Management of referral for specialist assessment of prison inmate (14HDC00547, 20 May 2016)

Prison health services ~ Gum health ~ Registered nurse ~ Medical officer ~ Gastroenterology referral ~ Right 4(5)

Over a period of a year, an inmate at a Department of Corrections (Corrections) facility (Prison 1) regularly presented written requests to prison staff for medical treatment of toothache and bleeding gums.

On 24 December 2011 the man was reviewed by a registered nurse (RN) and was placed on the dental waiting list. On 18 January 2012 the man was examined by the RN who reported no sign of blood in the man's mouth.

On 23 January 2012 the man was seen by a dentist and had scaling of his teeth, a polish, and some temporary fillings. On 22 February 2012 it was recorded that the man had reported improvement in his gum problem following dental attention, but it had recurred. A further dental appointment was made.

On 12 March 2012 the man underwent periodontal procedures. On 17 September 2012 he underwent extraction of two teeth. On 7 November 2012 a diagnosis of gingivitis was made, antibiotics were prescribed, and the problem appeared to resolve.

The man began to experience loose bowel motions. On 29 November 2012 the man saw a medical officer. No significant symptoms were observed. It was discussed with the man that given his young age (he was in his 20s) and negative family history, there was no indication to investigate further for malignancy.

In early December 2012 the man told prison staff that his bowel symptoms were persisting. Nursing staff arranged a medical review for 13 December 2012. However, the medical officer was sick and the man's appointment was rescheduled. The man was not able to attend a 19 December 2012 appointment owing to custodial restrictions.

On 14 January 2013 the man was seen by a locum medical officer, who sent a referral letter to the Gastroenterology Department at the local public hospital (DHB1). The referral queried diagnoses of irritable bowel syndrome or inflammatory bowel disease, and whether a colonoscopy was indicated.

The man was transferred to Prison 2 on 14 February 2013. The transfer documentation did not refer to the man's pending gastroenterology referral. Also on 14 February 2013, DHB1 wrote to Prison 1's health service declining the referral and requesting additional tests. On 20 February 2013 a medical officer provided Prison 1 health service staff with blood test and faecal specimen request forms to complete for the man. The forms were not actioned by Prison 1 staff, and staff did not tell Prison 2 that further tests were required or that the gastroenterology referral had been declined. The medical officer was not told that the man had been transferred to another prison.

A medical officer at Prison 2 wrote a referral to the local DHB (DHB2) shortly after the man's arrival. The medical officer "cut and paste[d]" the original referral, did not re-date it, and sent it to DHB2. He was not aware at the time that DHB1's referral had been declined and further tests had been requested. On 30 May 2013 the medical officer ordered a variety of blood tests. The results were unremarkable.

On 12 September 2013 the medical officer reviewed the man. He requested that the Prison 2 health service follow up with DHB1, but his request was not actioned. On 4 November 2013 the medical officer sent a further referral letter to DHB2's Gastroenterology Service, which was actioned. By that time, it had been eight and a half months between Prison 1's health service receiving notification from DHB1 that further information was required to process the original referral, and the actioned referral to DHB2.

On 7 May 2014 the man attended a specialist appointment with DHB2's gastroenterologist. Repeat blood tests were arranged. The man was released from prison on 6 August 2014 and did not attend a follow-up appointment on 5 November 2014. The repeat blood test results were not significant, and the gastroenterologist discharged the man back to primary care.

This case highlights a breakdown in communication within Prison 1 and between the health services of Prison 1 and Prison 2 regarding a transferring prisoner. The deficient communication meant that Prison 2's health service did not have all the relevant clinical information when the man arrived there, and this contributed to a delay in the man being re-referred for a gastroenterology assessment. The co-ordination and continuity of care relating to the man's bowel issue management was compromised. Corrections staff did not communicate and co-operate to ensure quality and continuity of services and, accordingly, breached Right 4(5).

Overall, the care the man received in relation to his gum health was found to be reasonable in the circumstances, although some aspects were suboptimal.

Criticism was made of Prison 2's medical officer for not ensuring that his documentation was accurate, dated correctly, and reflected in the electronic record.

The Deputy Commissioner recommended that Corrections:

- provide a written apology to the man;
- evaluate the effectiveness of the current process adopted to ensure that a transferring prisoner's custodial status takes into account information regarding pending specialist medical referrals, and is communicated to the health services of the facility the inmate is leaving and the recipient facility;
- provide an update and evidence of the completion, progress and effectiveness of all changes made to practice, including auditing its processes to review compliance with documentation standards expected of registered nurses and medical officers;
- share the learning from this case across all correctional health services; and
- explore the implementation of communication tools and further enhanced electronic methods to improve interdisciplinary clinical communication