Department of Corrections

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC00547)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. Between December 2011 and November 2012, Mr A, an inmate at a correctional facility (Prison 1) regularly presented written requests to prison staff for medical treatment of toothache and bleeding gums.

2. On 24 December 2011 Mr A was reviewed by a registered nurse (RN), RN F, and was placed on the dental waiting list. On 18 January 2012 Mr A was examined by RN F, who recorded that there was no sign of blood in his mouth.

3. On 23 January 2012 Mr A was seen by a dentist, Ms J, and had scaling of his teeth, a polish, and some temporary fillings. On 22 February 2012 it was recorded that Mr A had said that initially his gum problem had improved following dental attention, but it had then recurred. A further dental appointment was made.

4. On 12 March 2012 Mr A underwent periodontal procedures. On 17 September 2012 Mr A underwent extraction of two teeth. On 7 November 2012 Mr A was seen by medical officer Dr B, for an unrelated problem. A diagnosis of gingivitis was also made. Antibiotics were prescribed, and the problem appeared to resolve.

5. Mr A began to experience loose bowel motions. On 29 November 2012 Mr A saw medical officer Dr C. No significant symptoms were observed. It was discussed with Mr A that given his age (24 years) and negative family history, there was no indication to investigate further for malignancy.

6. In early December 2012 Mr A told staff that his bowel symptoms were persisting. Nursing staff arranged a medical review for 13 December 2012. However, the medical officer was sick, and appointments were rescheduled. Mr A was not able to attend a 19 December 2012 appointment owing to custodial restrictions. The next available appointment was 14 January 2013.

7. On 14 January 2013 Mr A was seen by a locum medical officer, Dr D. Dr D sent a referral letter to the Gastroenterology Department at Hospital 1. Dr D's referral queried diagnoses of irritable bowel syndrome or inflammatory bowel disease, and whether a colonoscopy was indicated. No blood count was undertaken or ordered.

8. Mr A was transferred to Prison 2 on 14 February 2013. The transfer documentation did not refer to Mr A's pending gastroenterology referral. Also on 14 February 2013, DHB1 wrote to Prison 1 Health Service declining the referral and requesting additional tests be done. On 20 February 2013 Dr B provided Prison 1 Health Service staff with blood test and faecal specimen request forms to complete for Mr A. However, the forms were not actioned by Prison 1 staff, and they did not pass on to Prison 2 staff the information regarding the requirement for the tests or that the DHB1 gastroenterology referral had been declined. Dr B was not told that Mr A had been transferred to Prison 2 the previous week.

9. Dr E, a medical officer at Prison 2, wrote a referral to DHB2 Gastroenterology Services shortly after Mr A's arrival. Dr E "cut and paste[d]" the original (Dr D's) referral, did not re-date it, and sent it to Hospital 2. He was not aware at the time that the DHB1 referral had been declined and tests had been requested. DHB2's records contain no account of contact from Prison 2 in February 2013. On 30 May 2013 Dr E ordered a variety of blood tests. The results were unremarkable. Dr E was unsure

whether Mr A would be returning to Prison 1, where he would be seen by DHB1, or whether he was to remain at Prison 2.

10. On 12 September 2013 Dr E reviewed Mr A. Dr E requested that prison health service staff follow up with Hospital 1, but his request was not actioned. On 4 November 2013 Dr E sent a referral letter to DHB2 Gastroenterology Services. By that time, it had been eight and a half months between Prison 1 Health Service receiving notification from DHB1 that further information was required to process the referral it had received (ie, 19 February 2013), and the actioned referral to DHB2 (4 November 2013).

11. On 7 May 2014 Mr A attended a specialist appointment with DHB2 gastroenterologist Dr N. The physical examination was unremarkable. Repeat blood tests were arranged. Mr A was released from prison on 6 August 2014 and did not attend a follow-up appointment with Dr N on 5 November 2014. The repeat blood test results were not significant, and Dr N discharged Mr A back to primary care.

Findings summary

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

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

14. Criticism is made of Dr E for not ensuring that his documentation was accurate, dated correctly, and reflected in the electronic record.

Complaint and investigation

15. HDC received a complaint from Mr A about the healthcare services provided to him by the Department of Corrections at Prison 1.

16. The following issue was identified for investigation:

Whether the Department of Corrections (Prison 1) provided an appropriate standard of care to Mr A.

[1] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

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

18. The key parties referred to in this report are:

Mr A	Consumer
Department of Corrections	Provider
Dr B	Medical officer
Dr C	Medical officer
Dr D	Locum medical officer
Dr E	Medical officer
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse
Ms J	Dentist
RN K	Registered nurse
RN L	Registered nurse
RN M	Registered nurse

Also mentioned in this report:

Dr N	Gastroenterologist
DHB1/Hospital 1	

19. Information was also reviewed from:

The Office of the Ombudsman
DHB2/Hospital 2

20. Independent clinical advice was obtained from general practitioner Dr David Maplesden (**Appendix A**).

Information gathered during investigation

Background

21. In November 2011 Mr A (23 years old at the time) was an inmate at Prison 1.

22. Mr A complained to HDC about delays in receiving treatment for his bleeding gums and, later, chronic diarrhoea.

23. Prison 1 operates a prison primary healthcare service (Health Service), which is largely led by registered nurses under the leadership of a Health Centre Manager.[2]

[2] Prison 1 Health Service achieved external Royal New Zealand College of General Practitioners Cornerstone Accreditation in 2012. Cornerstone is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand. Accreditation is a self-assessment and external peer review process used by healthcare organisations to

Clinics for inmates are held with a prison nurse in attendance and a custodial officer nearby.

24. Two contracted medical officers provided care to Mr A at Prison 1 in the period November 2011 to 2013 — Dr C[3] and Dr B[4]. A locum medical officer, Dr D, also provided some care to Mr A during this period. A contracted prison medical officer role involves weekly on-site prison visits. In addition, prison medical officers are also on call to provide advice to registered nurses outside of clinic visits.

25. Dr B told HDC that Corrections Health Units are nurse-led clinics with medical officers providing primary care. There are nursing staff assigned for clinics to assist the medical officer. Nurses are present at consultations and carry out duties assigned by the medical officer, including correspondence being reviewed and acted upon.

26. MedTech is the electronic patient management system used at the Prison 1 Health Service. At the time of these events, the contracted medical officers could not access the Prison 1 MedTech system remotely from an external source.

Bleeding gums

27. On 8 December 2011 Mr A presented a "chit" (a written request on a standardised prison form) to Prison 1 staff requesting medical treatment because he had a toothache. An appointment with a nurse was made for 12 December 2011. Mr A did not attend that scheduled appointment.

28. On 22 December 2011 a further chit was presented by Mr A, citing bleeding gums and toothache. An appointment with a nurse was made for 24 December 2011.

29. On 24 December 2011 RN F saw Mr A. She did not document an examination of his mouth at that time but recorded:

> "Prisoner states that when he wakes up in the morning he has blood in his mouth. Pottle given for sample and nurse to collect tomorrow. Prisoner also has front teeth [chipped] which at time causes him pain. Placed on dental list.

30. In response to the provisional opinion, RN F stated that she would not have placed a patient on the dental list without looking in the patient's mouth and, because she saw no blood, she asked for a saliva sample to be taken. The rationale for this was to see if there was any blood in the saliva.

---

assess their level of performance accurately in relation to established standards, and to implement ways to improve the healthcare system continuously.

[3] Dr C was engaged as a medical officer under a contract with a company of which he was a director. At the time of writing, he is no longer practising in New Zealand.

[4] Dr B is a vocationally registered general practitioner and Fellow of the Royal New Zealand College of General Practitioners.

31. On 27 December 2011 Mr A presented a further chit to Prison 1 staff regarding his bleeding gums. Mr A was triaged and it was noted that he had discarded his sample container. RN H arranged for a further container to be given to Mr A the next day and a sample to be taken in two days' time.

32. On 29 December 2011 RN G recorded:

> "Saliva 'sample' handed to pm [medical] round nurse. Sample looks bloodstained. [Appointment] already made for dentist."

33. On 8 January 2012 a further chit was presented by Mr A regarding his mouth bleeding. It was recorded by RN M that Mr A was awaiting dental review and so no further nursing appointment was made.

34. On 9 January 2012 Mr A complained to Prison 1 staff about delays in him seeing a medical officer and getting blood tests completed. RN I recorded in the clinical notes that there was no clinical indication for a blood sample to be taken, and that Mr A was awaiting a dental appointment.

35. Corrections' response to HDC outlined that Mr A was made aware of a management plan and the likely timeframe for a dental appointment. However, any advice given to Mr A about this was not documented.

36. Corrections stated:

> "There are several clinical entries for when nurses saw [Mr A] and what he reported his issues were, the examination completed and the plan moving forward. [Mr A] was advised of what the nurses thought it was and that he was being booked in to see the Dentist for further assessment. The documentation does not reflect that advice or information, nor that reassurance was given and this is an area of documentation that [we] must improve on."

37. On 11 January 2012 a further chit was presented by Mr A regarding his bleeding gums. No further action was taken as he was already on the dental waiting list

38. On 16 January 2012 Mr A complained to Prison 1 staff regarding delays in his assessment, and he provided two further chits — the first indicating that his teeth were cracked, broken and chipped. RN H recorded in the clinical notes that Mr A was on the dental waiting list. On the second chit, Mr A indicated that his gums bled heavily every night and morning. He said he was waking up throughout the night as a result. RN H arranged an appointment for Mr A to see a nurse on 18 January 2012.

39. On 18 January 2012 Mr A's mouth was examined by RN F, and no sign of blood in his mouth was found. A further saliva sample was taken and sent for testing the next day, and the result was normal. In response to the provisional opinion, RN F stated that her documentation on this occasion was not as adequate as it should have been.

40. There were no hepatitis serology results on file, and so arrangements were made for blood testing. (RN F stated in response to the provisional opinion that nurses would

not request bloods be taken in these circumstances, rather this would be done by a medical officer.) Hepatitis B and C serology, fasting glucose, and HbA1c tests[5] were requested. On 9 February 2012 the results were all reported as normal.

41. On 23 January 2012 Mr A was seen by a dentist, Ms J. She reviewed Mr A and performed scaling of his teeth and a polish, and provided some temporary fillings. There is no mention of any gum bleeding or gingivitis/periodontal disease in the notes.

42. On 25 January 2012, despite seeing the dentist two days earlier, Mr A again presented a chit regarding toothache. Prison 1 Health Service staff noted that he had just seen the dentist. A nursing review was arranged for 1 February 2012.

43. On 1 February 2012 Mr A was seen by RN M to discuss his sputum culture results, which were normal.

44. On 2 February 2012 Mr A asked Prison 1 staff if he could see the dentist. He was also advised by RN H to contact medical staff once ACC approval for chipped teeth treatment (a crown) was received. The records state that on 16 February 2012 Mr A did not attend a scheduled review appointment.

45. On 20 February 2012 Mr A presented a further chit regarding being seen about his gums. An appointment to see a nurse was made for 22 February 2012. At the nursing review on 22 February 2012, it was recorded by RN K that initially Mr A's gum problem had improved following dental attention, but that subsequently it had recurred. An appointment was made for him to see the dentist for a review.

46. On 28 February 2012 two further chits were presented by Mr A regarding bleeding gums and chipped teeth. He was noted to be on the dental waiting list, and a nursing review was arranged for 2 March 2012. On 2 March 2012 Mr A did not attend his scheduled appointment. The appointment was rescheduled for 6 March. Mr A presented further chits on both 3 and 5 March 2012 regarding his gum problem.

47. On 6 March 2012 Mr A attended his scheduled nursing appointment. RN L recorded:

> "[O]ccasional bleeding from gums during the early mornings & also when brushing the teeth. [On examination] no obvious signs of infections/inflammation noticed … Missed dental appt last month, added to March list."

48. On 7 and 11 March 2012 Mr A presented further health chits regarding his gums.

Further dental reviews

49. On 12 March 2012 Mr A was reviewed by the dentist, Ms J, as scheduled. Further periodontal procedures were undertaken to try to address his gum problem.

[5] The term "HbA1c" refers to glycated haemoglobin. It develops when haemoglobin joins with glucose in the blood, becoming "glycated". By measuring glycated haemoglobin (HbA1c), clinicians are able to obtain an overall picture of average blood sugar levels over a period of weeks/months.

50. An ACC letter declining a crown for chipped teeth was received by the Prison 1 Health Service on 10 April 2012.

51. Mr A continued to present chits to Prison 1 staff on a regular basis for a variety of problems (including ear ache, flu, and toothache, but not bleeding gums), for which he was seen over the next few months.

52. On 17 September 2012 Mr A had a dental review by Ms J, who extracted two teeth, one of which, an impacted molar, had been causing some cheek trauma.

Medical officer review

53. On 7 November 2012 Mr A was seen by medical officer Dr B for a dermatological problem. Mr A mentioned ongoing blood loss from his gums, especially following teeth brushing. No significant systemic symptoms were observed and, following examination, a diagnosis of gingivitis was made. Dr B prescribed Mr A one week's supply of antibiotics,[6] and a further week's supply was provided on 16 November 2012. Mr A complained to HDC that he was not given any information about possible side-effects of these antibiotics. Dr B could not recall this consultation but told HDC that it is his usual practice to advise patients about possible side-effects of medications. Mr A's gingivitis appeared to resolve.

Bowel issue development

54. Mr A then developed persistent loose bowel motions following the administration of antibiotics provided for his gingivitis, and a pattern similar to that noted above — of frequent provision of health chits — developed in relation to his symptoms.

55. On 20 November 2012 Mr A saw RN M. RN M recorded that Mr A did not have abdominal pain, fever, or blood or pus in his stools, and he appeared well. RN M advised Mr A to drink fluids and follow good hand-washing routines. Further nursing review was arranged.

56. On 23 November 2012, following review by RN M, a faecal specimen was taken. The culture results were negative, there were no red or white cells in the specimens, and faecal occult blood was negative.

Further medical review

57. On 29 November 2012 Mr A saw a medical officer, Dr C, for review. Dr C noted that the use of antibiotics over the last few weeks had coincided with abdominal cramps and loose bowel motions. There were no significant systemic symptoms or infection, or weight loss or sweats. An abdominal examination was normal. The diagnosis was "likely clavulanate related colitis[7] and should settle with time and loperamide[8]". Dr C prescribed Mr A loperamide.

[6] Curam Duo antibiotics.
[7] Colitis is inflammation of the inner lining of the colon. It may cause abdominal pain and diarrhoea with or without blood.
[8] A medicine that makes stools more solid and less frequent.

58. A negative family history of bowel cancer was noted, and it was discussed with Mr A that given his young age (24 years) there was no clinical indication to investigate further for malignancy. Dr C advised Mr A to report any persistent change in bowel pattern.

Further care

59. Mr A notified the Prison 1 Health Service on 1, 3, 5, and 8 December 2012 that his bowel symptoms were persisting despite his medication. On 8 December 2012 Mr A was seen by an RN. No new symptoms were noted. He was referred for a medical officer review.

60. On 9 December 2012 Mr A reported to Prison 1 staff that he had found blood on the toilet paper following a bowel motion.

61. On 11 December 2012 Mr A was reviewed by RN K, who noted that the medical officer review was scheduled for 13 December 2012. However, the medical officer was sick on 13 December 2012 and the appointment was rescheduled for 19 December 2012. Blood and saliva were sent for testing. Mr A was not able to attend the scheduled 19 December 2012 appointment because of "custodial restrictions relating to a misconduct situation". It is documented that Mr A was advised of this change.

62. The next available medical appointment was 14 January 2013 (owing to a medical officer leaving the Prison 1 Health Service suddenly and another being on leave). Mr A was booked for a 14 January 2013 appointment with a medical officer.

63. Over the next month, Mr A's symptoms remained stable, although they had not improved. He had no weight loss or other concerning new symptoms requiring urgent review.

64. On 20 December 2012 and 2 January 2013 further chits requesting review of his symptoms were presented by Mr A. On 26 December 2012 his symptoms were discussed with RN L at a nursing appointment.

65. Corrections told HDC that over the Christmas/New Year period Prison 1 had emergency medical officer cover only. On 14 January 2013 Mr A was seen by a locum medical officer (Dr D) with his previous history and normal results noted and a normal examination recorded.

Referral to DHB1

66. On 14 January 2013 Dr D sent a referral letter to the Gastroenterology Department (Outpatients) at Hospital 1 for a gastroenterology review, and added the motility agent mebeverine[9] to Mr A's medication.

67. Dr D's referral queried diagnoses of irritable bowel syndrome or inflammatory bowel disease, and whether a colonoscopy was indicated.

[9] An anti-spasmodic used in the treatment of irritable bowel syndrome.

68. No blood count (to exclude iron deficiency anaemia), inflammatory markers, coeliac screening test or faecal calprotectin test (in relation to inflammatory bowel disease) was undertaken or ordered on 14 January 2013.

Transfer to Prison 2

69. Mr A was transferred to a prison in another region, Prison 2, on 14 February 2013. Mr A's hard copy medical file was received at Prison 2 three days later on 17 February 2013. Although the transfer documentation noted that Mr A was being treated for diarrhoea and dermatitis, it did not refer to Mr A's gastroenterology referral. Dr B told HDC that medical officers do not complete transfer documentation.

70. Also on 14 February 2013, DHB1 Gastroenterology Department wrote to the Prison 1 Health Service regarding the referral it had received. The letter from Hospital 1 (declining the referral) was received by Prison 1 on 19 February 2013. At the time, Corrections did not have the ability to scan such letters into MedTech.

71. On 19 February 2013 the Prison 1 Health Service clinical notes record:

> "Letter received [Hospital 1] Gastroenterology. Referral declined due to further information [blood tests] being requested. Letter and Triage Slip placed in MO folder."

72. On 20 February 2013 medical officer Dr B reviewed the letter and provided Prison 1 Health Service staff with blood test and faecal specimen request forms to complete for Mr A. (These were additional tests requested by Hospital 1 before Mr A's referral to the DHB gastroenterology service would be accepted.) Dr B told HDC that he was not advised that Mr A had been transferred to Prison 2 the previous week. Dr B said that normally results from tests return to a MedTech inbox and would be added to any subsequent referrals to a gastroenterology clinic.

73. The request forms were not actioned by Prison 1 Health Service staff, and the information that the DHB1 gastroenterology referral had been declined, and that blood and faecal specimen tests were required, was not passed on to Prison 2 Health Service staff.

74. Corrections told HDC that the accepted practice and expectation was that Prison 1 Health Service staff would contact Prison 2 staff by telephone and email to alert them to "these matters". Corrections said that in this instance the expectation was not met by staff, and it accepted that this type of error could delay access to secondary health services.

75. Corrections stated:

> "This is not the standard [it expected] for the health services. Given the high volumes of patient movements across the country requiring the transfer of information (specifically DHB medical appointments and treatment changes), health services have been vigilant in this area, so this is disappointing."

Dr E

76. Dr E,[10] a medical officer at Prison 2, told HDC that he wrote a referral to DHB2 Gastroenterology Services shortly after Mr A's arrival at Prison 2 on 14 February 2013. Dr E said that at the time he was not aware that the DHB1 referral had been declined pending further blood tests.

77. Dr E stated that rather than creating a new referral, he "cut and paste[d]" Dr D's 14 January 2013 referral from Prison 1, and sent this to Hospital 2 shortly after Mr A's transfer to Prison 2 on 14 February 2013.

78. Dr E's referral letter is prefaced with:

> "I enclose a letter of referral that was sent to [Hospital 1] but patient was moved to here before he could get an appointment. He is still having the problem."

79. The referral was not requested as urgent. Dr E said: "I didn't realise that because I had used the previous letter there was no computer record of the new referral being done from our end." Consequently, there is no MedTech outbox entry indicating that a referral letter was sent.

80. When Dr E sent the letter to DHB2, he did not amend the date of Dr D's referral, so it is (incorrectly) still headed "14 January 2013". It is not clear exactly when Dr E wrote to DHB2 but, according to his response to HDC, it appears to have been on or about 14 February 2013. Corrections could not confirm the date on which the referral was sent.

81. Dr E told HDC that the referral was acknowledged by DHB2 and given low priority, and there was no request for additional information. However, DHB2's records provided to HDC contain no record of contact from or to Prison 2 in February 2013 regarding the referral.

82. Mr A's symptoms were subsequently monitored on an "as required" basis.

83. On 30 May 2013 Mr A saw Dr E regarding persistent loose bowel motions. A variety of relevant blood tests were ordered. The results were returned on 31 May 2013, and these were unremarkable other than a mild elevation in bilirubin[11] and ALP.[12]

84. Dr E told HDC that when he saw Mr A on 30 May 2013 he was unsure whether he would be returning to Prison 1, where he would be seen by DHB1, or whether he would be remaining at Prison 2.

85. On 8 July 2013 Dr E reviewed Mr A again, for an unrelated issue, and noted: "[D]iscussed results, still has diarrhea … minor weight loss …"

[10] Dr E had registration in the general scope of practice. He is not vocationally registered at the time of writing.
[11] Bilirubin is produced during normal breakdown of red blood cells. It passes through the liver and is excreted from the body.
[12] Alkaline Phosphatase Test, used to determine a variety of liver and bone disorders.

86. Dr E said that he telephoned Hospital 2 hoping to obtain a higher priority appointment, and left a message. This is not recorded in the clinical notes.

87. Over the next few weeks Mr A presented health chits to Prison 2 staff complaining of aching around his liver area, and that he also had various dermatological issues (pimples, acne, itching scalp). Mr A had also fallen over in his cell and banged his right side on his bed. On 1 August 2013 Dr E reviewed Mr A and altered his acne treatment.

88. On 12 September 2013 Mr A was reviewed by Dr E. Dr E recorded the following in Mr A's notes:

> "Still having some diarrhoea and guts ache, had seen Dr and got [a referral] to [DHB1] in Jan but was transferred up here. [Please] check with [DHB1] ? still has appt."

89. The request by Dr E to follow up the Hospital 1 referral was not actioned by Prison 2 Health Service staff until 31 October 2013, when it received a letter from an advocate on behalf of Mr A querying the delays in obtaining a specialist appointment.

90. Dr E also saw Mr A on 23 September 2013 (for folliculitis and snoring issues).

Referral to DHB2, November 2013

91. On 4 November 2013 Dr E reviewed Mr A and sent a further referral letter, by fax, to DHB2 Gastroenterology Services. The clinical notes include an acknowledgement of the referral by DHB2 the following day, 5 November 2013. The acknowledgement indicated that initially a low priority appointment had been scheduled for 11 months' time.

92. At that point, it had been eight and a half months since the Prison 1 Health Service was notified by DHB1 that further information was required before specialist referral would be accepted (ie, on 19 February 2013), and the provision of the referral to DHB2 (on 4 November 2013) that resulted in a specialist consultation appointment.

93. Corrections acknowledged to HDC that there had been a breakdown in communication between staff at Prison 1 and Prison 2.

94. DHB2 scheduled a gastroenterology specialist appointment for Mr A for 7 May 2014. Dr E gave Mr A advice on irritable bowel syndrome and prescribed him an antispasmodic.

95. Dr E saw Mr A again on 21 November 2013 (for a rash), and on 16 January 2014 (for a shoulder injury). On 13 February 2014 Dr E advised Mr A that an appointment with Gastroenterology Services at Hospital 2 was upcoming. Mr A refused further blood tests. On 6 March 2014 Dr E saw Mr A regarding his acne and a complaint of reduced vision in his right eye. On 3 April Dr E treated Mr A for haemorrhoids.

Specialist review — DHB2

96. On 7 May 2014 Mr A attended a specialist appointment with gastroenterologist Dr N, Clinical Director of DHB2 Gastroenterology Services. Mr A's physical examination was unremarkable. As there had been a slight rise in inflammatory markers in his earlier blood results, repeat blood tests and a faecal calprotectin test were arranged. The results were reported by Dr N as not being significant.

97. On 9 June 2014 Dr E saw Mr A in relation to an injury after having been restrained by prison officers. Mr A refused further blood tests. On 10 July Dr E saw Mr A for otitis externa (dermatitis of the ear canal).

98. On 6 August 2014 Mr A was released from prison and subsequently did not attend a follow-up appointment with Dr N that had been scheduled for 5 November 2014. The repeat test results were reported by Dr N as not being significant, and he discharged Mr A back to primary care, noting that his symptoms fitted with a functional bowel disorder.

Subsequent events and changes to practice

99. Corrections' response to HDC offered Mr A an apology for his management on 19 December 2012, and its custodial staff were reminded of the priority of health appointments over misconduct restrictions.

100. Corrections advised that it introduced the following changes:

- At Prison 1, a spreadsheet is in use for medical officers to track DHB appointments, including the referral date, length of wait, and outcomes. The spreadsheet is maintained by Corrections administration staff but overseen by nursing staff. This supports medical officers in knowing how an appointment is progressing, and provides a double check should a prisoner be transferred to another prison. When medical officer clinics are held, the database is made available to the medical officer. The ability to scan into MedTech is now available and undertaken.

- Reminders to staff to ensure that instructions given by medical officers are telephoned through to the new site at the time of a transfer.

101. Corrections reflected on overall documentation standards and told HDC:

> "Corrections Health Services continues to work with health staff around documentation requirements and are seeing an improvement in the quality of these. [Prison 1] health services are specifically undertaking a daily peer review/critique of entries as a quality improvement activity during team meetings and staff members are supported to improve their practice. Training by New Zealand Nurses Organisation (NZNO) has been facilitated which encompassed the importance of documentation and nurses' professional practice, accountability and registration.

> This is also supported by a recent review of the Corrections health information policy resulting in a stand alone clinical documentation standard[13] (Policy 3–17) which identifies additional information and resources. This now includes the guidelines for the use of (SOAPIE) Subjective, Objective, Assessment, Plan, Intervention, and Evaluation along with the principles of good record-keeping to support a more structured approach to record writing. All staff are provided with the outcomes from clinical reviews and HDC incident summaries as another way to support improvement from reflective learnings."

Response to provisional opinion

102. Mr A did not provide any further comment.

103. The Department of Corrections agreed that the report reflected the facts of the case accurately. The Department stated:

> "[W]e accept that an apology is in order in relation to the lack of continuity of care in relation to [Mr A's] bowel issue management and the opinion that the Department has therefore breached Right 4(5) of the [Code of Health and Disability Services Consumers' Rights]."

104. The Department also stated:

> "[There are] mechanisms in place for Health staff to place a transfer constraint on the movement of a prisoner where there are reasons, such as a forthcoming specialist appointment, to do so. However, there are likely to be situations where the transfer constraint is over-ridden e.g. where a prisoner's security classification requires them to be moved to another prison. The transfer of all appropriate health information is critical in these situations."

105. The Department said that it proposes to undertake the following actions:

- Remind all health staff of the importance of transfer constraints being in place.
- Remind all health staff of the importance of accurate completion of transfer documentation.
- Request that muster coordination staff consult with health staff on patients who have a transfer constraint before a patient is considered for transfer.

106. RN F's feedback has been incorporated into the "information gathered" section of the report where appropriate. She also stated: "I apologise for any stress the patient feels he went through and continue to improve my assessments and documentation."

107. Dr E had no further comment.

[13] Policy number 3–17. *Clinical Documentation Standards*. Version No: 1. Issued July 2014. Next review date: July 2017.

Opinion: Department of Corrections

Preliminary comment

108. Section 75 of the Corrections Act 2004 states:

> "*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."

109. 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.[14]

110. As this Office has acknowledged recently,[15] health service staff working in prisons are challenged by environmental routines and difficult personalities and behaviours, and deal with frequent requests for services and medication.

111. Corrections has a legal obligation and responsibility to operate its health services in a manner that provides inmates with a standard of care that is reasonably equivalent to that available to the public. It also has an organisational duty to facilitate continuity of care. This includes ensuring that its staff work together and communicate effectively.

112. 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 a GP and are entirely reliant on the staff at prison health centres to assess, evaluate, monitor, and treat them appropriately. Accordingly, I am concerned about instances of lack of communication and collaboration amongst the health team and between health services, particularly, in this case, when Mr A was transferred to another facility while a specialist referral was being considered by DHB1.

Bowel issue management — Breach

Initial management, late 2012

113. Mr A began to experience bowel symptoms after he was started on Curam antibiotics by Dr B. On 29 November 2012 Mr A saw Dr C, who was of the view that there were no significant systemic symptoms or infection, or weight loss or sweats. An abdominal examination was normal. The diagnosis was likely colitis, and Dr C prescribed loperamide. A negative family history of bowel cancer was discussed with Mr A, and he was told that given his young age there was no clinical indication to investigate further for malignancy, but he should report any persistent change in bowel pattern.

114. My in-house clinical advisor, general practitioner Dr David Maplesden, advised that the initial management of this issue was consistent with expected standards. He noted

[14] See Opinion 13HDC00853, 26 June 2015.
[15] See Opinion 13HDC00207, 26 June 2015.

that there were no particular "red flags" in the patient history or examination, appropriate preliminary investigations had been undertaken and were normal, and Mr A had been informed of the management plan.

115. Therefore, I am not critical of this particular aspect of Mr A's care.

Medical review delay, 19 December 2012

116. On 11 December 2012 Mr A had a medical officer review scheduled for 13 December 2012. However, the medical officer was sick on 13 December 2012 and the appointment was rescheduled for 19 December 2012. It is documented that Mr A was advised of this change. Mr A was not able to attend the scheduled 19 December 2012 appointment because of "custodial restrictions relating to a misconduct situation", but was booked for the next available appointment on 14 January 2013.

117. Dr Maplesden advised:

> "Given the persistence of [Mr A's] gut symptoms, the [medical officer] management plan which implied review was required if the symptoms persisted, the unavoidable delay the previous week, and the foreseeable very significant delay before a further [medical officer] review could be undertaken, I think it was a mild to moderate departure from expected standards that the review on 19 December 2012 did not take place."

118. I accept and agree with Dr Maplesden's advice. Although Mr A's risk of a more sinister cause for his symptoms (such as malignancy) was very low given his age and otherwise well presentation, his symptoms were nevertheless ongoing and needed further review.

119. Corrections has acknowledged that it was unreasonable for Mr A's 19 December 2012 medical appointment to have been delayed for custodial restriction reasons.

120. I note that Corrections offered an apology for Mr A's 19 December 2012 management, and custodial staff were reminded of the priority of health appointments over misconduct restrictions.

Initial referral to gastroenterology

121. On 14 January 2013, when Mr A's loose bowel motions continued, Dr D arranged a referral to DHB1's Gastroenterology Services. The referral queried diagnoses of irritable bowel syndrome or inflammatory bowel disease, and whether a colonoscopy was indicated.

122. Dr Maplesden advised that "management of [Mr A's] diarrhoea symptom was largely consistent with expected standards although could have been optimised by ordering of appropriate investigations prior to gastroenterology referral". Dr Maplesden was mildly critical that investigations were not undertaken prior to the referral being made, but noted that relevant blood tests were ordered by another medical officer in May 2013, with normal results.

123. I agree that earlier investigations could have expedited DHB1's processing of the referral.

Transfer

124. On 14 February 2013 Mr A was transferred from Prison 1 to Prison 2. On 20 February 2013 Dr B provided Prison 1 Health Service staff with blood test forms for Mr A because Hospital 1 had requested tests be performed before Mr A's referral to the DHB gastroenterology service would be accepted. However, Dr B was not advised that Mr A had been transferred to Prison 2 the previous week.

125. Prison 1 Health Service staff did not relay to Prison 2 Health Service staff the information regarding the need for these tests, and the fact that initially the gastroenterology referral had been declined. This was contrary to Corrections' accepted and expected practice (which was to telephone or email through such information).

126. When Dr E later saw Mr A on 12 September 2013, Prison 2 Health Service staff did not action Dr E's instructions to check with DHB1 on the status of the initial referral.

127. As noted by Dr Maplesden:

> "The communication issues noted had the potential to seriously impact on the patient's health. Although no apparent harm was done in this case, had the underlying condition been of a more sinister nature the delays encountered through suboptimal communication may have adversely affected the patient's prognosis. Thus the failure by [Prison 1] staff to adequately inform [Prison 2] staff that a DHB gastroenterology referral had been initiated for [Mr A], then that the referral had been declined and blood tests ordered, was a moderate departure from expected standards of provider communication."

128. I agree with Dr Maplesden and am critical of the systemic shortcoming identified.

Conclusion — Bowel issue management

129. This issue highlights a breakdown in communication within Prison 1 and between the health services of Prison 1 and Prison 2 regarding health matters relating to a transferring prisoner.

130. The deficient communication meant that Prison 2 Health Service staff did not have all the relevant clinical information when Mr A arrived at Prison 2, and this contributed to a subsequent delay in Mr A being re-referred for a gastroenterology assessment following his transfer. In my view, this delay should not have occurred.

131. In my opinion, the co-ordination and continuity of care relating to Mr A's bowel issue management was compromised. Corrections staff did not communicate and co-operate adequately in order to ensure quality and continuity of services for Mr A and, accordingly, breached Right 4(5) of the Code.

Gum disease management — Adverse comment

132. Mr A first complained about his gum health in December 2011. He was assessed regularly by nurses over the next 11 months, had two dental treatments, and was prescribed antibiotics by reviewing medical officer Dr B in November 2012.

133. Corrections stated that over this period there were several clinical entries by nurses who saw Mr A and noted his reported issues, the examinations they completed, and the plan moving forward. Mr A was advised of what the nurses thought was the cause of his gum issue, and told that he was being booked in to see the dentist for further assessment. However, the documentation does not reflect that advice or information, nor that reassurance was given. Corrections acknowledged that this was an area of documentation on which nursing staff must improve.

134. I agree. In my view, any explanation or advice given to Mr A about his management plan should have been documented clearly. Documentation is an important means by which healthcare providers can monitor a patient, evaluate treatment, and ensure continuity of care. I acknowledge that Corrections has reflected on the general quality of documentation produced by its staff and has implemented changes to improve overall standards.

135. Dr Maplesden concluded:

> "While some aspects of the management of [Mr A's] gum disease might have been improved … I feel his overall management in this regard was satisfactory and did not depart from expected standards to a significant degree."

136. In addition, Dr Maplesden commented:

> "As blood tests were being ordered, and noting [Mr A] was complaining of a significant amount of blood loss from his gums … it might have been prudent to request a complete blood count (CBC) [on 18 January 2012] to ensure the symptoms were not [a] manifestation of a leukaemic disorder even though the likelihood of this was slim given [Mr A's] overall satisfactory state of health."

137. I agree that such action would have been helpful in understanding the clinical picture at that time.

Conclusion

138. Although some elements of the care provided were suboptimal, taking into account the clinical advice I have received I am of the view that the management of Mr A's gum health by Prison 1 Health Service staff was largely reasonable in the circumstances.

Opinion: Dr E — Adverse comment

Action taken in February 2013

139. Mr A was transferred to Prison 2 on 14 February 2013. After Mr A's arrival at Prison 2, Dr E copied and pasted the body of Dr D's 14 January 2013 gastroenterology referral letter and attempted to send the referral to DHB2, without amending the date. Dr E told HDC that he did not realise that because he had edited and forwarded Dr D's previous referral letter, Prison 2 would not have an electronic record of his re-referral. A hard copy of the incorrectly dated referral is on the clinical file.

140. At that point, Prison 1 staff had not informed Dr E that DHB1 had declined the earlier 14 January 2013 referral and requested further blood tests. Dr E was also unsure whether Mr A would be transferred back to Prison 1 or remain at Prison 2.

141. I acknowledge that the shortcomings in communication between Prison 1 and Prison 2 regarding Mr A's transfer and the status of his gastroenterology referral would not have assisted medical officer Dr E. This included the fact that the DHB1 letter declining referral could not be scanned into MedTech, and so was unavailable to Dr E on 14 February 2013 in the absence of Mr A's physical file (which arrived three days later).

142. However, I consider that Dr E's "cutting and pasting" of Dr D's 14 January 2013 referral was ill-advised because, as a result, MedTech records did not subsequently feature an outbox entry for the referral. In addition, DHB2's records provided to HDC contain no record of contact from or to Prison 2 in February 2013 regarding this referral.

143. Having considered all the information provided, I accept that the gastroenterology referral was not urgent, and that Dr E attempted to organise and send a referral to DHB2 on or around 14 February 2013. However, I am concerned that the referral then appears to have gone astray, and that there is no evidence of the DHB receiving the referral. I am critical of Dr E for cutting and pasting the earlier referral, and for not ensuring that his documentation was accurate, dated correctly, and reflected in MedTech.

144. Had Dr E's referral document been clear and accurate, subsequent review of the clinical notes over the interim period while Mr A was being monitored (at the 30 May, 8 July, and 1 August 2013 medical officer reviews, for example) could have alerted other staff to a February 2013 referral having being made, and could have led to the status of the referral being followed up or queried with DHB2.

Referral to Gastroenterology Services, DHB2 — November 2013

145. On 30 May 2013 Mr A saw Dr E, and a variety of relevant blood tests were ordered. On 8 July 2013 Dr E reviewed Mr A again, for an unrelated issue, and noted: "[D]iscussed results, still has diarrhea … minor weight loss …"

146. Over the next few weeks Mr A presented health chits to Prison 2 staff. He had various dermatological issues. Mr A had also fallen over in his cell. On 1 August 2013 Dr E reviewed Mr A and altered his acne treatment.

147. On 12 September 2013 Mr A was reviewed again by Dr E. This was when the subsequent request by Dr E for Prison 1 Health Service staff to follow up the Hospital 1 referral was not actioned by Prison 2 Health Service staff.

148. Dr E saw Mr A on 23 September 2013 (for folliculitis and snoring issues).

149. On 4 November 2013 when Dr E re-referred Mr A to DHB2 Gastroenterology Services, this resulted in a specialist appointment on 7 May 2014 with consultant Dr N.

150. Dr Maplesden advised:

> "Given the absence of any change in [Mr A's] condition raising concern at development of sinister underlying pathology, I think [Mr A's] management during his time at [Prison 2] was reasonable noting the low prioritisation of the DHB appointment and the lack of control [Dr E] had over the prioritisation."

151. I accept Dr Maplesden's advice and am satisfied that the care provided by Dr E to Mr A from 30 May 2013 onwards, including the referral to DHB2 in November 2013, was reasonable in the circumstances.

Recommendations

152. I recommend that, within three weeks of the date of this report, Corrections provide a written apology to Mr A. The apology is to be sent to HDC for forwarding to Mr A.

153. I recommend that, within three months of the date of this report, Corrections undertake the following and report back to HDC:

a) In addition to the established spreadsheet of referrals, evaluate the effectiveness of the current process adopted to ensure that a transferring prisoner's custodial status, especially where transfer constraint is over-ridden, takes into account any information regarding pending specialist medical referrals, and the information is communicated to the health services of both the facility the inmate is leaving and the recipient facility.

b) Provide an update and evidence of the completion, progress and effectiveness of all changes made to practice as outlined at paragraphs 100–101 and 105, including auditing its processes to review compliance with documentation standards expected of registered nurses and medical officers as outlined in the Corrections policy document *3–17*.

c) Share the learning from this case across all correctional health services as part of quality improvement initiatives.

d) Explore the implementation of communication tools such as SBAR[16] and further enhanced electronic methods to improve interdisciplinary clinical communication.

Follow-up action

154. A copy of this report with details identifying the parties removed, except the expert who advised on this case and the Department of Corrections, will be sent to the College of Nurses Aotearoa Inc, the Nursing Council of New Zealand, the Royal New Zealand College of General Practitioners, DHB1, DHB2, and the Office of the Ombudsman, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[16] Situation, Background, Assessment, Recommendation. Available from http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx.

Appendix A: Independent clinical advice to the Deputy Commissioner

The following in-house clinical advice was obtained from general practitioner Dr David Maplesden:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Mr A]; response from [the] Manager Regional Health Centre; clinical notes [Prison 1] Health Centre and [Prison 2] Health Centre. [Mr A] complains about delays in accessing care for his chronically bleeding gums and delays in investigation of chronic diarrhoea. **Additional information was received from Corrections Services in early November 2014 and has been incorporated into this advice where relevant and in bold type.**

2. I have reviewed [Mr A's] clinical file. Prior to the end of 2011 there is a pattern of frequent presentation of chits requesting medical attention for a variety of medical problems, mostly of a minor nature, but generally determined by [Mr A] to be urgent. There is also a pattern of frequent non-attendance to nursing assessments offered in response to receipt of the chits.

3. Brief timeline and comments in relation to the bleeding gum history:

(i) 8 December 2011 — chit received for toothache. Nurse appointment 12 December.

(ii) 12 December 2011 — chit received for *bleeding gums and toothache.* [Mr A] did not attend his scheduled nurse appointment this day.

(iii) 22 December 2011 — chit received for bleeding gums and toothache. Nurse appointment made for 24 December.

(iv) 24 December 2011 — nurse appointment: *Prisoner states that when he wakes up in the morning he has blood in his mouth. Pottle given for sample and nurse to collect tomorrow. Prisoner also has front teeth chipped which at time causes him pain. Placed on dental list.*

Comment: It is not clear whether the nurse has examined [Mr A's] mouth to determine whether there is any obvious local pathology (laceration, gingivitis). While gingivitis would be by far the most likely cause of [Mr A's] symptom, no history has been taken to determine whether the gum bleeding could be manifestation of a more significant pathology such as bleeding dyscrasia secondary to a leukaemia. Such history and comment might include whether there was any evidence of bruising tendency, pallor or systemic symptoms such as fatigue, weakness or bone pain and would be helpful in determining whether more urgent MO review was warranted. Other than confirming [Mr A's] complaint was valid (ie there was blood in his saliva), I cannot see any particular clinical rationale for obtaining a saliva sample and I note this sample was not sent for microbiological testing in any case (see later). It may be that the RN was aware

from custodial officer comments that [Mr A] was not exhibiting any change in his usual activity pattern and, as stated, gingivitis would be the most likely cause of his symptoms in which case non-urgent dental referral was an appropriate management strategy and was undertaken. While I think [Mr A's] management might have been improved on this occasion, I do not think there was a significant departure from expected standards unless there was no preliminary examination of [Mr A's] oral cavity. If there was no examination at all, I would regard this as a mild departure from expected standards under the circumstances. **[Subsequent response confirms [Mr A's] mouth was examined on 24 December 2013 — I am mildly critical examination findings were not recorded in the notes.]**

(v) 27 December 2011 — further chit received regarding bleeding gums. Patient seen for triage and noted he had discarded his sample container so a further container was provided.

(vi) 29 December 2011 — *Saliva 'sample' handed to pm med round nurse. Sample looks bloodstained. Appt already made for dentist.* The sample was not sent for any further analysis and I agree that any such analysis would have been of limited clinical value.

(vii) 8 January 2012 — further chit received re mouth bleeding. Noted patient is awaiting dental review and no further current review undertaken.

(viii) 9 January 2012 — complaint received from [Mr A] regarding delays in seeing an MO and getting blood tests done. Staff note there is no intention to take blood tests as there was no clinical indication for this, and that [Mr A] was awaiting a dental appointment.

Comment: Blood tests and MO review may have been indicated if there were symptoms to suggest a condition other than localized gum disease being the cause of [Mr A's] symptoms as discussed further above. I am assuming no such symptoms were reported by [Mr A] — certainly no such symptoms are recorded in the clinical notes. It is not clear that the rationale for the planned management strategy (ie that the best person to review [Mr A] was the dentist because the cause of his bleeding was extremely likely to be localized gum disease, and there was not an urgent problem) was fully explained to [Mr A]. **[Subsequent response confirms [Mr A] was made aware of the management plan and likely time frame but this was not documented. Further training and policy development on clinical record keeping has since been undertaken.]**

(ix) 11 January 2012 — further chit received from [Mr A] re bleeding gums. No action taken as he is already on the dental wait list.

(x) 16 January 2012 — complaint received from [Mr A] regarding delays in his assessment and further two chits: (1) *My teeth have cracked, broken and chipped.* Noted to be on dental wait list for this; (2) *... gums bleed heavily every night and morning. Waking up threw out the night, at least 4 to 5 times a night ...* Nurse appointment made for 18 January.

(xi) 18 January 2012 — further chit received re bleeding gums then nurse review. Oral cavity examined with no sign of active bleeding. Arrangements made for further saliva sample (sent for testing 19 December 2012 — normal oral flora only). Noted no hepatitis serology results on file and arrangements made for blood testing. Hepatitis B and C serology, fasting glucose and HbA1c requested (results all normal 9 February 2012). [Redacted as unrelated to issues under investigation].

Comment: As blood tests were being ordered, and noting [Mr A] was complaining of a significant amount of blood loss from his gums (if this reporting was reliable) it might have been prudent to request a complete blood count (CBC) at this time to ensure the symptoms were not manifestation of a leukaemic disorder even though the likelihood of this was slim given [Mr A's] overall satisfactory state of health.

(xii) 21 January 2012 — [Redacted as unrelated to issues under investigation]. Seen later that day to gain consent for hepatitis testing.

(xiii) 23 January 2012 — seen by dentist for scaling, polish and some temporary fillings. No comment in dental notes regarding gum bleeding symptom or degree of gingivitis/periodontal disease present.

(xiv) 25 January 2012 — chit presented regarding toothache. Staff note he had just seen dentist and nurse review arranged for 1 February 2012. [Redacted as unrelated to issues under investigation].

(xv) 1 February 2012 — seen by nurse to discuss normal saliva culture results [redacted as unrelated to issues under investigation] and clearance given for this.

Comment: Hepatitis serology was not available at this point. [Redacted as unrelated to issues under investigation].

(xvi) 2 February 2012 — *requested to see dentist …* ACC approval was awaited (with respect to treatment for the chipped teeth) with appointment to be made once ACC approval was received.

(xvii) 20 February 2012 — chit received re bleeding gums and chipped teeth. Nurse appointment made for 22 February 2012. Further chit received 21 February 2012 regarding bleeding gums.

(xviii) Nurse review 22 February 2012, noted gum problem had improved following dental attention but since recurred. Appointment made for dentist.

(xvix) 28 February 2012 — chits received for bleeding gums and chipped teeth. Noted to be on dental wait list and nurse review arranged for 2 March.

(xx) 2 March 2012 — chit received regarding bleeding gums but did not attend scheduled nurse appointment that day. Appointment rescheduled for 6 March. Further chits received 3 and 5 March 2013 regarding gum problem.

(xxi) 6 March 2013 — nurse review, *occasional bleeding from gums during the early mornings & also when brushing the teeth. o/e no obvious signs of infection/inflammation noticed. Missed dental appt last month, added to March list.*

Comment: By this stage it appears obvious [Mr A] has a local gum condition causing annoying bleeding but not in any way life threatening, and that appropriate dental treatment has been undertaken with further non-urgent intervention awaited. I feel this was a reasonable and appropriate management strategy under the circumstances. It is not clear why [Mr A] felt the need to continue to bombard the health centre with chits unless this management strategy had not been clearly explained.

(xxii) Further health chits regarding gum bleeding were received on 7 and 11 March 2012, and [Mr A] was reviewed by the dentist as scheduled on 12 March 2012 at which stage further periodontal procedures were undertaken to try and address his gum problem. An ACC decline letter (regarding the chipped teeth) was received on 10 April 2012.

(xxiii) Chits were received on a regular basis for a variety of problems (including toothache but not bleeding gums) over the next few months as was [Mr A's] established pattern. On 17 September 2012 [Mr A] had dental review and extraction of two teeth, one of which had been causing local cheek trauma.

(xxiv) On 7 November 2012 [Mr A] was seen by the MO for a dermatological problem and mentioned ongoing blood loss from his gums, especially following tooth brushing. Absence of significant systemic symptoms is recorded and following examination a diagnosis of gingivitis was made and antibiotics prescribed (Curam) with repeat course provided on 16 November 2012. The problem appeared to resolve (or was not regarded by [Mr A] as requiring review) after this time with his attention subsequently focusing on bowel symptoms that followed his antibiotic therapy.

4. Comment: While some aspects of the management of [Mr A's] gum disease might have been improved as discussed in section 3, I feel his overall management in this regard was satisfactory and did not depart from expected standards to a significant degree.

5. [Mr A] developed persistent loose bowel motions following the antibiotics provided for his gingivitis, and a pattern similar to that noted above — of frequent provision of health chits relating to the same problem — developed in relation to the new symptoms. First nurse triage related to the symptoms was 20 November 2012. There were no complaints of abdominal pain, fever or blood or pus in the stool and [Mr A] appeared well. On 23 November 2012, following nurse review, faeces specs were taken with negative culture results, no red or white cells in the specimens, and negative faecal occult blood. MO review was undertaken on 29 November 2012. Absence of significant systemic symptoms was noted and abdominal examination was normal. Diagnosis was *likely clavulanate related*

colitis and should settle with time and loperamide. Negative family history of bowel cancer was noted and it was discussed with [Mr A] that given his young age (24 years) there was no clinical indication to investigate further for occult malignancy. He was advised to report any persistent change in bowel pattern.

Comment: [Mr A's] management to this point was consistent with expected standards. There was a temporal relationship between use of antibiotics and onset of the bowel symptoms. There were no particular 'red flags' in the patient history or examination. Appropriate preliminary investigations had been undertaken and were normal. [Mr A] had been informed of the management plan and rationale for this.

6. [Mr A] notified the health centre on 1, 3 5 and 8 December 2012 that his symptoms were persisting despite medication. He had nurse review on 8 December 2012 (no new symptoms noted) and was referred for MO review. On 9 December 2012 he reported he had found blood on the toilet paper after wiping following a bowel motion. On 11 December 2012 a chit was received regarding persistent loose bowel motions and [Mr A] was reviewed by a nurse the same day who noted MO review was scheduled for 13 December 2012. The MO called in sick that day and nurse notes state *appointments rescheduled.* The appointment was to have been on 19 December 2012 but [Mr A] was not able to attend due to *custodial restrictions relating to a misconduct situation.* The next available appointment was not until 14 January 2013 (delays related to a MO leaving and another on leave).

Comment: I think it was unreasonable that [Mr A's] medical appointment was delayed on 19 December 2012 for custodial reasons and this has been acknowledged in the facility response dated 23 July 2014. Given the persistence of [Mr A's] gut symptoms, the MO management plan which implied review was required if the symptoms persisted, the unavoidable delay the previous week, and the forseeable very significant delay before a further MO review could be undertaken, I think it was a mild to moderate departure from expected standards that the review on 19 December 2012 did not take place. While [Mr A's] condition was not acute and he remained otherwise well, his symptoms were disturbing for him and the persistence of the symptoms required further investigation and a change in management. Given [Mr A's] young age, the risks of a 'sinister' cause for his symptoms such as GI malignancy was very low, and I would be more critical of his management on this occasion if he had been at other than at very low risk of having a GI malignancy. The Department of Corrections has offered [Mr A] an apology for his management on 19 December 2012, and custodial staff have been reminded of the priority of health appointments over misconduct restrictions.

7. [Mr A's] symptoms remained stable although not improved over the next month. There was no weight loss or concerning new symptoms requiring urgent review. Further chits requesting review of his symptoms had been received from [Mr A] on 20 December 2012 and 2 January 2013, and his symptoms were discussed at a nurse appointment on 26 December 2012. He was seen by a locum

MO on 14 January 2013 with previous history and normal results noted and normal examination recorded. A referral was sent for gastroenterology review that day and the motility agent mebeverine added to [Mr A's] regime.

Comment: [Mr A's] symptom of loose bowel motions had now been persisting for over two months. There were no particular 'red flag' symptoms assuming the outlet type bleeding he had complained of on one occasion had settled. The referral queried diagnoses of irritable bowel syndrome or inflammatory bowel disease and whether colonoscopy was indicated. It might have been appropriate to have undertaken further preliminary investigations prior to referral to enable appropriate prioritization of the referral. Such tests might have included blood count (to exclude iron deficiency anaemia), inflammatory markers, coeliac screen and possibly fecal calprotectin (in relation to inflammatory bowel disease). I am mildly critical no such investigations were undertaken prior to the referral being made, but note relevant blood tests were ordered by another MO in May 2013 and were normal.

8. [Mr A] evidently transferred to another prison in mid-February 2013. **[Transfer date was 14 February 2013.]** On 20 February 2013 clinical notes record *Letter received from [Hospital 1] gastroenterology, referral declined due to further information being requested. Letter and triage slip placed in MO folder.* A blood test form was generated in relation to the tests requested but it does not appear the blood tests were undertaken at this time. On 30 May 2013 [Mr A] saw a MO for problems including persistent loose bowel motions and a variety of relevant blood tests were ordered (results returned 31 May 2013 — unremarkable other than mild elevation in bilirubin and ALP). On 8 July 2013 the MO reviewed [Mr A] and noted *discussed results, still has diarrhea ... minor weight loss ...* Over the next few weeks [Mr A] presented health chits regarding liver and kidney aching and he was reviewed by a MO on 12 September 2013: *still having some diarrhoea and guts ache, had seen Dr and got ref to [DHB1] in Jan but was transferred up here. P/check with [DHB1] ?still has appt.* It does not appear there was any action on this request until 31 October 2013 when a letter was received from NHDAS advocate on behalf of [Mr A] querying the delays in his specialist appointment. He was then reviewed by a MO on 4 November 2013 and referral made to [Hospital 2] gastroenterology service. It is not clear whether [Mr A] has had specialist review undertaken yet but the referral made on 4 November 2013 was of sufficient quality to enable appropriate prioritization and any further delay may relate to DHB rather than prison processes.

Comment: There appear to have been significant breakdowns in communication leading to delays in [Mr A] being re-referred for his gastroenterology assessment following his transfer from [Prison 1] in February 2013:

(i) It does not appear prison staff maintained an awareness that [Mr A] required blood tests and re-referral following the decline/advice letter from [Hospital 1] referred to on 20 February 2013
(ii) It does not appear the blood test request forms provided on that date were actioned

(iii) It does not appear the request by the MO to follow up the [Hospital 1] referral was actioned (see notes 12 September 2013)

These omissions and oversights are concerning and require further comment from the Corrections Service before I can complete this advice. The Service should be asked to confirm whether these oversights occurred and, if so, why did they occur and what remedial measures have been undertaken to prevent a recurrence. The medical officer involved (Dr E) should be asked to comment on his role in [Mr A's] management including the clinical rationale for the management strategies undertaken and why there was a delay of over eight months between notification further information was required before the [Hospital 1] specialist referral would be considered (February 2013) and provision of an alternative referral to [Hospital 2] (November 2013).

Additional information received from Corrections Services confirms there was a breakdown in communication between staff at [Prison 1] and [Prison 2]. The decline letter from [Hospital 1] was received at [Prison 1] but at the time there was no capacity to scan such letters into Medtech. While entries were made into the notes regarding information received and blood tests ordered (by [Prison 1] staff) these actions were not verbally conveyed to [Prison 2] staff and the need for intervention (by way of blood tests) went unrecognized until MO review on 30 May 2013. The actual transfer documentation did not refer to [Mr A's] gastroenterology referral at all. The response from [Dr E] refers to him 'cutting and pasting' the original referral to [Hospital 1] and sending this to [Hospital 2] shortly after [Mr A's] transfer to [Prison 2] (ie in February 2013) but he was not aware at the time the [Hospital 1] referral had been declined and further blood tests requested. He was also unsure at that stage whether [Mr A's] transfer was temporary or permanent. The referral was subsequently re-sent with blood test results as noted above. While awaiting gastroenterology review [Dr E] gave [Mr A] advice on irritable bowel syndrome and prescribed an antispasmodic. Corrections Services has acknowledged there was an unacceptable breakdown in communication on this occasion. Since these events a spreadsheet/register has been set up to enable MOs at the various prisons to track DHB referrals as prisoners are transferred across DHB boundaries. This should reduce the risks of a similar incident happening in the future.

Final comment: There were some minor deficiencies in the management of [Mr A's] mouth bleeding symptom, mostly related to documentation and this issue has been addressed in a satisfactory manner by Corrections Services. MO management of [Mr A's] diarrhea symptom was largely consistent with expected standards although could have been optimized by ordering of appropriate investigations prior to gastroenterology referral as discussed. The communication issues noted had the potential to seriously impact on the patient's health. Although no apparent harm was done in this case, had the underlying condition been of a more sinister nature the delays encountered through suboptimal communication may have adversely affected the patient's prognosis. Thus the failure by [Prison 1] staff to adequately inform

[Prison 2] staff that a DHB gastroenterology referral had been initiated for [Mr A], then that the referral had been declined and blood tests ordered, was a moderate departure from expected standards of provider communication. The remedial measures outlined in the response should go some way towards reducing the risks of such miscommunication being repeated."

Dr Maplesden provided the following further comment:

"I have reviewed the additional individual provider responses and other information obtained from Correction Services. The main issues clarified from this information are:

(i) On 20 February 2013 [Dr B] provided [Prison 1] Health Unit staff with blood test forms for [Mr A]. This was in relation to the additional tests requested by [Hospital 1] before [Mr A's] referral to the DHB gastroenterology service would be accepted. [Dr B] was not aware [Mr A] had been transferred to [Prison 2] almost a week previously. It is apparent the information regarding the requirement for these tests and the fact the gastroenterology referral had been declined was not relayed from [Prison 1] to [Prison 2], nor was [Dr B] made aware [Mr A] had been transferred. These issues serve further to illustrate the poor intra- and inter-facility communication practices in place at [Prison 1] at the time in question and, as stated previously, the remedial measures outlined in previous Correction Department responses may go some way towards resolving these issues.

(ii) [Dr E] has clarified that a referral to [DHB2] gastroenterology services was made shortly after [Mr A's] arrival at [Prison 1]. The referral was acknowledged and given low priority, and there was no request for additional information. [Mr A's] symptoms were subsequently monitored on an 'as required' basis as outlined in [Dr E's] response, with [Mr A] refusing some additional investigations and then electing to postpone the original gastroenterology clinic appointment scheduled for 6 August 2014. Given the absence of any change in [Mr A's] condition raising concern at development of sinister underlying pathology, I think [Mr A's] management during his time at [Prison 2] was reasonable noting the low prioritisation of the DHB appointment and the lack of control [Dr E] had over the prioritisation.

(iii) I remain of the view that the communication issues at [Prison 1] identified in this advice and my previous advice represent a moderate departure from expected standards of care, and that the remedial measures already undertaken by Correction Services are appropriate and should help in resolving those issues."