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

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

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2016] NZHRRT 33**

	Reference No. HRRT 064/2016
UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**DEPARTMENT OF CORRECTIONS**
	DEFENDANT

AT WELLINGTON

BEFORE:
Mr RPG Haines QC, Chairperson
Dr SJ Hickey MNZM, Member
Mr RK Musuku, Member

REPRESENTATION:
Ms N Wills, Director of Proceedings
Ms M Graham for defendant

DATE OF DECISION: 18 October 2016

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 28 September 2016.

[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:

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[1] [This decision is to be cited as: *Director of Proceedings v Department of Corrections* [2016] NZHRRT 33]

[2.1] A Consent Memorandum dated 22 September 2016.

[2.2] An Agreed Summary of Facts, an anonymised version 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 on the basis of which the parties seek a declaration in paragraph 2(a) below. A signed copy of the agreed facts is filed with this memorandum. 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 agreed summary of facts be published by the Tribunal as an addendum to the decision.
2. The plaintiff requests that the Tribunal exercises its jurisdiction in respect of the following matters:
   (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:
      (i) Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.
3. The defendant consents to the Tribunal making the above declaration based on the facts set out in the agreed summary of facts.
4. In the statement of claim the plaintiff also sought the following relief:
   (a) damages pursuant to s 57(1); and
   (b) costs.
5. 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.
6. The defendant does not seek any order prohibiting publication of the defendant's name.

[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. We are further satisfied the non-publication order sought in relation to the identity of the aggrieved person should be made.

DECISION

[5] By consent the decision of the Tribunal is that:

[5.1] 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.

[5.2] A final order is made prohibiting publication of the name, address 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 Chairperson.

.....	.....	.....
Mr RPG Haines QC **Chairperson**	**Dr SJ Hickey MNZM** **Member**	**Mr RK Musuku** **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 18 October 2016.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT No.

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **DEPARTMENT OF CORRECTIONS** of Wellington, Government Department

Defendant

AGREED SUMMARY OF FACTS

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

Nicola Wills - Director of Proceedings

AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by section 15 of the Health and Disability Commissioner Act 1994 ("the Act").

2. At all material times, the defendant was a Government Department with a Health Service which employed health practitioners to provide services to prisoners and was therefore a healthcare provider within the meaning of s 3 of the Act.

3. The plaintiff is acting for and on behalf of the aggrieved person, Mr E, who at all material times, was a prisoner of Auckland (also known as Paremoremo) Prison and was receiving health care from the defendant.

4. On 4 July 2013 the Health and Disability Commissioner received a complaint from Mr E regarding the health services provided to him while he was a prisoner at Auckland Prison.

5. On 26 June 2015 the Deputy Health and Disability Commissioner (appointed under s 9 of the Act) finalised her opinion that the defendant had breached the aggrieved person'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. A person being held in custody does not have the same choices or ability to access health services as a person living in the community. They do not have direct access to over-the-counter medicines ("OTCs"),[1] or to a general

[1] Medicine that can be purchased from a retail outlet and does not require a prescription.

practitioner and are entirely reliant on the staff at the Prison health centre to assess, evaluate, monitor, and treat them appropriately.

7. The Corrections Act 2004 ("the Act") states that "a prisoner is entitled to receive medical treatment that is reasonably necessary". The Act requires that "the standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public".[2]

Auckland Prison Health Centre

8. Auckland Prison has a health centre staffed by registered nurses ("RN's") who are employed by the defendant. Doctors and dentists are contracted by the defendant to provide medical and dental care.

9. At the time of these events, the defendant contracted a dentist to provide dentistry care to prisoners at the prison each Tuesday for seven hours. She remained on call to the prison while she was not working on site, which meant that she would attend if needed outside her regular hours.

10. At the time of these events, the Health Service nurses were on site from 7am until 10pm each day, after which a nurse was on call until 7am the following morning. The on-call nurse was available and contactable by custodial staff should a prisoner have health concerns after 10pm.

11. The defendant states that Nurses visited the unit where Mr E was housed twice daily.

12. To access non-urgent health services, prisoners can attract the attention of custodial staff or submit written requests for medical attention called "chits". Chits are collected by custodial staff on a daily basis and triaged

[2] Corrections Act 2004, section 75.

by health centre staff, usually the following day. Chits are required to be processed by health centre staff within seven days. Prisoners also have access to an emergency call bell in their cells to be used if they require emergency medical attention.

Defendant's Policies and Procedures

Medication Administration

13. The procedure for the administration of medication by the defendant is set out in the "Health Services Medicines Policy and Procedure" document that was issued in October 2008 and remained in place at the time of these events.

14. That policy applies to all Department of Corrections staff employed by or contracted to the Department of Corrections and one of its stated objectives is to ensure that "all patients receive access to appropriate medication as clinically indicated, within a custodial environment".[3]

OTC's

15. In accordance with that policy the defendant does not require OTCs, such as Brufen[4] and Pamol,[5] to be prescribed by a doctor. An RN can provide these to prisoners and custodial staff are permitted to provide Pamol to prisoners.

16. In accordance with the defendant's policy RN's providing OTC medication must record this action on the patient's medication chart and in the

[3] Health Services Policy and Procedures at 6.
[4] Ibuprofen, often known under the brand name Brufen, is an analgesic and an anti-inflammatory medication used to relieve mild to moderate pain, inflammation and fever. Throughout Mr E's progress notes, ibuprofen is interchangeably referred to as "Brufen".
[5] Liquid paracetamol, often known under the brand name Pamol, is used to relieve mild pain and fever. Throughout Mr E's progress notes, paracetamol is interchangeably referred to as "Pamol". Paracetamol is given to prisoners at Auckland Prison in liquid, and not tablet, form.

patient's electronic clinical file. When administering OTC medication there must be an assessment of the patient's condition.

17. Custodial staff are permitted to issue OTC's in order to ensure that all patients have access to OTC medication for pain relief so as to "provide safe, secure and humane containment".[6]

18. At Auckland Prison custodial staff are reluctant to administer OTC medication. In Mr E's case, despite repeated requests, he received OTC medication on only one occasion from a custodial officer.

19. Where custodial staff issue OTC medication they must document in the Over the Counter Medication Log Sheet ("OTC Medication Log Sheet") the date, time, patient's name, dose or number of tablets and the reason for the OTC medication. The logs are then reviewed by RN's to ensure that any patient regularly requesting Pamol is assessed for any causal health issues.

Prescription and Standing Order[7] Medication

20. With regard to prescription and standing order medication the "Health Services Medicines Policy and Procedure" document states:

> "**7. Pre-Administration of Medication**
> **7.1 Pre-Administration of Medication Policy**
> ...
> 7.1.2 Clinical Presentation
> ...
> - An assessment must be made of the patient's current health status and care plan considering the appropriateness of the medicine. If there are any concerns about giving the medicine, discuss these with the Pharmacist and/or Prescriber.
> - All Nurses are to make and record any relevant baseline observations prior to the medicines being given ...

[6] Health Services Medicines Policy and Procedure at 12.3.
[7] A set of written instructions from a registered medical practitioner or dentist (the issuer) to other persons to permit the supply or administration of prescribed medicines or specified controlled drugs without a prescription, and to provide medical treatment. Standing Orders are used in emergencies or when the issuer is unavailable.

7.2 Pre-Administration of Medication Procedures

...

7.2.2 Clinical Presentation

...

- Assess the patient's current clinical presentation and ensure that it is suitable to proceed with them receiving their medication.
- Record any baseline observations if required in the patient's electronic clinical file.

...

8. Administration of Medication

8.1 Administration of Medication Policy

Our Policy is that:

- Nurses must adhere to the instructions of the prescriber. Deviation from this must be discussed with the prescriber if clinically appropriate as soon as practical. These deviations e.g. withholding medication must be recorded on the medication chart or approved signing sheet. Use clinical judgement to determine if this deviation should be documented in the electronic clinical file.

..."

Documentation

21. The Corrections "Health Services Health Care Pathway" relevant at the time of these events and applying to all Health Services Staff employed by or contracted to Health Services, including dental services, states:

"**9. Documentation**

9.1 Policy on Clinical Documentation

When carrying out a health assessment or intervention, Health Services staff must:

...

- Document all assessments and clinical interventions in the prisoner's electronic file.
- Document all assessments and interventions before going off duty for the day.
- Document all external and internal conversations that relate to the prisoner's clinical care.

...

22. The "Health Services Medicines Policy and Procedure" document further states:

"**9.1 Post Administration Policy**
Our policy is that:

...

- All Health Services staff administering medications are responsible for ensuring the medication chart is current, legible, accurate, and provides evidence of the medication administration history of the patient.
- All Health Services staff administering medication are responsible for ensuring the medication signing sheet is current, legible, accurate and provides evidence of the medication administration history of the patient.
- By recording their signature/initials, the Nurse has made a statement that they have personally carried out the orders as prescribed.

...

9.2 Post Administration Procedure
9.2.1 Documentation

- Record the date, time, dose, route and sign/initial the patient's medical chart or signing sheet post administration of the medication."

23. With regard to recording the prescribing and administration of medications, Corrections use a number of forms of documentation. It is not always clear in Corrections Policies as to which form should be used in which situation. A description of the main documentation follows:

Doctor's Prescribed Medication Chart

The Prescribed Medication Chart ("PMC") is the form on which doctors' record prescriptions. The doctor records the date of the prescription as well as the name of the medication, route,[8] times at which the medication should be administered (ie, breakfast, lunch, dinner, bedtime) and the date the prescription is to be discontinued. The doctor is required to sign each prescription.

OTC Medication Log Sheet

The OTC Medication Log Sheet is a form on which the administration of OTCs is recorded, primarily by Custodial Officers. The form has a space

[8] For example, whether the medication is given orally or by injection.

at the top for the name of the OTC medication, the reason for use, recommended dose, precautions and contra-indications. Underneath there is a column each for the patient's name, dose, date, time and reason for the administration. There is a space in which both the patient and the person administering the medication are to sign at each administration. One page is used per medication.

Medication Administration Record

The Medication Administration Record ("MAR") is issued by the pharmacy when medication is ordered and sent. It is used to record the administration of prescription medication and is personalised by the pharmacy with details taken from the patient's prescription. MAR's come in one of two forms, a monthly cycle chart or a short cycle chart, depending on the length of time the medication is prescribed for. Both charts look similar. However:

a. A short cycle MAR has four columns on it, and each column is individually headed (morning, lunch, dinner and bed) and is signed vertically.
b. A monthly cycle MAR has individual boxes for each week, the four times of the day (morning, lunch, dinner and bed) are printed in each box, and the form is signed horizontally.

Medication Administration Signing Sheet

The medication administration signing sheet ("MASS") is used for recording the administration of PRN[9] (as required) medications, such as short course medications or standing order medications. On the MASS the administration of each medication is assigned a separate column under which staff record the date, dose and time the medication was given, and then sign next to each record.

[9] *Pro re nata* meaning "as the situation demands".

24. The documentation relating to Mr E's medication administration is unclear with administrations being recorded across two documents, namely a MASS and a MAR. Specifically:

    a. The administration of Pamol was recorded on a MASS.

    b. The administration of Brufen was recorded on a MAR and a MASS.

    c. The administration of Augmentin[10] and Metronidazole[11] was recorded on a MASS.

    d. There is no OTC medication log sheet at all.

25. The defendant has accepted that the "proper signing sheet" for Mr E's medications would have been a MAR.

PARTICULARS RELATING TO MR E

Removal of Mr E's tooth on 11 June 2013

26. On 11 June 2013, the Health Service's dentist removed, under local anaesthetic, Mr E's lower left molar (tooth 37) which was badly decayed and painful. The procedure took approximately 45 minutes as extraction was difficult.

27. The dentist gave Mr E 1g[12] of Pamol, which he took before he left the Health Service. She also provided him with gauze swabs to take to his cell and gave him verbal instructions. These were not documented in his clinical records.

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[10] A penicillin antibiotic used to treat infections caused by bacteria.
[11] An antibiotic used to treat infection caused by bacteria.
[12] The strength of the Pamol prescribed by Dr Ripley at 1gram was equivalent to 20ml.

28. After the procedure, Mr E went back to his prison cell. He was in shock and having hot and cold flushes. His jaw was very sore, and he was spitting out blood, and vomiting.

29. At 1.00pm Mr E informed custodial staff that he was not feeling well and asked to see a nurse. He was informed that he would have to wait until a nurse was able to see him. This did not occur for another four hours.

30. At 5.00pm a nurse assessed Mr E, gave him Pamol for the pain and cotton wool balls to stop the bleeding. Neither the pain relief nor the cotton wool balls alleviated Mr E's bleeding and associated pain.

12 June 2013

Prescription Medication

31. On 12 June 2013 Mr E's prescription as standing orders was for:
    a. Brufen 400mg twice daily; and
    b. Pamol 20ml twice daily.

Medical Care Provided

32. At 2.00am Mr E woke up in severe pain. He pressed the emergency call button in his cell to ask for more pain relief. Mr E was given Pamol by a custody officer. This was the only occasion that Mr E was given pain relief from a custody officer, despite multiple requests throughout June and July 2013. The custody officer did not document this administration.

33. Later on in the morning, the RN on shift at the prison assessed Mr E. She noted that he had been bleeding through the night, there was quite a bit of blood on his pillow case, and he had blood and saliva dripping out of his

mouth during the consultation. She gave him cotton balls to pack his mouth and called the Health Service dentist.

34. The RN discussed her assessment findings with the dentist who prescribed: "i) pack with gauze and bite down on to apply pressure ii) administer brufen & paracetamol" and instructed the RN to write up Brufen and Pamol as standing orders. The plan was to review Mr E at the evening shift.

35. By that evening Mr E's mouth was bleeding constantly and his jaw had locked closed. The left lower part of his face and neck were swollen and he struggled to swallow. At approximately 7.00pm a nurse attended to assess him on her rounds. Mr E told the nurse he felt that his mouth had become infected. The nurse advised Mr E that it was normal to have some swelling and that it would be better the following day. The Nurse failed to respond appropriately to Mr E's concerns regarding an infection, which as later discovered was in fact present. Mr E does recall being given pain relief medication at this time.

36. At 11.00pm Mr E woke up in pain and asked custodial staff to provide more pain relief. Despite custodial staff being authorised to administer Pamol, being an OTC medication that does not require a prescription, custodial staff failed to appropriately respond to Mr E's request for pain relief by refusing to provide any medication to him. Mr E was advised that he had to wait until 7am the next morning for a nurse to provide pain relief.

Medication Received

37. Mr E received his prescribed, as per the standing order, medication on 12 June 2013.

13 June 2013

Prescription Medication

38. On 13 June 2013 Mr E's prescription was for:

    a. Brufen 400mg twice daily (as per the standing order);

    b. Pamol 20ml three times daily, this was increased at midday from two times daily; and:

    c. From midday, Augmentin 625mg three times daily.

Medical Care Provided

39. The notes record that Mr E received 20ml of Pamol and 400mg of Brufen at 8am and was noted to have swelling at his jaw

40. At midday the RN assessed Mr E who was complaining of increased and constant pain. She noted his swelling had increased a lot and was covering the left jaw line and continuing under his chin. She discussed his condition with the doctor on site. The doctor advised the RN that Mr E would need regular pain relief and prescribed Mr E 20ml Pamol three times daily until 20 June 2013, and Augmentin "625g"[13] three times daily until 20 June 2013. Mr E was given 20ml of Pamol and 625mg of Augmentin at this assessment but contrary to the doctors directions Mr E's pain relief (and antibiotic) were not regularly administered.

41. Mr E experienced constant pain all day and recalls asking custodial staff three or four times to arrange for him to see a nurse in order to get more pain relief and to check for infection. He also submitted a chit to the Health Service, stating: "Can i please see the doctor asap as my mouth and [throat] have swollen up and I struggle to [swallow]." That chit was

[13] The prescription should have read "625mg". As each Augmentin tablet is 625mg, one hundred 625mg tablets would be required to make up a prescription for 625g of Augmentin.

recorded as being received by the Health Service the following day (14 June 2013). The defendant failed to appropriately respond to Mr E's multiple requests for a medical assessment because Mr E did not see a doctor regarding his medical concerns for another 7 days

42. Mr E recalls receiving pain relief at 7.00pm.

43. At 11.00pm that night, Mr E woke to pain and asked custodial staff for more pain relief. Mr E's request was refused and in doing so custodial staff failed to appropriately respond to Mr E's request for pain relief.

44. Due to the pain and swelling Mr E had difficulty eating after the 11 June 2013 procedure. In his progress notes from 13 June 2013 the following is recorded:

> "Upon examination E can only open his mouth 1.5cm and is having difficulty eating ([prescribed] soft diet via kitchen yesterday) …".

45. The defendant failed to put in place in a timely fashion, Mr E's soft food diet. Specifically, Mr E was not started on a soft food diet on 12 June 2013, when it was prescribed, nor was he started on a soft food diet on 13 June 2013 when this notation was recorded in his progress notes.

Medication Received

46. Despite repeated requests, on 13 June 2013 Mr E did not receive his full prescription for pain relief nor did he receive his antibiotic medication after his initial dose administered at midday.

14 June 2013

Prescription Medication

47. On 14 June 2013 Mr E's prescription was for:

a. Brufen 400mg twice daily (as per the standing order);
b. Pamol 20ml three times daily;
c. Augmentin 625mg three times daily; and
d. From approximately 11am, Metronidazole 400mg three times daily.[14]

Medical Care Provided

48. At around 11.00am Mr E asked custodial staff to get him a doctor. Mr E's request is not documented. However, it is recorded in Mr E's progress notes that the RN attended and assessed Mr E that morning.

49. The RN advised Mr E that he had a temperature, which was caused by an infection. The RN documented that she contacted the on-site doctor who had seen Mr E the day before. The doctor prescribed Mr E 400mg Metronidazole (written as "400" with no unit of measurement) three times daily until 21 June 2013, and Augmentin 625mg three times daily until 21 June 2013, both for infection. The RN recorded in Mr E's progress notes:

> "Upon examination swelling has increased. GP contacted for advice on medications. Medications changed to reflect Augmentin 625mg. 2 tabs TDS[15] Metronidazole 400mg TDS [review] with GP on Monday."

50. Mr E recalls receiving pain relief on the morning of 14 June 2013, and that he was started on antibiotics that night.

51. Following on from the progress notes recorded on 13 June 2013, Mr E's soft food diet commenced in the evening of 14 June 2013. At this stage Mr E was struggling with even soft food as his jaw was swollen and locked closed causing him difficulty with swallowing.

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[14] This prescription was written by the RN and later signed by the Dr.
[15] Three times daily.

Medication Received

52. On 14 June 2013 Mr E did not receive his full prescription for Brufen, Pamol, Augmentin or Metronidazole.

15 June 2013

Prescription Medication

53. On 15 June 2013 Mr E's prescription was for:

    a. Brufen 400mg twice daily (as per the standing order);
    b. Pamol 20ml three times daily;
    c. Augmentin 625mg three times daily; and
    d. Metronidazole 400mg three times daily.

Medication Received

54. Mr E received his first and second doses of each medication but did not receive his third dose of Pamol, Augmentin or Metronidazole.

16 to 19 June 2013

Prescription Medication

55. Between 16 June and 19 June 2013 Mr E's prescription was for:

    a. Pamol 20ml three times daily;
    b. Augmentin 625mg three times daily; and
    c. Metronidazole 400mg three times daily.

Soft Food Diet

56. Mr E's soft food diet had a three day timeframe and finished on 17 June 2013. Mr E was placed back on a regular diet without any review of his condition taking place to assess his requirement for a soft diet or

otherwise. Mr E was not able to accommodate a regular diet as at 17 June 2013.

Medication Received

57. Between 16 June 2013 and 19 June 2013 Mr E received some but not all of his prescription medication.

58. Specifically, on 16 June 2013 Mr E received pain relief on one occasion but no antibiotics; on 17 June 2013 Mr E received two doses of pain relief and antibiotics but not his third dose; and on 18 June 2013 Mr E received his antibiotics but only one dose of pain relief.

59. On 19 June 2013 Mr E received one dose of Augmentin and Metronidazole instead of the three doses prescribed. He received no pain relief.

20 to 27 June 2013

Prescription Medication

60. On 20 June 2013 Mr E's prescription was for:
    a. Pamol 20ml three times daily;
    b. Augmentin 625mg three times daily;
    c. Brufen 400mg three times daily; and
    d. Metronidazole 400mg three times daily.

61. On 21 June 2013 Mr E's prescription was for:
    a. Brufen 400mg three times daily;
    b. Augmentin 625mg three times daily; and
    c. Metronidazole 400mg three times daily.

62. Between 22 June 2013 and 27 June 2013 Mr E's prescription was for:
    a. Brufen 400mg three times daily.

Medical Care Provided/Medication Received

63. On 20 June 2013, the on-site Dr reviewed Mr E owing to his on-going pain. He recorded in the progress notes: "[J]aw healed to some degree L wisdom small open area now some [lymph nodes] L [anterior] triangle."[16] He recommenced Mr E on Brufen, recording "400g"[17] three times daily until 27 June 2013.

64. The MAR document which records the administration of Brufen to Mr E for the period 20 June to 27 June is particularly unclear with five administrations recorded on 24 June 2013 and 25 June 2013 despite his prescription being for 400mg three times daily.

65. Mr E's condition was not assessed by an RN on 24 and 25 June 2013 (as per the "Health Services Medicines Policy and Procedure" document), in order to support the additional administrations of Brufen given to him on those days.

66. Between 20 June and 27 June 2013 Mr E's prescription for Brufen was accurately administered on only 4 days.

67. On 20 June 2013 Mr E received no Pamol, only one dose of Brufen and was not provided his third dose of antibiotics.

68. On 21 June 2013 Mr E received only one dose of Brufen, Augmentin and Metronidazole.

69. On 27 June 2013, Mr E's prescription for Brufen ended.

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[16] The anterior triangle refers to the area underneath the chin.
[17] Rather than "400mg".

28 June to 3 July 2013

Prescription Medication

70. Between 28 June 2013 and 3 July 2013 Mr E had no prescriptions for medication related to his dental condition.

Medical Care Provided

71. Mr E remained in constant pain and was unable to fully open his jaw.

72. On 28 June 2013, it is recorded in Mr E's progress notes: "Doing reasonably well … However still complaining of tooth pain with swelling …". The RN that evening administered Brufen to Mr E.

73. Despite his prescription having ended, Mr E continued to receive Brufen between 28 June and 3 July 2013 (two or three times a day (11 occasions in total)) from various RN's. However, there are no records certifying that any of the RN's undertook a pre-medication assessment of Mr E's condition (as per the "Health Services Medicines Policy and Procedure" document), after 28 June 2013, so as to permit Health Services staff to administer this OTC medication.

4 July 2013 to 18 August 2013

Prescription Medication

74. Between 4 July 2013 and 15 July 2013 Mr E's prescription was for:

    a. Naproxen[18] 500mg once daily.

75. Between 16 July 2013 and 18 July 2013 Mr E's prescriptions were for:

    a. Naproxen 500mg once daily; and

[18] Commonly used for the reduction of pain, fever, inflammation, and stiffness.

b. Voltaren[19] 75g once daily.

76. Between 19 July 2013 and 14 August 2013 Mr E's prescription was for:

a. Voltaren 75g once daily.

77. From 14 August 2013 Mr E had no prescriptions for medication related to his dental condition.

Medical Care Provided

78. On 4 July 2013, owing to Mr E's on-going pain, the on-site doctor assessed Mr E and requested an X-ray of his jaw, to be reviewed by a dentist. Mr E's X-ray was taken the same day. The doctor charted "500g"[20] naproxen once daily until 18 July 2013.

79. Mr E did not receive any of the prescribed naproxen.

80. On 9 July 2013, Mr E's X-ray became available. The radiologist noted in the X-ray report:

> "? Tooth fragment left inferior wisdom tooth. ? How easy to remove. **Findings:** There is a partially erupted inferior left third molar and this is angled forwards. A dental opinion with regard to removal would be recommended."

81. On 9 July 2013, the dentist reviewed Mr E's X-ray and organised a review for 16 July 2013. On 16 July 2013, she reviewed Mr E. Mr E appeared well but concerned regarding the partially erupted tooth. The dentist recalls discussing the x-ray with Mr E, and advising that the tooth did not require extraction at that stage.

---

[19] An anti-inflammatory.
[20] Rather than "500mg".

82. The dentist recorded in Mr E's progress notes dated 16 July 2013 that the X-ray results showed no jaw fracture, and a partially erupted tooth next to the tooth that had been removed. She prescribed Mr E 75mg Voltaren for ongoing pain, to be given once daily until 26 July 2013.

83. On 23 July 2013, it is recorded in Mr E's PMC that the prescription for Voltaren was extended until 14 August 2013.

84. Mr E recalls receiving his first dose of Voltaren but nothing after that administration. There are no records to support Mr E having ever received his prescription Voltaren.

85. On 26 July 2013, Mr E was seen in his cell where he requested a dental appointment due to his concern that he had an abscess in his gum. He was provided with pain relief at this time.

86. He followed up his verbal request for a dental appointment with a chit to the Health Service requesting the same and stating that it was painful to chew on the right side of his mouth, and he was concerned that a filling had fallen out. It is recorded in Mr E's progress notes dated 27 July 2013 that the chit was received by the Health Service that day and that an appointment was booked for Mr E to see a dentist.

87. On 30 July 2013, Mr E submitted a further chit to the Health Service, requesting that he be reviewed by a dentist. The chit was received by the Health Service the same day and Mr E was subsequently seen, on 30 July 2013 by a different dentist, from the dentist who had removed his tooth on 11 June 2013, and two fillings were done. The dentist advised that there was no inflammation or infection at the site where Mr E's tooth had been removed on 11 June 2013, and that the tooth socket was healing well.

88. After not receiving his Voltaren, Mr E queried this with health staff and was advised to submit a chit. The chit received by the Health Service from Mr E on 31 July 2013, states:

> "I have to see the doctor to have Voltaren prescribed properly to me because my jaw is still [painful] from the tooth removal on the 11 June, thanks."

89. Mr E was subsequently advised that he was already prescribed voltaren. In Mr E's progress notes the following is recorded:

> "Got him to see the dentist yesterday, to sort out his fillings which he complained about a couple of days ago. [S]aw him this afternoon to ask him what exactly he wanted the doctor to do regarding the Voltaren, he said he wanted it prescribed once a day (at bed time) which is down on his script. No further action taken."

90. However, Mr E did not receive his voltaren medication as prescribed. His prescription for voltaren ended on 14 August 2013.

91. There are no progress notes relating to Mr E between 31 July 2013 and 18 August 2013.

92. On 18 August 2013, it is recorded in Mr E's progress notes that a further chit was received from Mr E, stating:

> "Could I please see the doctor to get my night meds increased as I am not sleeping at all well and can I please be prescribed Voltaren again for my jaw which is still giving me grief from tooth removal."

93. It is documented that Mr E was referred to a doctor for review of his Voltaren that same day. Mr E continued to experience pain relating to the

procedure. However, there are no further notes relating to Mr E's dental concerns after 18 August 2013, including whether he saw a doctor following the referral.

Medication Received

94. Mr E did not receive any of his prescribed Naproxen medication.

95. Mr E received his first dose of Voltaren and potentially a second dose on 26 July 2016 where his clinical notes record him receiving "analgesia as charted", but nothing after those administrations until his prescription ended.

EXPERT ADVICE RECEIVED

96. RN Dawn Carey, has provided expert advice in relation to the care provided to Mr E whilst he was a prisoner at Auckland Prison.

97. RN Carey reviewed Mr E's clinical records, the prescribed analgesia and its administration post molar extraction and focused on the reports of pain and treatment for pain post-extraction.

98. RN Carey advised that, relevantly:

a. The Doctor had prescribed analgesia based on his assessment of Mr E and considered him to be in significant enough pain to warrant analgesia X times a day on each occasion.

b. She would expect the prescription to be followed as there is an expectation by the Doctor that Mr E would be receiving as much analgesia as is prescribed.

c. The submitted MAR demonstrated a level of incompetence to a standard that is professionally embarrassing.

d. The documentation has fallen below required standards.

e. The nursing care in relation to safe medical administration was a severe departure from the expected standards.

BREACH – RIGHT 4(1) OF THE CODE

99. The defendant accepts that its actions as particularised in the statement of claim, and described in this summary of facts, amount to a breach of right 4(1) of the Code.

100. The defendant accepts that the care provided by the Department of Corrections to Mr E was below an acceptable standard. This includes:

a. Failing to appropriately respond to Mr E's requests for pain relief and/or medical assessments;

b. Failing to administer prescribed medication;

c. Failing to assess Mr E's condition and/or current clinical presentation prior to administering non-prescription medication;

d. Failing to reassess Mr E's need for a soft food diet after the initial three day diet had expired.

101. For the removal of doubt the defendant accepts that, on the basis of the above facts, the statement of claim has established that the defendant has failed to ensure that Mr E was provided services with reasonable care and skill as set out in the defendant's own policy and procedure documents including the "Health Services Health Care Pathway" and the "Health Services Medicines Policy and Procedure"

Nicola Wills
Director of Proceedings

Date:

I, _____ on behalf of the defendant agree that the facts set out in this Summary of Facts are true and correct.

On behalf of the
Department of Corrections

Date: