Failure to arrange medical review of prison inmate (13HDC01048, 1 March 2016)

Registered nurse ~ Department of Corrections ~ Delayed treatment ~ Seizure ~Right 4(1)

A man in his mid-30s was an inmate at a correctional facility. The man, who was generally healthy, experienced an unwitnessed blackout. Three days later a nurse was asked to review the man because he was feeling unwell. Following her assessment the nurse did not consider the man to be acutely unwell, so she booked him in to see the general practitioner (GP) at the routine weekly clinic, six days later.

The man was seen by the GP at the clinic as planned. The GP considered that the man had possibly been suffering a viral infection or a "thyroid issue", either of which had resolved. The GP ordered a thyroid screen and a full blood count.

Three days after the GP assessment the nurse arranged to see the man to collect blood for the tests ordered by the GP. At that time the man reported that he had a headache and had vomited that morning. The nurse took the blood sample but did not examine him. She noted that she would review him on the afternoon round. However, this never occurred.

Later that night, at around 10pm, two different nurses, were asked to see the man due to him having recently had an unwitnessed seizure and needing to be reviewed. One of the nurses assessed the man in his cell. The second nurse noted that the man 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. The second nurse advised the man to contact the prison officers overnight if he needed further assistance, and to see a nurse in the morning. The second nurse then returned to the health services clinic to record her assessment.

At 11.15pm, the man suffered a further seizure, and approval was sought for prison officers to enter his cell. After a few minutes the man appeared to have recovered and was able to speak with prison staff. At approximately 11.30pm, the man suffered a further seizure, became unconscious, and stopped breathing. Emergency services were contacted, and two ambulance units arrived at the prison at 12.05am. After 45 minutes, ambulance officers were able to detect a pulse, and the man was then transported to hospital. However, over the next few days he continued to experience seizures and later died.

It was held that for failing to undertake an adequate assessment and arranging medical review when she first assessed the man, and then failing to either review or make arrangements for someone else to review the man when he later reported a headache and vomiting the first nurse failed to provide services with reasonable care and skill and breached Right 4(1). For failing to refer the man for a medical review following her assessment, the second nurse also failed to provide services with reasonable care and skill breaching Right 4(1).

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