(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 34**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 033/2021
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]

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[1] [This decision is to be cited as *Director of Proceedings v Chief Executive, Department of Corrections* [2021] NZHRRT 34. 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 Right 4(2) by failing to provide services to the aggrieved person that comply with legal, professional, ethical and other relevant standards; and
>
> (b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter (Ms 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:

[6.1.1] Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill;

[6.1.2] Right 4(2) by failing to provide services to the aggrieved person that comply with legal, professional, ethical and other relevant standards.

[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 (Ms 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 20 July 2021

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 Ms 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. The defendant is a health care and disability services provider within the meaning of sections 2 and 3 of the Act, and at all material times was providing health and disability services to Ms A within the meaning of section 2 of the Act.
4. In December 2016, Ms A's partner complained to the Health and Disability Commissioner ("HDC") about the services provided to Ms A by the defendant.
5. In November 2019 the Deputy HDC finalised his opinion that the defendant had breached Ms 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. 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 healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of healthcare available to the public". People in prison do 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 medication or to a general practitioner ("GP"). They are entirely reliant on the defendant's staff to assess, evaluate, monitor, and treat them appropriately.

The Department of Corrections ("Corrections") Facility

7. At the material time in question, the Corrections Facility had a health centre which was staffed by registered nurses who were employed by the defendant and who were on site from 7am until 10pm daily. Outside of these times, a nurse was available

on call. In addition, the defendant contracted doctors to provide GP services for 16 hours each week, spread over four days.

8. All new arrivals at the Corrections Facility were required to undergo an initial health assessment ("IHA"). Following the IHA, prisoners could request access to non-urgent health services verbally or by submitting a Health Request Form (also known as a "health chit"). If a prisoner wished to request an appointment with the health service, she obtained a health chit from the custodial officer, completed the chit, and placed it in a locked chit box. The defendant had a policy which required health chits to be cleared daily and actioned according to clinical need.
9. The morning shift nurse collected the chits from the locked chit box, triaged them, and entered the details into Medtech.[1] The nurse then created a clinic appointment for the prisoner. The prisoner was first assessed by a registered nurse ("RN") to determine whether an appointment with a doctor or other health professional was required. If so, an appointment was made. If a patient was triaged as non-urgent, the patient was required to be seen within seven days.
10. Prisoners with multiple co-morbidities were housed in the care unit and visited by a dedicated RN, as moving the prisoners to and from the medical clinic would require three custodial officers to escort them.
11. All custodial staff were trained in first aid and tasked with dispensing paracetamol (Panadol) if requested by prisoners, particularly after hours when there was no RN on site. Custodial staff were briefed on the safe administration of Panadol, to be given as required for pain relief, no more than four hourly, and up to a maximum of 4g daily. The custodial staff were required to complete a Panadol log sheet when they administered Panadol to a prisoner, and the morning nurses collected the Panadol log sheets and entered the details into the Medtech daily record.

Ms A's admission

12. On 19 October 2016 Ms A was remanded to the Corrections Facility until her next court appearance in January 2017. Prior to incarceration, Ms A had a history of chest infections and asthma, and had previously undergone a thoracotomy[2] and

[1] An electronic medical records system.
[2] A surgical procedure to gain access into the pleural space of the chest.

decortication.[3] She was on a number of medications and had multiple co-morbidities including type 2 diabetes, a painful lipoma[4] on her back (for which she was on a surgical waiting list), a prolapsed disc, pain in her lower back and right leg, and numbness of the toes on her right foot. She was able to mobilise with crutches for short distances, but otherwise required a wheelchair. Ms A was also morbidly obese with a BMI of 53.9.

Initial assessment

13. At her Reception Health Triage appointment, Ms A discussed her health issues with the receiving RN and signed the "Consent to receive general health and dental services" form, and the "GP transfer request" form, consenting to the defendant uplifting her medical records from her GP.

14. Ms A had brought some of her medications with her in blister packs.[5] The Reception Health Triage Form states that Ms A was on the following medications: Losec,[6] gabapentin,[7] OxyNorm,[8] OxyContin,[9] diazepam,[10] quinapril,[11] and a Ventolin inhaler for asthma. Ms A was also taking metformin[12] and Lorstat[13] but this was not documented at that time. Ms A told the nurse that she was also on Novomix[14] and Novorapid[15] for diabetes, but had none with her on admission.

15. The receiving RN advised Ms A that her medical notes would be requested from her current GP, and that the medical officer would be asked to chart her medication once her medical notes had been received. The nurse subsequently requested Ms A's medical records from her medical centre, and booked Ms A for an IHA with a nurse, and for an appointment with the medical officer, both for the following day.

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[3] Surgical removal of the surface layer of the lung.
[4] A growth of fatty tissue that develops under the skin.
[5] Blister packs are prepared by a pharmacist with the medications for each day packed in a tear strip. The medication name and instructions are printed on each pottle.
[6] Medication used to reduce the amount of acid produced in the stomach.
[7] An anticonvulsant medication.
[8] An opioid medication containing oxycodone used to relieve moderate to severe pain.
[9] An opioid medication used to relieve moderate to severe pain. OxyContin is a longer acting preparation of oxycodone than OxyNorm.
[10] An anti-anxiety medication.
[11] Medication used to treat high blood pressure, heart failure, and diabetic kidney disease.
[12] Medication used to treat type 2 diabetes.
[13] Medication used to treat high cholesterol.
[14] A mixture of rapid- and longer-acting insulin used to treat diabetes mellitus.
[15] Rapid-acting insulin.

16. Because of her clinical status, Ms A was housed in the care unit, which was attended by dedicated nursing staff performing regular daily observations.
17. On 20 October 2016 Ms A saw a different RN for the IHA, which included a questionnaire that covered a general health assessment. The RN also recorded the following:
    - "Stated that she was in pain — gets anxious
    - Palm sized lump on her back was soft and tender to touch
    - May need a shower chair as pt [patient] uses crutches/wheelchair to mobilise."
18. Ms A advised the RN that she had problems with mobility owing to back pain, and used aids such as crutches and a wheelchair and, at times, needed assistance with activities of daily living.
19. Generally, when the health team identified that a prisoner had complex health needs, the Health Centre Manager or team leader would assign a nurse to initiate a treatment plan. However, this RN understood her role was to complete the IHA questionnaire rather than to assess Ms A or prepare a treatment plan for her.

Medical records and pain medication

20. On 20 October 2016 the original receiving nurse was asked to contact Ms A's GP medical centre because Ms A's medical notes had not arrived. The defendant's contracted GP, Dr B, was waiting for the GP notes so that she could prescribe Ms A's medications. Dr B said that the blister packs had not been mentioned, and that if Dr B had been aware of them she could have charted the medications, because a prison doctor can write a new prescription based on current blister packs.
21. On 20 October 2016, a different RN recorded that she had contacted Ms A's medical centre and asked for a list of medications to be faxed through urgently in order for the medical officer to chart insulin for Ms A. The RN noted that no fax confirmation had been received by 12.30pm that day.
22. The records of Ms A's medical centre show that on 20 October 2016, it received a phone call from the original receiving RN, who stated that she required Ms A's medical notes. The medical centre records state that the RN said she would send a fax (with the signed transfer request form).

23. On 20 October 2016 the receiving RN recorded that she had called the medical centre requesting Ms A's medical notes, and that the person who replied stated that she had not received any telephone calls or faxes requesting the medical notes. The receiving nurse recorded that she sent a fax at 2.50pm requesting the medical notes.
24. On 21 October 2016 Dr B telephoned Ms A's medical centre several times, and says each time she was connected to an answerphone. Dr B recalls that she and other prison health staff made several attempts to obtain the medical notes.
25. Ms A's blister packs ran out on 22 October 2016. The regular non-packaged medicine administration record shows that Ms A's Oxycodone, OxyNorm, and diazepam ceased on 22 October 2016 but her other medications were continued.
26. On 23 October 2016, a nurse recorded that Ms A became upset when told that her pain relief medications in her blister pack had run out and, because the Corrections Facility had not received her GP notes, the doctor was unable to chart her pain relief medications. Ms A told the RN that the lack of medication would cause her to "get the sweats and have to be admitted to hospital".
27. On 24 October 2016, a RN recorded that she had seen Ms A in the care unit at 9am during a scheduled medication round. Ms A advised that she had had a fall overnight. Ms A said that she had been unable to void or open her bowels since then, and had no feeling in her lower body. The RN entered Ms A's room to inspect and palpate Ms A. The nurse pinched one of Ms A's toes, following which Ms A flinched immediately, which indicated to the RN that Ms A did in fact have feeling in her toes. The nurse left to complete her medication round. Ms A said that during this incident she was left on the floor for several hours, lost control of her bowels, did not recall the nurse doing a pinch test, and crawled across the floor to get to the toilet.
28. The RN recalled testing Ms A's blood sugar levels ("BSLs") and as they were stable, she was not too concerned. When she returned to the care unit later that morning, she saw Ms A in the day room with other women, talking and laughing, with no signs of pain or discomfort. As Ms A did not report any further concerns, the RN saw no need to investigate further.
29. On 25 October 2016, Dr B recorded: "Rang [Ms A's medical centre] … re medical notes — left message as they are always busy." Dr B said that she did not receive a

reply to the message she had left. However, the medical centre's notes state that on 25 October 2016 a telephone call was received from Dr B asking for Ms A's medical records, and Dr B was advised that the fax from the prison still had not arrived, and that once it had been received, the notes would be faxed back. The medical centre records state that later that day, a fax and the consent form were received from the Corrections Facility, and the medical centre faxed through the notes to the Corrections Facility, as requested. By then it had been six days since Ms A had been incarcerated. On receipt of the notes, Dr B prescribed Ms A's medications, other than insulin.

Diabetes management

30. Ms A arrived at the Corrections Facility with no insulin, and at that time there was no documentation from her GP to confirm her medications (for example, the insulin doses). Ms A was on metformin and Dr B decided not to prescribe Ms A further insulin on the basis that metformin along with a diabetic diet were sufficient to maintain her metabolic control. Dr B advised that while Ms A was off the insulin she was monitored, and it was noticed that her BSLs were very well controlled, and so a decision was made to stop the insulin. Dr B said that Ms A's BSLs varied from 5.0 to 8.1 mmol/L,[16] and that excellent control is considered to be between 4.0 and 8.0 mmol/L.

31. Dr B advised that if Ms A had been administered her usual large dose of insulin and then been locked up for 15 hours, this would have been a risk, because the custodial officers would have had no way of knowing whether she was asleep or in a coma when they carried out the 15-minute observations.

32. Dr B stated that despite Ms A having been documented as an IDDM (insulin-dependent diabetic), Dr B considered that Ms A was a NIDDM (non-insulin-dependent diabetic) because she was able to maintain low BSLs. Dr B said that in prison, Ms A was on a diabetic diet, and that it was not uncommon to stop prescribing NIDDM patients insulin when their circumstances changed (i.e. when their diet changed). Dr B stated that it was far safer not to give Ms A insulin if her

[16] Ms A's BSLs were documented as being 5.5 and 5.8 mmol/L on 22 October 2016, 8.3 mmol/L on 23 October 2016, 7.8 mmol/L on 24 October 2016, and 8.6 mmol/L on 25 October 2016.

BSLs were to remain on the low side, as there were no nursing staff at the prison overnight, and they were unaware of Ms A's ability to respond and correct hypoglycaemia. Dr B said that the Medtech documentation on 26 and 27 October 2016 shows that Ms A was informed her BSLs were low enough to stop the insulin at that time, and that she agreed to the decision.

33. Dr B stated that if Ms A had been an IDDM, it would have been critical that she have her insulin, and she would have been put on an emergency protocol (a sliding scale of insulin depending on her BSLs) until her GP notes were received.
34. Dr B never saw Ms A in person during this time. However, Dr B stated that her management of Ms A's diabetes was no different than it would have been with a face-to-face consultation with Ms A.
35. On 26 October 2016, Ms A's BSL was 7.5 mmol/L. On 27 October, her BSL was 9.5 mmol/L. On 29 October it was 12.4 mmol/L, and on 30 October it was 12.9 mmol/L. There is no further record of Ms A's BSL until 17 November 2016, when it was 12.4 mmol/L, and the following day it was 11.2 mmol/L. No further BSLs were recorded. There is no record of any action being taken by clinical staff in relation to the increased BSLs, and no record that the increased BSLs were brought to Dr B's attention. Ms A said that she had good diabetes control prior to her admission to the Corrections Facility, but that she was refused insulin and that she was given a high carbohydrate diet in the Corrections Facility.

Increasing back pain

36. Ms A was administered OxyNorm from 26 October to 30 October 2016. On 26 October 2016, it was recorded that Ms A was feeling much better because her pain relief medication had been charted.
37. The medication charts required completion of the full name and initial of the signatory. However, most either do not contain the full name of the health professional, or the name is illegible.
38. On 15 November 2016 a RN assessed Ms A and did not have any concerns. She recorded "continue monitoring" by the custodial officers. She also picked up the Panadol logs and entered them into Medtech, recording that at 12.37am, 6.44pm, and 9.49pm on 14 November 2016, and at 10.21pm on 15 November 2016, custodial

officers administered Ms A Panadol for back pain. The dose of Panadol given was not recorded.

39. On 16 November 2016, a RN saw Ms A at 9.08am during the medication round, and Ms A said that the pain in her back was getting worse. The nurse's clinical judgement was that Ms A's presentation was generally fine, despite her verbalised report, and the nurse did not consider it necessary to complete any further assessment at the time. Ms A was independent with her activities of daily living, had a pleasant mood, and was conversing and laughing with others. However, the nurse booked Ms A for an appointment with the medical officer on 21 November 2016 (the next available date) so that her worsening pain could be reviewed.
40. A nurse on shift documented that at 6.52am and 4.30pm on 21 November 2016, and at 3am, 7.45am, 6.07pm, and 11.57pm on 22 November, the custodial officers gave Ms A Panadol for back pain, but the dose given was not recorded.
41. Dr B was asked to see Ms A about her painful lipoma, but when Dr B went to the care unit on 25 November 2016 she was unable to see Ms A. Dr B said that Ms A was known to the DHB pain clinic and, according to her clinical notes, Ms A was already meant to have been withdrawn from the opiate medication. Dr B said that therefore it would have been wrong to increase Ms A's OxyNorm or OxyContin, and so she prescribed Ibuprofen,[17] as there was no record that Ms A was unable to take it.
42. The clinical records record that Ms A was administered Panadol for back pain at 11.09am on 24 November, 11.30am and 4.10pm on 26 November, and at 2.45pm on 28 November 2016. There is no documented assessment of the effectiveness of the pain relief or follow-up pain assessment. The dose of Panadol given was not recorded.
43. On 30 November 2016, Ms A completed a health chit stating that on a few occasions she had not been given her metformin or her controlled pain relief on time, that drugs had been charted and given to her without her knowledge, and that she had not been given her insulin medication since she had been in prison and, as a result, her blood sugar results had been high.

[17] Ibuprofen is used to relieve pain and reduce inflammation.

44. On 1 December 2016, Ms A refused the ibuprofen, and on 4 December 2016 she complained that she found out she had been charted ibuprofen only when she developed gastric upset and night sweats. She signed a refusal form for ibuprofen that day.

Breathing difficulties

45. At approximately 7.50pm on 13 December 2016 the nurse on shift was contacted and told that Ms A was having problems breathing.

46. The nurse stopped the medication round so that she could attend to Ms A. When Ms A arrived at the health clinic, she was tearful, had very fast, shallow breathing, and said that she had pain when lying on her right side. Ms A said that the lump on her back hurt and was causing her breathing difficulties. The nurse auscultated Ms A's chest and lungs but did not document this. She noted that Ms A was not guarding her right side and, when palpated, the reaction was delayed.

47. The nurse gave Ms A salbutamol/Asthalin 2.5ml/5mg via a nebuliser,[18] following which Ms A's oxygen saturations seemed normal at 98%, and her peak flow reading[19] was average. The nurse said that she telephoned Dr B and informed her of Ms A's condition. Dr B instructed that Ms A was to continue to use her inhaler with the spacer, and was to be put on the list to see Dr B when she was next on duty.

48. At approximately 8.45pm, the escort officer and the nurse took Ms A back to her cell. Ms A was calm, with no signs of breathlessness, and was speaking in full sentences. She was advised to ask to see the on-call nurse if she had any further concerns and the nurse then completed the medication round.

49. On 14 December 2016 a nurse on the morning shift was doing the medication round when she received a health chit from Ms A requesting an appointment. The chit stated: "Finding it very hard to breathe and lower back pain increasing. Coughing up yellow [phlegm] at my chest & leaves me with a bloody aftertaste in my mouth …". After completing the medication round the nurse triaged the health chit. At that time she noted that Ms A was already on the 15 December 2016 nurses' clinic list at

[18] A nebuliser is a machine that converts liquid medication into a fine mist, which is breathed in through a mask or mouthpiece so that medication is able to reach the lungs.

[19] Peak flow is a measurement of how fast a person can blow air out of the lungs. It shows how wide the airways are at the time of taking the test. A normal rate depends on the person's gender, age, and height. For a 43-year-old woman it varies from 410–450.

12.15pm, and the doctor's clinic list at 2.00pm. The nurse documented, "already booked for 2", rather than recording that Ms A was booked to see the doctor at 2.00pm the following day. The nurse did not assess Ms A or have any discussions with her, as she considered that Ms A could wait until the next day to be seen by the nurse and doctor. The nurse discussed Ms A at handover with the nurse on the afternoon shift.

50. On 14 December 2016 Ms A presented for her medications at 3.30pm and appeared to be very short of breath and wheezy, and had audible dyspnoea (difficulty breathing). Ms A had trouble completing sentences. On auscultation, both Ms A's upper and lower lung fields had crackles and a loud wheeze. Ms A's peak flow reading was 175, but she found it difficult to complete as she kept coughing with the effort and was unable to complete three readings. The nurse assessed Ms A but did not complete palpation and percussion as she "did not have knowledge of what was expected to be palpated for wheezing/crackling lungs. On reflection, [she] could have percussed Ms A's lung field." The nurse started Ms A on the antibiotic amoxicillin, as per the defendant's standing order.[20] Between 3.30pm and 8.45pm, Ms A did not inform any custodial officers or health staff that her symptoms were deteriorating, and did not ask to be assessed again.

51. At approximately 8.45pm, the nurse arrived at Ms A's unit with the night medications. When the custodial officers opened the cell door, Ms A was lying flat on her back in her bed and holding/guarding her left lung area. Ms A said that she had 8/10 pain with breathing. On inspection the nurse noted that Ms A's whole body was involuntarily shaking and she was very diaphoretic.[21] The nurse asked the custodial officers to bring Ms A to the medical clinic for further assessment, but was told that this was not practicable as normally moving her was time consuming, and it would take further time to do so as she was unwell. The nurse then telephoned Dr B, who told her to transport Ms A to hospital via ambulance as an emergency.

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[20] A written instruction issued by a medical practitioner, dentist, nurse practitioner, or optometrist. It authorises a specified person or class of people (eg, paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs. The intention is for standing orders to be used to improve patients' timely access to medicines — for example, by authorising a paramedic in an emergency or a registered nurse in a primary healthcare setting.

[21] Perspiring.

Middlemore Hospital

52. On 14 December 2016 Ms A was admitted to Middlemore Hospital and diagnosed with a viral exacerbation of her asthma. She was treated with antibiotics (augmentin and roxythromycin), a corticosteroid (prednisone), and salbutamol nebulisers. Subsequently she was weaned off salbutamol nebulisers to salbutamol via a spacer.
53. Ms A was discharged on 22 December 2016.

Corrections policies

54. Corrections' "Medicines Management Policy" (October 2016) states that patients who report having been prescribed medicines prior to coming to prison must be prioritised for a consultation with a prescriber. The RN is responsible for accessing the patient's medical records before the patient is assessed by the prescriber.
55. The "Medicines Management Policy" states: "The patient will receive adequate information to enable them to make an informed decision about the care they receive … The patient has the right to refuse treatment."
56. Corrections' "Health Care Pathway Policy/Procedure" (reviewed in October 2015) provides guidance to Health Services staff for the delivery of healthcare services at each stage of imprisonment. This policy states that all people in prison who have needs that are significant and/or complex in nature must have a treatment plan. It states that people in prison who do not need a treatment plan must have a plan of care if they need clinical interventions.
57. The "Health Care Pathway Policy/Procedure" also specifies that health assessments will be clinical assessments that are "appropriate to clinical presentations, according to current good practice, and provided in a timely manner", and the plan of healthcare interventions should then be matched with the assessed needs.

Defendant's response to complaint

58. Since these events the defendant has made a number of significant changes to its health service at the Corrections Facility, including the following:

    - An additional full-time clinical quality assurance advisor was appointed.
    - A new role of practice leader was developed, and two Clinical Quality Assurance Advisers were made available to support and strengthen clinical practice.
    - Additional full-time equivalent registered nurses were employed.
    - Medical officer hours were increased from 16 to 20 hours per week.

- A new contract was put in place for additional GP support when a facility-contracted medical officer is not on site.
- A new contract was put in place with a local pharmacy for medication to be provided immediately following any external additional GP support.
- The region established a regional clinical governance group to provide assurance and oversight of health services across the region.
- Strengthening of clinical practice continues to occur through regular documentation audits.
- All standing orders except for those associated with emergencies were withdrawn in May 2017. Standing orders training has been in place since that date.
- The local operating manual was reviewed and updated.
- A new local operating manual process for accessing and reviewing GP notes was put in place.
- The health care team at the Corrections Facility was introduced to the New Zealand Formulary[22] and HealthPathways[23] and encouraged to use both as a day-to-day clinical resource.
- Timely responses and plans were put in place to address any noted practice deficits as they arise.
- One of the two regional clinical quality assurance advisors was on site two days a week from October 2017 to January 2018 to provide additional support to the team with their clinical practice.
- An external consultant was employed on a short-term contract to implement a team building programme aimed at strengthening the Health Centre culture.
- A new permanent Health Centre Manager has been appointed, along with a Nurse Practitioner.
- A two-day Comprehensive History and Physical Assessment Workshop was delivered in May and June 2019 to all nurses at the Corrections Facility.
- A Clinical Assessment Red Flag Tool has been developed to aid decision making for follow up and determine if follow up is via a Medical Officer or when an emergency department is required.
- A review of Panadol Administration was undertaken in June 2020 by a Senior Adviser from the National Office Health Quality and Practice Team. This included working jointly with custodial services to strengthen the process for access to Panadol, reporting and recording requirements, including a requirement to specifically alert health services staff when a patient has had a third dose of panadol within a 24 hour period. A new policy has been developed for the Prison Operations Manual, with amendments planned for the Medication Management Policy which is currently being reviewed.

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[22] The New Zealand Formulary is an independent resource for health professionals, with clinically validated medicines information and guidance on best practice so that safe and effective medicines can be selected for patients.

[23] HealthPathways is web-based information portal that supports primary care clinicians to plan patient care through primary, community, and secondary healthcare systems. It is like a "care map", so that all members of a healthcare team — whether they work in a hospital or the community — can be on the same page when it comes to looking after a particular person.

- A consultation process was undertaken in order to strengthen the leadership and management of health services across Corrections. This review included a number of new appointments including a Chief Medical Adviser, Chief Māori Health Adviser, Chief Nurse/National Operations Director, along with four Regional Operations Directors (RODs) to supplement the existing Regional Clinical Director in the regions and Manager Health Quality and Practice in National Office. This aligns with a new reporting framework where audit results, patient complaints, clinical incidents/adverse events and key performance indicators are reviewed. There is monthly reporting between the RODs and the Corrections Health Leadership Team and Health Services Strategic Leadership Team.
- A National Audit Programme was introduced in 2020 with a focus on ensuring the appropriate systems are in place and policies and procedures are adhered to across all correctional facilities. National Office senior advisers maintain oversight over the audits, collate and analyse data as well as ensuring appropriate corrective actions/improvements are implemented.
- Medication Management and Medical Care has been identified as a critical Health and Safety risk for Corrections. A comprehensive programme is in place to improve the management of medications including looking to the use of electronic prescribing and the national electronic prescription service by the Ministry of Health which will provide access to prescribing information that is shared by community pharmacies and district health boards. A Medication Competency framework is in development and will include regular observation of nurse practice to ensure the safe administration of medications. Corrections is currently exploring options to update the current patient management system (MedTech) and the implementation of an electronic medication administration chart (drug chart) which will ensure all prescribed medications are clearly recorded.

59. The defendant has acknowledged that it did not meet the accepted standard of care in relation to the assessment, management, and documentation of Ms A's respiratory symptoms.

60. The defendant has accepted that in this case there was a lack of comprehensive pain assessments, inadequate documentation in relation to recording the results of any pain assessments, and a lack of formally documented plans of care. It has also accepted that the Panadol log signing sheet was potentially confusing with regard to the number of doses custodial staff gave the patient.

61. The defendant has accepted that at the time of these events there was an inadequate process for obtaining medical notes for people newly arrived to prison, and that regular medications were not being prescribed within an appropriate time frame.

An action plan was developed to improve the processes. The procedure for managing new arrivals was reviewed and updated, training was provided to the health team on the new procedure, and monitoring of compliance was undertaken.

62. With regard to the management of Ms A's diabetes, the defendant has accepted that the communication between the health team and Ms A did not meet the required standard. Further, the defendant has acknowledged the clinical documentation did not, in many instances, meet the accepted standard, and that there was little evidence in the documentation of the evaluation of treatments recommended and/or the interventions undertaken. The defendant has recognised the importance of careful, considered, and accurate documentation, and advised it is committed to high-quality comprehensive communication and documentation of all patient care.
63. The defendant also advised that a series of documentation audits were undertaken at the Corrections Facility in 2017, and any registered nurses who did not meet the required standard were provided with coaching plans to help to support their practice. In addition, there are now two new GPs at the Corrections Facility, and the Health Centre manager has provided orientation to the medical officer role and established clear expectations with regard to documentation.
64. The defendant has accepted the deficits in health care service delivery at the Corrections Facility at the time of this complaint and advised that significant efforts were made (and continue to be made) to undertake the necessary improvements in clinical practice and to ensure that the health service delivery at the Corrections Facility is both appropriate and meets the standard required. The clinical practice improvements, progress and gains made will be maintained and sustained through the continuous quality improvement framework provided by the Corrections Facility Health Centre Action Plan and supported through monitoring and evaluating assurance processes via the Region Clinical Governance Group.
65. Following these events, Ms A was allocated a primary nurse to oversee and update her comprehensive treatment plan for diabetes management, pain management, and mobility support. The Health Centre manager followed up with the local DHB for dietician advice and support for Ms A, and a medical officer was scheduled to see Ms A on a three-monthly basis for regular assessments of her long-term conditions.

Expert advice

66. Registered nurse Barb Cornor[24] provided expert advice to the Deputy HDC and advised that although there are difficulties and barriers when working in a prison, "[t]his should not concede to any deviance from the legal, professional or ethical requirements and/or conduct of a health professional. The prisoner with health issues remains a person with health issues, whatever their reason for incarceration."

Care planning and evaluation

67. Corrections' "Health Care Pathway Policy/Procedure" states that all people in prison who have needs that are significant and/or complex in nature must have a treatment plan. RN Cornor advised that Ms A did not have the full health assessments required when Ms A arrived at the Corrections Facility, following her fall on 24 October 2016, following the stopping of her insulin, and when her respiratory condition was deteriorating. As there were a number of staff providing services to Ms A, effective planning was essential in order to achieve continuity of care.

68. RN Cornor advised that clinical staff should have developed plans with Ms A in relation to ceasing her insulin, indications for deterioration of any of her health conditions, her mobility, and lifestyle changes for her type 2 diabetes. RN Cornor said that the plans of care for Ms A were limited, and only documented in response to an incident, or not documented at all.

69. When Ms A's condition deteriorated, the nurses contacted Dr B on 13 and 15 December 2016. However, there was no formal plan of care documented following the calls, and no follow-up by Dr B.

Medication management

70. RN Cornor advised that on Ms A's admission there was a missed opportunity to write a new prescription based on her current blister packs, to provide Ms A with the pain relief medication she required. Ms A was also not prioritised for a consultation with a prescriber, as required by Corrections' "Medicines Management Policy".

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[24] RN Cornor has a Masters degree in nursing with six years' previous experience as a health manager with the Department of Corrections. She was also involved in the development of Corrections' health policy and procedure.

71. RN Cornor advised that during the four days Ms A was without her usual pain relief medication, she was at risk of withdrawal symptoms resulting from not taking the narcotics she was prescribed regularly, and would have experienced increased pain. RN Cornor noted that the lack of pain relief and any possible withdrawal effects were not factored into Ms A's care or treatment during this period. RN Cornor advised that Ms A was put at high risk during this period. The Deputy HDC's in-house GP advisor similarly advised that the nature and dosages of the medication Ms A brought with her to prison suggested it would have been clinically unwise and possibly harmful to stop them suddenly (particularly the opiates). RN Cornor considered that the delivery and adequacy of pain relief for Ms A was a departure from accepted practice.
72. RN Cornor advised that custodial staff administered several doses of Panadol to Ms A in November 2016. The doses of Panadol given were not documented in Ms A's clinical records. Ms A's ongoing pain was not followed up with an assessment of the effectiveness of the Panadol to relieve the type of pain she was experiencing.

Diabetes management

73. Between 29 October and 17 November 2016, Ms A's blood sugar levels were taken four times, and ranged between 11.2 mmol/L and 12.4 mmol/L. These readings were higher than her initial BSL readings from 22 to 27 October 2016, which ranged from 5.3 mmol/L to 9.5 mmol/L. No action was taken by clinical staff to reassess Ms A's insulin requirements in light of her increased BSLs.

Respiratory assessments

74. RN Cornor advised that Ms A's previous respiratory conditions provided evidence of the need to prioritise immediate assessment and intervention for any respiratory signs or symptoms. However, there was no care plan implemented to inform staff about this. The lack of regular assessment and intervention was a significant departure from accepted practice.
75. Despite her concerning symptoms on the evening of 13 December 2016, there is no record of Ms A being assessed on the morning of 14 December 2016. It was not appreciated by the defendant's Health Centre staff that Ms A's condition was deteriorating until she came to the medical centre at 3.30pm for her medications,

despite having put in a health chit at 10am advising of her breathing difficulties. RN Cornor advised that the delay in assessment of Ms A's condition "is a significant departure from accepted practice or standard of care for a patient presenting with a respiratory illness, resulting in a seriously deteriorated health condition requiring hospitalisation."

76. At approximately 8.45pm on 14 December 2016, an RN found Ms A lying flat on her back in her bed holding/guarding her left lung area. Ms A had 8/10 pain with breathing, her body was shaking, and she was very diaphoretic. A full respiratory assessment was not performed, despite Ms A's previous complex history of respiratory issues.

Record keeping

77. RN Cornor advised that the documentation of assessments, treatments, and outcomes was poor. She stated that there was no consistency of staff documenting the time of their clinical entries, and the records were very difficult to follow. She observed that in the majority of the clinical documentation there was a lack of documentation of signs and symptoms, a shared plan of care, decisions made, or care delivered. She stated: "[A]ny other health professionals working within this environment could not follow a plan of care and be [assured that] the patient remains safe in the health status." RN Cornor was also critical that although the medication charts required completion of the full name and initial of the signatory, the majority either did not contain the full name of the health professional or were illegible. RN Cornor said that the staff did not document the advice given to Ms A, including the side effects to look out for and other methods of reducing her insulin needs, such as diet and exercise. Ms A received multiple doses of Panadol from custodial staff. While the timing of the doses was transcribed into Ms A's clinical notes, the doses given were not recorded on 14, 15, 21, 22, and 25 November 2016. This was clearly information that should be documented in the clinical records. Overall, the documentation was very poor.

Breach of Rights 4(1) and 4(2) of the Code

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

79. Ms A was unwell and suffering from painful conditions. The defendant has acknowledged there were a number of failures within the Corrections Facility which led to Ms A receiving treatment that was well below the accepted standard of care, including:

    a. Very poor planning of Ms A's care;
    b. Failure to provide Ms A with pain medication over four days in accordance with her prescription after her blister packs ran out and failure to prioritise a consultation with a prescriber;
    c. Administration of paracetamol against recommended practice;
    d. Failure to reassess Ms A's insulin requirements in light of her increased blood sugar levels; and
    e. Failure to perform a full respiratory assessment on 14 December 2016 despite Ms A's symptoms, physical distress, and previous history of respiratory issues.

80. The defendant has acknowledged that, while individuals had a responsibility for the failures that occurred, in this case there was a pattern of failures by multiple providers responsible for Ms A's care. The defendant has accepted that such a pattern of failures indicated systemic problems at the Corrections Facility, for which, ultimately, the defendant was responsible. Paragraph 58 above outlines the steps the defendant has taken to rectify these issues. The defendant has also accepted that it did not provide medical treatment to Ms A that was reasonably necessary, and that the standard of health care at the Corrections Facility at the material time were not reasonably equivalent to the standard of health care available to the public.

81. Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

82. The defendant has accepted that the clinical documentation did not meet the accepted standard, and there was little evidence in the documentation of the evaluation of treatments recommended and/or the interventions undertaken. The documentation in this case was suboptimal, and risked compromising the quality and continuity of Ms A's care.

83. The defendant has accepted that in this case it breached Rights 4(1) and 4(2) of the Code, and has provided a written apology to Ms A.

_____
Greg Robins
Acting Director of Proceedings

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

_____
For or on behalf of the defendant
Date: