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

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

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2021] NZHRRT 33**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 035/2021
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**CHIEF EXECUTIVE, DEPARTMENT OF CORRECTIONS**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms J Foster, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms SB Isaacs, Member

REPRESENTATION:
Mr G Robins, Acting Director of Proceedings
Mr M Freedman, Principal Solicitor
Department of Corrections for defendant

DATE OF HEARING: **Heard on the Papers**

DATE OF DECISION: **20 July 2021**

(REDACTED) DECISION OF TRIBUNAL[1]

---

[1] [This decision is to be cited as *Director of Proceedings v Chief Executive, Department of Corrections* [2021] NZHRRT 33. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 8 June 2021.

[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 21 May 2021;

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

[3] In the Consent Memorandum the parties request that the Tribunal exercises its jurisdiction and issues:

> 2. (a) A declaration pursuant to s 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 (Mr A).

[4] Having perused the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached 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] 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 of any other details which might lead to the identification of the aggrieved person (Mr A). There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms J Foster	**Dr SJ Hickey MNZM**	**Ms SB Isaacs**
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 ……

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT /21

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **THE DIRECTOR OF PROCEEDINGS**

Plaintiff

AND **CHIEF EXECUTIVE, DEPARTMENT OF CORRECTIONS**

Defendant

[REDACTED] AGREED SUMMARY OF FACTS

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

Greg Robins – Acting 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 Mr A.
3. At all material times the defendant was the Chief Executive of the Department of Corrections (a government department) exercising statutory functions conferred under the Corrections Act 2004. Under section 75 of the Corrections Act 2004, the defendant is required to provide people in prison with "medical treatment that is reasonably necessary", and 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". Every prison has a health service which employs and contracts health practitioners to provide health and disability services to people in prison. The defendant is a health care and disability services provider within the meaning of section 3 of the Act, and at all material times was providing health services to Mr A within the meaning of section 2 of the Act.
4. On 31 March 2017 the Health and Disability Advocacy Service referred Mr A's complaint about the services provided to him by the defendant, to the Health and Disability Commissioner ("HDC").
5. On 6 May 2020 the Deputy Health and Disability Commissioner finalised his opinion that the defendant had breached Mr A's rights under the Health and Disability Commissioner (Code of Health and Disability Services 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. "The Prison" where Mr A was at all material times, has a health service which is staffed by registered nurses employed by the defendant. In addition, the defendant contracts with doctors to provide medical care, and a pharmacy ("the Pharmacy") to provide pharmacy services to the Prison.

7. At the material time in question, the Prison's health staff would order medication from the Pharmacy by faxing or emailing the Pharmacy a patient's medication chart which had been signed by a prison doctor. The medication chart would be accompanied by an order form which specified the medications to be dispensed. The Pharmacy would then generate a prescription from those details for the prescriber to sign. The Pharmacy would then send the processed medications to the prison nurses so that they could be checked against the charts before being administered to patients.

8. Mr A became a patient of the Prison's health service in April 2016. At the time Mr A had a history of chronic pancreatitis[1] and gout.[2] His regular medications included allopurinol[3] and colchicine.[4]

Relevant policies and procedures in place at the time of events

9. The defendant's 'Health Services Health Care Pathway' policy (dated 2008, reviewed 2015)'[5] stated that all patients who had health needs that were significant and/or complex in nature must have a Treatment Plan, and patients who did not need a Treatment Plan must have a plan of care if they needed clinical interventions.

---

[1] Inflammation of the pancreas.
[2] A metabolic disease marked by a painful inflammation of the joints, deposits of urates in and around the joints, and usually an excessive amount of uric acid in the blood.
[3] A medication that decreases high blood uric acid levels and is specifically used to prevent gout.
[4] A medication used in the treatment of gout.
[5] Section 10.1: 'Policy on Creating Treatment Plans or a Plan of Care'.

10. The Health Care Pathway policy also provided that when a patient was transferred to a defendant's facility from inpatient admission, then a plan of care must be developed if a treatment plan was not necessary. Plans of care and treatment plans were to be completed in partnership with the patient.

11. In terms of recording prescriptions, the defendant's 'Health Services Medicines Policy and Procedure' (dated 2008, reviewed January 2016)'[6] stated:

    a. All patients receiving medication must have a Health Services approved medication chart.

    b. Prescriptions and medication charts must meet all legislative and professional requirements which include:

        (i) Being legible, indelibly printed, signed, contain the name of the recipient, the medicine dosage, the route, preparation, adequate instructions for use and number of times the medicine may be given.

        (ii) Medication charts must be re-charted by the Medical Officer, if the medication chart is full, illegible, unclear, ambiguous or incomplete.

        (iii) Nurses must present the medication chart to the Medical Officer for re-charting if it is full, illegible, unclear, ambiguous or incomplete.

12. The Prison's 'Health Services Local Operating Manual' in place at the time provided the following procedure for repeat prescriptions and ordering medications:

> **"28-day Cycle Medications**
>
> …
>
> - All medication charts with newly charted medications which need to be blister packed will be faxed to the pharmacy by the nurse on the day when the new medications are prescribed.

[6] Section 6.1.2.

- The pharmacy has records of all the Patient[s] and what blistered medications they are currently on.
- The pharmacy will regenerate prescriptions every four weekly for all long-term medications, until being noted about the stopping date.

…

- Delivered cycle medications and signing sheets will be checked against the current medication charts by the nurses.

…

- Stopping of a medication, dose changing of a medication, Patient transfers and released is noted on the Pharmacy Ordering Sheet and is faxed to the pharmacy on a daily basis to ensure the 28-cycle information is updated daily.

...

Review and Signing of the repeated scripts

- The regenerated scripts will be sent in an envelope to the health centre.
- They are placed in the Health Officer's folder for checking and signing against patient's current medication chart.
- Signed scripts will be returned to the pharmacy.

…"

Mr A's first hospital admission

13. On the morning of 17 June 2016, Mr A became dizzy while mopping in the Prison. He then experienced sudden, sharp chest pain and collapsed, hitting his head on the floor. Mr A lost consciousness for two to three minutes. After Mr A regained consciousness, prison guards noticed that he had weakness and a facial droop on his right side, and slurred speech.

14. Mr A was seen by a prison doctor, who noted that he had right-sided weakness and numbness, and slight right facial droop. The doctor gave Mr A glyceryl trinitrate[7] (GTN) and aspirin.

15. Mr A was admitted to the public hospital. He was diagnosed with a left middle cerebral artery[8] subacute stroke,[9] with secondary diagnoses of type 2 myocardial infarction[10] and triple vessel coronary artery disease.[11]

---

[7] A medication that relaxes the muscles surrounding blood vessels and so helps more blood and oxygen reach the heart.
[8] This artery is one of the three major arteries that supply blood to the brain.
[9] A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain bursts or becomes blocked by a clot.
[10] A heart attack.
[11] A disease where the three main vessels in a person's heart are blocked.

16. On 24 June 2016 the public hospital discharged Mr A back to the Prison. The hospital discharge summary advised Mr A to take aspirin for three weeks and clopidogrel long term. He was given a discharge prescription for a one-month supply of clopidogrel, among other medications. A month's prescription is common practice for discharged patients from hospitals. Hospitals advise patients to follow-up with their GP in a month for further prescriptions and to ensure the patient is assessed.

17. Clopidogrel is an antiplatelet[12] medication used in the prevention of blood clots, heart attack, or stroke. At the time of these events, long-term clopidogrel was accepted first-line treatment for secondary prevention of stroke in patients without atrial fibrillation.[13] The risk of heart attack or stroke is increased if a patient prescribed clopidogrel stops taking it.

June 2016 – prescription transcribing error

18. On 24 June 2016 a prison doctor charted one month of clopidogrel for Mr A (until 24 July 2016), together with long-term aspirin. The doctor had misread the public hospital discharge letter and in error stopped the clopidogrel after a month and carried on with aspirin, when the hospital instructions were to stop the aspirin after a month and continue the clopidogrel.

19. Also on 24 June 2016, prison health staff faxed Mr A's prescription to the Pharmacy, as well as an order form. Shortly after receiving the fax, the Pharmacy received a phone call from the Prison's health service requesting that the prescription from the public hospital be filled urgently. Later that day the Pharmacy dispensed 28 tablets of clopidogrel.

20. On 27 June 2016 Mr A was seen by the prison doctor for a post-discharge check. The doctor noted that Mr A was experiencing no further chest pain,

[12] Platelets are tiny blood cells that help the body form clots to stop bleeding.
[13] Very rapid, uncoordinated contractions of the atria of the heart, resulting in a lack of synchronism between heartbeat and pulse beat.

and the weakness in his face and arm was settling, although the right side of his face was still slightly droopy. The doctor also recorded incorrectly that Mr A was to receive "DAPT[14] 1/12,[15] then aspirin alone".

July 2016 – clopidogrel dispensed

21. On 9 July 2016 the Pharmacy received a faxed medication order form from the Prison health service. Also sent with the order form were the public hospital discharge prescription dated 24 June 2016 and Mr A's medication chart. However, on the medication chart the clopidogrel entry (charted incorrectly as a short-term medication by the prison doctor) had been struck out by hand, with the handwritten annotation: "ERROR crossed out by mistake". The annotation was undated and the writer was not identified. The faxed order form included a note stating that "clopidogrel crossed out on med chart in error" and requesting that the Pharmacy dispense the clopidogrel as per the public hospital prescription.

22. The same day, the Pharmacy dispensed 28 clopidogrel tablets to the Prison for Mr A.

23. The Pharmacy also provided a medication signing sheet to the Prison. Prison health staff subsequently filled in the signing sheet, recording that Mr A was given his medication (including clopidogrel and aspirin) daily during the period 11 July 2016 to 7 August 2016. The signing sheet also included a handwritten note that clopidogrel was "stopped 24/7/16". The annotation was undated and the writer was not identified.

August 2016 - clopidogrel stopped

24. On 1 August 2016 the Pharmacy dispensed medication for Mr A to the Prison health service including 28 tablets of clopidogrel.

---

[14] Dual antiplatelet therapy, i.e. the combination of aspirin with a second antiplatelet medication such as clopidogrel.
[15] For one month.

25. On 5 August 2016 the Pharmacy received a faxed order form from the Prison health service which included a note in relation to Mr A that stated: "clopidogrel 75mg stopped on 24/7/16 THX". The writer of the note is not identified. The medication chart that was sent to the Pharmacy along with this order form was the same medication chart sent to the Pharmacy on 9 July 2016.[16] The Pharmacy advised HDC that the Prison health service did not provide a new medication chart to confirm the stopping of clopidogrel that was requested in the order form.

26. On the same day, the Pharmacy dispensed to the Prison Mr A's medication including aspirin, but no clopidogrel.

September 2016 – clopidogrel not dispensed

27. On 4 September 2016 the Pharmacy dispensed to the Prison Mr A's medication including aspirin, but no clopidogrel.

28. On 14 September 2016 Mr A signed a contract with the defendant that allowed him to self-administer his medication. Under the contract, Mr A was able to hold up to seven days' worth of his medication for self-administration. The contract listed Mr A's medications as including aspirin and clopidogrel. The agreement was also signed by a prison doctor and a registered nurse ("RN") employed by the Prison.

[16] Which included clopidogrel charted as a short-term medication, and also included the striking out of the clopidogrel and the handwritten annotation: "ERROR crossed out by mistake".

Mr A's second hospital admission

29. At 3am on 17 September 2016 Mr A began to experience chest pain. He was seen later that morning by a RN who documented that Mr A was experiencing sharp chest pain on his left side, shortness of breath, and mild dizziness. The RN performed an ECG[17] and recorded that the ECG showed a possible inferior myocardial infarction.[18]

30. The RN contacted a prison doctor, who advised that Mr A should be transferred to the emergency department ("ED").

31. Mr A was admitted to the public hospital and diagnosed with ischaemic heart disease[19] alongside the pre-existing triple vessel coronary artery disease. He underwent percutaneous coronary intervention,[20] and four drug-eluting stents[21] were placed in his heart.

32. Mr A was discharged on 22 September 2016. The public hospital discharge summary advised that Mr A was to "continue both blood thinners (clopidogrel and aspirin) for 12 months followed by aspirin only". The public hospital also provided a discharge prescription for clopidogrel for three months, as well as prescriptions for GTN, aspirin, and atorvastatin.[22]

33. On 23 September 2016 Mr A was seen by a prison doctor who documented that Mr A had been prescribed "clopidogrel for 12/12". The doctor told HDC that he added clopidogrel to Mr A's existing medication chart[23] as a regular medication for a period of one year from 23 September 2016 to 23

---

[17] An electrocardiogram, a medical test that detects heart problems by measuring the electrical energy generated by the heart as it contracts.
[18] A heart attack. An inferior myocardial infarction specifically affects the inferior muscular tissue of the heart.
[19] Ischaemic heart disease is a condition where a waxy substance called plaque builds up inside blood vessels and restricts the normal flow of blood.
[20] Percutaneous coronary intervention (formerly known as angioplasty with stent) is a procedure that uses a narrow tube called a stent to open up blood vessels in the heart that have narrowed as a result of plaque build-up.
[21] A drug-eluting stent has been coated in medicine to prevent the blood vessel from forming scar tissue and closing around the stent.
[22] A statin medication used to lower lipid levels in the blood.
[23] This medication chart still included clopidogrel as a short-term medication (as charted by the initial prison doctor) and the striking out of the clopidogrel with the handwritten annotation: "ERROR crossed out by mistake".

September 2017. The doctor also noted that Mr A was to take aspirin long term.

34. The defendant told HDC that Mr A self-administered clopidogrel between 24 and 30 September 2016. However, this is not recorded on the medication signing sheet.

November – December 2016 – clopidogrel stopped again

35. On 4 October 2016 the Pharmacy dispensed to the Prison health service 28 tablets of clopidogrel for Mr A.

36. On 27 October 2016 the Pharmacy received a faxed order form from the Prison that included the typed annotation: "Clopidogrel 70mg stopped on 23/9/16. Pls send a new whole blister cycle. Needs colchicine in mane[24] pack. Thx." The writer of the note is not identified on the form. The defendant advised HDC that the charted stop date for clopidogrel of 23 September 2017 appeared to have been misread as 23 September 2016.

37. On 3 November 2016 the Pharmacy dispensed to the Prison health service 28 tablets of clopidogrel for Mr A.

38. The medication signing sheet for October 2016 showed lines through the dates 3 October 2016 to 23 October 2016. The medication signing sheet for November 2016 showed lines through the dates 31 October to 27 November 2016. The defendant told HDC that Mr A self-administered clopidogrel during these times, but the signing sheets do not record this. There is also no record of medication administration to Mr A for 1 and 2 October 2016, or for 24 to 30 October 2016.

39. The Pharmacy told HDC that sometime in November 2016, the Pharmacy received a telephone call from someone at the Prison health service informing the Pharmacy that clopidogrel for Mr A had been stopped.

[24] Morning.

40. On 5 December 2016 the Pharmacy dispensed to the Prison health service Mr A's medication including aspirin, but no clopidogrel.

41. On 5 December 2016 a prison RN recorded on Mr A's signing sheet for December 2016: "Awaiting clopidogrel order pharmacy 5/12/17 ordered." The RN was unsure why she dated the note December 2017, when the record was for December 2016. The RN was unable to recall whether she ordered clopidogrel for that cycle from the Pharmacy and, if so, whether the clopidogrel arrived at the Prison. The defendant told HDC that there is no documentation to confirm that clopidogrel was ordered past the end of November 2016.

Mr A's third hospital admission

42. On 7 December 2016 Mr A felt dizzy while in the yard at the Prison. He was seen by a prison doctor, who documented that Mr A was taking clopidogrel and aspirin. The doctor undertook an ECG and noted: "Abnormal ECG — no chest pain" and referred Mr A to the public hospital ED.

43. Mr A was discharged from the public hospital on the same day with a diagnosis of "Presyncope[25] — potentially exacerbated by hot working conditions".

January – February 2017 – clopidogrel not dispensed

44. On 5 January 2017 the Pharmacy dispensed to the Prison health service Mr A's medication including aspirin, but no clopidogrel. The Pharmacy's dispensing records show that a prison doctor signed the prescriptions for the medications.

45. On 14 January 2017 the Pharmacy received a medication chart from the Prison that included clopidogrel as a long-term medication for the period 23 September 2016 to 23 September 2017, as charted by a prison doctor.

[25] Feeling of light-headedness and faintness.

The chart still showed clopidogrel charted as a short-term medication by the initial prison doctor, and included the striking out of clopidogrel and the handwritten annotation that clopidogrel had been crossed out by mistake.

46. On the same day, the Pharmacy dispensed to the Prison health service Mr A's medication including aspirin, but no clopidogrel. The Pharmacy's dispensing records show that a prison doctor signed the prescriptions for these medications.

47. The Pharmacy did not supply clopidogrel to the Prison on 14 January because "[clopidogrel] was not ordered and the pharmacy only supplies medications that are ordered by the nurses at the Health Centre". The Pharmacy also told HDC that "if a medication is missed due to any reason … then the nurses notify [the Pharmacy] immediately and the pharmacy remedies the problem and the missing medication is sent out urgently". The Pharmacy said that this did not happen.

48. On 3 February 2017 the Pharmacy dispensed to the Prison health service Mr A's medication including aspirin, but no clopidogrel. The Pharmacy's dispensing records show that a prison doctor signed the prescriptions for these medications.

49. On 11 February 2017 a prison RN noticed that clopidogrel was missing from Mr A's medication pack. The RN faxed an order form to the Pharmacy to request that clopidogrel be restarted. The RN did not alert her manager or any colleagues that clopidogrel was missing.

Mr A's fourth hospital admission

50. On 21 February 2017 Mr A began to experience chest pain. A prison RN undertook an ECG and noted an inferior myocardial infarction. Mr A was admitted to the public hospital.

51. While Mr A was in the public hospital, a hospital pharmacist noted that Mr A had not received clopidogrel since 3 December 2016. Mr A was discharged from hospital on 22 February 2017 with a diagnosis of chest pain. The public hospital discharge summary noted: "Mr A has been provided with a script for [clopidogrel] (3 months' supply) as he should have been on dual anti platelet therapy until 23/09/2017."

52. The Prison's clinical notes show that a pharmacist from the Pharmacy rang the Prison health service on 22 February 2017 to say that the Pharmacy had received a call from the public hospital asking why Mr A had not received clopidogrel for several months. The clinical notes also record: "Pharmacist [said] they didn't receive any notification that [Mr A] is on clopidogrel. As per the medtech notes and drug chart [a prison doctor] charted clopidogrel on 23/9/2017".[26]

53. Later that day, the Pharmacy received the public hospital prescription for clopidogrel and an order form from the Prison health service requesting urgent delivery of clopidogrel. The Pharmacy dispensed to the Prison 25 tablets of clopidogrel for Mr A.

Mr A's fifth hospital admission

54. On 24 February 2017 Mr A was seen by a prison RN regarding complaints of left-sided chest pain, shortness of breath, and "4 episodes of black outs since this morning". The RN undertook an ECG and noted a possible inferior myocardial infarction, and he was transferred to the public hospital.

[26] This date should read 23/9/2016.

55. A medication history form completed while Mr A was in the public hospital recorded a comment that clopidogrel for Mr A "was last dispensed 03/11/2016 (1 month supply) then stopped in error — medication chart misread by community pharmacy".

56. An angiogram undertaken at the public hospital revealed significant coronary artery disease,[27] and Mr A underwent a balloon angioplasty[28] to his right coronary artery. He was discharged from hospital on 28 February 2017.

Emotional impact on Mr A

57. These events have had an enormous emotional and mental impact on Mr A who, since these events, has found it hard to trust whether he is being treated properly by the Prison health service, and whether he is getting the right medication or not.

Defendant's response to complaint

58. The defendant advises that since these events it has made a number of changes to its health service, both at the Prison and more widely, including the following:

- A new medication filing system was introduced to formalise the system used for tracking patient medication.
- Clinical Governance meetings were established by the Prison Health Services, and a Clinical Governance Group was established to provide assurance and oversight of Health Services across all prison sites in that region;

[27] A condition that reduces the blood flow through the coronary arteries to the heart muscle and typically results in chest pain or heart damage.
[28] A procedure to open narrowed or blocked arteries caused by deposits of plaque.

- A new Local Operating Manual (LOM) was developed to incorporate changes to the model of care and rebuild at the Prison in order to reflect clinical best practice;
- Enhancements were made to the medication administration process to ensure each step is carried out in accordance with the LOM and Medicine Management Policy, in order to ensure greater consistency across the paperwork used as a receipt for medications;
- A new Standard Operating Procedure between the defendant and the Pharmacy was implemented describing all the processes associated with medical management for the Prison, with random quality audits demonstrating good compliance and confirming changes to dispensing processes.

Breach of Right 4(1) of the Code

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

60. The defendant accepts that:

    a. Cessation of Mr A's clopidogrel was a serious oversight that was perpetuated even after being picked up by the public hospital and despite many opportunities to identify and rectify the error.

    b. Its systems and processes failed Mr A on multiple occasions and in multiple ways. There was inadequate communication and documentation, a lack of critical thinking, and poor compliance with policy by multiple providers which contributed to Mr A not receiving his clopidogrel medication as intended. The failures by staff responsible for Mr A's care represented a pattern of poor care and were largely a result of broader systems issues, for which the defendant accepts ultimately it was responsible.

61. In particular, the defendant accepts the failures in delivery of health care to Mr A between June 2016 and March 2017 included the following:

    a. Failure to develop a plan of care for Mr A after any of his public hospital admissions between June 2016 and February 2017 contrary to the defendant's policies and legal requirements.

    b. Failure to educate Mr A about his own health such that he could have recognised the significance of the missing clopidogrel and reported it to health staff.

    c. Contrary to the defendant's policies and legal requirements, Mr A's medication chart was ambiguous and at times illegible and difficult to follow, and the prison nurses failed to present his chart to the prison doctors for replacement.

    d. The signing sheets for Mr A's medications did not record whether Mr A was given medication to self-administer, and there were gaps in the dates covered.

    e. There was a poor standard of communication with the Pharmacy in respect of Mr A's medications.

    f. There were inadequacies in care provided to Mr A by a number of contracted doctors, for which the defendant was ultimately responsible.

62. The defendant accepts that it breached Right 4(1) of the Code by not providing services to Mr A with reasonable care and skill.

_____

Greg Robins
Acting Director of Proceedings

Date:

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

_____

For or on behalf of the defendant

Date: