Serco New Zealand Limited

Department of Corrections

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC01769)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2011 Mr A was sentenced to a period of imprisonment. Mr A was sent to prison (Prison 1).

2. In 2012, Mr A was diagnosed with low grade B-cell non-Hodgkin's lymphoma,[1] stage IV. He commenced chemotherapy in 2013, in Month2.[2] He had admissions to Hospital 1 between Month1 and Month4 for chemotherapy and treatment of pneumonia and circulation issues with his hands and feet.

3. Mr A was transferred from Prison 1 to Prison 2 for court hearings from 24 Month4 to 11 Month5, and from 14-18 Month5. At that time, Prison 2 was operated by Serco New Zealand Limited (Serco) pursuant to a contract with the Department of Corrections (Corrections).

First transfer to Prison 2

4. Mr A's hospital discharge summary and other healthcare information was provided to the health centre at Prison 2. This included instructions to dress blisters on Mr A's toes daily and at other times as needed. At this time, Mr A was prescribed medications including OxyContin, OxyNorm[3] and paracetamol for pain relief. Some of Mr A's medications (excluding OxyContin and OxyNorm) and his drug chart and signing sheets were left on the bus when Mr A was transferred from Prison 1 to Prison 2. They were not returned to Prison 2 until 27 Month4.

5. There is no record that Mr A's feet were checked or treated between 24 and 27 Month4. The clinical record states that Mr A was to be seen in a nurse clinic on 28 Month4 to review the blisters on his feet, but there is no record that this occurred. A doctor at Prison 2 saw Mr A on 31 Month4 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 31 Month4.

6. Mr A shared a cell with another prisoner from 28 Month4 to 11 Month5. That prisoner said he cleaned Mr A's toes with toilet paper every morning.

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

8. When Mr A returned to Prison 1 on 11 Month5, nursing staff recorded comments in the clinical record about Mr A's poor physical state, and noted that toilet paper was soaked off his toes with warm water.

[1] Lymphoma is the general term for cancers that develop in the lymphatic system.
[2] Relevant months are referred to as Months 1-9 to protect privacy.
[3] OxyContin and OxyNorm are types of opioid pain relief medication (analgesia) and are controlled drugs.

Second transfer to Prison 2

9. Mr A returned to Prison 2 on 14 Month5, where he remained until 18 Month5. The healthcare plan sent from Prison 1 to Prison 2 required health staff to "check and dress feet daily to prevent further damage"; however, there is no record that this occurred.

10. On 23 Month5, Mr A handed a bag of medications to a Corrections officer at Prison 1 and told the officer he had been given the medication when he left Prison 2 without instructions on what to take or how often. Mr A was not an approved self-medication prisoner, and there is no record of this medication having been handed to him at Prison 2.

11. Mr A died in hospital later that year.

Findings

12. The lack of treatment of Mr A'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 Mr A's care, and ultimately Serco is responsible for those failures. Accordingly, Serco failed to ensure that Mr A was provided services with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[4]

13. Adverse comment is made about the failure of Corrections' systems to ensure that Mr A's documentation and medications arrived at Prison 2.

Complaint and investigation

14. The Commissioner received a complaint from the former Chief Ombudsman about the services provided to Mr A by Prison 2, after an investigation was undertaken by the Inspector of Corrections.[5] The following issues were identified for investigation:

- *The appropriateness of the care provided by Serco New Zealand Limited (trading as Prison 2) to Mr A in Month4 and Month5 2013.*
- *The appropriateness of the care provided by the Department of Corrections to Mr A in Month4 and Month5 2013.*

15. This report is the opinion of Kevin Allan, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

[4] Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.
[5] The complaint was supported by the executor of Mr A's estate, Ms B, and Mr A's brother.

16. The parties directly involved in the investigation were:

Serco New Zealand Limited (Prison 2)	Provider
Department of Corrections	Provider
The former Chief Ombudsman	Complainant
Ms B	Executor of consumer's estate
Mr C	Consumer's brother

17. Other parties mentioned in this report:

RN D	Head of Clinical Services at Prison 2
RN E	Registered nurse
Dr F	Medical practitioner[6]

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

Information gathered during investigation

Background

19. In 2011 Mr A was sentenced to a period of imprisonment and sent to Prison 1.

20. Mr A had a mass near his right eye that initially was investigated in 2012 at Hospital 1. He underwent further investigations in 2012 and was diagnosed with low grade B-cell non-Hodgkin's lymphoma, stage IV,[7] and was to commence chemotherapy on 21 Month1. However, Mr A was admitted to Hospital 1 from 13 to 27 Month1, where he was treated for pneumonia.

21. On 15 Month2 Mr A was admitted to Hospital 1 overnight for the insertion of a portacath.[8] He commenced chemotherapy treatment on 22 Month2 and remained in hospital for the treatment until 24 Month2. On 7 Month4 Mr A was admitted to hospital for further planned chemotherapy but was found to be suffering from pneumonia again.

22. On 14 Month4, Hospital 1 advised Prison 1 that Mr A would remain in hospital for a further five days for treatment because he had cold hands and feet. On 20 Month4 the

[6] Dr F is vocationally registered in general practice.
[7] In stage IV adult non-Hodgkin's lymphoma cancer is found throughout one or more organs that are not part of a lymphatic area (lymph nodes, tonsils, thymus, or spleen); or in one organ that is not part of a lymphatic area and has spread to lymph nodes away from that organ; or cerebrospinal fluid, the liver, bone marrow, or lungs.
[8] A portacath is a small medical appliance that is inserted beneath the skin. A catheter connects the port to a vein. The port has a septum through which drugs can be injected and blood samples can be drawn many times, usually with less discomfort for the patient than a needle stick.

charge nurse advised Prison 1 that Mr A still had "a couple of black toes" and would be having a vascular review to consider amputation of the toes.

23. On 23 Month4, Mr A was discharged from Hospital 1 to Prison 1. The charge nurse at Hospital 1 advised Prison 1 health service staff that Mr A was fit to travel to a court appearance, and that he required dry dressings on his feet and should be encouraged to keep wearing socks and gloves.

24. The discharge summary information (as recorded in the Prison 1 notes on 24 Month4) included:

> "Was initially treated for probable pneumonia. Reacted to [antibiotics] and they also queried a reaction to chemo[therapy]. He was commenced on cream for severe purpuric rash.[9] Dusky 3rd, 4th finger [right] hand, 4th and 5th fingers [left] hand and feet. Treated with [ten days of] Ilioprost[10] infusion due to pain and tingling in feet, commenced on gabapentin[11] and OxyContin/OxyNorm[12] with good effect. Has dry dressing to blisters on feet that he had picked at. Follow up continue felodipine[13] as per vascular, vascular [outpatient appointment] [1 month], continue gabapentin. To be weaned off OxyContin/OxyNorm as vasospasm improves. Also advised to use socks to avoid further injury."

Prison 2

25. At the time of these events, Prison 2 was operated by Serco New Zealand Limited (Serco) and was one of the privately managed correction facilities in New Zealand. Serco is a multi-national service provision company.

26. Since these events, Prison 2's healthcare services have come under the management of the Department of Corrections (Corrections) since 1 April 2016.

27. The Ministry of Health has a memorandum of understanding (MOU) with Corrections dated 4 December 2012, which ensures that offenders are provided with the same health services as those provided to the general population in New Zealand. This MOU applied to Serco until December 2014, at which time service level agreements between Serco and two district health boards were signed.

Serco medication policy

28. Serco has a medication policy[14] that requires all prisoners receiving medication to have a Health Services approved medication chart on which medical officers document all medication they prescribe. The policy requires that prescriptions for controlled drugs be written on a controlled drug prescription pad. The nurse or healthcare assistant (HCA) administering the medication must adhere to the

[9] Purpura, also called blood spots or skin haemorrhages, refers to purple-colored spots on the skin.
[10] Ilioprost is used to treat circulatory problems.
[11] Gabapentin is used for the treatment of neuropathic pain.
[12] OxyContin and OxyNorm are types of opioid pain relief medication (analgesia) and are controlled drugs.
[13] Felodipine is a medication used to control hypertension (high blood pressure).
[14] Medication Policy version 2.0 dated 17 January 2013.

instructions of the prescriber. The policy states: "Deviation from [the prescriber's instructions] must be discussed with a Medical officer if clinically appropriate as soon as practical. These deviations e.g. withholding medications must be recorded on the medication chart or approved signing sheet."

29. The medication policy states that all controlled drugs, apart from methadone,[15] are to be administered by a registered nurse (RN).

30. The medication policy requires that a controlled drug register (CDR) be kept in the prison health centre, and that two people (one of whom must be a registered nurse), must sign the CDR for all controlled drugs being transferred in and out of the controlled drug safe. When administering controlled drugs, two health staff members (one of whom must be a registered nurse) must check the controlled drug against the medication chart prior to administration. If this is not possible because no other health service staff member is on site, then one registered nurse may check the controlled drug with another person on site. The process for administering controlled drugs includes:

> "• Sign the balance in the Controlled Drug Register
>
> …
>
> • Record in the patient's electronic clinical file of any circumstances where the patient has not received their controlled medication and the reasons why."

Secondary care

31. Serco told HDC that when a prisoner is received at Prison 2 or presents to the health service with a condition that requires secondary care,[16] a referral is sent to the relevant DHB, and this is tracked by the health administrator to ensure it is acknowledged and appointments are arranged. For an acute medical condition, the doctor or nurse will hand over to emergency department staff verbally and with a written referral.

Health care at Prison 2 24 Month4–11 Month5

32. On 24 Month4 at 8.30am Mr A was transferred from Prison 1 to Prison 2 for the court appearance. Before he left, his medications were administered[17] and his medications and medication charts were given to prison transportation staff to accompany him.

33. The health centre manager at Prison 1 contacted the head of clinical services at Prison 2, RN D, and provided information about Mr A, and also sent via facsimile a copy of the Hospital 1 discharge summary (dated 23 Month4) including a wound care plan. The wound care plan relating to the blisters on Mr A's third and fourth right toes and fifth left toe noted that Mr A had impaired circulation and stated that the blisters on his toes were to be dressed once daily and at other times as needed.

[15] Methadone is used as a substitute drug in the treatment of morphine and heroin addiction.
[16] Hospital level.
[17] Including OxyContin and OxyNorm.

34. RN E saw Mr A in the Prison 2 receiving office and completed a reception health triage, which placed him as priority "3 — routine". RN E recorded her observations of Mr A:

> "[A]ppears fine. Sitting on an office chair with wheels saying he needs a wheel chair as he is unstable on his feet. However, when told we do not have any wheelchair for him here he mentioned to me he will be able to 'shuffle' around. Informed him his meds would have arrived with him and that we will continue same. Has no other issue. Happy to be moved to the unit now."

35. RN D later advised the Inspector of Corrections that there were two wheelchairs held on site but Mr A was not provided with one "as he was mobile without and this was confirmed again in [Month5] when he commented he could move short distances unaided".

36. At 9.47pm on 24 Month4, RN E emailed RN D stating that she had seen Mr A in the receiving office at 3.55pm and that his transfer orange bag, which was sealed when it arrived, contained Mr A's hard copy medical file and some medication. The email states that a healthcare assistant opened the bag and found only OxyNorm and OxyContin and no drug chart or signing sheet. The email states that no other medications were in the bag.

37. At this time, Mr A had been prescribed the following medication (as stated on the Hospital 1 discharge summary):

- OxyNorm 5–10mg up to every two hours (PRN) as needed
- Panadol 1g four times daily
- Omeprazole[18] 20mg twice daily
- Allopurinol[19] 100mg once daily
- Lamivudine[20] 100mg once daily
- Aspirin 100mg once daily
- Fatty cream
- Laxsol[21] 2 tablets twice daily
- Gabapentin 200mg three times daily
- OxyContin 35mg twice daily
- Felodipine[22] 5mg once daily

38. Because some of Mr A's medications were missing, a medical practitioner at Prison 2 wrote a prescription for Cartia,[23] Panadol, felodipine, gabapentin, fatty cream, Laxsol, allopurinol and omeprazole.

[18] Omeprazole is used to treat gastroesophageal reflux disease and peptic ulcer disease, and to prevent upper gastrointestinal bleeding in people who are at high risk.
[19] Allopurinol is used to treat gout or kidney stones, and to decrease levels of uric acid in certain cancer patients.
[20] Lamivudine is used to treat chronic hepatitis B.
[21] For the treatment of constipation.
[22] Felodipine is given to treat high blood pressure. It is also taken to help prevent chest pain.

39. RN E told RN D in her email that she had administered all Mr A's evening medications except for the gabapentin, which she had arranged for the pharmacy to deliver urgently in the morning as it was not in stock.

40. Mr A's missing medications were found later at Prison 3, as they had been left on the bus when he arrived at Prison 2. The medications and documentation that had been found at Prison 3 were not returned to Prison 2 until 27 Month4.

Accommodation

41. Mr A was placed in a cell with another prisoner from 24 to 27 Month4. On 28 Month4 he was moved into a double cell with another prisoner (Prisoner A) where he remained until he was returned to Prison 1. Prisoner A was also an older prisoner.

42. During the Inspector of Corrections' investigation (detailed below at paragraph 74), the Inspector of Corrections interviewed Prisoner A. Prisoner A said that he spent a lot of time with Mr A, and that he had to clean Mr A's infected feet twice a day. Prisoner A said he cleaned Mr A's toes every morning using toilet paper.

43. Prisoner A said that he spoke to medical staff and staff in the unit to get help for Mr A, but nobody came to see Mr A. Prisoner A said he wrote a note, which he showed to staff, asking for Mr A to see the doctor, but his requests were ignored. Prisoner A stated: "We on several occasions had asked for medication for him and he was not given any."

44. Prisoner A said that he offered Mr A his bottom bunk because Mr A was unable to climb into the top bunk owing to his infected toes; however, Mr A declined the offer, so the two made a bed for Mr A on the floor. Mr A slept on the floor during the time he shared the cell with Prisoner A.

Treatment

45. There is no record that Mr A's feet were checked and dressed between 24 and 27 Month4. On 27 Month4 the clinical records state: "At Court today. Booked for nurse clinic Mane (morning) [28 Month4] to review his blisters on feet." The notes indicate that a medical improvement outcome form was completed on that day. However, there is no record that Mr A was seen at the nurses' clinic on 28 Month4.

46. RN D told HDC that it was the responsibility of the registered nurse allocated to the nursing clinic to ensure that all prisoners booked for the clinic on a given day were seen. Serco was unable to locate either electronic or paper copies of the staff rosters for the periods of time Mr A was in Prison 2 and, therefore, the nurse responsible for the nursing clinic has not been identified.

47. Dr F, the visiting medical officer at Prison 2, told HDC that he prescribed OxyContin to Mr A on 29 Month4 without consultation because his medication had not arrived with him at Prison 2. He told HDC that he would not normally do this without seeing the patient, but he had access to all of Mr A's medical notes and wanted continuity of

[23] Cartia is also used to treat high blood pressure.

the OxyContin. Dr F recalls reading in the Hospital 1 discharge summary that Mr A's wounds needed daily dressing, and passing this information to the "duty nurse/HCA".

48. On 31 Month4 Mr A was seen by Dr F, who noted that Mr A had "severe peripheral vascular disease with dry gangrenous right middle toe". Dr F noted: "Systemically well, watch carefully for any signs of infection if gets unwell over the long weekend, send to [Hospital 2]. Better if he goes back to [Prison 1], he is well known to [Hospital 1] staff."

49. Dr F told the Inspector of Corrections that his expectation when he wrote his notes on 31 Month4 was that health staff would keep an eye on Mr A, and watch for signs of infection. There is no record of any checks of, or dressings done on, Mr A's toes for the ten days following Dr F's examination.

Medication

50. The medication administration signing sheets (MASS) show that Mr A did not receive his paracetamol as prescribed from 28 Month4 to 3 Month5 inclusive, on 6 Month5 or from 15 to 18 Month5 inclusive. There is no documentation reporting the reason for the non-administration.

51. The CDR shows that OxyContin medication was not signed out to be administered to Mr A from 4 to 6 Month5. The medication was to be issued twice daily.[24] The CDR also shows that Mr A's OxyNorm medication was not signed out to be administered on those three days. However, in conflict with the CDR, the MASS state that OxyContin and OxyNorm were issued to Mr A on 4 and 5 Month5.

52. On 7 Month5, Dr F saw Mr A again and noted that he had missed his OxyContin for four days. Dr F told HDC: "A large portion of this consultation was about missing the Oxycontin for a period of four days. [Mr A] focussed the consultation on the amount of pain he was feeling and the need for the Oxycontin to be resumed."

53. The records state: "[Mr A] is to continue these medications already charted." Dr F stated that he vividly recalls asking the HCAs (who are responsible for administering medication to inmates) to supply Mr A's medication immediately and to ensure that he received the daily prescribed dose without breaks. Dr F said that at the same time, the HCAs were made aware of the requirement for daily dressings.

54. The MASS for OxyContin shows that Mr A did not always get his medication twice daily, as prescribed. In particular, the MASS shows that on 27 Month4 and 8, 10, 14, 15 and 16 Month5 OxyContin was administered only once daily, and on 6 Month5 it was not administered at all.

55. There is also no record that Mr A received his gabapentin as prescribed on 16 Month5. Again, there is no explanatory documentation.

[24] Morning and evening.

Return to Prison 1

56. On 11 Month5 Mr A was transferred back to Prison 1. The Reception Triage Assessment Form notes: "[L]ooks absolutely shocking — says meds have been mismanaged, gave week['s] supply of something and then everything else each day at lunchtime. Toes still black, 2 look ready to drop off …" On 13 Month5 at 4pm, RN D emailed the health centre manager of Prison 1 Health Services stating that she was concerned that the record about Mr A's condition was an "over the top emotional response". However, RN D told HDC that she only became aware of the "missed cares and medications following a phone call from the [health centre manager] at [Prison 1] after Mr A had left [Prison 2]" (on 18 Month5).

57. The clinical notes for 12 Month5 state:

> "Seen at cell today for am meds, prisoner reports 'best nights sleep in two weeks' and advised has been sleeping on a mattress on the floor while at [Prison 2] as bed available to him was top bunk, which he reports unable to get onto because of painful feet, cell mate also not able to get onto top bunk."

58. Mr A was administered pain relief prior to his feet being checked, and he reported to the nurse that his cell mate had been wrapping his toes in toilet paper. On examination the nurse noted that toilet paper was stuck to Mr A's toes. She soaked this off with warm water. The notes state: "[E]xudate present, feet smelly — necrotic flesh, gauze inserted between toes, socks replaced." It was noted that Mr A had lost 6kg since 6 Month4.

59. RN D told the Inspector of Corrections that Mr A was moved several times while in Prison 2 and was in different cells with different prisoners throughout his stay. She stated:

> "[Prison 2] provided appropriate kit including mattress, bedding, bed etc, we are aware that some prisoners prefer to place mattress on the floor rather than use the bed. Although this is not necessarily ideal and advised by staff to use the bed (health and safety reasons), prisoners make this decision themselves."

Return to Prison 2 14–18 Month5

60. On 14 Month5 Mr A was again transferred to Prison 2 for a court appearance, and returned to Prison 1 on 18 Month5.

61. Prior to the transfer, Mr A's bandages were removed to enable him to wear shoes, and his feet were dressed. The Prison 1 health records note that all medications and administration records were sent with Mr A for transfer to Prison 2. The records note that his controlled drug prescription and his controlled drugs were in a bag with his medications. The "health care plan prisoner transfer information" form sent from Prison 1 to Prison 2 advised that Mr A's current treatment was to "attend oncology and vascular appointments; manage pain effectively with use of analgesia as prescribed; and check and dress feet daily to prevent further damage".

62. On arrival at Prison 2, Mr A was seen by a registered nurse who noted that his evening medications had been given in the receiving office, and recorded: "[L]eg dressing in situ." The record notes that Mr A was able to walk short distances without assistance, and that he had been seen the previous day at Hospital 1 and had been told that he would not need an amputation.

63. During the four days Mr A was at Prison 2 there is no record that his feet were checked and dressed as required by his healthcare plan.

Return to Prison 1

64. When Mr A was returned to Prison 1 on 18 Month5, he told the nurse completing the reception health triage assessment that his feet had not been looked at since he was last at Prison 1.

65. On 23 Month5, a Corrections officer on duty at Prison 1 was talking to Mr A in his cell and, during the conversation, Mr A handed the officer a brown paper bag containing medication. The Corrections officer told the Inspector of Corrections that Mr A said that a nurse at Prison 2 gave him the medication prior to his transfer back to Prison 1. When the officer asked Mr A when he was to take his medications, Mr A said that he had not been told when to take them or how many he was to take.

66. The Corrections officer took the bag of medications to the nurse on duty. On 24 Month5 the nurse recorded:

> "Informed that [Mr A] had handed to custody a brown bag of medications that he had in his cell. He informed custody that he received them at [Prison 2]. I went to the unit to speak to [Mr A] in regards to this but he is currently off site on medical escort. The bag contained the following medications:
>
> - 3 blisters of OxyContin 35mg …
> - 1 blister OxyNorm 5mg
> - 9 blisters gabapentin 200mg
> - 9 blisters omeprazole 20mg
> - 2 blisters Laxsol + felodipine 5mg
> - 1 blister lamivudine 100mg
> - 3 blisters omeprazole, allopurinol 100mg, lamivudine and aspirin
> - 1 blister allopurinol and omeprazole
> - 1 blister ferrous sulphate."

67. Mr A was not an approved self-medication prisoner, and there is no record at Prison 2 of this medication having been handed to him at Prison 2.

Mr A's letters of complaint

68. Mr A wrote two letters of complaint (on 12 and 20 Month5) about his lack of treatment at Prison 2 and being placed in a double cell with a top bunk to sleep. In his first letter Mr A wrote:

> "My feet were stinging with the pain I asked to see the doctor which was the next day he had a look at them and said we will have to keep an eye on them about 2 weeks later nothing happened, when I had to go to the toilet I had to crawl on my knees until I could reach the toilet and pull myself up."

69. In his second letter of complaint he again complained that his feet were never checked during the five days he was at Prison 2.

70. Mr A's complaints were referred to RN D. RN D told the Inspector of Corrections that Prison 1 staff advised her of the complaints by telephone on 18 Month5. RN D said that Mr A's complaints were discussed at that time, and she understood that Mr A was happy with the outcome. However, there is no documentation to confirm that Mr A's complaints were addressed by RN D. RN D told HDC that she was not aware that the complaints were formalised or sent to Prison 2.

Subsequent treatment in Prison 1

71. On 12 Month6, Mr A experienced extreme pain from the lymphoma. He was nauseated, pale and had a distended abdomen. Mr A was taken to Hospital 1 and remained there until 23 Month6, when he was returned to Prison 1.

72. In Month7, a healthcare assistant was assigned to ensure that Mr A's daily care, hygiene and medical needs were provided. During Month7 and Month8 Mr A's condition improved slightly, and he managed his daily cares with the assistance of the healthcare assistant.

73. In Month9 a nurse was called to the unit where Mr A was located because of his deteriorating condition. Mr A was admitted to Hospital 1. His condition deteriorated further, and he died in hospital.

Further information

74. In any prisoner death in the Department of Corrections' custody, the Inspector of Corrections conducts the Department's investigation into the death. That investigation is monitored by the Ombudsman. The investigation was completed on 4 August 2014.

75. The Inspector of Corrections determined that "[Mr A] received a high level of care from Health Services at [Prison 1] in relation to the management of his deteriorating health condition, both prior to the diagnosis and subsequent treatment/support of his terminal condition." The Inspector of Corrections raised concern about the standard of care provided to Mr A at Prison 2 and recommended that Prison 2 take appropriate steps to "establish why the shortcomings occurred, establish whether or not what occurred in [Mr A's] case is systemic at [Prison 2], and prevent the issues from recurring."

76. Following the Inspector of Corrections' investigation, clinical reviews of Mr A's care were completed by the Prison 2 health service and the Head of Health Services at Serco. As a result of the combined clinical reviews, a detailed health action plan was compiled that covered training and audits on medication compliance, case management system (CMS) requests, MedTech documentation training, and

controlled drug management. As part of the health action plan, registered nurses are required to oversee all medication rounds.

77. From Month3 the CDR was audited on a three-monthly basis by a pharmacist and a registered nurse; however, this audit is now carried out only every six months (per legislative requirements). From 9 Month8 health staff conducted regular audits of medication management with a focus on compliance by staff when signing off medication that had been given. Serco told HDC that audits indicate that signing sheets are accurate and matching the prescriptions.

78. Serco stated that improvements in medication management at Prison 2 are ongoing. Roster times have been changed to reflect the time needed to prepare medications; the TRAKA system[25] has been introduced for improved access to medication, and assessments are completed of prisoners eligible to "hold" a week's supply of their own medication in their cell.

79. A local competency document has been introduced for registered nurses and healthcare assistants to ensure that legislative and company requirements are followed.

80. Medication delivery rounds are supervised more robustly by custodial staff to support registered nurses and healthcare assistants. There is now regular auditing of medication charts and signing sheets, and registered nurses and healthcare assistants have completed training covering medication procedure, use of Medico Paks,[26] safe storage of medications, documentation, administration, and controlled drug management. The training occurred on 4 June 2014, and management intends to include this training in its annual training schedule.

81. With regard to sleeping arrangements for a prisoner with high health needs, an "Advice to Unit Manager" form is now sent to the appropriate custodial housing supervisor outlining the medical reason for either a single cell or a lower bunk. The expectation from the health service is that the advice is followed by custodial unit staff, with regular updates on the condition of the prisoner.

82. A revised audit schedule has been implemented that focuses on end-to-end service for prisoners at Prison 2. This will audit the processes in the receiving office when prisoners arrive, the time taken to prescribe medication, the medication administration process, compliance with policy, and the discharge or transfer process.

83. The registered nurses who were employed at the time Mr A was at Prison 2 received Serco-funded training on wound care,[27] and there was a plan in place for peer training

[25] TRAKA's key management solutions allow for control and management of medication, including a dual authorisation process for staff to access medication.
[26] Medico Pak is a disposable medication compliance system that can be configured to a patient's individual needs. It can be utilised as a multi-dose weekly pack, a seven-day unit dose, or as a monthly supply. The system allows healthcare professionals to tear off what is needed at the time, such as a single dose, a strip to cover a full day's dose, or more if required.
[27] The training was conducted in late 2013.

on wound care. The health action plan also required Serco staff to receive training using the IT systems IOMS[28] and MedTech. The training included the "SOAP" method of completing documentation, which captures subjective, objective assessment and planning data, use of the recall tab for rebooking follow-up appointments, and placing alerts on IOMS and MedTech including disability alerts. This training was completed by health staff in late 2013.

84. The Prison 2 health unit has gained Cornerstone[29] accreditation through the Royal College of General Practitioners, which involves regular, thorough auditing of clinical practice within the health service.

85. Serco told HDC that in late 2014 a change management process was instigated and the outcome was to introduce a new Health Leadership Team with a new Head of Clinical Services, Clinical Team Leader, and five additional staff.

86. Dr F told HDC: "I feel let down by the suboptimal treatment that [Mr A] received while at [Prison 2]. It was my expectation that the Health team would follow my instruction but in this case this was not adhered to."

87. Dr F noted the following improvements, which he considers have created a safer clinical environment for patients and healthcare providers at Prison 2:

> "
> - Clinical services at [Prison 2] have improved after clinical review of this case.
> - We have more staff — nurses and HCAs.
> - A full time on-site team leader.
> - Regular staff meetings leading to improved communication.
> - Effective hand over of patients with complex medical problems/needs.
> - Auditing of patient notes and medication charts.
> - Training opportunities for nurses and HCAs — for upskilling."

Further information from RN D

88. RN D stated that it was her role to manage contracted doctors, other external contractors and employed staff.

89. RN D told HDC that she did not meet or have any contact with Mr A during his visits to Prison 2. She acknowledged that Mr A's feet needed care, but said: "I was not aware he did not get this care until after he had left." She told HDC that she was not directly involved in Mr A's care including his medication management and wound care. She stated: "As no documentation around dressings can be found … I agree that potentially he did not receiv[e] dressing changes as outlined in his Treatment Plan."

90. RN D said that medication rounds were managed by the healthcare assistants in the cells, and wound care in the clinics was overseen by registered nurses. RN D said that

[28] Integrated offender management system.
[29] Cornerstone is an accreditation programme designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand.

the nurse on the early shift would be the designated shift leader for the day, and it was that nurse's responsibility to allocate staff against the duties for the day.

91. RN D said that during the four years she was employed by Serco she requested, from three different prison directors, the employment of a team leader to support and oversee the staff clinically. She said that her workload was too big to provide adequate clinical oversight, and she needed someone on the floor to help manage nursing staff.

Responses to the provisional opinion

92. Responses to the provisional opinion were received from Ms B, Serco and Corrections. Where appropriate, these have been incorporated into the report.

93. Serco told HDC that it does not dispute any of the information gathered during the investigation or the preliminary conclusions that the Deputy Commissioner has drawn on the basis of that information. Serco told HDC that it is determined to learn from the mistakes identified by the Deputy Commissioner.

94. Corrections submitted to HDC that Mr A missing his dose of Gabapentin on 24 Month4 was only partly as a result of its inaction.

Relevant legislation

95. Section 75 of the Corrections Act 2004 states:

> "**75 Medical treatment and standard of health care**
> (1) A prisoner is entitled to receive medical treatment that is reasonably necessary.
> (2) 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."

Opinion: Serco New Zealand Limited (Prison 2) — Breach

Introduction

96. Mr A was a prisoner serving a sentence of imprisonment at Prison 1. In 2012, Mr A was diagnosed with low grade B-cell non-Hodgkin's lymphoma stage IV. He commenced chemotherapy in Month2. He had admissions to Hospital 1 between Month1 and Month4 for chemotherapy and treatment of pneumonia and circulation issues with his hands and feet. Mr A required medication for pain and other conditions, and he had blisters on his feet that were to be checked and dressed daily.

97. Mr A was transferred from Prison 1 to Prison 2 on two occasions in order to attend court hearings. Mr A was at Prison 2 from 24 Month4 to 11 Month5 and from 14 to 18 Month5.

98. RN D, the head of clinical services at Prison 2 at the time of these events, told HDC that medication rounds were managed by the healthcare assistants, and wound care was overseen by registered nurses. RN D said that the nurse on the early shift would be the designated shift leader for the day, and it was that nurse's responsibility to allocate staff against the duties for the day. Serco has been unable to provide HDC with the health staff rosters for the time of these events, which is concerning.

99. There were a number of failures within Prison 2 that led to Mr A receiving treatment that was well below the accepted standard of care. While individual providers have a responsibility for the failures that occurred, in this case there was a pattern of failures by multiple providers responsible for Mr A's care. I consider that such a pattern of failures indicates systemic problems at Prison 2, for which ultimately Serco is responsible.

24 Month4–11 Month5

100. On 24 Month4 the health centre manager at Prison 1 faxed a copy of Mr A's general discharge summary from Hospital 1 to Prison 2. The discharge summary letter included a wound care plan relating to the blisters on Mr A's third and fourth right toes and fifth left toe. The wound care plan noted that Mr A had impaired circulation, and stated that the blisters to his toes were to be dressed once daily and at other times as needed.

101. Mr A's toes were dressed at Prison 1 before he was transferred to Prison 2. However, there is no record that Mr A's feet were checked or dressed by staff at Prison 2 until 31 Month4.

102. On 27 Month4 a medical improvement outcome form was completed and Mr A was booked to attend the nursing clinic on 28 Month4 for a review of his feet. However, there is no record that he was seen on 28 Month4. RN D explained that it was the responsibility of the nurse allocated to the nursing clinic to ensure that all prisoners booked for the clinic on a given day were seen. As Serco was unable to locate the staff rosters for this time, the nurse responsible for the nursing clinic has not been identified, and it is not clear why Mr A was not reviewed.

103. On 31 Month4 Mr A was reviewed by Dr F, who noted that Mr A had severe peripheral vascular disease with a dry gangrenous right middle toe. Dr F recorded that Mr A was systemically well, but instructed that staff were to "watch carefully for any signs of infection [and if he became] unwell over the long weekend [to] send [him] to [Hospital 2]". However, there is no record that there was any follow-up by Prison 2 health staff as directed by Dr F, or that Mr A's feet were checked following Dr F's examination. Dr F told HDC that he felt let down by the suboptimal treatment that Mr A received while at Prison 2, and it was his expectation that the health staff would follow his instructions.

104. My expert advisor, RN Dawn Carey, stated that there is evidence of a consistent lack of wound care or wound assessment being provided to Mr A by nursing staff despite documentation and communication advising that this was needed.

105. I note that Prisoner A said to the Inspector of Corrections, and Mr A said to Prison 1 health staff, that Prisoner A attempted to assist Mr A and wrapped Mr A's toes in toilet paper. The Prison 1 nurse noted that Mr A had toilet paper stuck to his toes, which she soaked off with warm water, exudate was present, his feet were smelly, and he had necrotic flesh. Mr A also wrote in his first letter of complaint that he had to crawl to the toilet on his knees owing to the state of his feet.

106. There is no evidence, either from Serco, Prison 2 staff, or in the records, that nursing staff at Prison 2 checked or dressed Mr A's feet between 24 Month4 and 11 Month5 as required by the Hospital 1 discharge summary and Dr F. Accordingly, I find that nursing staff at Prison 2 failed to check and dress Mr A's feet between 24 Month4 and 11 Month5. In my view, that failure was unacceptable and falls well below accepted standards of nursing care.

Medication management

107. Mr A did not receive his paracetamol as prescribed from 28 Month4 to 3 Month5 inclusive, on 6 Month5, or from 15 to 18 Month5 inclusive. There is no documentation that reports the reason for the non-administration. Mr A also did not receive his gabapentin as prescribed on 16 Month5. Again, there is no record of the reason for the non-administration.

108. Furthermore, as indicated on the MASS, on six occasions Mr A did not receive his OxyContin medication twice daily in accordance with his prescription. The CDR shows no OxyContin was signed out to be administered to Mr A from 4 to 6 Month5, and no OxyNorm was signed out to be administered to Mr A from 4 to 6 Month5. The OxyNorm was prescribed as a PRN medication — to be taken on an "as needed" basis. This gave Mr A a means to request pain relief medication when he needed it. I would have expected health service staff to offer Mr A this medication and document the reasons for non-administration if it was not taken.

109. It is particularly concerning that the MASS and CDR for 4 and 5 Month5 contain conflicting information regarding OxyContin and OxyNorm (the MASS shows the medication was administered, but the CDR does not show that the medication was signed out to be administered). This does not comply with the Serco medication policy, which requires that when a controlled drug is removed from the controlled drug safe for administration, staff sign the balance in the CDR.

110. RN Carey advised me that safe medication administration is an indicator that sits within the competencies set by the Nursing Council of New Zealand. It is evident that either the MASS or the CDR misrepresents the medication actually administered to Mr A.

111. Mr A's medication should have been administered as prescribed. At a minimum, I would have expected Prison 2 staff to offer Mr A his medication in accordance with

his prescription, and document on each occasion whether the medication was administered, and, if not, document the reason why. The Serco medication policy requires that deviations from the prescription, for example, withholding medication, should be recorded on the medication chart or approved signing sheet and on the electronic file if appropriate. It is clear that this policy was not followed in relation to Mr A's medication.

112. I agree with RN Carey's observation that had Mr A not been receiving prescribed controlled drugs, the extent of the suboptimal medication administration may not have been detected. I note Ms Carey's comment: "I am also concerned about the response of [Prison 2] that it was realised that [Mr A] had not been receiving his prescribed medication [on 7 Month5] — and the fact that suboptimal medication administration systems continued."

113. Mr A was unwell and suffering from a painful condition. 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 in custody do not have direct access to over-the-counter medications or to a GP, and are entirely reliant on prison staff to assess, evaluate, monitor, and treat them appropriately.

114. In my view, medication management at Prison 2 was inadequate. By consistently failing to provide Mr A with medication in accordance with his prescription, Prison 2 staff failed to ensure that Mr A was provided with care of an acceptable standard. In my view, ultimately Serco is responsible for the multiple medication management shortcomings of its staff, including the failure of staff to comply with its own policies, which represent a lax culture towards medication management within the health service.

115. Prisoner A told the Inspector of Corrections that he had asked for medication and help for Mr A, but Mr A was not given any. In my view, it is very concerning if these concerns were not responded to and Mr A was left in pain.

Other issues

116. When Mr A arrived at Prison 2 on 24 Month4 he said he needed a wheelchair because he was unstable on his feet. The response was that Prison 2 did not have a wheelchair for him, and it was noted in the clinical record that Mr A said that he would be able to shuffle around. However, RN D told the Inspector of Corrections that there were two wheelchairs available in Prison 2 at the time.

117. Between 28 Month4 and 11 Month5 Mr A changed cells several times. For part of that period he shared a cell with Prisoner A, who said that Mr A was not able to climb into the top bunk because he was unwell. Prisoner A was also an older prisoner and unable to climb into the top bunk. Prisoner A said that he offered Mr A the bottom bunk but Mr A refused, and so a bed was made for Mr A on the floor, where he slept during the time he shared the cell with Prisoner A.

118. In my view, these incidents demonstrate a lack of care and concern for Mr A.

14–18 Month5

119. On 14 Month5 Mr A was again transferred to Prison 2 for a court appearance and returned to Prison 1 on 18 Month5. The healthcare plan transfer information form from Prison 1 to Prison 2 advised that Mr A's current treatment was to: attend oncology and vascular appointments; manage pain effectively with use of analgesia as prescribed; and check and dress feet daily to prevent further damage.

120. However, during the four days he was in Prison 2 there is no record that Mr A was seen in order to check and dress his feet. On 18 Month5, on his return to Prison 1, Mr A told the nurse that his feet had not been looked at since he left Prison 1 on 14 Month5.

121. It appears that RN D was aware of this issue on 13 Month5 when she sent an email to the health centre manager criticising the record made by the receiving nurse at Prison 1 regarding the state of Mr A's feet when he returned to Prison 1 on 11 Month5. However, I note that RN D told HDC that she was not aware that Mr A did not receive treatment for his feet until after he had left Prison 2. She also noted that she was not directly involved in Mr A's care, including his medication management or wound care.

122. Again, there is no evidence, either from staff or in the records, that nursing staff at Prison 2 checked or dressed Mr A's feet between 14 and 18 Month5. Accordingly, I find that nursing staff at Prison 2 failed to check or dress Mr A's feet during that period. I am concerned that the Prison 2 nursing staff again did not follow the treatment plan that was provided as part of Mr A's healthcare plan. Despite the issues that had arisen when Mr A was at Prison 2 between 24 Month4 and 11 Month5, again there was no daily check of Mr A's feet to check for infection and prevent further damage.

123. I am also concerned that on 23 Month5 Mr A handed a corrections officer a bag containing medications, including controlled drugs. Mr A said that he was given the bag by a nurse at Prison 2 prior to his transfer back to Prison 1, but there is no record in Mr A's clinical records as to the circumstances in which this medication was given to him. This is particularly concerning, as Mr A was not approved to self-medicate.

Summary

124. Mr A's clinical management on both occasions while he was a prisoner at Prison 2 was seriously suboptimal in light of his medical condition, especially the state of his feet. Nursing staff did not check or dress his feet daily as required during either of the periods Mr A was in Prison 2. In addition, Mr A's prescribed medications were not administered in accordance with his prescriptions, and staff failed to document the reasons for non-administration.

125. Ms Carey advised that the nursing care provided to Mr A at Prison 2 demonstrates "significant and severe departures from the accepted standards of safe medication administration and in addition the nursing care in relation to [Mr A's] wound care and

wound assessment was suboptimal and also a significant departure from accepted standards". I agree with this advice.

126. In my view, the lack of treatment of Mr A's feet, and the failures with respect to medication management, cumulatively amount to a significant departure from accepted standards. While individual providers have responsibility for the failures that occurred, in this case there was a pattern of failures by multiple providers responsible for Mr A's care. Ultimately Serco is responsible for those failures. Accordingly, I find that Serco New Zealand Ltd failed to ensure that Mr A was provided services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Department of Corrections — Adverse comment

127. From the time of his diagnosis with lymphoma in 2012 until his death, Mr A was under the care of both the health service at Prison 1, and Hospital 1, apart from the periods of time he was transferred to Prison 2. The Inspector of Corrections determined that Mr A received a high level of care from health services at Prison 1 in relation to the management of his deteriorating health condition, both prior to the diagnosis, and during the subsequent treatment and support of his terminal condition.

128. I have received no evidence to suggest that while Mr A was at Prison 1 he did not receive a standard of care equivalent to that expected for any person in the community. I note that Prison 1 health services arranged for a healthcare assistant to assist Mr A during the end stages of his life.

129. However, on 24 Month4 when Mr A was transferred to Prison 2, some of his medications were left on the bus and later found at Prison 3. In response to the provisional opinion, Corrections stated that Mr A missing his gabapentin that evening was only partly as a result of its inaction. In any event, Mr A did not receive his gabapentin that evening.

130. Furthermore, Mr A's drug chart and signing sheet were not in the bag that arrived with Mr A, and the medications and documentation that had been found at Prison 3 were not returned to Prison 2 until 27 Month4. It is concerning that the systems to ensure that Mr A's documentation and medications arrived at Prison 2 failed on this occasion, particularly in light of his co-morbidities.

Recommendations

131. In the provisional report, I recommended that Serco New Zealand Limited provide a written and signed apology to Mr A's family. The apology has been provided to HDC and will be forwarded to the family with this report.

132. I recommend that Prison 2 undertake the following:

a) Provide evidence that the revised audit schedule (as detailed above, at paragraph 82) has been implemented, and provide the results of the first audit to HDC within six months of the date of this report.
b) Conduct an audit to assess compliance with professional standards regarding documentation, and provide the results of this audit to HDC within six months of the date of this report.
c) Provide training to health service staff about respect and appropriate responses to prisoners' healthcare needs, and provide evidence of that training to HDC within six months of the date of this report.
d) Provide training to health service staff on wound care management, and provide evidence of that training to HDC within six months of the date of this report.

Follow-up actions

133. A copy of this report will be sent to the Chief Ombudsman.

134. A copy of this report with details identifying the parties removed, except the expert who advised on this case, Serco New Zealand Limited, and the Department of Corrections, will be sent to the relevant district health boards, the Nursing Council of New Zealand, the Coroner, and the Medical Council of New Zealand.

135. A copy of this report with details identifying the parties removed, except the expert who advised on this case, Serco New Zealand Limited, and the Department of Corrections, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the referral from [the Chief Ombudsman] regarding the care provided to [Mr A] at [Prison 2]. 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 following documentation on file: referral from [the Chief Ombudsman] including investigation report by [the Inspector of Corrections] of Department of Corrections, clinical review report by [Serco], clinical review report and action plan by [Prison 2] dated 3 December 2013; response from [Prison 2 Health] including [Mr A's] clinical notes.

3. [Mr A] was transferred from [Prison 1] to [Prison 2] on two occasions in order to appear [at Court]. I have been asked to review the nursing care provided to him during his periods of detention at [Prison 2]: 24 [Month4]–11 [Month5] and 14–18 [Month5], and to specifically consider the following issues:

i. Management of medication, in particular [Mr A's] analgesia

ii. Appropriateness of his sleeping arrangements

iii. Wound care management of his necrotic feet

iv. Transfer documentation for [Mr A's] transfers back to [Prison 1]

4. Provider response(s)

Responses have been received from [Prison 2] and reviewed. For the purposes of brevity the content of the responses will not be detailed in this advice. I note that the provider acknowledges that [Prison 2] Health Unit did not provide [Mr A] with the necessary standard of health care.

5. Review of Medtech records focussing on scope of advice and relevant time periods

i. On 24 [Month4] [Mr A] transferred from [Prison 1] to [Prison 2]. Documentation reports: *Contacted [RN D] at [Prison 2] Head of Health and gave information about this prisoner. Have also faxed a copy of d/c information .... D/C summary. Was initially treated for probable pneumonia. Reacted to Ab's and they also queried a reaction to chemo. He was commenced on cream for severe purpuric rash. Dusky 3rd, 4th finger R) hand, 4th and 5th fingers L) hand and feet ...* The accompanying Prisoner Transfer Information (PTI) form identified that [Mr A] had developed compromised microcirculation to his hands and feet. *... Has been assessed for possible amputation. Requires care to prevent further compromise to integrity of hands and feet and risk of cross infection, as well as pain management.* The question *Does the prisoner have a Treatment Plan*

currently in place and/or have a significant or complex health need was marked as affirmative.

Comment: The 'wound care plan' reported as accompanying [Mr A's] faxed [Hospital 1] discharge summary has not been submitted for my review. This care plan is reported as detailing [Mr A's] need for daily plus PRN (as required) wound dressing care[1].

ii. The Medication prescription chart (MPC) shows that on 24 [Month4], [Mr A] was prescribed the following as oral analgesics:

OxyNorm PRN 5–10milligrams (mgs)

Panadol 1gramme QDS (four times per day)

Gabapentin 200mgs TDS (three times per day)

Oxycontin 35mgs BD (two times per day)

iii. On 27 [Month4], Medtech entry identifies [Mr A] as *at court today. Booked for nurse clinic mane 28 [Month4] to review his blisters on feet.* A subsequent same day entry reports [Mr A] as giving his verbal consent for *Cardiovascular clinic — MIO completed.*

Comment: There is no reportage of [Mr A's] attendance at the nurse clinic on 28 [Month4].

iv. On 31 [Month4], the Medical Officer (MO) reviewed [Mr A] *... has severe peripheral vascular disease with dry gangrene right middle toe ... systemically well, watch carefully for any signs of infection. If gets unwell over the long weekend send to [Hospital 2]*.

Comment: There is no reportage of subsequent nurse monitoring following this MO review.

v. Medication administration signing sheets (MASS) for [Mr A's] OxyNorm show no administration times or the amount of medication administered.

Comment: These details are required and expected as part of safe administration of medications especially when prescribed with a variable dose/PRN.

vi. The MASS shows that [Mr A] did not receive his paracetamol as prescribed on 28 [Month4]–3 [Month5] inclusive, on 6 [Month5], on 15–18 [Month5] inclusive. There is no contemporaneous documentation that reports reason for non administration.

[1] Inspector of Corrections Report 4 August 2014 paragraph 34.

vii. The MASS shows that [Mr A] did not receive his gabapentin as prescribed on 16 [Month5]. There is no contemporaneous documentation that reports reason for non administration.

viii. The MASS shows that [Mr A] did not receive his Oxycontin as prescribed on 24 [Month4], 27 [Month4], 6 [Month5], 8 [Month5], 10 [Month5], 15 [Month5] and 16 [Month5]. There is no contemporaneous documentation that reports reason for non administration.

ix. On 7 [Month5], [Mr A] was reviewed by the MO who noted *Oxycontin missed for 4 days, he is to continue these medications already charted.*

Comment: I note that [the Inspector of Corrections] reviewed the relevant Control Drug Register (CDR) sheets as part of his investigation[2]. These CDR sheets have not been submitted for my review. [The Inspector of Corrections] reports that the CDR shows that no Oxycontin tablets were signed out for administration to [Mr A] on 3–6 [Month5] inclusive. Also, that no OxyNorm tablets were signed out for administration to [Mr A] on 4 and 5 [Month5]. This is contrary to the submitted MASS documents.

x. On 11 [Month5], [Mr A] was transferred back to [Prison 1]. The accompanying PTI form identified that [Mr A] *... was being treated for ... peripheral vascular disease, gangrene ...* [Prison 1] reception health entry reports … *Looks absolutely shocking — says meds have been mismanaged, gave the weeks supply of somethings then everything else each day at lunchtime, Toes still black, 2 look ready to drop off ...*

xi. On 12 [Month5], [Mr A] gave [Prison 1] staff a letter detailing that at [Prison 2] they *... put me on a mattress so I had to sleep on the floor I was in no fit state to be able to climb up the ladder to reach the top bunk, my cell mate was elderly and not able to sleep up top either my feet were stinging with the pain ...* The nursing review of [Mr A's] feet details *... reports cell mate has been wrapping toes in toilet paper, o/e toilet tissue stuck to toes, soaked off with warm water, exudate present, feet smelly — necrotic flesh, gauze inserted between toes ...*

Comment: I note that [the Inspector of Corrections'] report refers to reviewing an email[3] sent on 13 [Month5] from the [Prison 2] Head of Clinical Services (HCS) to her counterpart at [Prison 1]. This email has not been submitted for my review. This email is reported as expressing concern about the [Prison 1] nursing entry (11 [Month5]) on the integrated Medtech system. The [Prison 2] HSC is reported as believing the entry to be an *over the top emotional response.* I concur with [the Inspector of Corrections'] conclusion that this communication indicated that [Prison 2] HCS was aware that [Mr A's] feet required nursing review and wound care.

[2] Inspector of Corrections Report 4 August 2014 paragraphs 38–40 inclusive.
[3] Inspector of Corrections Report 4 August 2014 paragraph 43.

xii. On 14 [Month5] [Mr A] again transferred to [Prison 2] to attend a court appointment. The accompanying PTI reported … *the prisoner's current treatment is: ... manage pain effectively with use of analgesia as prescribed. Check and dress feet daily, to prevent further damage ….*

xiii. On 18 [Month5], [Mr A] transferred back to [Prison 1].

Comment: The accompanying PTI from [Prison 2] is somewhat confusing. It appears to be a 'copy/paste' of the [Prison 1] document without the necessary amendments. There is no reportage of [Mr A's] feet being reviewed or dressed by [Prison 2] nursing staff for the period 14–18 [Month5]. As also noted (5vi, vii, viii) [Mr A] continued to not receive his analgesia as prescribed.

xiv. 18 [Month5] [Prison 1] reception health entry reports [Mr A] recounting that at [Prison 2] … *prisoner states he is just issued all the meds in the mane and takes them all, wasn't sure what they were and states he often felt sick after taking them ... Prisoner states the wounds in his feet have not been looked at since last here, last Thursday ...*

6. Clinical advice

Registered and enrolled 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[4].

Of relevance section 75 of Corrections Act, 2004 (Medical treatment and standards of health care) states that:

(i) A prisoner is entitled to receive medical treatment that is reasonably necessary

(ii) 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

i. Management of medication, in particular [Mr A's] analgesia

Safe medication administration is an indicator that sits within the competencies set by Nursing Council (NCNZ)[5]. It is a nursing competency that all nurses are deemed to have achieved following successful completion of their programme of education, examinations and registration. [The Inspector of Corrections'] review of the relevant CDR pages indicates that the submitted MASS sheets misrepresent medication administration to [Mr A] and do so repeatedly. Had [Mr A] not been prescribed controlled medications the extent of the suboptimal medication administration may never have been realised. This leads me to question whether

[4] For example, Nursing Council of New Zealand (2012), Code of Conduct for Nurses; Health & Disability Services Standards (2008); The Medicines Act (1981) and associated regulations; The Misuse of Drugs Act (1975) and associated regulations.
[5] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
NCNZ, *Competencies for the enrolled nurse scope of practice* (Wellington: NCNZ, 2010).

any of the submitted [Prison 2] MASS sheets can be relied on. I am also concerned about the response of [Prison 2] when it was realised that [Mr A] had not been receiving his prescribed medication — 7 [Month5] — and the fact that suboptimal medication administration systems continued.

I consider the nursing care provided to [Mr A] at [Prison 2] to demonstrate significant and severe departures from the accepted standards of safe medication administration.

ii. Appropriateness of his sleeping arrangements

[Mr A's] inability to access a top bunk was due to his health needs. While it may have been unavoidable for him to have spent his first night on a mattress on the floor at [Prison 2] I consider it inappropriate and am critical that this situation continued without resolution.

iii. Wound care management of his necrotic feet

During his two periods of detainment at [Prison 2], there is evidence of a consistent lack of wound care or wound assessment being provided to [Mr A] by nursing staff. This is despite documentation and communication advising of such a need. Whilst this in itself is suboptimal, I am also critical that non-existent wound care continued to be a feature after the [Prison 2] HCS became aware of this issue on 13 [Month5].

In my opinion, the nursing care in relation to wound care and wound assessment at [Prison 2] was suboptimal and a significant departure from accepted standards.

iv. Transfer documentation for [Mr A's] transfers back to [Prison 1]

The purpose of transfer documentation is to ensure the safe transfer of clinical care of a patient from one registered health provider to another. The PTI is well designed but similar to all documentation tools its effectiveness is dependent upon the user. The PTI which accompanied [Mr A] to [Prison 1] on 11 [Month5] did not identify his need for wound care. This is unsurprising as [Prison 2] nursing staff had not acted on his need for wound assessment or wound care. The PTI which accompanied [Mr A] on 18 [Month5] still had the [Prison 1] details throughout. Whilst clinically correct in parts — his need for daily dressings is acknowledged — there is an absence of any contemporaneous [Prison 2] nursing assessment of needs. This is again unsurprising in the context of the care provided by [Prison 2].

Dawn Carey (RN PG Dip)."

The following further advice was received from RN Carey on 23 November 2015:

"Thank you for the request that I provide additional clinical advice in relation to the referral from [the Chief Ombudsman] regarding the care provided to [Mr A] at [Prison 2] during two periods of detention: 24 [Month4]–11 [Month5] and 14–18 [Month5]. My advice is limited to the nursing care provided to [Mr A]. 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.

I have reviewed the additional responses from Serco NZ Limited (trading as [Prison 2]) including supplementary documents; from Department of Corrections including supplementary documents; previous clinical advice on this case dated 28 April 2015.

I have now received and reviewed the Controlled Drug Register sheets for Oxycontin and OxyNorm and note that [Mr A] did not receive this medication in accordance with his prescription or as indicated by entries on the medication administration signing sheets (MASS). Namely, [Mr A] did not receive Oxycontin on 4–6 [Month5] inclusive and did not receive OxyNorm tablets on 4–5 [Month5] inclusive.

I note that the [Prison 2] response details significant changes that cover training sessions, improved communication networks and regular auditing to monitor compliance. In my opinion, these remedial actions are appropriate.

Following a review of the additional information I have found no cause to amend my criticisms — detailed in section 6 of my previous advice — of the nursing care that was provided to [Mr A] at [Prison 2]."