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

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

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IN THE HUMAN RIGHTS REVIEW TRIBUNAL [2020] NZHRRT 4

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| | Reference No. HRRT 041/2019 |
| UNDER | SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994 |
| BETWEEN | DIRECTOR OF PROCEEDINGS |
| | PLAINTIFF |
| AND | COUNTIES MANUKAU DISTRICT HEALTH BOARD |
| | DEFENDANT |

AT WELLINGTON

BEFORE:
Ms J Foster, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Dr JAG Fountain, Member

REPRESENTATION:
Ms K Eckersley, Director of Proceedings
Ms B Johns for defendant

DATE OF DECISION: 5 February 2020

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## (REDACTED) DECISION OF TRIBUNAL[1]

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**[1]** These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 14 October 2019.

[1] [This decision is to be cited as: *Director of Proceedings v Counties Manukau District Health Board* [2020] NZHRRT 4]

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

**[2.1]** A Consent Memorandum dated 14 October 2019.

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

**[3]** The Consent Memorandum is in the following terms:

> **MAY IT PLEASE THE TRIBUNAL**
>
> 1. The plaintiff and defendant have agreed upon a summary of facts, a signed copy of which is filed with this memorandum, together with an anonymised copy.
> 2. The plaintiff requests that the Tribunal exercises its jurisdiction and issues:
>    (a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>    (b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter.
> 3. In relation to the declaration being sought in paragraph 2(a) above, the parties respectfully refer to the agreed summary of facts. The parties are agreed that it is not necessary for the Tribunal to consider any other evidence for the purpose of making the declaration sought. The parties request that the anonymised agreed summary of facts be published by the Tribunal as an addendum to the decision.
> 4. The defendant consents to the Tribunal making the above declaration based on the facts set out in the agreed summary of facts, and the non-publication order sought in paragraph 2(b).
> 5. The defendant does not seek any order prohibiting publication of the defendant's name.
> 6. In the statement of claim the plaintiff also sought the following relief:
>    (a) damages pursuant to s 57(1); and
>    (b) costs.
> 7. These other aspects of the relief claimed by the plaintiff have been resolved between the parties by negotiated agreement. There is no issue as to costs.

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

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

## DECISION

**[6]** By consent the decision of the Tribunal is that:

**[6.1]** A declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.

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

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

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| ..... | ..... | ..... |
| **Ms J Foster** | **Dr SJ Hickey MNZM** | **Dr JAG Fountain** |
| **Deputy Chairperson** | **Member** | **Member** |

"A"
This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 5 February 2020.

**BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL**

**HRRT 041/2019**

| | |
|---|---|
| **UNDER** | Section 50 of the Health and Disability Commissioner Act 1994 |
| **BETWEEN** | **THE DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994<br><br>**Plaintiff** |
| **AND** | **COUNTIES MANUKAU DISTRICT HEALTH BOARD**<br><br>**Defendant** |

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# (REDACTED) AGREED SUMMARY OF FACTS

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Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

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

Ms K Eckersley – Director of Proceedings

## (REDACTED) AGREED SUMMARY OF FACTS

### INTRODUCTION:

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

2. The aggrieved person in these proceedings is Miss A.

3. At all material times the defendant, Counties Manukau District Health Board, was a healthcare and disability services provider within the meaning of s 3 of the Act, and was providing health services to Miss A within the meaning of s 2 of the Act.

4. On 9 December 2016 Miss A's father, Mr B, complained to the Health and Disability Commissioner ("the Commissioner") about services provided to his daughter by the defendant.

5. On 20 June 2018 the Commissioner finalised his opinion that the defendant had breached Miss A's rights under the Health and Disability Commissioner (Code of Health and Disability Service Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

### BACKGROUND

6. Miss A was first seen by the defendant's ophthalmology service in December 2006 at the age of five when she failed a pre-school eye test. She was treated and monitored, and then discharged in May 2007.

**Referral, 12 June 2012**

7. On 6 June 2012 Miss A (aged 10 years) was seen by her community optometrist. Her visual acuity had dropped from a prior reading of 6/7.5 to 6/24 in the right eye, and from 6/7.5 to 6/18 in the left eye.[1]

8. On 12 June 2012 Miss A's optometrist referred her to the defendant's specialist ophthalmology service ("the Manukau SuperClinic") to assess the unexplained reduction in visual acuity of both eyes.

9. At the time, the Manukau SuperClinic 'Referral and Appointment Centre Desk File, Referral Management and FSA Scheduling Process' guided the process for managing referral documents requiring a first specialist assessment ("FSA"). On 20 June 2012 the defendant graded Miss A's referral as a priority 3. The grading form recorded that Miss A should be seen within three months. However, it was amended by hand to indicate that she should be seen within two months.

10. On 13 July 2012 the defendant sent a pro forma letter addressed to Miss A's parent/guardian to the registered address on her file, advising that she had been referred to the ophthalmology service with a priority grading of 3. The letter stated that the approximate waiting time for an appointment was 16 weeks. The letter also stated: "Counties Manukau Health is required to see all patients referred for an appointment within five months of receiving their referral."

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[1] Visual acuity reflects a comparison against normal vision. The first number is the distance in metres from the chart to where the patient stands (6m), the second number is how well the patient can read when standing at 6m, compared with a normal person. Thus 6/9 means that a patient standing 6m away from the chart can read only as well as a normal person standing 9m away. Normal vision is 6/6 (previously, in feet, 20/20). The World Health Organisation regards vision of 3/60 or worse (both eyes) as being "blindness".

11. On 29 October 2012 the defendant sent a further standard letter to Miss A's parents requesting that they contact the service to arrange a suitable appointment time. On 1 November 2012, the defendant issued a letter confirming a scheduled appointment date of 21 November 2012.

**Clinic appointment, 21 November 2012**

12. On 21 November 2012 Miss A (now aged 11 years) was seen in the Manukau SuperClinic for her FSA. The consultant ophthalmologist diagnosed Miss A with possible early fruste forme keratoconus (progressive thinning of the cornea, which most commonly affects teenagers) as there was no obvious clinical evidence of keratoconus.

13. In the resulting clinic letter, written up on 26 November 2012, the reviewing consultant ophthalmologist described Miss A as having visual acuity of 6/7.5 in the right eye and 6/9.5 in the left eye. The clinic letter also stated:

> "... Clear corneas. No clinical sign of keratoconus. However, on refraction, retinoscopy shows light appearance and topography confirmed the presence of slightly irregular astigmatism."

14. Miss A was given eye drops, advised not to rub her eyes, and recommended to go back to her optician for refraction checking.[2]

15. The clinic letter requested that Miss A be reviewed again at the Manukau SuperClinic in one year's time (i.e. November 2013) or sooner if there were any problems.

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[2] The act of determining the nature and degree of the refractive errors in the eye and correction by lenses.

16. The clinic letter was sent to Miss A's General Practitioner ("GP"), but was not copied to the referring optometrist. The letter was also not copied to Miss A's family.

**12-month specialist follow-up appointment cancelled**

17. The planned 12-month follow-up ophthalmology review appointment for Miss A did not go ahead in November 2013.

18. Mr B contacted the Manukau SuperClinic when his daughter was not recalled as planned, and was told the clinic was short-staffed and could not always make appointments requested by the clinic team.

19. The planned appointment for Miss A in November 2013 had been cancelled. While there was no reason entered on the defendant's system to indicate why, the defendant advised the Commissioner that at that time, due to an orthoptist vacancy, there were four half day sessions held for that period instead of eight half day sessions.

20. On 17 November 2014 the defendant sent a letter addressed to Miss A to the registered address on her file informing her that an appointment had been made for her at the ophthalmology clinic on 8 December 2014.

21. Miss A's family advised the Commissioner that they did not receive this letter despite their address not having changed, and having received other correspondence at that address. The defendant's records confirm that a text message reminder for the 8 December 2014 appointment was sent to the mobile number on the file on 2 December and the morning of the appointment, although Miss A's family advised they received no telephone call or text message alerts confirming the appointment. Miss A did not attend the 8 December 2014 appointment.

22. That afternoon, the defendant sent a "fail to attend" letter to Miss A's family noting that the appointment had been missed and that the specialist would like them to make another appointment for Miss A. The letter also stated that if the defendant had not heard anything within 14 days, Miss A's care might be discharged back to her GP. At the time, a copy of such a letter was not routinely sent to GPs to alert them to missed appointments, although the defendant did send an HL7 electronic message to her GP advising of Miss A's non-attendance.

23. At this time, Miss A's planned follow-up specialist appointment was 12 months overdue. It had been two years since Miss A's FSA in November 2012.

24. On 10 December 2014, Mr B called the Manukau SuperClinic call centre. He apologised as he forgot the appointment and wished to reschedule the appointment. The Manukau SuperClinic tried to book another appointment but, as there were no appointments available, Miss A was put on the waiting list.

25. In March 2015, when Miss A's GP became aware from the family that the 12-month follow-up did not happen in November 2013, he contacted the ophthalmology department himself to ask if Miss A had been "lost to follow-up", and his attempt at re-referral was rejected.

**2015 referral**

26. On 25 March 2015 the Blind and Low Vision Education Network New Zealand ("BLENNZ")[3] sent two forms to the defendant. The first form (also sent to Greenlane Eye Clinic/Starship) requested information from

[3] The Blind and Low Vision Education Network NZ (BLENNZ) website outlines that it is a school that is made up of a national network of educational services for children and young people in New Zealand who are blind, deafblind, or have low vision.

the defendant about Miss A in order "to determine eligibility for [BLENNZ] services". It included an annotation stating: "URGENT PLEASE!" The second was a referral form from Ms W (a learning support teacher from Miss A's school) and her grandmother seeking the assistance of BLENNZ in respect of "vision concerns" and to "ensure her educational opportunities are optimised". The first form recorded in the 'General Comments/Reason For Rejection' section that it was not treated as a referral, but a request for information.

27. The defendant received these forms on 26 March 2015. A 'Referral Management' label and a 'Referral & Waitinglist Management' stamp attached to these forms are both dated 30 March 2015. The label recorded that the patient was current to the service, that this was a second referral, and there was a planned appointment date of 8 June 2015.

28. On 14 August 2015 the defendant sent a letter to Miss A advising that an appointment with the ophthalmology service had been made for 24 August 2015.

**August 2015 appointment – severe keratoconus**

29. On 24 August 2015 (two years and nine months after her previous specialist review) Miss A was reviewed by the consultant ophthalmologist at the Manukau SuperClinic.

30. The consultant ophthalmologist assessed that Miss A's vision was significantly reduced, with visual acuity recorded as 6/60 in the right eye and 6/30 in the left eye. On examination, the anterior segment of the

eyeball showed bilateral papillary conjunctivitis[4] with bilateral very advanced keratoconus, especially in the right eye. A Pentacam test[5] confirmed the diagnosis of severe keratoconus.

31. A clinic letter was sent back to BLENNZ (copied to Miss A's GP and to the "patient", but not to the community optometrist). It concluded that Miss A had bilateral keratoconus. The right eye was very severe and beyond treatment for crosslinking.[6]

32. The treatment plan was for Miss A to have left corneal crosslinking surgery, to use Patanol drops[7] twice a day in both eyes, and for there to be a discussion about the use of contact lenses to improve her vision. Miss A was booked into the Contact Lens Clinic at the Manukau SuperClinic.

33. On 30 September 2015 Miss A was seen at the Contact Lens Clinic. On 9 October 2015 the defendant wrote to the family advising that surgery for Miss A had been booked for the morning of 20 October 2015.

**20 October 2015 – day surgery**

34. On 20 October 2015 Miss A underwent left eye corneal collagen crosslinking[8] day surgery. She was discharged home with drops and painkillers the same day. The discharge summary was sent to her GP. Miss A was seen again for follow-up reviews on 21 October, 23 October,

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[4] A type of allergic conjunctivitis. A foreign body causes prolonged mechanical irritation, which results in a reaction in the eye.
[5] A type of comprehensive eye scanner.
[6] Also referred to as corneal collagen crosslinking — a procedure where the epithelium is removed from the surface of the cornea. Riboflavin drops are applied to the eye and the cornea is also exposed to UVA light.
[7] Patanol eye drops are used to treat seasonal, allergic conjunctivitis — inflammation of the eye due to pollens that cause an allergic response, resulting in watery, itchy and/or red eyes.
[8] Treatment used to strengthen the cornea in people with keratoconus.

12 November, 18 November, 2 December, and 16 December 2015 (for a left eye contact lens fitting, which corrected her vision to 6/7.5).

35. On 21 November 2016 Miss A was reviewed at the Manukau SuperClinic. Miss A reported being happy with the vision provided by her left eye contact lens. Visual acuity was recorded as 1/60 uncorrected in the right eye and 6/9 in the left eye with the lens. A further Pentacam test revealed marked progression in the right eye, but the right cornea was too thin for safe collagen crosslinking.

## DEFENDANT'S RESPONSE TO COMPLAINT

36. During the period relating to this complaint, there was significant demand for the cornea service, and limited anterior segment and contact lens services at Counties Manukau DHB ("CMDHB").

### Capacity issues

37. Other specific capacity issues at CMDHB impacting on patients receiving their follow-up appointments around this time, included:

- The incidence of chronic disease associated with the ageing population which had placed, and continues to place, significant demands on ophthalmology resources, with referrals to the service increasing year on year.
- In 2009, the service moved into a new purpose-built facility, which soon reached maximum capacity.
- In 2013, planning commenced to expand the facility further with a number of options being considered. The shortage of ophthalmologists became an important concurrent factor impacting upon the ability to expand services, and required a concentrated recruitment drive to run alongside the facility expansion planning.
- In the interim period, the ophthalmology department increased extra clinic capacity by adding weekend and evening clinics and an extra locum workforce to try to manage the challenges.

**Overdue specialist follow-up appointments**

38. During the period related to this complaint, the defendant's ophthalmology service used an electronic follow-up reporting system to capture overdue appointments. These appointments were flagged and reflected in an expired/overdue follow-up report — titled "Planned Appointments Process Report/Expired Planned Appointments" ("PAPR").

39. The planned appointment process allocated a time frame for the next appointment (in this case a 12-month follow-up for Miss A) and had a priority assigned to each appointment. The priority indicated how long over the planned time frame the appointment could be booked. Miss A's priority was listed as "4" (weeks). A four-week priority meant that the appointment could be booked up to a month either side of the planned appointment time. Miss A's November 2013 follow-up appointment expiry date is listed on the PAPR as 3 January 2014.

40. The process for managing outpatient follow-up waiting listings was provided for by the defendant's "iPM Management — Managing Outpatient Planned Follow Up Waiting Lists (via Day Clinic View)" document. All patients who required a follow-up appointment had a comment added on file to inform staff booking the next follow-up appointment, to indicate the type of clinic or appointment required. However, as the numbers of follow-up appointments increased rapidly, this system no longer worked efficiently. Due to huge volumes of overdue follow-up appointments in the ophthalmology service, the longest overdue follow-up appointments were booked as a priority.

41. The process for any patients who contacted the ophthalmology service directly asking for a more urgent appointment was that they were

contacted by the ophthalmology nurse specialist and assessed over the telephone. A more urgent appointment may or may not have been booked according to the outcome of that assessment. All clinics were fully booked as a result of the increasing numbers of urgent cases that needed to be seen. In the ophthalmology department, there were so many overdue follow-up appointments that all had the same clinical priority, and it became extremely difficult to manage.

**Acuity tool not in use**

42. The defendant did not use a specific clinical acuity tool at the time of Miss A's care to assist prioritisation. The service prioritised overdue patients according to the length of time the patient had been waiting, i.e. how overdue his or her appointment was, and on clinical priority as specified at the time of booking. The service managed the overdue appointments by identifying those patients who had waited the longest and were expected to be more at risk — these patients were seen at the extra clinics and as soon as practicable.

43. Patients, or their health providers, who advised the service that they were concerned were reassessed, escalated, and given appointments sooner than they would have been if they had remained on the overdue list.

44. The defendant's appointment coordinators and the registered nurses received clinical oversight by consultants in the ophthalmology service. Any query or concern could be referred to the charge nurse manager and/or the consultants, who would review and provide advice to the appointment coordinators and registered nurses about whether a patient should be reprioritised.

45. Clerical booking practices were overseen to ensure that patients with the highest priority were being booked first. Extra weekend and evening clinics were booked under supervision of the Charge Nurse and former Service Manager in an attempt to reduce the backlog, including 20 Saturdays in 2012 resulting in approximately 2,200 appointments. The Service Manager met monthly with the ophthalmology team to monitor the situation and discuss further opportunities to manage the overdue follow-ups. The defendant also engaged the assistance of locums to help reduce the number of overdue appointments, and continued its active recruitment of suitable ophthalmologists (despite shortages in the industry).

**Changes implemented by the defendant**

46. The defendant acknowledges that while the ophthalmology service has been successful in managing cataract demand (the most common cause of loss of vision), it has struggled to meet ongoing significant demand growth for progressive eye conditions that can also result in irreversible blindness if not treated effectively. This is because the defendant's ophthalmology service was unable to meet clinic demand due to the volume of patient numbers exceeding both capacity and staffing, together with lack of funding.

47. Since 2016, the defendant has instituted many changes and strategies to address the various issues and challenges impacting on its ophthalmology services, and following the recommendations of the Commissioner. In particular:

    a. A new outpatient suite (from 2017) at Middlemore Hospital campus, which has not only added capacity but also enabled ophthalmologists and glaucoma specialists to train four

advanced practice optometrists to provide community based care for CMDHB's stable glaucoma patients.

b. A series of mega clinics in May and June 2018 with the support of RANZCO to help reduce the backlog of patients, with ongoing evening and weekend clinics for specific conditions as required.

c. All patients and GPs now receive a notice attached to their clinic letters highlighting access issues and are advised to contact CMDHB if there is any delay in receiving a follow-up appointment.

d. A referral of a child with keratoconus is usually seen for an FSA within a month (orthoptist and optometrists are aware this condition is a semi-urgent priority).

e. Optometrists and GPs are being educated on the importance of sending detailed clinical referrals to the service.

f. Optometrists can apply to access CareConnect and Testsafe Clinical Portal to access records of patients, including clinic letters. The defendant is also investing in technological solutions, including external notification to referring parties such as optometrists.

g. Brief treatment and re-referral guidelines now accompany letters to the GP and optometrists.

h. The Acuity Index Tool – developed in conjunction with RANZCO for prioritisation of follow-up appointments – was implemented in 2018 and provides a daily report to the follow

up clinic scheduler, charge nurse manager and service manager. It provides explicit direction for the schedule to prioritise all follow up patients according to their clinical priority.

i. Keratoconus progression clinic is run on a two-weekly rotation and occurs every three to six months to avoid missing any progression of the disease. Corneal collagen crosslinking is booked straight away if any documented progression of keracotonus.

j. The defendant is actively working to reduce its patient waiting times.

k. The defendant has developed an Ophthalmology Workforce Plan which describes future service requirements to meet the increasing demand.

48. The Ministry of Health has also been working with DHBs, including the defendant, who have a backlog of ophthalmology patients, to address capacity and demand issues and committed to further funding for such DHBs. The defendant reports on its progress on a monthly basis to the Ministry.

**EXPERT ADVICE**

49. Professor Charles McGhee provided independent expert advice to the Commissioner. Professor McGhee is a consultant ophthalmologist with 25 years' clinical experience, with particular expertise in keratoconus and its management. He is also Chair and Professor of Ophthalmology and Head of Department at Auckland University.

50. Professor McGhee acknowledged that the demand for eye services has increased almost exponentially across New Zealand, which has impacted adversely on the defendant's provision of eyes services. However, he advised that this demand should not result in abrogation of services to other patients who may have preventable vision loss, from unmonitored waiting times and follow-up appointments.

51. Professor McGhee noted that the defendant's ophthalmology service had been in crisis since 2009, and advised that one would have expected by 2012, if not earlier, the defendant would have a fully established systematic review and scoring system for all delayed follow-ups. This did not appear to be the case.

52. Professor McGhee advised that the defendant's processes and systems in place at the time of these events, specifically in relation to prioritising and booking overdue follow-up appointments and identification of higher-risk patients, appeared completely inadequate and below the standard of expected care. A 20-month delay of a planned 12-month review in a child with ocular allergy, eye rubbing, suspected keratoconus and mild intellectual disability is simply unacceptable and certainly contributed to more advanced disease than could be treated (halted) by collagen crosslinking, and thus significant loss of visual acuity.

53. Professor McGhee concluded that undoubtedly Miss A's case highlighted significantly greater visual loss in a progressive disease affecting children and young adults, that probably could have been treated at a much earlier stage had her review appointment occurred in the planned 12-month period.

## BREACH OF RIGHT 4(1) OF CODE

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

55. The defendant acknowledges that any loss of vision in a child is devastating for the child and for everyone involved in the child's care.

56. The defendant also acknowledges that Miss A did not receive follow-up specialist eye care in line with the appropriate clinical time frames requested by her clinicians, and that she experienced significantly greater visual loss than she would have if reviewed and treated at a much earlier stage.

57. The defendant accepts that it breached Right 4(1) of the Code by not providing services to Miss A with reasonable care and skill, in particular by:

    a. failing to arrange a timely follow-up appointment for Miss A in line with appropriate clinical time frames;

    b. failing to have an adequate prioritisation system for overdue follow-up specialist appointments;

    c. missing opportunities to identify and remedy the ongoing delay in Miss A being seen for specialist follow-up;

    d. not taking sufficient account of potential clinical risks associated with heavy demand and a lack of capacity at the ophthalmology service, and not taking sufficient or adequate action to rectify the situation despite awareness of the issue.