Department of Corrections

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC02198)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the Department of Corrections' response to a consumer's bowel symptoms. The report highlights the importance of robust systems for ordering and acting on test results, and the importance of communication with consumers about their results.

2. The woman (aged in her thirties) resided at Auckland Region Women's Corrections Facility (ARWCF) in April and May 2019.

3. The woman attended a nursing appointment at ARWCF after submitting a Health Request Form for "blood in [her] stool". A physical examination was not performed at the appointment, and the nurse generated a laboratory form for a faecal occult blood test under the medical officer's name — despite not having the authority to do so — and did not tell the medical officer that she had done so.

4. An abnormal test result was returned the following day but was not actioned, either by way of a further nursing assessment or referral to a medical officer, and the woman was not informed of the result, despite a subsequent nursing assessment.

5. The medical officer saw the positive test result in her inbox on the day it was returned and booked the woman for the first available clinic appointment, which was in 11 days' time. However, the woman was released from ARWCF prior to the appointment. The health service was not informed of the woman's release, and the woman was not told of her outstanding test result or of the importance of seeing a doctor in the community for her symptoms.

6. The health service became aware of the woman's release about a week later. However, although there was a release address and telephone number in the woman's prisoner file, Corrections did not contact her about her test result. Ultimately, she was not provided with her abnormal test result until over two years later.

Findings

7. The Deputy Commissioner found Corrections in breach of Right 6(1)(f) of the Code for not having informed the woman of her abnormal test result.

8. The Deputy Commissioner also found Corrections in breach of Right 4(1) of the Code. The Deputy Commissioner considered that Corrections' process for the ordering of laboratory tests by nurses was inadequate; there was a lack of guidance around the responsibility for following up abnormal results by way of a medical appointment or further investigations; and the process for managing the timing of healthcare appointments was inadequate. Corrections' systems also failed to ensure that the health service was informed of the woman's release, and that the woman was informed of the need to see a doctor on her release.

9. The Deputy Commissioner criticised the nurse for ordering a test under the medical officer's name without the authority to do so, and without informing the medical officer. In addition,

Names have been removed (except Auckland Region Women's Correctional Facility, the Department of Corrections and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the nursing staff had no system in place to ensure that the woman's test result was actioned and that she was reviewed by a medical officer on receipt of the result.

Recommendations

10. The Deputy Commissioner recommended that Corrections provide HDC with an update on the changes made since these events, including the review and development of its policies; report on the current wait times in the health service at ARWCF and the further actions taken to ensure that patients' health needs are prioritised appropriately; undertake an audit of prisoners who have been released, to check whether the appropriate steps were taken in relation to their discharge summaries and health information; and provide the woman with a written apology.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Ms A (via the Nationwide Health and Disability Advocacy Service) about the services provided to her at Auckland Region Women's Corrections Facility. The following issue was identified for investigation:

- *Whether the Department of Corrections provided Ms A with an appropriate standard of care in 2019.*

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

13. The parties directly involved in the investigation were:

Ms A	Consumer
Department of Corrections	Provider/correctional facility

14. Further information was received from:

Dr B	General practitioner (GP)
RN C	Registered nurse (RN)
RN D	Registered nurse

15. Independent expert advice was obtained from RN Barbara Cornor (Appendix A), and in-house clinical advice was obtained from GP Dr David Maplesden (Appendix B).

Information gathered during investigation

Introduction

16. Ms A (aged in her thirties at the time of events) resided at Auckland Region Women's Corrections Facility (ARWCF) from 15 April 2019 to 21 May 2019. Ms A told HDC that while at ARWCF, she experienced five weeks of painful, malodorous stool, accompanied by bleeding from the bowel, which she described as "profuse".

17. This report concerns ARWCF's response to Ms A's symptoms. Ms A was subsequently diagnosed with advanced colorectal cancer. I take this opportunity to express my sincere sympathies to Ms A and her family for her diagnosis.

Initial assessment

18. At a health assessment on 20 April 2019, urine and faecal samples were requested from Ms A to investigate her symptoms of diarrhoea and abdominal discomfort. Corrections said that samples were provided by Ms A, but they were not sent to the laboratory "due to handling error". In response to the provisional opinion, Ms A told HDC that she never had a stool sample at this time, and that the only stool sample she provided prior to her diagnosis was in May 2019 (discussed below).

19. Two days later, a urine sample was provided by Ms A and sent to the laboratory, but a faecal sample was not provided, and was not followed up by nursing or medical staff. In response to the provisional opinion, Ms A told HDC that she does not recall providing a urine sample.

20. On 8 May 2019, Ms A submitted a Health Request Form at ARWCF for "blood in [her] stool … quite a lot of blood". An appointment with a nurse was booked for 10 May 2019.

Nursing appointment

21. On 10 May 2019, Ms A saw RN C. The documented reason for Ms A's appointment was dark red blood in her stool, which had been present since her hepatitis B vaccination in February that year.

22. RN C documented that Ms A had "nil complaint of abdominal pain, rectal pain". A physical examination was not performed at the appointment, and Ms A was advised to inform the health service if her condition worsened.

23. RN C told HDC that she was concerned that something was going on, and hence she asked Ms A to provide a faecal sample the next day, for further investigation with a faecal occult blood test.[1]

24. RN C generated the laboratory form for the test herself, under medical officer Dr B's name.[2] RN C did not inform Dr B that she had completed the form under her name, and told HDC

[1] A simple test that can detect the presence of minimal amounts of blood in the faeces, to look for early signs of bowel cancer.
[2] Dr B is a vocationally registered GP.

that she was not aware at the time that she had to do so. However, RN C noted that Dr B checks her inbox regularly (for results).

25. The Department of Corrections (Corrections) told HDC that it is not uncommon for a registered nurse to generate a laboratory request form on behalf of a medical officer, particularly if the medical officer is off site. However, Corrections acknowledged that this is not considered best practice.

26. Dr B told HDC that at Corrections, laboratory requests can be generated in her name by the nursing staff only for sexually transmitted disease tests, and for cardiovascular risk assessment blood tests. She stated that a faecal occult blood test is not a test the nurses are authorised to generate in her name, and she was not informed about this test request at the time.

27. RN C told HDC that her understanding at the time was that she could generate laboratory forms under the medical officer's name for all laboratory tests. She stated that the nurses were told to do this, as they might miss an important result if the form was under their own name. RN C also stated that the direction for ordering only specific tests (as outlined by Dr B) occurred after the events.

28. The section on "Laboratory Requests" in the ARWCF Local Operating Manual[3] does not provide information on which laboratory forms or requests a registered nurse can complete under a medical officer's name. It also makes no reference to informing the medical officer when this has been done.

29. The faecal sample was provided by Ms A and sent to the laboratory the following morning, on 11 May 2019.

Faecal occult blood test result

30. The result of Ms A's faecal occult blood test was received by ARWCF on the same day it was submitted — 11 May 2019 — and the result was positive.

31. Corrections' "Health Screening and Assessment" section of its Health Care Pathway Policy (April 2019) states that referral to the medical officer or nurse practitioner by the registered nurse who undertakes a health assessment will be based on the outcome of the health assessment. Results from all laboratory tests are received electronically and are linked to the specific patient and filed, and can be viewed by both registered nurses and the medical officer.

32. Despite Ms A's result being abnormal, Dr B was not asked by any of the nursing staff to review or follow up Ms A. RN C stated that she was not rostered as clinic nurse again, so she

[3] The Local Operating Manual provided by Corrections is dated September 2020; however, Corrections told HDC that this was in place in May 2019.

did not have a chance to check the result. Notwithstanding this, Dr B did view the positive test result in her inbox on the day it was received.

33. Dr B told HDC that regardless of the faecal occult blood test result, Ms A needed an examination and a diagnosis for the cause of the rectal bleeding. Dr B said that in the presence of reported rectal bleeding, it would be expected that the faecal test would be positive for blood, so this does not add to the diagnostic process and is not a test she would have ordered in this context. Dr B stated: "[T]he patient needed a detailed history with clinical examination in order to establish a diagnosis."

34. Dr B booked Ms A for the first available clinic appointment, which was 22 May 2019.

35. Corrections told HDC that in 2019, no formal processes were in place to manage waiting lists for access to healthcare appointments, nor were there any reporting processes that enabled monitoring of waiting times.

36. Ms A was not told of her positive result at this time. Corrections acknowledged that its "Management of Test Results and Medical Reports" policy, along with the ARWCF Local Operating Manual, do not outline clearly who is responsible for informing a patient of any test results.

Requests for test results

37. In her complaint to HDC, Ms A stated that despite repeated verbal and written requests for either an update of her results, or to see a doctor, these were declined.

38. Corrections told HDC that of the 19 custodial staff members identified as working in Ms A's unit between 7 May and 17 May 2019,[4] 14 remain in active employment with Corrections. It stated that it contacted them by email on 13 December 2021. The nine staff members who were able to respond have confirmed that they do not recollect having had discussions (and have not identified any relevant emails) about Ms A's faecal sample results or requests to see a doctor.

39. On 13 May 2019, Ms A submitted a Health Request Form, which stated that she needed her results for her smear test (which had been taken on 9 May 2019) and her results for the faecal sample "ASAP". This request was actioned the following day, and an appointment with a nurse was made for 20 May 2019.

40. On 20 May 2019, Ms A was seen in the nurses' clinic by RN D.[5] The reason for the presentation was documented by RN D as "requesting smear/[faecal] results". RN D recorded that Ms A was happy to hear that her smear results were normal, and that she would return to three-yearly smears.

[4] Corrections did not provide HDC with the relevant information for the period of 18–21 May 2019.
[5] RN D no longer works at ARWCF.

41. Despite Ms A's faecal test results being available in the clinical record on 11 May 2019, RN D documented a plan to await the faecal test results, and to follow up when these arrived.

42. RN D told HDC that unfortunately she is unable to recall this consultation. She stated that if the results had been in the record, she would have informed Ms A immediately and then referred her to the medical officer for an appointment. It is unclear why this did not occur.

Release from prison

43. Ms A was released from ARWCF the next day, on 21 May 2019. As such, she was not able to attend her clinic appointment with Dr B on 22 May 2019. The health services were not informed of Ms A's release, and Ms A was not told of her outstanding test result at this time, or of the importance of following up with her GP in the community.

44. The "Health Care on Release" section of Corrections' Health Care Pathway Policy (April 2019) states that "there will be a system in place so that Health Services and custodial staff share information about patients who are being released". The policy outlines that the standard of care is for patients to have current health information to support a transfer to general practice when they are released, as well as to support continuity of access to the specialist services they need when they are released.

45. The policy stipulates that the registered nurse is responsible for reviewing and evaluating the health care that has been provided in prison, and for updating the patient's health record before the patient is released. In addition, it states that the registered nurse is responsible for completing the documentation needed to provide continuity of health care, including information for the case manager and a discharge summary for the patient and primary care.

46. Corrections told HDC that while this policy requires an agreed local procedure with custodial staff to support the notification that a person is to be released, health services are not always notified when people are released. Corrections stated: "[R]elease processes described by this policy can only be actioned when health services are notified a patient is to be released." As the health services were not notified about Ms A's release, Ms A's health record was not updated before she was released, and a discharge summary was not provided to her.

47. Corrections acknowledged that access to real-time planned release information of people in its care is an area where improvement is vital to ensure continuity of care when people are released. It stated: "We regret that we missed the opportunity to ensure [Ms A] had knowledge of the test results and the follow up that was required on her release."

Communication with Ms A after release

48. On 30 May 2019, Dr B documented in Ms A's file that Ms A had been released without being seen by her, and that Ms A did not appear to be aware of her results. Dr B sent a task to the nursing staff to inform Ms A of her results, and documented:

> "I am not clear on the cause of the [positive] result — may relate to haemorrhoids but the [patient] need[s] review/investigation of this result as needs to have cancer ruled out. Tasked nurse for [patient] to be informed of result so that can get checked."

49. Dr B told HDC that she was not told by the nursing staff that they were unable to make contact with Ms A, but on 6 July 2019 she was asked by one of the nursing staff[6] to write a letter to inform Ms A of her result. The medical records contain no documentation that nursing staff attempted to contact Ms A prior to this.

50. On 6 July 2019, an electronic letter for Ms A was generated by Dr B, as per the request by nursing staff. The letter stated:

> "I have received a result that showed there was blood in the faeces sample that the nurses asked you to do. I was not able to see you before you left. I am not clear on the cause of this result. It may relate to haemorrhoids but you must see your doctor to have a cause established and to be sure that there is not a cancer."

51. Dr B told HDC that as per her usual practice for patient correspondence, she printed the letter and placed it in the out-tray, with the expectation that this would be sent to Ms A by the nursing staff. However, there is no evidence that this letter was ever sent.

52. Corrections told HDC that the address where Ms A was to reside on electronic-monitoring bail was recorded on the bail order, and in the notes in its "Integrated Offender Management System" (IOMS). Corrections stated that as the address was notified to its custody team via the Court, and not by Ms A to the ARWCF Receiving Office, the address was not recorded in the contact details section of the "offender homepage". Corrections stated: "It is likely that the nurse who was tasked with sending the doctor's letter referred to this screen alone and was not aware of other sources of information in the system."

53. Ms A told HDC that despite having a release address and telephone number in her prisoner file, she was not contacted by Corrections after her release in relation to her faecal occult blood test result. In addition, despite having the contact details for Ms A's GP practice in the community, the practice was not contacted either.

54. Ms A stated that over the following two months after her release, she was repeatedly refused the faecal sample results despite multiple attempts to obtain these from ARWCF directly. She said that she was not permitted to speak with the health centre, and they did not take her calls. As such, she assumed that the results were normal.

55. Corrections told HDC that it has no record of any communication from Ms A following her release. It advised that it would be expected that any communication would be documented in the clinical record, particularly if the person was seeking clinical information.

[6] Dr B cannot recall which nurse this was.

Subsequent events

56. After her release from prison, Ms A's health deteriorated, and over the next two years she was seen multiple times by many providers across the country (as she relocated a number of times), at both hospitals and medical centres, for ongoing colorectal symptoms. Concerns raised about these providers are not included in this investigation, and have been addressed separately.

57. On 20 June 2021, Ms A presented to hospital and was diagnosed with locally advanced rectal cancer. Ms A was not provided with her May 2019 abnormal faecal occult blood test result until August 2021.

Further information

Ms A

58. The Advocacy referral of Ms A's concerns states that Ms A feels that because of her background, she was discriminated against by the health professionals involved in her care, and this precluded her from accessing appropriate treatment commensurate to her symptoms. In addition, the referral stated that Corrections' response to Ms A's concerns "distressed her greatly". The referral noted:

> "[Ms A] is also in disbelief that not only was there no attempt to return her many calls, send the results to her doctor and/or to her known location where she was being electronically monitored, and that no apology was extended by the health team for their failings …"

Corrections

59. Corrections told HDC that both RN C and RN D attended a two-day policy training course in May 2018, which included education on key policies and documentation.

60. RN C also told HDC that at the time of the events, she did not have training in MedTech (the electronic medical system at ARWCF), and that she learnt how to use the systems and its features herself. In response to this, Corrections provided HDC with RN C's induction checklist (undated), which shows that RN C underwent "Overview of MedTech32", "MedTech Training", and "MedTech Files" training as part of her induction. Corrections told HDC that RN C has many years of experience in using MedTech within Corrections.

Internal review

61. When Ms A initially raised her concerns with Corrections on 2 August 2021, they were passed on to the Office of the Inspectorate [7] for consideration. The Office of the Inspectorate's review found:

1. There is no evidence that the health team at ARWCF made any attempt to contact Ms A or her GP about the faecal occult blood test result;
2. Faecal occult blood testing is a standard early detection test for bowel cancer; and

[7] The Office of the Inspectorate is part of the Department of Corrections, and works to ensure that all prisoners are treated in a way that is fair, safe, secure, and humane. It investigates complaints received from prisoners and from offenders in the community.

3. The follow-up care provided by the health team at ARWCF in 2019 did not meet the expected professional standards.

62. Corrections told HDC that the failures in its communications with Ms A are deeply regretted. On 21 September 2021, an apology was sent to Ms A for these failures. In response to the provisional opinion, Ms A told HDC that she never received this apology from Corrections.

Dr B

63. Dr B stated that in hindsight, she regrets not contacting Ms A's GP directly about Ms A's result, although she acknowledged that this may not have affected the subsequent course of events. Dr B told HDC that she is sorry that Ms A experienced a delay in the diagnosis of her bowel cancer, and the distress this caused her.

Responses to provisional opinion

64. Ms A was provided with an opportunity to comment on the "information gathered" section of the provisional opinion, and her comments have been included in this report where relevant. She told HDC that while she was in prison, she "felt like a nothing", and that she was "treated like no one" by Corrections.

65. In response to the provisional opinion, Corrections told HDC that it accepts the provisional opinion and all the recommendations. Corrections told HDC:

> "Corrections acknowledges that [Ms A's] test results were not given to her while she was in our care and custody. While a letter was drafted following her release from ARWCF to inform her of the test results and the importance of seeing a doctor [to] follow up on the results, we hold no documentation evidencing that the letter was sent. I want to reiterate that Corrections deeply regrets the failures in our communications with [Ms A]. I am truly sorry for the shortcomings in our services to [Ms A] and any affect our omission to provide her results have had on her ability to obtain a timely diagnosis."

66. RN C told HDC that the nurses are now using the patient/staff task system in MedTech to ensure that results are acted on, and that she is now generating lab forms that nurses are allowed to generate.

Opinion: Department of Corrections — breach

Introduction

67. Under section 75 of the Corrections Act 2004, prisoners are entitled to receive medical treatment that is "reasonably necessary", which must be "reasonably equivalent" to the standard of health care available to the public. The Code also requires Corrections, as a healthcare provider, to operate its health service in a way that provides consumers with services of an appropriate standard.

68. The issue in this case is not only the failure of Corrections to inform Ms A of her positive faecal occult blood test result, but also the failure either to ensure that she was reviewed adequately for her concerning symptoms prior to her release, or at least to ensure that she was aware of the importance of seeing a doctor in the community for her symptoms. Neither of these actions occurred. While ultimately Ms A did see a doctor in the community after her release, the continuity of care was hindered, and I consider that this case shows multiple deficiencies in Corrections' systems and processes.

Ordering of test by registered nurse

69. On 10 May 2019, Ms A attended a nursing appointment at ARWCF after submitting a Health Request Form for "blood in [her] stool … quite a lot of blood". A physical examination was not performed at this appointment, but RN C generated a laboratory form for Ms A to undertake a faecal occult blood test. My independent advisor, RN Barb Cornor, noted that RN C sent Ms A's sample to the laboratory with a form she had no authority to sign, and she did not inform the medical officer that she had used her name, or ask her to review the results. RN C relied on Dr B seeing the results in her inbox herself. In my view, this is not a robust system, and it has the potential for results to be missed.

70. It is concerning that RN C stated that Corrections' nursing staff were told to order tests under the medical officer's name, whilst Dr B stated that this can be done only in very specific circumstances. Corrections also said that it is not uncommon for a registered nurse to generate a laboratory request form on behalf of a medical officer, but it acknowledged that this is not considered best practice.

71. Corrections' policy on "Laboratory Requests" does not provide information on which laboratory forms or requests a registered nurse can complete under a medical officer's name, to guide nursing staff on the process, and the policy does not state the importance of ensuring that the medical officer is informed when this has been done.

72. Despite an abnormal faecal occult blood result being returned on 11 May 2018, there is no evidence that any of the nursing staff ensured that the result was actioned either by way of a further nursing assessment or referral to a medical officer. However, RN Cornor advised that the ARWCF Local Operating Manual was not clear on the process for abnormal results.

73. I am concerned that at this appointment, an investigation was ordered by a nurse who had no authority to do so, and it appears that no system was in place to ensure that the results of the test would be actioned. The processes in place at Corrections around the ordering and follow-up of laboratory tests should be outlined clearly in its policies, to ensure that nursing staff are guided to investigate symptoms and action test results appropriately, and that results are referred to a medical officer when necessary.

Ms A's release

Lack of review prior to release

74. Notwithstanding Dr B[8] not being alerted to the abnormal result by nursing staff, Dr B saw the positive faecal occult blood test result in her inbox and booked the first available clinic appointment for her to see Ms A — 11 days later on 22 May 2019. Corrections told HDC that in 2019, no formal processes were in place to manage waiting lists for access to healthcare appointments.

75. RN Cornor advised that in current practice, whoever views the result of any test — whether normal or abnormal — should inform the medical officer or GP immediately after it is received. She stated that "ARWCF practice is a severe deviation from normal practice", and noted that on receipt of abnormal results it is important for the patient to be followed up as a priority and provided with an urgent appointment.

Communication between custodial staff and health service about release

76. Ms A was released from ARWCF on 21 May 2019 and, as such, was not able to attend her clinic appointment with Dr B on 22 May 2019. The health service was not informed of Ms A's release, and Ms A was not told of her outstanding test result at this time.

77. Corrections' "Health Care on Release" policy states that "there will be a system in place so that Health Services and custodial staff share information about patients who are being released". However, this "system" is not elaborated on, and Corrections acknowledged that health services are not always notified when people are released. A further process outlines that when the health service discharges a patient from its care, the patient's health record is to be updated and a discharge summary provided. However, as Corrections noted, "release processes described by this policy can only be actioned when health services are notified a patient is to be released". This was not the case with Ms A.

78. Corrections acknowledged that access to real-time planned release information of people in its care is an area where improvement is vital to ensuring continuity of care when people are released.

79. RN Cornor considers that the management of Ms A's release from ARWCF in this circumstance was not consistent with ARWCF's own policy, and was a severe departure from normal practice.

Ms A's release — conclusion

80. There were multiple issues with Ms A's release, which stemmed in part from inadequate policies and procedures at Corrections.

81. Had the process in place allowed for medical officer appointments to be waitlisted by urgency, Ms A may have been seen by Dr B before her release, and earlier action may have been taken regarding her symptoms. In addition, there was a lack of effective

[8] My in-house GP advisor, Dr David Maplesden, advised that Dr B's overall approach to this situation was conscientious, and he made no criticism about the care she provided.

communication between the different teams within Corrections, namely the health service and custodial staff, and, as a result, the health service was unaware that Ms A was to be released, and therefore that an earlier appointment was needed.

82. Had the health service been informed of Ms A's release, at the very least she would have been provided with a discharge summary noting her abnormal result and the importance of follow-up in the community. I am critical of Corrections for these failures.

Communication provided to Ms A

83. Both before and after her release from ARWCF, there was no communication with Ms A about the abnormal faecal occult blood result received on 11 May 2019. On 13 May 2019, Ms A submitted a Health Request Form for an update on her result, and, despite seeing a nurse on 20 May 2019, the result was not provided to her.

84. Ms A was released from ARWCF on 21 May 2019. The health service was not informed of Ms A's release, and therefore Ms A was not told of her outstanding test result at this time, or of the importance of her to follow up with her GP in the community.

85. As set out in paragraphs 48–55, despite the health service becoming aware of Ms A's release on or before 30 May 2019, and having a release address and telephone number in her prisoner file, Ms A was not contacted by Corrections in relation to her faecal occult blood test result after her release, and there is a lack of evidence of any attempts to contact her. In addition, despite having the contact details for Ms A's GP practice, no contact with the practice occurred. Ultimately, Ms A was not provided with her abnormal faecal occult blood test result until August 2021, over two years later.

86. RN Cornor advised that the failure to inform Ms A of her positive result "appears to be [a result of] a breakdown of communication" between healthcare staff prior to her release, and a lack of communication between healthcare and custodial staff following her release. RN Cornor noted that the ARWCF Local Operating Manual is not clear on the process of informing the patient of a result, and who is responsible, which Corrections has accepted.

87. It is this Office's expectation, and a consumer's right, that the consumer will be informed of an abnormal test result. Corrections failed in its duty to provide this information to Ms A on multiple occasions — before and after her release — and despite Ms A specifically requesting it.

88. I acknowledge Corrections' submissions that the custodial staff members it was able to contact do not recall these requests, and there is no record of any communication from Ms A following her release. However, this does not necessarily mean that Ms A did not contact Corrections as she states she did, and I note that there is documented evidence of Ms A requesting the result on 13 May 2019 (prior to her release).

89. Regardless, a consumer should not have to ask to be informed of an abnormal result. I consider that the systems Corrections had in place to allow for adequate communication with consumers about their test results were not fit for purpose. As noted above, the

"Management of Test Results and Medical Reports" policy and the ARWCF Local Operating Manual do not document clearly who is responsible for informing the patient of any test results. Despite RN C having requested the test, Dr B having viewed the test result, and Ms A having attended an appointment with RN D on 20 May 2019, Ms A was not informed of her result. In relation to the appointment with RN D, it is not clear why she documented that the test result was not available when it was, but she told HDC that had the result been available, she would have informed Ms A, and HDC has not received evidence to suggest that she did not do so deliberately.

90. In addition, while the "Health Care on Release" policy states that "there will be a system in place so that Health Services and custodial staff share information about patients who are being released", the "system" is not outlined, and Corrections acknowledged that health services are not always notified when people are released. This meant that the health service responsible for Ms A was not aware that she was being released, and could not action its processes accordingly.

91. Ms A was not informed of her abnormal test result until over two years after the result was reported, which is unacceptable.

Conclusion

92. It is clear that Corrections did not provide medical treatment that was "reasonably necessary" for Ms A, and that the standard of health care she received at ARWCF was not "reasonably equivalent" to the standard of health care available to the public. Given the factors outlined above, I consider that there was an overarching service failure in this case.

93. I acknowledge that in the context of Ms A having reported rectal bleeding, it was not unexpected for the faecal occult blood test result to be abnormal. However, an abnormal result is still an abnormal result. This was information that Ms A had a right to be informed of. Despite Ms A requesting the result, it was not provided to her until over two years later. It is clear that this failure did not involve only one clinician or ARWCF staff member. It follows that I find Corrections in breach of Right 6(1)(f)[9] of the Code.

94. Corrections' process for the ordering of laboratory tests by nurses was not well defined at the time, and, as a result, RN C ordered a test for Ms A under the medical officer's name when she had no authority to do so. Despite the faecal occult blood test subsequently being reported as abnormal, this did not act as a prompt for nursing staff, and there was a lack of guidance at ARWCF around the responsibility for following up abnormal results by way of a medical appointment or further investigations. As a result, no follow-up appointment with a medical officer was booked by the nurses. Dr B saw Ms A's result only because it was sent to her inbox and she recognised that a medical appointment was required. Further, due to the lack of formal processes in place to manage the timing of the healthcare appointment, and the failure of Corrections' systems to ensure that the health service was informed of Ms

[9] Right 6(1)(f) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including the results of tests."

A's release, Ms A was not seen by a medical officer at ARWCF in relation to her symptoms, or informed of the need to see a doctor on her release.

95. For these reasons, I consider that Corrections failed in its responsibility to ensure that Ms A received services of an appropriate standard. Accordingly, I find that Corrections breached Right 4(1)[10] of the Code.

Opinion: RN C — adverse comment

96. On 10 May 2019, Ms A attended a nursing appointment with RN C after submitting a Health Request Form for "blood in [her] stool … quite a lot of blood". RN C generated a laboratory form for Ms A to undertake a faecal occult blood test. RN C generated the form under Dr B's name despite not being authorised to do so, and without informing Dr B that she had done so.

97. RN Cornor noted that a full assessment of Ms A was not completed on 10 May 2019, and stated that "this is understandable in these circumstances where a specimen if found abnormal would then provide reason for further and fuller assessment by the nurse and/or a GP". However, this did not occur. Despite an abnormal result being returned on 11 May 2018, there is no evidence of RN C or any other nursing staff having a system in place to ensure that the result was actioned either by way of a further nursing assessment or referral to a medical officer. RN C said that she was not assigned as clinical nurse after this, so did not have a chance to review the result, and was confident that Dr B would see the result.

98. I am concerned that RN C ordered a test for Ms A's symptoms under the medical officer's name without the authority to do so, and without informing the medical officer. RN C told HDC that her understanding at the time was that she could generate laboratory forms under a medical officer's name for all laboratory tests, and this is supported by Corrections' comment that it is not uncommon for a registered nurse to generate a laboratory request form on behalf of a medical officer. I note that Corrections' policy did not provide information on which laboratory forms or requests a nurse could complete under a medical officer's name. While it would have been beneficial for RN C to have consulted Dr B prior to ordering the test, and, having ordered the test, RN C should have told Dr B that she had done so in her name, I acknowledge the lack of guidance provided by Corrections.

99. In addition, I am concerned that there is no evidence that RN C had in place any system for follow-up to ensure that the test result was actioned and Ms A was reviewed by a medical officer on receipt of the result. I acknowledge that at the time of events, Corrections' policies did not outline the process for the ordering of laboratory tests and communication with the

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

medical officer adequately. However, I remind RN C of the importance of following up and actioning any test results ordered.

Changes made since events

Corrections

Health Equity and Outcomes framework

100. In September 2021, the Department of Corrections' Health Equity and Outcomes framework was finalised. Access to health services is now reported as two clinical indicators — wait times to see a medical officer, dental officer, or nurse when a Health Request Form is submitted, and wait times from reception into prison to the Initial Health Assessment. Currently, this data is reported at an all-of-Corrections level, with the next phase to analyse the data at a site level.

101. There is now a requirement for Health Request Forms to be triaged and acknowledged within three days, to prioritise access to appointments. Corrections stated that recent internal reporting shows that women in prison with an immediate health need will wait 1.9 days to see a medical officer (the policy requires within 24 hours), women with a semi-urgent health need will wait 2.3 days (the policy requires within 10 days), and women with a routine health need will wait 6.7 days (the policy requires within 30 days).

102. In response to the provisional opinion, Corrections told HDC that a national audit of the Health Request Form (HRF) process was undertaken in March 2021, and that AWRCF demonstrated 100% compliance with this audit — indicating that HRFs are being triaged and responded to within the required 72 hours, and that follow-up actions are being documented in the clinical record. Corrections told HDC that National Health Outcome and Equity measures have been introduced, which provide information on the wait times to access health services based on triage scores. Corrections said that an updated report is expected by the end of November 2022, and this will include data specific to AWRCF as compared to an average national measure.

"Management of Test Results and Medical Reports" policy

103. Corrections told HDC that in early 2021, the Chief Medical Officer was working on a policy to support the management of test results and medical reports in response to another issue, and it was timely to include clearer instructions on the procedure to be followed for abnormal results. An additional section on the management of test results when a patient has left Corrections' care was also added.

104. Corrections told HDC that the new policy requires all verbal conversations related to test results and medical reports to be documented in the MedTech record.

Laboratory test ordering policy

105. Corrections stated that its Chief Medical Officer is leading a piece of work to establish standing orders for the ordering of laboratory tests by nursing staff. Corrections said that the policy will make it clear that when tests are required in direct response to abnormal presentations or symptoms, ordering of such tests will require consultation with a medical officer, and will need to be signed by the medical officer.

106. Corrections stated: "[T]his will ensure there is awareness around who is accountable for managing normal and abnormal results and escalation pathways when results are received."

New roles at ARWCF

107. Corrections told HDC that in September 2019 and February 2021, a fixed-term Practice Leader role was introduced at ARWCF to support clinical practice, and to ensure that systems and processes were in place to support the delivery of safe, quality health care. Corrections stated that the Practice Leader is responsible for building practice capability and confidence in professional practice within its health services alongside the clinical practice delivery and management teams.

108. Additionally, ARWCF is recruiting a nurse practitioner role to support its health services with a team member who is recognised as an authority in primary healthcare practice, and is a clinical expert who can provide expert nursing assessment and care delivery. Corrections told HDC that this role will also influence best practice, the use of guidelines and policy, audit and quality improvement/development activities, and education of other health services and staff.

Health service restructure

109. Corrections told HDC that its health services were restructured in May 2020 in order to:

- Bring both operational and national office-based health functions together;
- Strengthen health leadership and accountability through the creation of a team of senior health sector leaders and practitioners both within the national office and regionally;
- Establish specialist heads of profession with a strong focus on delivering a model of care that best meets the needs of Māori as an over-represented group in our prisons; and
- Establish clinical governance and direct line of sight through reporting and structural oversight.

110. As part of the restructure, the Chief Medical Officer is in the process of appointing regional medical officers to support medical practice across all health services. In addition, a formal monthly Health and Custody meeting is held to provide a forum to discuss key issues, and to support the development of policies and procedures and the efficient delivery of healthcare services within the custodial environment.

Health Care Pathway review

111. Corrections told HDC that currently its Health Care Pathway section "Health Care on Release" is under review. Corrections stated that recently the Health Practice Team appointed a new staff member who will undertake this work.

112. Corrections told HDC that in 2021, ARWCF introduced a Discharge Nurse role to take responsibility for managing all the release requirements of pending releases. This includes attending site release planning meetings, reviewing releases for the next six weeks, arranging discharge information and medication scripts, and supporting connection with a general practitioner in the community on release. Corrections stated that this trial is to be reviewed nationally to identify the requirements for implementation of this role across all sites, including ARWCF.

113. In response to the provisional opinion, Corrections told HDC that currently, the Integrated Offender Management System (IOMS) and the MedTech patient management system (PMS) do not "speak" to each other, so multiple systems need to be accessed to get the required information. Corrections stated that the Health Quality and Practice Team will work with the Custodial Services Team to provide clear information on accessing Release Reports from IOMS.

114. In addition, Corrections said that a project to replace the current PMS is underway, and that the replacement will remove the need to use multiple data sources to get relevant information, and will provide health staff with visibility of release addresses and key contacts on release.

Recommendations

115. I recommend that the Department of Corrections:

a) Provide HDC with an update on:

   i. The review of the Management of Test Results and Medical Reports policy;

   ii. The appointments of new health services roles;

   iii. Its new laboratory test ordering policy;

   iv. The Health Service Restructure; and

   v. The review of the Health Care on Release process.

   This update, along with evidence of the reviews and changes made, is to be provided to HDC within six months of the date of this report.

b) Provide HDC with the latest report on the current wait times in the health service at ARWCF, along with details of what further actions Corrections will take to ensure that patients' health needs are prioritised appropriately, and that patients will be seen

within the new timeframes outlined in paragraph 101. An update on this work should be provided to HDC within six months of the date of this report.

c) Undertake an audit of a random sample of 10 prisoners who have been released, to check whether the appropriate steps were taken in relation to providing them with their discharge summaries and health information, including necessary prescriptions, and provide the outcome of the audit to HDC. Where the audit does not show 100% compliance, Corrections is to provide HDC with details of further changes made to address this, within six months of the date of this report.

d) Provide Ms A with a written apology for its breaches of the Code. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding.

Follow-up actions

116. A copy of this report with details identifying the parties removed, except Auckland Region Women's Correctional Facility, the Department of Corrections, and the experts who advised on this case, will be sent to the Office of the Ombudsman and the Office of the Inspectorate, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from RN Barbara Cornor:

"**Health & Disability Commissioner**

Barbara Cornor
Registered Nurse, RGON, MN
NC 051169

Complaint: Auckland Region Women's Corrections Facility (Department of Corrections)
[Ms A]
HDC ref: 21HDC02198

Expert advice requested is to review enclosed documentation and advise whether I consider the care provided by Auckland Region Women's Corrections Facility (AWRF) to [Ms A] was reasonable in the circumstances, and why.

I was asked to comment on:

1. The adequacy of the care provided on 10 May 2019 (including the adequacy of assessment and investigations undertaken, and whether any further investigations were warranted)

- 10 May 2019 [Ms A] was undergoing a cervical smear by a nurse when she provided a 'chit' stating 'blood in my stool with quite a lot of blood'. The nurse documented the same and that the patient had no abdominal pain. The plan by that registered nurse was to provide a 'stool for assessment'. [Ms A] was informed.
- The specimen was provided by [Ms A] the following day, to another registered nurse.
- That nurse completed a laboratory request form FOBT (for occult blood test). A test which identifies if there is blood in the faeces.
- Nurses at ARWF are unable to generate laboratory requests for this test, nor are they able to generate tests under the Medical Officer's (GP) name, but the nurse who received the specimen did so, also, did not inform the GP.
- The nurse did not complete a full assessment of the patient. This is understandable in these circumstances where a specimen if found abnormal would then provide reason for further and fuller assessment by the nurse and/or a GP.
- The result of the cervical smear was normal with no abnormalities documented by the registered nurse completing the assessment and examination.
- [Ms A] had been received at AWRF 15 April 2019. A detailed medical examination states 'no bowel problems'.

- Mid-Stream Urine and Faeces specimens were requested 20 April due to [Ms A] identifying she had diarrhoea. These specimens were provided but not sent to the laboratory 'due to handling error'. A mid-stream urine was further provided and sent to the laboratory but the faeces specimen was not provided by the patient, nor was it followed up by nursing or medical staff.
- Other health assessments during her time at AWRF were for [other issues]. There is no further documentation of bowel issues.

Comments:

- The adequacy of the care provided on the 10 May 2019. The registered nurse involved followed a standard of practice to determine the blood in the stool with a plan and informed [Ms A].
- The nurse the following day sent the specimen to the laboratory with a form she had no authority to sign, nor did she inform the MO she had used her name or to review the results.
- Normal practice within a community general practice would be for the nurse or GP to ask the patient to provide a faecal sample and they would follow-up with the patient when the results were available.

2. The appropriateness of the wait time before booking a Medical Officer appointment to discuss the stool result with [Ms A]

- A positive faecal occult result was received into her MedTech health documentation record on 13 May 2019.
- [Ms A] also submitted a Health Request Form 14 May 2019, requesting her cervical smear and faecal occult blood results.
- On 20 May 2019 [Ms A] was informed by a registered nurse, of her cervical smear results and although they were available in [Ms A's] Medtech notes, the nurse told [Ms A] she would be informed of the stool results when they were received.
- A follow up appointment with the MO was booked for 22 May 2019. It is suggested by both the medical officer and the registered nurse, this was the earliest available appointment. [Ms A] did not attend as she had been released on 21 May 2019.

Comment:

- Six days does seem a while for the cervical smear results to be shared but without understanding the wait time for appointments, this may be normal. As the result is normal there is no need for follow-up. Many community general practices have the ability to communicate with their clientele through text/email to provide test results if they are normal and do not require a follow-up visit. Of course, this practice cannot be done in a corrections facility.
- The AWRCF Local Operating Manual Sept 2020, provides information on how to manage test results and who is responsible for informing the patient. It does refer to

abnormal responses appearing in red; however, it is not clear on the process and who is responsible for informing the patient of the result. At the time of the test, patients are informed that if the result is normal, they will not be contacted, but they can submit an HRF for a follow up appointment with the nurse to discuss the results. This is not documented in [Ms A's] clinical notes.

- Corrections Department states 'laboratory tests that are abnormal, the nurse will generally see them before they have been reviewed by the MO, however, best practice is that before the results can be discussed with the patient, the results will be discussed with the MO'. This process identifies who discusses the results with the patient. There is no documentation that supports this was what had occurred.
- It is unknown why the nurse did not report the positive occult blood to [Ms A]. It is not easy to share a result which may have a negative impact on the patient's life, although bleeding from the rectum does not result in a definitive life sentence. Most nurses have very little or no formal training or confidence and there is reluctance to discuss a possible diagnosis and become something the nurse felt she could not do.
- The above comments and policy are unclear to this reviewer. In current practice and as best practice, any negative/abnormal result of any test and/or laboratory result should be informed to the MO (or GP) by whoever has viewed it, immediately it is received. AWRF practice is a severe deviation from normal practice. It is important for the patient to be followed up as priority and provided with an urgent appointment.
- All policy and manuals should reflect the Corrections Department statement 'laboratory tests that are abnormal, the nurse will generally see them before they have been reviewed by the MO, however, best practice is that before the results can be discussed with the patient, the results will be discussed with the MO'. This process identifies who discusses the results with the patient. There is no documentation that supports this was what had occurred.
- 'Corrections Department Health Care Pathway Policy, April 2019, Release of Prisoners
    - Standard 24.1 The patient has current health information to support a transfer to general practice when they are released.
    - 24.2 The patient has current health information to support continuity of access to the specialist services they need when they are released. Health care on release policy
    - 24.3 There will be a system in place so that Health Services and custodial staff share information about patients who are being released.
    - 24.4 The registered nurse is responsible for reviewing and evaluating the health care that has been provided in prison and updating the patient's health record before they are released.

  - 24.5 The registered nurse is responsible for completing the documentation needed to provide continuity of health care, including information for the case manager and a discharge summary for the patient and primary care, using the Front Sheet from the patient's MedTech record.'

- The release of [Ms A] is a severe departure from normal practice within our hospitals and particularly of Corrections Department policy as per above. The policy has not been acknowledged at all.
- Corrections Department state 'In early 2021, the Chief Medical Officer was working on a policy to support the Management of Test Results and Medical Reports in response to another issue and it was timely to include clearer instructions on the procedure to be followed for abnormal results. An additional section on the management of test results when a patient has left our care was added. As a newly introduced policy, it will be reviewed in March 2022, and it will also be appropriate to schedule an audit to ensure the new processes have been embedded. This will be considered as part of the 2022 National Audit Schedule.'
- Management of Test Results and Medical Reports should be reviewed and reported in March 2022 to ensure it meets all requirements and is clear and consistent in reporting abnormal results for the nurse, the MO and to the patient.
- 'Health Care on Release of Prisoners' policy requires review and particularly to include communication with Custodial Staff prior to any release, be it from the prison or the courts.

3. The adequacy of the attempts to contact [Ms A] (or her GP) about her result after she was released from prison

- On 30 May 2019, the GP noted in the MedTech notes [Ms A] had been released without being made aware of the positive faecal occult blood test. The registered nurse was sent a task to inform patient of the result.
- The GP generated a letter on the 6 June 2019 informing [Ms A] to see her general practitioner about the positive result that had been received.
- The GP entry on the 7 June 2019, noted that she had been asked to write a letter regarding the results. The MO advised that [Ms A] must see a doctor to have the cause of bleeding established. The letter was printed off, signed and placed in an out-tray with the expectation it would be sent to [Ms A].
- The MO regrets they did not contact [Ms A's] GP to advise of their concerns and request they also attempt to contact the patient to arrange follow up.
- The letter was not sent by anyone due to 'lack of release address provided in our system'. The nurse who was asked to send the letter 'was not aware of other ways to try and trace your contact details' and there was 'no request from your GP for your medical records'. The MO at AWRF was not notified the letter had not been sent.

- HDC correspondence shows that [Ms A] phoned the prison Health Centre to enquire regarding the results. This is not documented in the Medtech clinical notes.
- There is no electronic MedTech record to AWRF for any request of [Ms A's] medical notes by a community general practitioner.

Comment:

- If all processes/policies within the AWRF had been followed [Ms A] would not have been released at the time her appointment was made.
- As discussed, prior, although the nurse should not have signed the laboratory authorisation, a positive result came through to AWRF on 13 May 2019. It was not reported through documentation or verbally to the MO. Had a registered nurse reported and/or recognised the results, they too should have made an earlier appointment. Had the MO been aware of the results an appointment would have been provided at an earlier stage and prior to [Ms A's] release. This is a severe departure of practice.
- The ability to inform [Ms A] of her positive result appears to be a breakdown of communication between health staff prior to release and communication and support between health and custodial staff following her release (The Swiss Cheese Theory comes to mind). Corrections Department have identified 'access to real-time planned release information of people in their care' as an 'area where improvement is vital' and recognise ensured continuity of care provision to all released prisoners is a priority.
- A meeting will be 'held in February 2022' to discuss potential solutions and ensure standardised processes are jointly agreed and implemented. A plan must be developed and will require urgent review of process and the ability to ensure full communication between corrections, health staff and the person being released. All released prisoners must be ensured optimum continuity of their health care. It is suggested this plan be followed up within three months to ensure it is developed, implemented and an audit plan commenced.
- [Ms A] states she was on home detention following release. How does that not inform someone within corrections of her address? Nursing and Corrections working together could have solved this dilemma and the gap that developed in the continuity of care not to have continued to widen.
- [Ms A] states she sought medical attention following release for her health issue. The laboratory faecal occult results are available on a national Testsafe portal making these results accessible to other medical practitioners.

Barb Cornor"

Appendix B: In-house clinical advice to Commissioner

The following expert advice, as it relates to the care provided at ARWCF, was obtained from GP Dr David Maplesden:

> "…
>
> Event 3 [10/5/19 nursing review]: Management is inadequate and nursing advice might be considered. There is no record of enquiry regarding additional bowel symptoms associated with the PR blood loss (particularly change in bowel pattern) or additional screening for possible 'red flag' symptoms for malignancy. Passage of dark red blood per rectum is not consistent without the 'outlet type' blood loss (bright red, coating stool) associated with haemorrhoids. There is no record of a physical examination or efforts made to facilitate a MO assessment for this. Requesting faecal occult blood (FOB) is not recommended in patients with overt rectal blood loss[1] as noted correctly in the MO provider response, and the MO also notes the request was made against Health Unit policy without the knowledge or authorisation of the MO. There is no record of any safety-netting advice provided.
>
> Events 4–6 [13/5/19 blood test received, 30/5/19 and 6/6/19]: [Ms A] required MO review irrespective of the FOB result and delays in acknowledging the result led to delays in an appropriate review being organised prior to her release from the facility. I am mildly critical of the apparent (at least) one week delay before the result was reviewed or actioned by an MO. Nursing advice might be sought on the apparent failure by nursing staff to facilitate timely MO review once the result was received, and the apparent failure to try and contact [Ms A] directly with the result following her release, as directed by the MO (or at least a failure to document any attempts at contact). The MO was conscientious in attempting to contact [Ms A] in writing regarding her need for follow-up, but I am mildly critical she did not take the additional step of communication with the community GP listed in [Ms A's] file (although I cannot state this would necessarily have altered the subsequent course of events). However, as discussed the FOB result was in many ways irrelevant as [Ms A] required further review given she was experiencing colorectal symptoms. I note the Department of Corrections has strengthened its results management procedures and policies which is appropriate. It is unclear why the MO letter was not sent to [Ms A] (if this was the case) and this might require further internal review. **The MO concerned ([Dr B]) provided an additional response to HDC dated 7 March 2022. She confirms the FOB result was received on 11 May 2019 and was reviewed by her the same day. Following review of the result [Dr B] booked [Ms A] for her next available appointment (22 May 2019) and sent a message to nursing staff: *I am not clear of the cause of the pos result — may relate to haemorrhoids but the pt need review/investigation of this result as needs to have a cancer ruled out.* [Dr B] confirms she had no knowledge when [Ms A] was likely to be**

[1] https://aucklandregion.communityhealthpathways.org/ Section titled 'Colorectal Symptoms' Accessed 11 January 2022

released from prison and the appointment was made with the assumption it would be completed and [Ms A] assessed and managed as clinically indicated. I therefore retract my statement above referring to delays in acknowledging the result. I believe [Dr B's] overall approach to the situation was conscientious and, on reflection, I am not sure how many of my colleagues would have made an effort to contact the prisoner's regular GP under the circumstances: young patient with outlet type rectal bleeding (most likely benign cause) which she had been sufficiently concerned about to seek medical advice while in prison and presumably would do the same in the community if her symptoms persisted, particularly as [Dr B] had made the effort to write to the patient advising her to seek such an assessment. I believe best practice would be to notify the patient's GP in the circumstances described but I withdraw the mild criticism referred to above.

… ”