Provision of health care to prison inmate
(14HDC01769, 15 June 2016)

Prison ~ Wound care ~ Treatment ~ Medication management ~ Pain ~ Circulation issues ~ Right 4(1)

An older man was transferred from one prison to a second prison for short periods on two occasions in order to appear in Court. The man's hospital discharge summary and other healthcare information was provided to the health centre at the second prison. This included instructions to dress blisters on the man's toes daily and at other times as needed. At this time, the man was prescribed medications for pain relief. Some of the man's medications and his drug chart and signing sheets were left on the bus when he was transferred to the second prison. They were returned to the second prison several days later.

There is no record that the man's feet were checked or treated while he was at the second prison. The clinical record states that the man was to be seen in a nurse clinic to review the blisters on his feet, but there is no record that this occurred. A doctor saw the man and recorded in the notes that staff were to watch carefully for any signs of infection. However, there is no record that this occurred or that his feet were checked or treated after this appointment.

The man shared a cell with another prisoner, who said he cleaned the man's toes with toilet paper every morning.

The medication administration signing sheets show that the man was not always administered paracetamol, OxyContin and OxyNorm in accordance with the prescriptions, and there is no documentation reporting the reason for non-administration.

When the man returned to the first prison, nursing staff recorded comments in the clinical record about his poor physical state, and noted that toilet paper was soaked off his toes with warm water.

The man returned to the second prison for a few days. The healthcare plan sent to the second prison required health staff to "check and dress feet daily to prevent further damage"; however, there is no record that this occurred.

On his return to the first prison, the man handed a bag of medications to an officer and said he had been given it when he left the second prison, without instructions on what to take or how often. The man was not an approved self-medication prisoner, and there is no record of this medication having been handed to him at the second prison.

The lack of treatment of the man's feet and the failures in relation to medication management cumulatively amount to a significant departure from accepted standards. There was a pattern of failures by multiple providers responsible for the man's care, and ultimately the second prison is responsible for those failures. The operator of the second prison failed to ensure that the man was provided services with reasonable care and skill and breached Right 4(1).

Adverse comment is made about the failure of the operator of the first prison's systems to ensure that the man's documentation and medications arrived at the second prison.