Department of Corrections

Registered Nurse, RN C

Registered Nurse, RN D

A Report by the

Health and Disability Commissioner

(Case 13HDC01048)

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Executive summary

1. Mr B, aged in his late 30's, was an inmate at a prison. Mr B had a history of asthma and eczema but was otherwise healthy.

2. In 2011, on 29 Month1[1], registered nurse (RN) RN C assessed Mr B in the Prison Health Services Clinic as he was feeling unwell, and noted that he had possibly experienced a blackout three days earlier. RN C did not consider Mr B to be acutely unwell, so she booked him in to see a doctor at the routine weekly clinic on 4 Month2.

3. On 4 Month2, Mr B was reviewed by general practitioner (GP) Dr E, who noted that Mr B had not been taken to the daily main prison clinic as an urgent case, and did not present in a manner requiring urgent care. Dr E noted that there was no record that Mr B had reported any health issues since RN C's assessment of him on 29 Month1. Dr E considered that Mr B had possibly been suffering a viral infection or a "thyroid issue", either of which had resolved. Dr E ordered a thyroid screen and a full blood count.

4. On 7 Month2, RN C arranged to see Mr B to collect blood for the tests ordered by Dr E. Mr B had a headache and had vomited that morning. RN C took Mr B's blood but did not examine him. She noted that she would review him on the afternoon round. However, RN C did not review Mr B that afternoon and does not recall why.

5. At around 10pm that evening, RN D and RN F arrived at the prison and were advised that Mr B had recently had an unwitnessed seizure and needed to be reviewed. RN D assessed Mr B in his cell, accompanied by RN F, who did not assess Mr B.

6. RN D noted that Mr B had recently had a seizure, had banged his head on the wall, and had a lump on his forehead. She noted that he was feeling a lot better and his conversation was coherent. RN D advised Mr B to contact the prison officers overnight if he needed further assistance, and to see a nurse in the morning. RN D then returned to the Health Services Clinic to record her assessment of Mr B.

7. At 11.15pm, Mr B suffered a further seizure, and approval was sought for prison officers to enter his cell. After a few minutes Mr B appeared to have recovered and was able to speak with prison staff. At approximately 11.30pm, Mr B suffered a further seizure, became unconscious, and stopped breathing. Emergency services were contacted, and two ambulance units arrived at the prison at 12.05am.

8. After 45 minutes, ambulance officers were able to detect Mr B's pulse. He was then transported to hospital.

9. Over the next four days in hospital Mr B continued to experience seizures, and his condition deteriorated. On 11 Month2, respiratory support for Mr B was withdrawn and, sadly, he died early the following morning.

[1] Relevant months have been referred to as Month 1-Month2 to protect privacy.

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Findings

10. On 29 Month1, RN C failed to undertake an adequate assessment of Mr B, and subsequently failed to arrange for an immediate medical review. Furthermore, on 7 Month2, RN C did not either review Mr B herself or make arrangements to ensure that another registered nurse was alerted to the need to review Mr B. Accordingly, RN C failed to provide services to Mr B with reasonable care and skill and breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

11. On the evening of 7 Month2, RN D's management plan for Mr B was suboptimal and demonstrated a departure from accepted standards of nursing care. By failing to refer Mr B for a medical review, RN D failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

12. The Department of Corrections was not found directly liable or vicariously liable for RN C's or RN D's breaches of the Code. However, other comment was made about the timeliness of custodial staff responses to medical emergencies.

Complaint and investigation

13. The Commissioner received a complaint from Mr A about the services provided to his son, Mr B, by the Department of Corrections. The following issues were identified for investigation:

- *Whether the Department of Corrections (the prison) provided an appropriate standard of care to Mr B between 1 Month1 and 12 Month2.*
- *Whether RN C provided an appropriate standard of care to Mr B between 1 Month1 and 12 Month2.*
- *Whether RN D provided an appropriate standard of care to Mr B between 1 Month1 and 12 Month2.*

14. The parties directly involved in the investigation were:

Mr A	Complainant
RN C	Registered nurse/provider
RN D	Registered nurse/provider
The Department of Corrections	Provider

Also mentioned in this report:

Dr E	General practitioner
PO G	Prison officer
PO H	Prison officer

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

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PCO I	Principal corrections officer
PO J	Prison officer
Mr K	Mr A's lawyer

15. Information was also reviewed from:

RN F	Registered nurse/provider
Coroner	

16. Independent expert advice was obtained from registered nurse Dawn Carey (**Appendix A**).

Information gathered during investigation

Introduction

17. Mr B (aged in his late 30's at the time of these events) was an inmate at the prison. Mr B had a history of asthma and required both Ventolin[3] and Flixotide[4] inhalers. He also had a history of eczema. Otherwise, Mr B was in good health.

18. Between Month1 and Month2, Mr B experienced seizures and blackouts. He was seen by a nurse and a doctor in the Department of Corrections Health Service (the Health Service). On 7 Month2, Mr B suddenly became unconscious and stopped breathing, and was transferred to hospital. He died four days later having suffered a serious brain injury.

19. This report considers the care provided to Mr B by the Department of Corrections (Corrections) and its staff between Month1 and Month2.

The Prison Health Service

20. Corrections provides primary healthcare services to inmates through its Health Service, which is staffed by nurses and doctors. Nurses at the prison health service are employed by Corrections, while doctors are contracted by Corrections to provide medical care.

21. Inmates can access the Health Service in a number of ways. To access non-urgent health services, inmates can attract the attention of custodial staff or submit written requests for medical attention, called "chits". Chits are collected by custodial staff on a daily basis and triaged by Health Service staff.

22. In addition, nurses undertake daily medication rounds to supply or administer required medication to inmates in their cells. During medication rounds, inmates can attract the attention of the nurses and request medical attention. If an assessment is required, the

[3] A prescription medicine, inhaled for immediate relief in the treatment or prevention of asthma or similar reversible breathing difficulties.
[4] A prescription steroid medication used as a preventative for asthma, rather than for immediate relief.

HDC

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nurses usually arrange for the inmate to attend the Health Service Clinic (the Clinic) rather than undertaking an assessment in the inmate's cell, unless an urgent assessment is required.

23. Inmates also have access to an emergency call bell in their cells, to be used if they require urgent medical attention.

Nursing service

24. In 2011, Health Service nurses were on site from 6am until 9pm each day. During the week there were four nurses on shift during the day shift, and four on the afternoon shift. On weekends, there were four nurses on the day shift, and three on the afternoon shift. In addition, there was a team leader on each shift and a Health Centre Manager. From 9pm until 6am the following morning, one nurse was on call.

Documentation

25. During daily medication rounds, or while inmates are in lockdown,[5] nurses attend to inmates in their cells, rather than at the Clinic. With regard to the documentation of assessments by nurses in an inmate's cell, Corrections told HDC that nurses could "record any notes on paper in some form or another … ". Following their assessments of inmates, the nurses return to the Clinic to record their assessments in the Medtech[6] system.

26. In response to the provisional opinion, Corrections advised that the option to access clinical records outside the secure computer network is not available owing to constraints imposed by cell phone jamming across prison sites. It advised that nurses have access to manual processes while in the cells, and that it is its expectation that a nurse would manually document any observations at the time of an assessment. It stated:

> "[A]t the prison all nurses when they are on an accommodation block have access to a 'notes sheet' that records the patients name, current location and current medication. There is space on this form for nurses to record any requests for further support or care, including any observations and staff are expected to transfer this information into the electronic record after they return to the health centre."

27. Furthermore, it advised that in an emergency situation, the "emergency bag" contains provisions for making manual notes, which are then transferred into the electronic record. The manual notes can be transferred with the patient if the patient is then transferred to another facility. Corrections stated that it is not acceptable to conduct an assessment without recording it in some manner.

[5] At approximately 4.45pm every day, all prisoners were required to be locked in their cells and viewed by custodial staff.
[6] An electronic patient management system.

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Assessments

29 Month1 — first review, RN C

28. On 29 Month1, RN C undertook the daily medication round, during which Mr B attracted her attention and requested a review as he was feeling unwell. RN C asked Mr B to come to the Clinic for the assessment. Mr B accompanied RN C to the Clinic, escorted by a prison officer.

29. With regard to her assessment of Mr B, RN C recorded in the clinical notes:

> "Seen in upper prison clinic on request of prisoner. States he has been having heart palpitations lasting a short time, and query a black out [three days ago], found himself on the floor, and cannot remember how he got there. [Blood pressure] 106/60[7]\[weight] 58 … Blood sugar Level (BSL) — 9.5 [elevated]."

30. This was the first occasion on which Mr B reported to the Health Service regarding having experienced a blackout, or similar event. RN C recalls also checking Mr B's pupils. RN C told HDC:

> "I would also have checked his respirations and pulse and skin colour. I know that his observations were normal and required no immediate follow up. I don't know why those other observations are not recorded in Medtech. I may have been phoned, called away to another prisoner or the officer may have said he had to go before I could complete my documentation after the assessment. I may have had to go and give medications before lockdown and not gotten back to complete the documentation. I apologise for my documentation being incomplete."

31. RN C said that Mr B "did not appear to be in any discomfort or look unwell". She said that she had never observed Mr B having a fit or seizure, and that there was "no acute indication that required immediate referral". RN C booked Mr B to see a doctor at the next routine weekly clinic on 4 Month2. She believes that she "verbally handed over details" of her assessment of Mr B to the afternoon staff, however, this is not documented.

4 Month2 — second review, Dr E

32. On 4 Month2, Mr B was reviewed by general practitioner (GP) Dr E,[8] with RN C also present. Dr E stated that she took into consideration that Mr B "had not been taken down to the daily main prison clinic as an urgent case; nor did he present in a manner requiring urgent care", and he had not reported any health issues since RN C's assessment of him on 29 Month1. Dr E recorded in the clinical notes:

> "Here for review has had an episode of feeling unwell when ended up on the floor? This lasted about 2–3 mins where he couldn't [lift] his head, felt like lead. Vomited after this. Maybe 19th [Month1]. Had a six day period of feeling heart palpitations. No Diarrhoea and no fevers and otherwise well. Wasn't incontinent of urine nor faeces at the time of this episode.

[7] Normal blood pressure for a healthy adult is generally considered to be between 140/90mmHg and 90/60mmHg.

[8] Dr E is vocationally registered in general practice.

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> [History] of superficial head injury in […] or so when hit on left side of forehead and required stitches but not [knocked out]. Is feeling well now. [Family history] [details of family history]. \[blood sugar level] 7[9] pulse regular 60/min … Plan for fasting bloods and review if needed. He will let nurse know if any further issues."

33. Dr E said that Mr B told her that he had had only one loss of consciousness "some two weeks prior" to her assessment of him. She believes he was referring to the same event he had reported to RN C on 29 Month1. Dr E said that Mr B told her he had experienced palpitations in the six days following 19 Month1, but he had been feeling well since the palpitations ceased, approximately 10 days prior to her assessment of him.

34. Dr E told HDC that her "diagnostic opinion was that [Mr B] had been suffering a viral infection of some sort which had resolved … or possibly a thyroid issue which had also resolved. A viral infection could have caused him to faint and to vomit. A thyroid issue could have caused the palpitations …"

35. Dr E ordered a thyroid screen and a full blood count. This was the only time Dr E saw Mr B.

9.30am 7 Month2 — third review, RN C

36. At 9.30am on 7 Month2, RN C saw Mr B in order to collect the blood for the tests ordered by Dr E. RN C recorded that Mr B had a headache, had vomited that morning, and his temperature was 35.5°C.[10] RN C did not examine Mr B at that time, but noted: "Will review on p.m. round."

37. However, RN C did not review Mr B that afternoon. She told HDC that she does not recall why she did not do so. RN C also noted that at 4.45pm every day custodial staff perform lockdown, at which time all inmates are locked in their cells and viewed by custodial staff. RN C said that if there had been any concerns about Mr B's health at that time, custodial staff would have contacted the Health Service. No further concerns about Mr B were raised while RN C was on duty that day.

Evening 7 Month2 — fourth review, RN D

38. At approximately 10.10pm on the evening of 7 Month2, night watch Prison Officer (PO) PO G received a call via the emergency call bell in Mr B's cell. According to PO G, Mr B told him that he had experienced a fit and was not feeling well, and he asked to see a nurse.

39. Shortly after PO G's call from Mr B, RN D and RN F, who were off duty, arrived at the main prison building on a personal matter. RN D said that as they were leaving, PO G told them that Mr B had recently had an unwitnessed seizure and needed to be attended to. RN C and RN F decided to attend to Mr B to "save getting on-call [nurse] out of bed".

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[9] Results between 5–11 from a non-fasting glucose blood test are unclear and generally indicate that further assessment is required.

[10] Normal body temperature in an adult is between 36.4°C and 37.6°C (approximately 0.6°C either side of 37°C).

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40. PO G contacted the Principal Corrections Officer (PCO), PCO I, and sought permission to unlock Mr B's cell for the nurses. PO G then arranged for transportation of the nurses to Mr B's cell. At approximately 10.20pm, RN D and RN F, accompanied by PO H, PO G, and PO J, arrived at Mr B's cell and found him sitting on his bed. RN D assessed Mr B, but RN F did not assess him.

41. RN D recorded in the clinical notes:

> "Prisoner states he has had a seizure, and has banged his head on wall. [On arrival] prisoner sitting on bed. Prisoner stated he was feeling a lot better. Conversation coherent. Has sustained lump to L) side forehead, nil bruising noted. Nil c.o nausea, vomiting. B/P 140/70 HR 74 (reg) Afebrile. Mobility unaltered. C/o pain R) wrist, nil bruising noted …"[11]

42. RN D recorded that the lump on Mr B's forehead had a "bubble type appearance, not painful to touch. Approx 1.5cm x1cm" and appeared to have fluid under the skin. She told HDC that Mr B had "good colour" but, as she did not have access to a torch, she could not assess his pupil dilation.

43. RN D told HDC that she asked Mr B "if there had been any trouble for him in the wing recently … [Mr B] quietly answered no. [She] also asked [Mr B] if he had taken any illegal substances recently. Answer no."

44. RN D then returned to the Clinic to review Mr B's clinical notes. She noted that Mr B had recently been seen by a doctor, and that bloods had been collected that morning. She noted his history of palpitations in Month1, and the prior collapse and vomiting. Having reviewed Mr B's clinical notes, she returned to his cell to discuss with him his options.

45. Initially, RN D told HDC that she advised Mr B to see a nurse in the morning, to which he agreed. RN D said that there was no clinical indication for referral to hospital for medical assessment at that time. PO H and PO J both told Corrections in statements provided during its internal review of these events, that they recall that Mr B was "advised to see the nurse" the following morning.

46. However, subsequently RN D told HDC that she gave Mr B two options: either to see a nurse the following morning; or to go to hospital that evening for further assessment. RN D said that Mr B chose to wait until the following morning to see the registered nurse, which she agreed to arrange. There is no record of RN D's discussion with Mr B.

47. According to RN D, RN F put Mr B's mattress on the floor, and advised him to prepare a bed there in case he had a further episode during the night. RN D asked the prison officers to check Mr B regularly during the night. RN F recalls RN D "advising the officers that if they [became] concerned or the prisoner's health deteriorate[d]

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[11] RN D did not take to Mr B's cell anything with which to record her assessment of him. This was in accordance with usual practice at the time. For this reason, the records were written after the assessment, when RN D returned to the Clinic.

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over night, [they were to] call an ambulance". RN D recorded: "Prisoner prepared bed on floor. Will ring bell for prison officers if requires further assistance."

48. RN D told HDC that it was usual practice for Health Service staff not to take into inmates' cells anything to document assessments, so she had to go back to the Clinic, which was approximately five minutes away, to record her assessment of Mr B on Medtech.

49. RN D and RN F then left the prison. PCO I told HDC that following RN D's review he was informed that there were no concerns regarding Mr B.

Deterioration of Mr B

50. PO G told Corrections, during the course of its internal review of these events, that at approximately 11.15pm the prisoner in the cell next to Mr B alerted him that Mr B "appear[ed] to be having a fit". PO G said that Mr B did appear to be "having a fit". PO G instructed PO H to retrieve the key to Mr B's cell from the guard room, and PO G contacted PCO I via radio to request permission to unlock Mr B's cell.

51. PCO I told Corrections that at 11.20pm PO G contacted him and told him that Mr B appeared to be having problems breathing. PCO I told PO G to stand by with a cell key and to monitor Mr B until he arrived. He gave PO G approval for an "emergency unlock" if it was required in the interim.

52. PO G stated that he monitored Mr B while he waited for PCO I. Mr B appeared to be "ok after a few minutes" and began talking to PO G. Mr B then had another fit. PO G called Mr B's name and kicked the door in an attempt to get a response from him. According to PO G, Mr B was "ok after a few seconds".

53. At 11.30pm, PCO I and PO J arrived at Mr B's cell. PCO I unlocked and entered Mr B's cell. Mr B was lying on the mattress on the floor taking short quick breaths. According to PCO I, Mr B said that he did not know what was wrong, but he was not feeling well. Mr B said that he could not move or stand.

54. PCO I stated that while he was speaking to Mr B:

> "[H]e grimaced, [clenched] his teeth and clenched his fists tightly. His colour changed quickly, face turned red, and he was not responding. He became still, his colour returned to normal, but did not respond to anything. He was unconscious. Could not identify signs of breathing."

55. PCO I asked PO G to squeeze Mr B's earlobe to see if he reacted to pain stimulus. However, Mr B did not respond. PCO I said that Mr B's eyes were partially open but not moving. At 11.54pm, PCO I went to the guardroom and called an ambulance. PCO I told Corrections that, while waiting for the ambulance:

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"I got the officers to put the prisoner on his back, and clear his airway, one hand under neck, other hand on forehead, and head tilted back, in preparation for CPR.[12] Officers [G, H and J] commenced CPR resuscitation."

Ambulance service

56. At 12.05am, two ambulances and a fire engine arrived at the prison. With the assistance of the prison officers, the ambulance officers moved Mr B from his cell and into the corridor between cells. POs G and J continued CPR while the ambulance officers used a defibrillator[13] to try to resuscitate Mr B. He had a cardiac arrest and was treated with eight shocks and five doses of 1mg adrenaline and amiodarone,[14] and was intubated.[15] After approximately 45 minutes, the ambulance officers were able to detect Mr B's pulse.

57. Mr B was then transported to a public hospital (the hospital). He remained unconscious throughout the transfer.

The hospital

58. At approximately 1am on 8 Month2, Mr B was admitted to the hospital. A drug screening test taken on arrival was negative. At 4.20am, Mr B was admitted to the Intensive Care Unit (ICU), where he was sedated and ventilated. At 1.15pm, the hospital informed Corrections that Mr B was in a critical condition.

59. Over the next four days, Mr B continued to have seizures, and his condition deteriorated. At 10.15pm on 11 Month2, respiratory support for Mr B was withdrawn. Sadly, Mr B died the following day.

Subsequent events

60. Following Mr B's death, Corrections undertook a review of the care provided to him. Corrections advised:

"Consequent to [Mr B's] death the Corrections Health Management Team have consulted with the National Clinical Governance Committee and concluded that further support should be provided to frontline staff in order to deliver best practice health assessments for all prisoners in emergency situations.

Opportunities are being investigated for the provision of advanced physical assessment training courses which align with the current mandatory Pre-Hospital Emergency Care training [that] all nurses are required to complete and maintain with refresher courses.

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[12] Cardiopulmonary resuscitation (CPR) is an emergency procedure involving manual chest compressions, performed to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest.

[13] A device used to deliver a therapeutic dose of electrical energy to the heart of a patient who does not have a pulse.

[14] An anti-arrhythmic medication, used to assist in restoring a normal heartbeat.

[15] A medical procedure involving the insertion of a tube into the body.

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A project has been instigated to improve clinical documentation including the description of medical care provided …"

Further information

RN C

61. With regard to her documentation of her 29 Month1 assessment of Mr B, RN C said:

"In comparison to my Medtech entries of 17 [Month1] and 7 [Month2], the 29 [Month1] entry seems cut short. In the other two entries I have documented my plan for treatment. It may have been that I was logged out during my entry on 29 [Month1] and did not get back to it because of a lack of log in access … I cannot say for sure if this happened on the day in question … but it may explain why the entry was short.

I believe the prison Medtech system at the time was integrated between all the prisons in New Zealand and used two points of logging in. I believe when we logged on to the system it went to [another centre] and sometimes the system got over loaded and logged us out … I recall we would have to wait until someone logged off in [another centre] for example before we could log on at [the prison].

If I did have issues on this particular day, it is possible I didn't complete my documentation. I had to be down at the main clinic for handover by 1200 hrs and may have decided to log on in the main clinic, however, finding a computer that was free to use was another added problem … we had 4 computers for approximately 6–8 nurses on duty, plus for 2 visiting forensic nurses to use for completing their documentation. When the computers are out of action due to an overload the medical staff would have to revert back to the old way of handwritten documentation. We had the old paper forms available to put into the clinical charts when this happened."

Corrections

62. With regard to RN C not reviewing Mr B on the afternoon of 7 Month2, Corrections stated:

"Workloads can fluctuate due to a variety [of] demands, an emergency on site for example, may mean that work has to be prioritised and some people deferred. However, patients have access to custodial staff at all times (either in person, or via their emergency call bell in their cell) and if required when symptoms persist can request access to health staff."

63. Corrections told HDC that placing the mattress on the floor is common where there is the potential for seizures. Corrections stated: "Having implemented this does not infer that the nurse believed seizure activity was likely but that it was possible."

64. Following this incident Corrections carried out a clinical review conducted by a registered nurse and a GP. The report notes that RN C failed to document Mr B's heart rate and that this would have been "an expected base-line recording" but notes that Mr B was booked for further assessment with a doctor. The report goes on to

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state that "there was no heart rate taken when [Mr B] first presented with a history of palpitations and an ECG was not ordered during the initial Medical Officer consultation. While this is not a significant departure from standard practice, these assessments may have provided information to support further assessments or interventions for [Mr B]."

65. The report concludes that at the point of the clinical assessment carried out by Dr E on 4 Month2, the treatment plan was "within the accepted range of expected care from General Practice".

66. In relation to RN D's decision not to refer Mr B for an assessment on 7 Month2, it is noted that RN D's decision was "based on her clinical decision on the information at hand at that current point in time and not with the benefit of hindsight". In relation to RN D's decision-making, the report states that "[Mr B] was stable and reported feeling much better when assessed by the nurse. The nurse could also have decided to send [Mr B] to the emergency department to err on the side of caution for a review." The report concludes that "[t]he clinical assessment and care provided was equal and similar to what would be expected from primary care services."

Relevant Department of Corrections policies

Health Services Health Care Pathway (relevant in 2011)

67. "**8.2 General Procedure for Clinical Management**

In their clinical management of prisoners, Health Services staff will:

- Communicate with appropriate internal and external services, if required, so that they have all the relevant information before they carry out a clinical intervention. This also means the prisoner receives continuity of care.

…

- Place a recall or an appointment in the Appointment Book functionality when required using the MedTech functionality to ensure continuity of care.

…

9.1 Policy on Clinical Documentation

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

…

- Document all assessments and interventions in the prisoner's electronic clinical file.
- Document all assessments and interventions before going off duty for the day.

…

11.1 Policy on Accessing External Health Providers

Our policy on accessing external health providers is that:

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…

- Health Services must access external health providers when they need to, according to the symptoms a prisoner presents with …

11.2 Policy on Making Referrals to External Health Providers
Our policy on making referrals to external health providers is that Health Services staff must:

- Refer a prisoner, as clinically indicated, to secondary or tertiary health services after the prisoner has had a health assessment. The Medical Officer is the main person who should refer prisoners to secondary and tertiary services; however, a registered nurse can refer a prisoner to an external provider if this is within their scope of practice.

…"

Response to provisional opinion

RN C

68. In her response to the provisional opinion, RN C reiterated her submission that following her assessment on 29 Month1 she was satisfied that Mr B did not require a referral for urgent medical review.

69. RN C submitted that her actions are supported by the action subsequently taken by the doctor who assessed Mr B on 4 Month2. RN C stated:

> "[T]he medical officer is the main person who should refer prisoners to secondary and tertiary services …. The medical officer did not consider [Mr B] to need referral either to emergency services or to secondary or tertiary services after her assessment on 4 [Month2]."

70. RN C further submitted: "Ms Carey's opinion that emergency treatment was required on 29 [Month1] is with the benefit of hindsight, and as also previously noted, it remains unclear as to the cause of [Mr B's] sad death."

71. RN C accepted that her documentation for the 29 Month1 assessment was incomplete, but stated that it was "probably related to the medtech system in 2011". RN C said that she "wishes to apologise to [Mr B's] family for that and to offer her condolences".

RN D

72. In relation to RN D's discussion with Mr B about his management options following her assessment on the evening of 7 Month2, RN D reiterated that she discussed the option of Mr B either seeing a nurse in the morning or going to hospital for further assessment.

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73. RN D submitted that HDC is drawing unfair conclusions based on the fact that she has provided two differing accounts — her first response stated that she advised Mr B to see the nurse the following morning and that she did not consider that a hospital referral was indicated, while her second response stated that she also gave Mr B the option of going to hospital that night but Mr B chose to see the nurse the following morning. RN D submitted that her first statement was made before the HDC investigation commenced, while her second statement was made after she was notified as part of the investigation and, therefore, was more carefully considered.

74. RN D also submitted that HDC should not rely on the statements of the prison officers, as she considers it unlikely that they would have heard her conversation with Mr B, and they recounted the information she told them following her conversation with Mr B.

75. RN D stated that "in the circumstances, it is unfair … to conclude that [she] did not discuss the option of a referral to hospital with [Mr B]".

76. In relation to the appropriateness of waiting until the next morning for Mr B to be reviewed by a nurse rather than referring him to the hospital for urgent review that night, RN D submitted that her actions were reasonable in the circumstances. She referred to the clinical review carried out by Corrections following the incident and noted that, at the time of her assessment, Mr B was "stable and reported feeling much better", that although she "could also have decided to send [Mr B] to the emergency department to err on the side of caution for a review … [t]he clinical assessment and care provided was equal and similar to what would be expected from primary care services".

77. RN D noted that Corrections' clinical review was carried out by clinicians who "are appropriately qualified to comment on [her] decision regarding referral in this case", as well as "having a detailed understanding of the provision of primary health services in a prison setting". RN D submitted that Corrections' review "appropriately has regard to Mr B's presentation at the time of that assessment and the fact that he was in a supervised environment overnight pending further nursing assessment in the morning".

78. RN D noted that another review was carried out by the Inspector of Corrections, which concluded that "the standard of health care afforded to [Mr B] in prison was entirely consistent with what might be expected within the community".

79. Furthermore, RN D submitted:

> "While prisoners are of course entitled to the same standard of care as non-prisoners, the prison environment creates particular challenges and pressures not seen in the community setting. It is therefore appropriate that evidence from appropriately qualified and experienced experts is taken into account."

80. RN D concluded that "… this evidence supports [her] actions and that, on balance, [her] actions were reasonable and did not breach the Code".

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Mr A

81. In response to the "information gathered" section of the provisional opinion, Mr A stated that his family has lost a valued and loved member, and that this has caused him a great deal of unhappiness and financial hardship because "Corrections just didn't care enough".

Preliminary matters

Overview of health care in Corrections

82. The Corrections Act 2004 (the Act) states that "a prisoner is entitled to receive medical treatment that is reasonably necessary". The Act requires that "the standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public".[16] In addition, in accordance with the Code, Corrections has a responsibility to operate its health service in a manner that provides consumers with services of an appropriate standard.

83. In assessing the appropriateness of the care provided in this case, I have also considered that a person being held in custody does not have the same choices or ability to access health services as a person living in the community. People being held in custody do not have direct access to medical care, and are entirely reliant on the staff at the health centre to assess, evaluate, monitor, and treat them appropriately, including appropriate referral or escalation of care.

84. For the avoidance of doubt, I note that my role does not extend to determining Mr B's cause of death. My role is to assess the quality of care provided to Mr B, in light of the information that was known to his healthcare providers at the time that care was provided. Accordingly, my opinion should not be interpreted as having any implication as to the cause of Mr B's death.

85. Furthermore, I note that during my investigation no concerns were raised regarding the standard of care Dr E provided to Mr B.

86. During the course of my investigation I have considered the roles of the two registered nurses who attended Mr B on the evening of 7 Month2. RN D and RN F both agree that RN F did not assess Mr B. Accordingly, my opinion in relation to the assessment of Mr B on the evening of 7 Month2 relates only to RN D.

[16] Corrections Act 2004, section 75.

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Opinion: RN C — breach

29 Month1 — first review

Assessment

87. On 29 Month1, RN C assessed Mr B in the Clinic at his request. She recorded in the clinical notes:

> " … States he has been having heart palpitations lasting a short time, and query a black out on the 26th [Month1], found himself on the floor, and cannot remember how he got there. [Blood pressure] 106/60 \[weight] 58 … Blood sugar Level (BSL) — 9.5 [elevated]."

88. RN C recalls also checking Mr B's pupils, respirations, pulse, and skin colour. However, she did not document these assessments. She does not know why she did not document anything further, but said she may have been called away or interrupted before she was able to complete her clinical notes. In response to the provisional opinion, RN C stated that her lack of documentation was "probably related to the medtech system in 2011".

89. The importance of the medical record is well established. It is often stated by medical defence lawyers that "if it isn't documented, it didn't happen". Indeed, this Office has often observed that providers whose evidence is based solely on their subsequent recollections (in the absence of written records) may find their evidence discounted.[17]

90. In the absence of any other evidence, I do not accept RN C's statement that she checked Mr B's pupils, respirations, pulse, and skin colour. I consider it more likely than not that RN C's assessment of Mr B is accurately reflected in her clinical documentation.

91. My expert advisor, Ms Dawn Carey, advised:

> "I would have expected the RN to have done a full set of respiratory and cardiovascular observations … I would also have expected the RN assessment and documentation to have noted relevant history pertaining to the symptoms such as a description of the palpitations; how long do they last, how frequently do they occur, do they occur at rest or upon exertion or following inhaler use, accompanied by pain or breathlessness …"

92. RN Carey advised that such questioning is necessary to evaluate the clinical significance of the reported symptoms. I agree with RN Carey's advice, and am critical of RN C's inadequate assessment.

Referral for medical review

93. RN C documented that Mr B had a possible blackout on 26 Month1. Subsequently, on 4 Month2, Dr E referred to Mr B having had a blackout on 19 Month1. Dr E also noted that Mr B confirmed that he had had only one blackout, and she believed that

[17] See, for example, Opinion 12HDC00779 at www.hdc.org.nz.

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this was the event referred to in RN C's notes. Having considered the information available, I accept that as at 29 Month1, Mr B had experienced only one possible blackout that RN C was aware of, although the exact date of the event is unclear. Furthermore, the palpitations were also a new symptom.

94. When RN C assessed Mr B, she did not consider him to be acutely unwell or requiring immediate follow-up, so she booked him to see a doctor in the routine weekly clinic six days later, on 4 Month2.

95. RN Carey advised that "[b]ased on the available documentation" it is her opinion that [Mr B] should have been reviewed by a medical officer on 29 [Month1]. She stated: "In my opinion, this would be the expected response had [Mr B] presented to a community 'accident and medical' clinic or practice nurse clinic …"

96. I agree with RN Carey's advice. Given the information available to RN C at that time (Mr B's recent palpitations and a possible blackout), I would expect that a registered nurse would be concerned and would escalate those concerns by seeking immediate medical review.

97. I acknowledge that RN C arranged for medical review of Mr B in the routine weekly clinic; however, I consider that her failure to arrange for an immediate review of Mr B was suboptimal.

9.30am, 7 Month2 — third review

98. At 9.30am on 7 Month2, RN C collected Mr B's blood sample and recorded that he had a headache and had vomited that morning. RN C noted that she would review him during the afternoon round. However, she did not review Mr B that afternoon. She said that if custodial staff had had any concerns regarding Mr B during lockdown, they would have contacted the Health Service.

99. RN Carey advised that RN C performed a reasonable assessment of Mr B on 7 Month2, and her plan to review him that afternoon was appropriate. However, RN Carey advised that "due to the fact that [Mr B] was limited in his ability to access health care and [RN C] was aware that the reported symptoms could be part of a trend", she was critical that RN C did not put arrangements in place to alert another registered nurse to the need for review of Mr B.

100. The Corrections Health Services Health Care Pathway with regard to general procedure for clinical management, valid at the time of these events, states that a healthcare provider should: "Place a recall or an appointment in the Appointment Book [in Medtech] to ensure continuity of care."

101. I am critical that RN C did not either review Mr B herself on 7 Month2 or place a recall or appointment in Medtech to alert another registered nurse on duty to the outstanding need to review Mr B.

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Conclusion

102. On 29 Month1, RN C failed to undertake an adequate assessment of Mr B, and subsequently failed to arrange for his immediate medical review. Furthermore, on 7 Month2, RN C did not either review Mr B herself or make arrangements to ensure that another registered nurse was alerted to the need to review Mr B, in the event that she was unavailable to do so. Accordingly, RN C failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RN D — breach

7 Month2 — clinical assessment

103. At 10.00pm on 7 Month2, RN D was told that Mr B had recently had an unwitnessed seizure and needed to be reviewed.

104. When RN D arrived at Mr B's cell, he was sitting on the bed and greeted her. RN D recorded that Mr B had experienced a seizure and banged his head on the wall. She noted that he had a lump on the left side of his forehead, which was approximately 1.5cm by 1cm with a "bubble type appearance", but he had no bruising. Mr B told her that he was feeling "a lot better" and was not nauseous.

105. RN D asked Mr B whether there had been any trouble for him in the wing recently, or whether he had taken any illegal substances, and he responded "No" to both questions.

106. Ms Carey advised me that RN D's assessment of Mr B was "… generally comprehensive … She assessed him for signs of post-ictal[18] confusion and complications relating to his sustained head injury … I note that he denied a headache, was coherent, conversing normally and [not] complaining of visual disturbance such as diplopia". I accept RN Carey's advice and consider that RN D's assessment of Mr B was in accord with accepted standards.

Escalation or referral for medical review

107. Initially, RN D said that she advised Mr B to see a registered nurse the following morning. She said that there was no clinical indication for referring him to hospital for medical assessment at that time. Likewise, PO H and PO J both recall that Mr B was "advised to see the nurse" the following morning.

108. However, RN D subsequently said she told Mr B that he could either see a nurse the following morning, or go to hospital that evening for further assessment, and he chose to wait until the following morning to see a nurse, which she agreed to arrange. There is no record of RN D's discussion with Mr B regarding these options.

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[18] The altered state of consciousness following a seizure.

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109. RN D's initial statement to HDC, as well as statements from PO H and PO J, made to Corrections shortly after these events, refer only to RN D advising Mr B to see a nurse in the morning.

110. I note RN D's submission in response to the provisional opinion that her first statement to HDC was provided before she was notified of the investigation and therefore it is unfair to criticise her for omitting all the details regarding her assessment and discussions with Mr B. I also note her submission that she considers it likely that the prison officers did not hear her discussion with Mr B, and that their recollections are consistent with the plan she subsequently relayed to them after the discussion regarding options had occurred. However, there is no documentation that RN D suggested that Mr B could be referred to hospital for medical review that evening.

111. The importance of the medical record is well established. It is often stated by medical defence lawyers that "if it isn't documented, it didn't happen". Indeed, this Office has often observed that providers whose evidence is based solely on their subsequent recollections (in the absence of written records) may find their evidence discounted.[19]

112. In the absence of any documentation to support RN D's submission that she offered to Mr B the option of going to hospital for medical review that evening, I remain of the view that it is more likely than not that RN D did not suggest this as an option to Mr B.

113. At the time of these events, Corrections had in place a comprehensive policy that covered general procedures for clinical management, including communication with internal and external providers, as well as accessing and making referrals to external providers. The policy detailed the obligations of health professionals in accessing and referring inmates to both internal and external providers, when clinically indicated. The clinical decision-making as to when a referral is clinically indicated is the individual responsibility of the health professional.

114. RN Carey is critical of RN D's failure to seek a further medical review of Mr B. She advised:

> "[RN D] should have sought a medical review of [Mr B] either by the oncall MO or at a hospital … [Mr B] was not a known epileptic and this was the second reportage of possible seizure activity[20] without a cause being determined. Also he was noted to have a head injury, which in my opinion required ongoing monitoring."

115. RN D submitted in response to the provisional opinion, with reference to Corrections' clinical review, that the decision not to refer Mr B for urgent assessment was reasonable in the circumstances. RN D noted that the finding of the review was that

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[19] See, for example, Opinion 12HDC00779 at www.hdc.org.nz.

[20] RN Carey clarified that she considers the first report of "possible seizure activity" to have been during Mr B's consultation with RN C, in which it was recorded "… query had a black out … ". She considers 7 Month2 to have been episode two.

HDC

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her "clinical assessment and care provided was equal and similar to what would be expected from primary care services".

116. However, I note Ms Carey's advice that, taking into account that "[Mr B] was not a known epileptic and this was the second reportage of possible seizure activity without a cause being determined", it would have been appropriate practice to refer him to hospital for ongoing monitoring and notify the on-call nurse.

117. I accept Ms Carey's view that RN D's management plan was suboptimal and demonstrates a departure from accepted standards of nursing care. Accordingly, by failing to refer Mr B for a medical review, RN D failed to provide services to Mr B with reasonable care and skill on the evening of 7 Month2, and breached Right 4(1) of the Code.

Opinion: Department of Corrections — other comment

Assessment and referral

118. Corrections had a duty to Mr B to ensure that services were provided that complied with the Code. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994, an employing authority may be vicariously liable for acts or omissions by an employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

119. This Office has previously found providers not liable for the acts or omissions of staff, when those acts or omissions clearly relate to an individual clinical failure made by the staff member.[21]

120. I am satisfied that, in general, Corrections had appropriate systems in place to enable the provision of adequate care to Mr B. However, it was suboptimal that RN D was unable to assess Mr B's pupillary response on 7 Month2 because there was no torch available.

121. As outlined above, at the time of these events, Corrections had a comprehensive policy in place detailing the obligations of health professionals in accessing and referring inmates to both internal and external providers, when clinically indicated. In my view, Corrections' expectations in respect of referrals were clear, and it took reasonable steps to prevent RN D's breaches of the Code. The clinical decision-making around when a referral is clinically indicated is the individual responsibility of the health professional. RN Carey advised that based on the information known to RN D, she should have referred Mr B for medical review.

[21] See, for example, Opinion 12HDC01483 (12 July 2013) available at: www.hdc.org.nz.

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122. I consider that RN C’s and RN D’s failures were individual failings. Accordingly, I do not consider that Corrections is directly liable or vicariously liable for RN C’s or RN D’s breaches of the Code.

Custodial staff response to medical emergencies

123. Custodial staff are not clinically trained, and are not expected to make clinical decisions. However, Mr B was reliant on custodial staff to ensure that he received health services. For this reason, it is essential that custodial staff, as the first point of contact for inmates, respond appropriately when presented with medical emergencies. I am concerned that on the evening of 7 Month2, when custodial staff attended to Mr B at 11.30pm, there was a 24-minute delay between when custodial staff unlocked Mr B’s cell, and when an ambulance was called at 11.54pm. This is particularly concerning given Mr B’s comments to custodial staff that he could not move or stand, and his subsequent seizure.

Recommendations

124. I recommend that RN C:

a) Provide a written apology to Mr B’s family for her breach of the Code. The apology is to be sent to HDC within **three weeks** of this report, for forwarding to Mr B’s family.
b) Provide an undertaking to this Office, within **three weeks** of this report, to undergo further education and training on the assessment of a deteriorating patient, if she returns to work as a registered nurse.

125. I recommend that RN D:

a) Provide a written apology to Mr B’s family for her breach of the Code. The apology is to be sent to HDC within **three weeks** of this report, for forwarding to Mr B’s family.
b) Undertake further education and training on the assessment of a deteriorating patient. RN D is to report back to this Office, within **four months** of this report, with evidence of the training undertaken.

Follow-up actions

- A copy of this report with details identifying the parties removed, except the Department of Corrections and the name of the expert who advised on this case, will be sent to the Nursing Council of New Zealand. They will be advised of RN D and RN C’s names.
- A copy of this report will be sent to the Coroner.

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Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from HDC's in-house nursing advisor, registered nurse Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from barrister, [Mr K]. [Mr K] has complained about the standard of nursing care provided at [the prison] to his client's son, [Mr B]. Following a cardiac arrest at [the prison] on 8 [Month2], 2011, [Mr B] died in the ICU at [the hospital]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation: complaint and correspondence from [Mr K] including report from [a doctor]; response from Corrections Services (CS) including statement from [RN D], statement from [Dr E]; [the prison] clinical file for [Mr B] including Medtech notes ([Month1] and [Month2] 2011), […] referral letter, Prisoner treatment plan, Doctor's prescribed medication chart; [the ambulance service's]) patient report form.

3. I have been asked to review the nursing care provided to [Mr B] on 29 [Month1] and 7 [Month2] and to respond to specific questions.

4. For the purposes of brevity I have not repeated the provider's response. I note the content is in keeping with the available contemporaneous clinical documentation.

5. Review of clinical records and comments
   (i) [Mr B] was a [male in his late 30's] who was 170cms in height. He was a known smoker, had a documented medical history of asthma and eczema. Regular medications were Salbutamol inhaler, Fluticasone inhaler and steroidal creams.

   (ii) Thursday, 29 [Month1]: [Mr B] was reviewed at his request. He reported to the RN that he had been having *heart palpitations lasting a short time, and query a black out on 26th [Month1], found himself on the floor and he cannot remember how he got there.* Documented observations: blood pressure (BP) 106/60mmHg, weight 58kgs, and blood glucose level (BGL) 9.5mmols/L. I note that his recorded BP was normal whilst his BGL was elevated.

   (iii) [Mr B] was subsequently reviewed by the Prisoner Medical Officer (MO) on [4 Month2]. Medtech entry reports that *had an episode of feeling unwell when ended up on the floor. ?This lasted 2–3 mins where he couldn't his head, felt like lead* (sic). *... Vomited after this ... Had a six day period of feeling heart palpitations ... Wasn't*

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incontinent of urine nor faeces at the time of this episode … Is feeling well now. [Details of family history] ... BGL 7, *pulse regular 60/min. Plan for fasting bloods and review if needed.*

(iv) Thursday, 7 [Month2] 9.20am: the RN reports seeing [Mr B] to obtain consent and process the requested blood tests. ... *Prisoner states he had another episode of nausea and vomited this morning prior to his bloods. C/o slight headache ... T 35.5. Plan: will review on pm med round.* The CS response reports that the planned review did not occur due to other commitments.

(v) Thursday, 7 [Month2] approximately 10pm [RN D] and other RN colleague arrived at [the prison] for the purpose of collecting her professional portfolio. The night watch Prison Officer mentioned that … *there was an unwell prisoner in [the prison]*. [RN D] agreed to see [Mr B] *to save getting on call out of bed ...* Nursing standards and competencies apply regardless of [RN D] not being the rostered duty RN.

(vi) Medtech entry 7 [Month2] 10.30pm: *Asked to see … Prisoner states he has had a seizure, and he has banged his head on wall. O/A Prisoner sitting on bed ... stated feeling a lot better. Conversation coherent. Has sustained a lump to L side forehead, nil bruising noted. No c/o nausea, vomiting. BP 140/70, HR 74 reg. Afebrile ... will ring bell for prison officers if requires further assistance.* Response reports that a note was made for the morning duty RN to review [Mr B].

(vii) At approximately 12.30am, [Mr B] reported experiencing shortness of breath and then collapsed. Cardiopulmonary resuscitation was commenced by attending Prison Officers before the arrival [of Paramedics]. [Mr B] was transferred to [the hospital], and he was cared for in the ICU. Despite therapeutic hypothermia being commenced, he demonstrated significant hypoxic brain injury and died in the ICU on 12 [Month2].

6. Response to specific questions:

(i) <u>Assessment of 29 [Month1]</u>

a. Did the nurse undertake an adequate assessment of [Mr B]?

No, there is no evidence that an adequate assessment was undertaken by RN C. Based on the reported symptoms, I would have expected the RN to have done a full set of respiratory and cardiovascular observations — BP and heart rate noting rate, rhythm — and if available, a 12 lead electrocardiogram (ECG). I would also have expected the RN assessment and documentation to have noted relevant history pertaining to the symptoms such as a description of the palpitations; how long do they last, how frequently do they occur, do they occur at rest or upon exertion or following inhaler use, accompanied by pain or breathlessness etc. In

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my opinion, such questioning is a typical feature of RN assessment and necessary to enable the RN to evaluate the clinical significance of the reported symptoms.

b. Should the nurse have facilitated a higher priority referral for medical review?

Yes. Based on the available documentation I consider that [Mr B] should have been reviewed by a medical officer (MO) on 29 [Month1]. In my opinion, this would be the expected response had [Mr B] presented to a community 'accident and medical' clinic or practice nurse clinic.

Had the RN undertaken a comprehensive assessment of [Mr B] and this indicated that the palpitations were benign or non cardiac; I would accept the delayed (4 [Month2]) MO review. However, I consider that most — non cardiology specialist — RNs would still discuss such findings with the MO and seek agreement first. I would also expect such a discussion to be reported in the Medtech notes.

c. Was the documentation of the nurse's assessment of the required standard?

No, as in the 'plan' assigned to [Mr B] should be documented e.g. booked for MO review, whether the RN gave [Mr B] any clinical advice etc. Registered nurses are responsible and accountable for ensuring that their practise meets the expected legislative and professional standards. The maintenance of accurate and contemporaneous clinical documentation is necessary for continuity of care and is a competency requirement set by NCNZ[22].

In my opinion, the standard of clinical documentation demonstrates a mild departure from the expected standards.

d. Should a formal follow-up plan have been put in place?

In general yes, but it would depend on what the RN considered as possible reasons for [Mr B's] reported symptoms. A response should be sought from RN C.

e. Any other comments you may wish to make about the nursing consult

In my opinion, [RN C's] assessment in response to [Mr B's] reported symptoms was inadequate and a moderate departure from expected standards. I am strongly of the opinion that if a RN lacks the clinical knowledge of how to 'triage' reported symptoms then they must seek advice from a senior RN colleague or MO. I would also expect such advice to be sought before the patient is discharged from the health facility.

(ii) <u>Assessment of 9.20 am, 7 [Month2]</u>

a. Did the nurse undertake a reasonable assessment of [Mr B]?

Yes, nausea, vomiting and a slight headache are not unduly concerning symptoms in adults.

[22] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).

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b. Was the plan put in place reasonable?
Yes, it was reasonable and appropriate that [RN C] planned to review [Mr B's] condition later the same day.

c. Was the documentation of this encounter of the required standard?
Yes.

d. Was the suggested follow up / management plan reasonable in the circumstances
Yes.

e. When the suggested follow up plan was unable to occur, should this have triggered a further nursing review?
Yes, due to the fact that [Mr B] was limited in his ability to access health care and [RN C] was aware that the reported symptoms — 7 [Month2] — could be part of a trend. I am mildly critical that there was nothing in the [the prison's] system that supported another RN being alerted to the outstanding need for a review.

f. Any other comments you may wish to make
No.

(iii) <u>Assessment of 11.30 pm, 7 [Month2]</u>
a. Did [RN D] undertake a reasonable assessment of [Mr B]?
Yes, [RN D's] reportage demonstrates a generally comprehensive assessment of [Mr B]. She assessed him for signs of post-ictal confusion and complications relating to his sustained head injury. Whilst I am mildly critical of the failure to assess and record his pupillary reaction, I note that he denied a headache, was coherent, conversing normally and able to move his mattress without complaint of visual disturbance such as diplopia.

b. Should further investigations / referral to hospital have been sought at this time?
In my opinion, the RN should have sought a medical review of [Mr B] either by the oncall MO or at a hospital. I consider that this should have been sought at this time as [Mr B] was not a known epileptic and this was the second reportage of possible seizure activity without a cause being determined. Also he was noted to have sustained a head injury, which in my opinion required ongoing monitoring.

c. Should the on call nurse have been called in and notified of the situation?
Yes. While I consider [RN D's] initial response was appropriate and in accordance with expected standards of nursing assessment, I am of the opinion that [Mr B] required further medical assessment and ongoing monitoring.

d. Was the management plan put in place adequate?
No. In my opinion the management plan was suboptimal and demonstrates a moderate departure from the expected standards of nursing care.

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e. Was the documentation of this encounter of the required standard?
Yes.

f. Any other comments you may wish to make.
[RN D] and her colleague demonstrated collegial support — wishing to not disturb the oncall RN — and appropriate care in relation to the prompt first aid assessment and treatment provided to [Mr B]. Unfortunately collegial generosity and being 'off duty' does not change the professional standards that apply to the decision making and the inadequacy of the management plan that was put in place for [Mr B].

7. Clinical advice
Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards[23]. In my opinion, the nursing care provided to [Mr B] at [the prison] departed from expected standards in relation to assessment, monitoring, management and clinical documentation."

The following further expert advice was obtained from RN Carey on 13 January 2015:

"1. Thank you for the request that I provide additional clinical advice in relation to the additional information being received from the providers. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the complaint from barrister, [Mr K]; response from [RN C]; response from [RN D]; response from Department of Corrections. No response has been received from [RN F].

3. I have reviewed the additional responses. I acknowledge that in my advice dated 28 May 2014, I reported that the received complaint letter concerned the standard of nursing care provided. The received complaint refers to the 'standard of care' without further specification and I apologise for reporting otherwise.

I note that [RN C] reports that she completed observations — respiration rate, pulse and skin colour — on 29 [Month1] but did not record these assessment findings in the Medtech entry. She also reports that an ECG machine was not available at the prison in 2011. Due to the passage of time, [RN C] cannot remember why she did not document all of [Mr B's] vital signs but shares work related factors that may have affected her documentation on that occasion.

[23] For example Health and Disability Services Standards (2008); The Health Practitioner's Competence Assurance Act (2003); Nursing Council of New Zealand (NCNZ) *Competencies for registered nurses* (2007); New Zealand Nurses Organisation *Documentation* (2010).

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While I note [RN C's] assertion that there was no acute indication for an immediate medical officer (MO) referral on 29 [Month1], I continue to hold the opinion expressed in 6(i)b of my preliminary advice. In my experience, it would not be uncommon for vital signs to be unremarkable in a patient who reports a history of palpitations but is not currently experiencing them. As previously noted, I would expect the RN assessment to explore the symptoms — description, onset, duration etc — and to discuss this assessment with a MO before deciding that it was appropriate to discharge a patient without being seen. Following a review of [RN C's] response, I remain critical of the nursing assessment in response to [Mr B's] reported symptoms.

I note that [RN D] was unable to assess [Mr B's] pupillary response on 7 [Month2] as there was no torch available. I had expressed mild criticism of the lack of pupillary assessment but noted that the assessment was otherwise comprehensive. I am no longer critical of [RN D] failing to assess [Mr B's] pupillary response. I do however remain of the opinion that while [RN D's] initial response on 7 [Month2] was appropriate, a medical review of [Mr B] should have been sought. I remain critical that this did not occur.

I acknowledge the work completed by the Department of Corrections following [Mr B's] death and the subsequent investigations. I note that both RNs report factors that made it difficult to consistently meet clinical documentation standards in 2011. In my opinion, the Department's exploration of opportunities for nursing staff to gain advanced physical assessment training has validity and is appropriate.

4. Clinical advice

Following a review of the additional responses I remain of the opinion that the nursing care provided to [Mr B] departed from the expected standards of nursing care in relation to assessment, monitoring, management and clinical documentation."

Names have been removed (except 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.