months of the date of this report.

c) Reflect on the deficiencies in care identified in this case and provide a written report on her reflections and the changes to practice she has instigated as a result of this case, within three months of the date of this report.

97. I recommend that the optometry clinic apologise to Ms A for the deficiencies identified in this report. The written apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

98. I recommend that the optometry clinic amend the Optometrists Communication and Record Keeping Policy to include the role of ancillary staff and clarify how pre-testing is integrated

into patient care. A copy of the updated policy is to be provided to HDC within three months of the date of this report.

Follow-up actions

99. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, will be sent to the Optometrists and Dispensing Opticians Board | Te Poari o ngā Kaimātai Whatu me ngā Kaiwahakarato Mōhiti, and it will be advised of Mr B's and Ms C's names.

100. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, will be sent to the New Zealand Association of Optometrists and the Cornea and Contact Lens Society of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent clinical advice was obtained from optometrist Mr Brett Hooker:

'HDC Independent Advisor Report prepared by Brett Hooker for case 21HDC02273

I have been asked to provide an opinion to the Commissioner on case number 21HDC02273, I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My qualifications, training, relevant experience:

BOptom, University of Auckland, New Zealand, 1993; Cert Oc Pharm (Therap) TAPIOT, University of Auckland, New Zealand, 2005; 30 years of Optometry Practice experience, primarily in a privately owned group practice.

Background

On 25 July 2018, [Ms A] was seen by [Mr B] at [the optometry clinic], as she was experiencing visual problems with her right eye. [Mr B] diagnosed her with dry eye and prescribed eye drops.

On 30 July 2018, [Ms A] returned to [the optometry clinic] as there was no improvement in her vision. She was examined by [Ms C] and advised that she had cataracts in both eyes. Given the reduction in [Ms A's] visual acuity, [Ms C] referred her to an ophthalmologist for further assessment and to check her eye pressures.

On 24 August 2018, an ophthalmologist at [the ophthalmology clinic] diagnosed [Ms A] with retinal detachment. Two surgical attempts to repair the retinal detachment were unsuccessful.

Expert advice requested

Please review the enclosed documentation and advise whether you consider the care provided to [Ms A] by [Mr B] and/or [Ms C] and/or [the optometry clinic] was reasonable in the circumstances, and why.

For your information, the ACC external expert advice has been initially omitted from this request. Sections of [the optometry clinic's] response and [Mr B's] response, as they relate to that advice, have also been redacted.

As you will note, the clinical notes from [the ophthalmology clinic] have been included in this request, for your reference. Please consider the care provided by [Mr B] and [Ms C] at the time of events, without considering the outcome from the [ophthalmology clinic].

I would ask that you attempt to mimic your usual working practice when you review these images, for example in relation to the time that you would usually spend on radiological analysis.

In particular, please comment on:

1. What eye examination and tests were carried out by [Mr B] on 25 July 2018 and [Ms C] on 30 July 2018 for [Ms A]?
2. Whether the eye examination and tests carried out by [Mr B] on 25 July 2018 and [Ms C] on 30 July 2018 were appropriate and reasonable for [Ms A] during her presentations to [the optometry clinic].
3. Whether there were any eye examination and tests that should have been performed for [Ms A] on 25 July 2018 and/or 30 July 2018, as part of accepted practice (or from the NZAO), given [Ms A's] age and symptoms presented.
4. What advice and recommendation should have been provided to [Ms A] on 25 July 2018 and/or 30 July 2018?
5. The adequacy and appropriateness of the documentation taken by [Mr B] on 25 July 2018 and [Ms C] on 30 July 2018.
6. The adequacy of relevant procedures and policies in relation to comprehensive eye examinations in place at [the optometry clinic] at the time of events.
7. Any other matters you consider relevant in this case.

For each question, please advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Response to questions

What eye examination and tests were carried out by [Mr B] on 25 July 2018 and [Ms C] on 30 July 2018 for [Ms A]?

25 July 2018: Auto Refractor RE, History, Slit Lamp examination of the Anterior Eye, Refraction & Visual Acuity.

Visual field screening results & Retinal photography images were included in the information supplied to me but without any record of who performed those tests. They were likely done by an ancillary staff member.

30 July 2018: History, Slit Lamp Examination of the Anterior Eye, Refraction, Visual Acuity, Amsler Grid testing, Tonometry.

Retinal photography images were included in the information supplied to me but without any record of who performed those tests. They were likely performed by an ancillary staff member.

Whether the eye examination and tests carried out by [Mr B] on 25 July 2018 and [Ms C] on 30 July 2018 were appropriate and reasonable for [Ms A] during her presentations to [the optometry clinic].

25 July 2018: Accepted practice includes among other things, examination of the retina. The retina was photographed on 25 July, but there is no comment on this in the clinical records. Examination of the retinal images provided to me show an inferior retinal detachment. In my opinion, and that of my peers, failure to recognise this represents a significant departure from accepted practice. Visual Field screening was also undertaken but again there is no comment in the notes. The Visual Field Screening printout provided to me shows a superior visual field defect. This corresponds to an inferior retinal detachment. In my opinion, and that of my peers, the failure to recognise this represents a significant departure from accepted practice.

30 July 2018 Accepted practice includes among other things, examination of the retina. The retina was again photographed on 30 July, and again, there is no comment on this in the clinical records. Examination of the retinal images provided to me clearly show an inferior retinal detachment. In my opinion, and that of my peers, failure to recognise this represents a significant departure from accepted practice.

Whether there were any eye examination and tests that should have been performed for [Ms A] on 25 July 2018 and/or 30 July 2018, as part of accepted practice (or from the NZAO), given [Ms A's] age and symptoms presented.

Excerpt from:

ODOB Standards of Clinical Competence for Optometrists

Task 3. Examination of the eye and visual system, Section 3.2 Implements an examination plan that is progressively modified on the basis of findings.

From the information supplied to me, it is apparent that [Ms A] was seen for only a short consultation on both dates, and on both dates, the Optometrist failed to recognise the need to progressively modify their examination on the basis of findings and conduct a retinal examination. It is accepted practice to conduct a retinal examination. This should have been undertaken under the circumstances.

There is enough information in the presenting symptoms, retinal images, and visual field screening to have raised suspicion of retinal detachment on both 25 and 30 July 2018 and the consultation should have been modified to include a retinal examination.

Retinal examination would have been further enhanced by undertaking a dilated fundus examination (DFE), which is the accepted level of practice based on the other findings.

(In this case however, a DFE was not needed to make the diagnosis of a retinal detachment.)

In my opinion, and that of my peers, failure to perform a retinal examination whether it be dilated or undilated represents a significant departure from accepted practice.

What advice and recommendation should have been provided to [Ms A] on 25 July 2018 and/or 30 July 2018?

[Ms A] should have received an acute ophthalmic referral on 25 July 2018. Had that occurred, she would not have presented again on 30 July 2018. Given that she was not referred on 25 July, she most certainly should have been referred acutely when she presented again on 30 July 2018. It is my opinion, and that of my peers, that failure to provide an acute referral on either of these occasions represents a significant departure from accepted practice.

The adequacy and appropriateness of the documentation taken by [Mr B] on 25 July 2018 and [Ms C] on 30 July 2018.

25 July 2018: the notes could be described as brief, at best. There is a significant difference between the notes on 25 July 2018 and guidelines set out in the Optometrists & Dispensing Opticians Board (ODOB) Standards of Clinical Competence for Optometrists.

30 July 2018: there is marginally more information in the notes for this visit. However, the notes still fall well short of what is expected in the ODOB Standards of Clinical Competence for Optometrists.

In my opinion, both consultations represent a moderate to significant departure from accepted clinical practice.

The adequacy of relevant procedures and policies in relation to comprehensive eye examinations in place at [the optometry clinic] at the time of events.

The [*optometry clinic's*] *optometrists communication & Record keeping policy* document supplied to me is dated effective 1 December 2016. The policy includes, among other things, sections on Case history, Examination procedure and Management plan. It refers to the *Standards of Clinical Competence for Optometrists in New Zealand* which is a document that all optometrists registered in New Zealand should be familiar with. The policies place the onus of responsibility with the Optometrist without any reference to the role that ancillary staff play.

It is apparent that [the optometry clinic] uses a system of pre-testing in which preliminary tests are carried out by non-optometric staff members. I could not see any mention in the policy document as to how pre-testing is integrated into patient care. It is my opinion and that of my peers that this represents a moderate departure from accepted practice.

Any other matters you consider relevant in this case.

Particular relevance should be noted of the following clauses, from the *Standards of clinical competence for optometrists.*

Elements/Competencies:

3.1 Formulates an examination plan based on the patient history in order to obtain information necessary for diagnosis and management.

3.2 Implements an examination plan that is progressively modified on the basis of findings.

3.3.4 (a) Assesses and evaluates the structure and health of the components of the posterior segment including but not limited to: retina, choroid, vitreous, blood vessels, optic nerve head, macula and fovea.

(b) Uses and interprets results of tests including but not limited to: direct and indirect ophthalmoscopy, retinoscopy, photography, diagnostic pharmaceuticals, slit-lamp biomicroscopy and fundoscopy, visual acuity, colour vision tests, Amsler test, visual field assessment, photostress test, pupil reactions, auxiliary lenses for fundus viewing and optic nerve head assessment.

4.1 Interprets and analyses examination findings and results in order to determine the nature and aetiology of conditions or diseases and to establish a diagnosis or differential diagnoses.

5.9.1 Recognises the need for referral to other professionals for assessment and/or treatment, discusses this with the patient and recommends a suitable professional.

5.9.2 Makes a timely referral to other professionals, with appropriate supporting documentation.

In this case, it is my opinion that neither optometrist met the above standards.

Both optometrists failed to appropriately make a diagnosis of a retinal detachment when there was enough information available to do so. The relevant information available was: recent onset of blur, reduced vision, visual field defect, retinal detachment visible on retinal photographs (particularly on 30 July 2018).

Additional testing such as a DFE would have made diagnosis easier.

Given there are no comments in the notes about the retinal photography and visual field screening, it is my opinion that the optometrists most likely did not review the retinal photographs or field results. In my opinion, it is less likely that the optometrist reviewed the photos and field results but failed to recognise the retinal detachment, but that is certainly a possibility. It is my recommendation that comment on tests such as retinal photos and visual field screening are made in the clinical notes to indicate that they have indeed been reviewed.

> [The optometry clinic] apparently uses a system of pre-testing in which preliminary tests are carried out by non-optometric staff members. This is a common form of accepted Optometry practice. Pre-testing however, is of no use if the tests performed are not reviewed by the Optometrist. While the staff members performing pre-testing are not qualified to, or expected to interpret the test results, it is common "safety net" practice for staff members to flag clearly abnormal results with the Optometrist. The visual field test on 25 July 2018 was clearly abnormal. The retinal image of the RE on 30 July 2018 was clearly abnormal.
>
> It is my opinion and that of my peers that not having a safety net procedure in place around pre-testing is a significant departure from accepted practice.
>
> In my opinion, it is a concern that two optometrists working at [the optometry clinic] were practising below [the clinic's] stated policies & procedures, and below the standards set out by the ODOB.
>
> As a result of this case, I would recommend that [the optometry clinic] have a formal review mechanism in place to ensure that optometrists understand and practise to the expected standard.
>
> Brett Hooker
> Optometrist
>
> 18 July 2023'

The following further advice was obtained from Mr Hooker via email dated 26 March 2024:

> 'A diagnosis of Retinal detachment should have been made on 25 July (and also on 30 July given that it was missed on 25 July). The diagnosis should have been made because the retinal detachment was visible on the retinal photographs and there was a corresponding visual field defect.
>
> Had a diagnosis of retinal detachment been made on either of those dates, then an acute ophthalmic referral would have been the appropriate management.
>
> Kind regards
>
> Brett'