Health and Community Services
COMPLAINTS COMMISSION

FINAL
INVESTIGATION REPORT

Investigation into the Prison Health Service at Darwin Correctional Centre.

De-identified

26 February 2016

Pursuant to section 61 of the *Health and Community Services Complaints Act* any information or document obtained during an investigation is not admissible in any proceedings before a Court, Tribunal or Board except for the prosecution of a person for an offence under the Act or for proceedings in respect of a registered provider by the relevant Professional Board

GLOSSARY

Central Australian Rural Practitioners Association Standard Treatment Manual	CARPA
Code of Health and Community Rights and Responsibilities	The Code
Commissioner for HCSCC	Commissioner
Darwin Correctional Centre (Holtze and Berrimah)	DCC
Department of Health	DOH
Health and Community Services Complaints Commission	HCSCC
Health and Community Services Complaints Act (NT)	The Act
Medical Request Form	MRF
Memorandum of Understanding	MOU
Northern Territory Department of Correctional Services	Corrections
Prison Health Service	PHS
Top End Health Service	TEHS

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1. AUTHORITY

Section 48 (1) of the *Health and Community Services Complaints Act* ("the Act") provides:

> *The Commissioner may, as he or she thinks fit, investigate*
> *(a) any matter referred under section 20 (1) or 21 (1);*
> *(b) a complaint that the Commissioner has decided to investigate under section 27; or*
> *(c) an issue or question arising from a complaint or a group of complaints if it appears to the Commissioner*
>
> *(i) to be a significant issue of public health or safety or public interest; or*
> *(ii) to be a significant question as to the practice and procedures of a provider.*

This investigation was carried out pursuant to section 48(1)(c)(i) and (ii) of the Act, as the complaints raised significant issues of public health and public interest as well as significant questions as to the practices and procedures of the Prison Health Service at Darwin Correctional Centre.

2. BACKGROUND TO INVESTIGATION

2.1 THE PRISON HEALTH SERVICE

The Prison Health Service (PHS) at Darwin Correctional Centre (DCC) is administered by the Northern Territory Government's Department of Health (DOH), through the Top End Health Service (TEHS). The PHS clinical team operates with assistance provided by prison officers employed by the Northern Territory Department of Correctional Services ("Corrections").

The PHS deals with a vulnerable population of patients who present with high level healthcare needs. The DCC has a maximum capacity of 1048 prisoners, in addition to a 48 prisoner pre-release work village. DCC was at 84% capacity with 885 prisoners as at 22 September 2015. Prisoners at DCC are predominately male (91%) and Indigenous (77%).[1] A significant proportion of Indigenous prisoners are from remote communities. The health disadvantage experienced by Indigenous Australians is well-documented,[2] as are the disproportionately high health needs of prisoners with regards to mental health, substance use, chronic disease, infectious diseases and disability.[3] Although they constitute a minority of the prison population, female prisoners have even more specialised health needs.[4] These compounding factors of disadvantage pose difficulties for the provision of health services within the challenging working environment of a correctional institution.

Whilst it is important to keep the operational context of the PHS in mind, prisoners are entitled to the same standard of health care in prison as that expected in the general community. This is evident at section 82(2) of the *Correctional Services Act,* which requires:

> *The Commissioner must ensure that prisoners are provided with access to health care that is comparable with that available to persons in the general community in the same part of the Territory.*

These accepted standards and legislative requirements will be applied in assessing the health services provided by PHS.

2.2 FIRST COMPLAINT

In mid 2014 the first complainant ("Ms A") contacted the HCSCC complaining that she had been unable to see a doctor at the PHS despite repeated requests. She reported that she had been suffering dizzy spells and headaches, urinating multiple times per night and had sore and swollen legs. Around 10 days later she was taken to the Royal Darwin Hospital and found to be 8 months pregnant. Up until this time, she had received no antenatal care and was taking a medication contraindicated during pregnancy.

The Commissioner referred the matter for investigation in June 2014.

2.3 SECOND COMPLAINT

In early 2015 the HCSCC received a complaint from the second complainant ("Ms B") concerning delays and treatment at the PHS. Ms B reported that from early 2014 she had complained of pain to her right wrist and shoulder and requested medical attention. Four months later she was x-rayed

[1] Figures as at 22 September 2015.
[2] See for example Australian Institute of Health and Welfare 2015. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW.
[3] Australian Institute of Health and Welfare 2013. The health of Australia's prisoners 2012. Cat. no. PHE 170. Canberra: AIHW, p 3.
[4] Australian Institute of Health and Welfare 2013. The health of Australia's prisoners 2012. Cat. no. PHE 170. Canberra: AIHW, p 70-72.

and found to have a wrist fracture. However, she continued to be in pain and she alleges that she did not receive proper treatment.

The Commissioner referred the matter for investigation in February 2015.

2.4 OTHER COMPLAINTS

The complaints by the first and second complainants follow a pattern of complaints made to the HCSCC by male and female prisoners, which raise similar issues in relation to accessing health services at PHS. In 2014/15 HCSCC received 154 enquiries by prisoners. This comprised 38% of its total number of enquiries.

Some examples of complaints received by HCSCC in 2015 include:

- Mr C suffered a broken cheekbone following an assault. He was not x-rayed or conveyed to the hospital for seven days. He was treated after contacting HCSCC, and found to require reconstructive surgery.
- Mr D requested medical treatment for a fungal foot infection over a 14-15 month period but received no assistance.
- Mr E hurt his back and chipped his tooth in an altercation, but did not receive medical assistance for a six - eight week period.
- Ms F waited for dental treatment for 18 months, whilst taking daily analgesia to assist with dental related pain. She was treated after contacting HCSCC.
- Mr C requested medical assistance to treat his Hepatitis C over several months. He suffered rapid weight loss and developed severe jaundice and depression. He was conveyed to the hospital for more comprehensive assessment after contacting HCSCC.
- Mr G developed a painful ear infection including constant ringing, which persisted over a five month time period before a referral was made to a hearing specialist.

2.5 SYSTEMIC ISSUES

The complaints by the first and second complainants were referred directly for investigation under Part 7 of the Act. The basis for direct referral was the seriousness of the allegations and the systemic issues raised. Problems in accessing health services and delays at PHS appeared to have had a detrimental impact on the medical treatment received by the complainants. This is consistent with the large proportion of complaints received by HCSCC about the PHS, which raise similar concerns about:

- the management of medical request forms;
- triage processes;
- waiting periods;
- communication with patients;
- access to specialist medical services; and
- medical follow-up and recall systems.

The complaints also raise specific issues of access to women's healthcare.

These issues warranted a detailed inquiry into PHS processes that affect all prisoners under PHS care. Although the two complaints investigated concern female patients who are a minority in the prison population, the systemic issues identified are equally relevant to males and females.[5]

[5] With the exception of finding 9.3(vi) which relates to women's healthcare.

3. SCOPE OF THE INVESTIGATION

3.1 ISSUES

The investigation considered the quality and standard of care provided to the two complainants, and underlying systemic issues in the provision of health services by PHS.

The questions investigated were as follows:

1. The Prison Health Service failed to provide a medical service or antenatal care to Ms A until she was eight months pregnant.
2. The Prison Health Service failed to provide adequate treatment to Ms B for her wrist and shoulder injury.
3. There are systemic delays in accessing medical services at DCC**.**

3.2 BASIS OF COMPLAINT

Section 23 of the Act provides the bases upon which a complaint can be made to the HCSCC. The following subsections are relevant to the current investigation:

(1) A complaint may be made in respect of one or more of the following:

(a) that a provider acted unreasonably by not providing a health service or community service;
(c) that a provider acted unreasonably in providing a health service or community service;
(j) that a provider acted in disregard of, or in a manner inconsistent with, any of the matters that the Commissioner may have regard under section 5 in determining whether or not a provider has acted reasonably in providing a health service or community service.

(2) A reference in subsection (1)(c) to a provider acting unreasonably in providing a health service or community service includes the provider failing to do any of the following:

(a) to exercise due care and skill;
(b) to treat a user in an appropriate professional manner that took into account the user's needs, wishes and background;
(d) to provide a user with information on treatment or health services available, in language and terms that the user understands, sufficient to enable the user to make an informed decision;
(e) to provide a user with a reasonable opportunity to make an informed choice of the treatment or services available;
(f) to provide a user with adequate information on the availability of further advice on his or her condition or of relevant education programs;
(g) to provide a user with adequate information on the treatment or services received;
(h) to provide a user with a prognosis that it would have been reasonable for him or her to be provided with.

The *Code of Health and Community Rights and Responsibilities* ("the Code") sets out the rights and responsibilities of users and providers in delivering health services in the Northern Territory. Pursuant to section 5 of the Act, the Commissioner must consider the Code, as well as generally accepted industry standards of health services expected of a provider and other relevant information in determining whether a provider has acted reasonably.

The principles extracted from the Code are relevant this investigation:

Principle 1: Standards of Services

1. Users have a right to:

a) timely access to care and treatment which is provided with reasonable skill and care ;

d) care and treatment that takes into account their cultural or ethnic background;

e) providers who seek assistance and information on matters outside their area of expertise or qualification;

f) services provided in accordance with ethical and professional standards, and relevant legislation.

Principle 2: Communication and the Provision of Information

1. Providers have a responsibility to:

a) provide accurate and up to date information responsive to the user's needs and concerns, which promotes health and well-being;

b) explain the user's care, treatment and condition in a culturally sensitive manner, and in a language and format they can understand. This includes the responsibility to make all reasonable efforts to access a trained interpreter;

d) provide information about other services, and as appropriate, how to access these services;

e) provide prompt and appropriate referrals to other services, including referral for the purpose of seeking a second opinion.

Principle 3: Decision making

1. Subject to any legal duties imposed on providers, users have a right to:

a) make informed choices and give informed consent to care and treatment.

4. INVESTIGATION PROCESS

In carrying out the investigation, the Commission has:

- Provided a copy of the complaints to DOH.
- Examined the complainants' medical records.
- Interviewed the complainants.
- Obtained copies of PHS policies and procedures.
- Interviewed the District Manager for Prison Health and Watch House, the PHS Clinic Manager and a PHS Team Leader.
- Considered DOH's other written responses.
- Conducted an on-site visit of the PHS to observe how Medical Request Forms are received and processed and how triage is undertaken.
- Provided a copy of the draft investigation (in full or relevant sections as required) to DOH, the then PHS Clinic Manager, Corrections and the first and second complainants and their representatives for comment.

5. OVERVIEW OF PHS' OPERATIONS AND PROCEDURES

5.1 STAFFING AND ORGANISATIONAL STRUCTURE OF PHS

The PHS' day-to-day operations are managed by the PHS Clinic Manager, who reports to the District Manager Prison Health and Watch House ('the District Manager'). These two management roles are currently filled by professionals with a nursing background who are based at DCC. The District Manager reports to the TEHS' Director of Primary Health Care.

The PHS currently employs two full time doctors, 17.4 nurses, two Aboriginal Health Practitioners, a pharmacist and two administrative officers. The nursing team includes five team leaders who are responsible for higher level duties. A pharmacy technician is due to commence soon. In addition, a number of allied health services regularly visit the PHS, including a physiotherapist, diabetes nurse educator, optometrist, audiologist and dentist.

The resourcing and staffing of the PHS has increased over time. In late 2013/ early 2014 PHS employed only 1 full time doctor and around 11 nurses. High staff turnover, particularly a reliance on locum doctors, was identified by staff interviewed as a major problem for the service which has also gradually improved.

5.2 TRANSITION FROM BERRIMAH TO HOLTZE CORRECTIONAL PRECINCT

In late 2014, adult prisoners were moved from the correctional facility at Berrimah to a new correctional precinct at Holtze. It is common understanding that the transition to the new facility at Holtze created additional challenges for health service delivery. Both complainants were previously in custody at Berrimah and experienced the transition to the new prison at Holtze.

Due to differences in the resourcing, layout and facilities of the two correctional centres, the PHS has adapted some of its practices at the new facility. It is common ground that PHS facilities at DCC Holtze are far improved from the facilities at DCC Berrimah. The complaints under investigation concern events at Berrimah, throughout the transition phase, and at the new facility at Holtze. The systemic issues findings of this report are relevant to the present operation of the PHS at DCC Holtze.

5.3 CLINICAL RESOURCES

PHS clinical staff use the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual. The CARPA Manual is a widely used resource for remote health practitioners in central and northern Australia. It provides practical guidance for primary healthcare services including advice about managing emergencies, chronic diseases and common medical conditions.

Clinical staff are able to seek guidance from the TEHS' Director of Nursing and Director of Medical Services, who have oversight of professional clinical practice issues but are not involved in the day-to-day running of the PHS.

5.4 CORRECTIONAL ESCORTS

Prison officers employed by Corrections provide security for the PHS and assist with the coordination of clinical activities, such as the logistics of medication rounds and the movement of patients for attendance at the PHS clinic and external appointments. Prison officer escorts are provided for all external appointments. The number of escorts required is dependent upon a

prisoner's security classification, but is generally two officers per prisoner. Prison officers are in attendance at the clinic, although most prisoners do not require an individual escort for consultations with PHS staff.

The prison complex is often subject to "lockdowns", during which time it may not be possible for prisoners to move between blocks and therefore attend appointments at PHS or externally. Lockdowns may occur due to fights, power failures and other issues that compromise security.

The "Schedule 1 PHC Health Service Schedule" describes the services provided by PHS and its relationship with Corrections. The document confirms that PHS staff are to provide "reasonable notice of intended transfer for medical or other health appointments off-site" and Corrections is responsible for arranging transport and providing an escort. According to the District Manager, at the time of interview there was no other current documentation regulating the relationship between DOH and Corrections. A Memorandum of Understanding (MOU) was in the process of agreement since DOH took over the service in 2012. It was finally signed by both agencies on 22 September 2015. Whilst the MOU provides a broad framework for the delivery of health services in NT correctional settings including a statement of roles and responsibilities, it does not provide specific operational instructions for either party.

PHS staff reported that there are often insufficient Prison Officers to escort clients to appointments or to provide security for PHS staff during clinic times. The number of escorts available to PHS fluctuates, and is determined by Corrections depending on overall operational requirements of the prison. The Team Leader reported varying levels of cooperation with correctional officers in recalling clients to the clinic depending on the officer concerned. The unpredictable nature of correctional escorts was identified by staff as a major obstacle to the effective delivery of services, although the Team Leader emphasised that this has "improved dramatically" since the transition to DCC Holtze.

In addition, the Clinic Manager reported that correctional officers on duty in the evening are responsible for scheduling prisoner movements for the following day through the Prisoner Movement and Information System, which allows prisoners access through secured entries to attend the clinic. He mentioned that if this is not executed correctly the clinic might see a lot fewer patients, which may be up to only a third of the number of scheduled appointments.

5.5 POLICIES AND PROCEDURES

As part of the investigation, HCSCC requested that DOH provide all policies and procedures governing healthcare services at the DCC, including:

- Management of medical requests;
- Triage;
- Waiting lists or periods;
- General access to medical services and/or medical practitioners;
- Access to specialist medical services;
- Evacuation of patients to external health services, including transfer of patient information and communications with external health services;
- Record keeping.

The District Manager stated that the PHS is still in the process of setting up systems and up-skilling staff since DOH took over management of the clinic from a private provider in 2012, emphasising the disruption caused by the transition to DCC Holtze. There is a notable absence of current policies and procedures in the responses and documentation provided to HCSCC in the course of this investigation.

The documents and oral evidence provided to HCSCC are summarised below insofar as they are relevant to this investigation.

Health assessment upon admission to custody

PHS' procedures require that prisoners undergo a health assessment within 24 hours of reception into prison. If the initial assessment is done by a nurse, a Medical Practitioner is to follow this up with a full examination within 72 hours of reception.[6] Medical Practitioners must identify any prisoners at risk of self-harm or suicide, those with urgent physical or chronic health needs and those who have been discharged from a hospital within 7 days prior to arrival.

New prisoners undergo standard blood and urine screening tests, including tests for a blood count, hepatitis, diabetes, syphilis and common sexually transmitted diseases. Follow up items are then "generated" from the care plan.

Pregnancy tests are undertaken with respect to women of child bearing age who have given informed consent. Where positive results are found, women are linked into pregnancy care and health promotion services.

The District Manager reported that the procedure for health assessments has recently changed. Initial assessments are undertaken on the day of admission into custody for the purposes of identifying immediate health concerns. A more comprehensive assessment is undertaken on the fifth day of incarceration. The main rationale for the change is that upon admission into custody a large proportion of prisoners are quickly released to work. Shifting the comprehensive assessment to the fifth day allows PHS staff to focus more resources on patients who will remain at DCC and require ongoing care. The District Manager also noted that there is less time pressure directed at PHS staff from correctional officers on day 5 assessments.

Requests for medical assistance

In order to access the PHS, prisoners must ordinarily complete a Medical Request Form (MRF). The instructions on MRFs state that prisoners must complete a form, available in the block office, in order to request an appointment. A note on the form states that if a prisoner does not write down the reason they wish to have an appointment, they will be given an appointment to see a nurse or Aboriginal Health Practitioner (AHP) as a "routine request." They must then place their form in the "Medical Box" located in each block for staff to collect on the evening medication round. There are currently 13 request form boxes located throughout the prison. According to the form staff "check forms each day, triage and arrange follow-up."

The form further notes that in an emergency, "immediate access to the health centre staff can be gained via a Prison Officer." The District Manager stated that she would expect genuine urgent needs to be reported to the PHS by correctional officers.

DOH provided "in draft" procedures in response to a request for documents detailing the management of medical requests, which were drafted in mid-2013 and developed for the Berrimah facility. The procedures relate to the operation of medication rounds, daily and weekly duties and responsibilities, and procedures for the assessment of new prisoner receptions.

The medication round procedures stipulate that nurses are to check medical request boxes on their evening round. They should document any verbal wants and needs, reminding prisoners to submit a MRF. Once the nurse has returned to the main clinic, they must "enter medical requests". The document titled "Morning and Evening Medication, Rationale and Procedure" states that upon return to the clinic, nurses must "triage any [MRFs] ASAP and make PCIS appt, place the rest in the box in

[6] Those returning to prison less than six months since their previous time in custody are only screened if there is a clinical concern.

pharmacy if no time to enter on PCIS." It notes that it is "Everyone's responsibility to enter medical requests on PCIS."

A more recent document[7] titled "Triaging Process at Darwin Correctional Centre (Holtze)" notes that MRFs are to be collected by (Corrections) sector managers and faxed to the PHS, although the DCC Holtze was in the process of changing the locks on the MRF boxes so that all boxes may be opened by one key, enabling forms to be "retrieved on a daily basis, in a more structured fashion." The Clinic Manager explained that upon relocating to DCC Holtze each block had a different set of keys, which made PHS reliant on correctional staff to collect MRFs, scan and forward them to PHS. It appears that during this time MRFs may not have been collected on a daily basis. According to the Clinic Manager, this was resolved in early May 2015 and PHS staff are now solely responsible for collecting the forms.

The MRFs have recently been re-designed to include categories that patients may select in requesting assistance. The categories are:

1. *Nurse/ AHP/ GP*
2. *Mental health*
3. *Dental*
4. *Medication*
5. *Information*
6. *Compliment or complaint*

The District Manager reported that the redesigned forms provide an internal complaints mechanism for patients, as well as allowing requests for information to be dealt with more quickly.

Triage

The Clinic Manager stated that a "triage" decision is made according to the information provided by the patient on the MRF, as well as on assessments made by nurses who see patients on medication rounds and their knowledge of a patient's history. He stated however, that given that they receive 40-50 requests per day, they do not have sufficient resources to undertake a comprehensive assessment of each request, which might involve cross-referencing a patient's records.

Each MRF received is allocated an appointment date, which places the patient on a "recall list" for a specified date. PHS staff sign the MRF to confirm it has been sighted and an appointment scheduled. It is then entered on the patient's electronic record. Nurses process all MRFs, and consultations arising from an MRF are initially with a nurse. If a doctor is required, the nurse refers them, usually taking them to see a doctor directly.

DOH provided three one-page documents (undated), signed by the District Manager, outlining the triage process at Berrimah and Holtze prisons.

- "Triaging Process at Darwin Correctional Centre (Berrimah)" states that requests are "triaged ASAP" and the Team Leader must be informed of "immediate concerns, self-harm/suicidal ideation, acute emergencies, and mental health issues." Appointments are made "as deemed appropriate to the condition" and can be made "High Priority" to be seen the following day.
- "Triaging Process at Darwin Correctional Centre (Holtze)" states that "significant issues, including threats of suicide and/or self harm may be seen immediately."

[7] This document is undated, but is presumably more recent because it was provided to the HCSCC as a part of DOH's response to the Notice to Produce dated 24 February 2015.

- "Initiating and Triaging the Waiting Lists" states that the clinic recall list for the following day is printed out in the evening by the Team Leader, who highlights and prioritises patients. The list is reviewed by the morning Team Leader, who coordinates the clinic's work that day with the correctional officer. The doctor's list is generally provided by the doctor the previous night, although the Team Leader can assist by providing a brief list for the following day which the doctor can add to as necessary. The Team Leader interviewed confirmed this account.
- A further document titled "Team Leader Role (Berrimah), in draft," dated 20 June 2013 states that priorities include "antipsychotic injections, those at risk, iv antibiotics, major dressings, fasting drug levels etc."

The District Manager stated she would not expect genuinely urgent matters to come via MRFs but through Prison Officers, who are trained in first aid, communicating with the PHS.

Where a patient submits multiple requests, the Clinic Manager noted that this can act as a "reminder" to staff that they have an outstanding appointment. However, he noted that "the squeaky wheel is not necessarily the one that's of the highest priority," and that the clinic also receives "frivolous" requests which staff must prioritise appropriately.

A notable exception to the absence of triage policies is the "Dental Guidelines for Inmates and Detainees," The guidelines set out four stages of priority for dental treatment; namely:

1. *Relief of pain;*
2. *Treatment of acute conditions;*
3. *Stabilising of the oral structures ie treating decay and gum problems;*
4. *Preventative, restorative, maintenance and rehabilitative dentures.*

The PHS dental service has a Dental Triage Assessment Form, which must be completed by a PHS health practitioner following an initial assessment and classification into one of five triage categories.[8] The Guidelines contain a table of appointment or waitlist times, including the recommended maximum waiting time for each category. This investigation makes no findings as to the operation of the dental service other than to note that it has a comprehensive triage process in place.

Overall, PHS procedures provided to HCSCC contain minimal guidance as to how clinical staff should prioritise patients, particularly those with acute conditions, in a systematic manner based on the limited information provided on a MRF.

Recall lists and waiting times

DOH provided a copy of the policy "Client Recall Systems" from the Remote Health Atlas, last reviewed on 7 March 2013. The policy relates to the recall of clients by means of their "Electronic Health Record (EHR)," for the purposes of routine and other planned episodes of health care, including review of test results. The policy outlines that clinical staff are responsible for using recall systems effectively for the systematic follow up of clients, and for ensuring that clients understand the significance of test results, treatments and care plans. The policy notes that recalls need to be regularly reviewed and prioritised, although it does not provide detail on how to prioritise recalls other than to note that those at risk of harm must be prioritised. It notes that "routine and non-urgent recalls are of lower priority, but must be attended in a timely manner."

[8] The classifications are 1. Emergency condition, defined as (i) acute dental and/or facial trauma resulting in tooth, jaw or soft tissue damage; (ii) loss of function; (iii) supervening infection; (iv) acute oral-facial infection resulting in facial swelling; and (v) uncontrolled bleeding from an oral wound. ; 2. Medical condition; 3. Oral health condition, defined as a. pain lasting more than 30 seconds; b. pain lasting less than 30 seconds; c. non acute oral health condition requiring attention; 4. Oral health need; 5 General request for care.

The daily appointment list is referred to as the "recall list." It includes not only appointment requests received through MRFs but also recalls for chronic conditions, follow up of results, dental, allied health services and tracking of public health programs.[9]

DOH submitted that the average number of patients on the daily recall list is 65-80 per day, which is approximately 508 appointments per week. However, on average only around 35-60 patients are seen per day, which equals approximately 333 patients per week. This represents a shortfall of approximately 175 patients per week who are on the recall list but do not attend an appointment.

Doctors have a separate recall list. The two doctors have around 20-25 patients combined on their daily recall list over 5 days per week, which is an average of 113 consultations per week. Of these, they see an average 88 patients per week, which represents a shortfall of 25 patients on the recall list.

The Clinic Manager and Team Leader emphasised that the number of patients seen can be much less depending on factors outside of the control of PHS. Furthermore, DOH noted that the amount of time clinical staff spend with patients is reflective of the "immediate need of the client at point of care" and there is no "target" number of appointments that the clinic aims to meet.

The District Manager reported that as at 9 September 2015 there were a total of 83 unserviced recalls. It is difficult to reconcile the accuracy of this number, given that DOH's own figures suggest a shortfall of around 175 appointments per week. She stated that the clinic is always behind on recalls, but this is common of primary health care services and also reflective of the positive work done by the clinic's public health programs in tracking targeted health areas.

Staff interviewed reported that patients who are not able to be seen on the date of their scheduled appointment are not immediately rolled over to the following day's list. However, they had different information about what occurred with these appointments.

The District Manager was not able to specify what occurs with an appointment that is missed, deferring the matter to the Team Leader. She stated that Team Leaders re-book urgent issues for the following day, and noted that it is her expectation that urgent matters are seen immediately and non-urgent matters are seen within one week. This assertion did not appear to be based on data gathered by PHS, and is not consistent with the pattern of complaints received at HCSCC.

The Clinic Manager stated that patients who are not seen are transferred to a list which is printed at the end of each week. According to the Clinic Manager, the "what did we miss list" is then re-prioritised, although the clinic is never able to catch up. Patients from the weekly list who are not seen are transferred to a monthly list, and those from the monthly list who are not seen are transferred to a quarterly list. The Clinic Manager conceded that a person can be effectively "forever on a list." The unserviced appointment remains on the patient's record as outstanding. All staff interviewed noted that there is an expectation when a patient comes into the clinic that unserviced work should be completed wherever possible.

The Clinic Manager was not able to speak to average waiting periods and stated that the PHS had no data on this. He emphasised that the PHS has been chronically under resourced, although this situation has improved.

The Team Leader interviewed stated that Team Leaders will attempt to re-book matters they identify as urgent for the following day. However, he stated that there was no fixed practice as described by the Clinic Manager of carrying names over to weekly, monthly and quarterly lists, although this did occur sporadically. In this Team Leader's opinion, there is "no great system" in place to recapture unserviced appointments. Team Leaders attempt to "bump ahead recalls" that are not seen on their appointment date, but patients can be missed.

[9] The public health programs currently tracked includes mental health, child health, maternal, chronic conditions, communicable diseases, Hepatitis B and C, alcohol and other drugs.

Referrals and external appointments

DOH provided the Patient Care Information System (PCIS) user reference guide for creating referrals, which facilitates health staff referring clients to external health services. The electronic system generates referral documents.

Communication between prison facilities and Royal Darwin and Alice Springs Hospitals is facilitated by a Protocol, which was approved and last updated on 7 February 2012 (prior to DOH taking over management of PHS from a private provider). It details communications in relation to attendance at the emergency department, inpatient admissions and outpatient departments. PHS referrals must be accompanied by a referral letter containing relevant clinical information. Patients discharged from ED will be provided with a discharge letter, and those who attend appointments at RDH with "appropriate information relevant to ongoing care." Information from RDH is to be sent with the Corrections escort or faxed to clinical staff. The protocol notes that clinical notes need to be typed and verified which may cause a delay, but clinical staff can contact the hospital to facilitate the provision of information. DOH has acknowledged that these Protocols require significant updating.

The Team Leader stated that outpatient clinics at RDH have different practices in relation to the supply of documentation and PHS does not always receive documentation. The District Manager reported that they have recently become aware that PHS staff are able to have access to a joint database, which will improve their staff's ability to access information from RDH.

DOH submitted that transport of prisoners to external medical services is the responsibility of Corrections staff, although PHS administrative staff will liaise with Corrections to arrange escorts. Prisoners are not made aware of the time or date of their external appointments in order to maintain the "safety and good order" of the prison. In an emergency, the clinic can call an ambulance through the Corrections Communication Centre, which ensures that an ambulance can quickly transport a patient to hospital.

Staff interviewed reiterated the role of Corrections staff and institutional factors outside of the control of PHS in the difficulties of patients attending external appointments. The implementation of Telehealth was identified as an important development to improve access for patients. It is currently in limited use. The District Manager reported that negotiations in order to maximise the use of Telehealth are in progress, although there is no implementation plan in place.

Communications with patients

According to the *Prisoner Reception Health Assessment Policy*, medical officers must ensure that prisoners are advised about health assessments in a manner that encourages participation and discussion between the prisoner and the health professional. They must also be told about the availability and access to health care services within the institution and any eligibility criteria.

The Clinic Manager reported that after submitting a MRF, patients are not told that an appointment has been made. If asked, nurses are able to disclose that an appointment has been booked but not the specific time of the appointment due to security reasons. He also noted that if patients were given an appointment time and then were not seen this would generate angst.

Patients are never advised of the time of an external appointment due to security reasons. If asked, clinical staff are able to confirm that a referral has been instigated and they are on a waiting list or an appointment date has been set.

The District Manager stated that in an attempt to improve communications with patients a communications book has been implemented. Nurses take this on medication rounds and note any

queries from patients that might be answered on the spot or taken on notice to be followed up and communicated to the patient on the following medication round.

Discharge

DOH stated that informal discharge procedures have been developed over the past 18-24 months.[10] This involves printing client summaries and highlighting outstanding external appointments, advising external providers that the client is no longer a user of the PHS and ensuring clients are provided with discharge information and relevant medications upon release. Care plans are transferred to the client's clinic if known. DOH have noted that these procedures will be reviewed and formalised, and in particular protocols will be developed to minimise the number of clients with unknown health care providers.

[10] DOH response dated 24 December 2015.

6. THE FIRST COMPLAINT

6.1 CHRONOLOGY OF MS A'S TREATMENT

The first complainant will be referred to as Ms A.

The following chronology incorporates evidence from Ms A's medical records, including MRFs, notes from consultations with PHS health staff and administrative documentation.

Ms A was admitted into custody in 2013 and imprisoned at the DCC facility in Berrimah. This complaint relates to services provided at the Berrimah facility, prior to the move to Holtze.

Ms A's health was assessed by a nurse on her day of admission. The notes state that she had a sore on her right knee and suffered from hypertension for which she was taking Ramipril.

The standard assessment of new female prisoners includes enquiries as to the possibility of pregnancy. Under the question "suspected pregnancy, or pregnant?" the records state "not pregnant; Comments: doesn't use contraception" and her last period was listed as "last month ? Date."

In the course of routine pathology checks conducted by the PHS upon reception, urine and blood samples were screened for various purposes including sexually transmitted infections and pregnancy. The records note the pathology request for a "Pregnancy test (Bhcg) – blood."

The pregnancy test results from this test were never obtained. Pathology test result reports state "no specimen received" and indicate there was insufficient blood.

The day following her admission, a doctor prescribed Ramipril as it appears to have been missed on Ms A's medication chart. The doctor did not examine her.

Several days later, a nurse followed up a test result indicating Ms A was suffering a urinary tract infection. She commenced Cephlex in accordance with the CARPA Manual, noting that "as pregnancy status not yet known recall done for Urine retest in 10 days."

Various pathology requests were made around two weeks after her admission, although these did not include a pregnancy test.

Several days later, Ms A's record shows "Pregnancy Test – Urine Beta Hcg" as a service item, although the progress notes say "Pt states urine was collected 4/7 ago days will follow up." A pathology request confirms that a urine sample was collected for a "Urine, Micro, Culture and Sensitivity" test. The pathology test results report notes that the sample was likely to have been contaminated by the patient in the collection. There is nothing to indicate this was followed up or retested.

Three weeks after her admission, Ms A was treated for a small wound on her right leg, and around five weeks after admission for a sore right ear for which she was referred to a doctor. There is no record that Ms A's ear problem was reviewed by a doctor.

Almost four months following her admission, Ms A was seen by a nurse for "bloods and urine screen;" the notes state she was "identified as a "contact'". Pathology tests were requested for syphilis and common sexually transmitted infections. A pregnancy test was not ordered. No issues requiring treatment were identified.

Around five months following her admission, Ms A submitted a MRF requesting an appointment. The form stated "every time I take my blood pressure tablets I get headspins and I also need to get my cholesterol checked."

A note made the following day indicates that a nurse attempted to recall Ms A to follow up the MRF, but she was out on a work party.

Around two weeks later Ms A was given her medications.

Three and a half weeks after submitting the first MRF, Ms A submitted a second MRF stating "I am suffering from headaches morning an night and dizzy spells. Im passing urine up to 8 times every night."

Ten days later, Ms A submitted a third MRF stating "Im dizzy when I exert myself. I have headaches every day. Im up weeing all night. Im short of breath. I just do not feel well and would like a thorough check up please."

She was provided with medications two days later.

Four days after submitting the third MRF, Ms A submitted a fourth MRF stating "I again request to see the Dr, I pass urine alot at night. Dizzy spells with exercise, short winded. Im very thirsty. Not at times." On the same day, Ms A contacted the HCSCC, saying that she had submitted several MRFs but had not been able to see a doctor. She complained of dizzy spells and headaches, urinating at least 8 times per night which caused her difficulty sleeping and sore and swollen legs. HCSCC contacted PHS to obtain information about Ms A's treatment, and were advised that a "recall" was in place, but "due to current resourcing… (1RN to 90 inmates) cannot give indication of when she will be seen by a doctor."

Nine days later, Ms A approached a nurse on medication round and handed her a note. The nurse's record states that Ms A reported "urinary frequency, SOB [shortness of breath] on exertion, feeling faint, puffy feet that comes and goes, extreme thirst, pain and stiffness in left shoulder, headache every morning."

Ms A was then brought to the clinic for review by a doctor. The doctor's consultation notes state that Ms A had been "complaining enuresis, polyuria, dizziness, swollen ankles and [h]eadache for what appear to be a few weeks." The notes state that she was brought into the clinic due to dizziness, and that she "says that she is feeling fuller in the stomach in the last month." An abdominal mass is noted "in epigastric region approx. 6cm diam fixed not pulsatile non tender." The notes conclude "have discussed patient with radiology consultant with view to CT abdomen but he has suggested referral to RDH ED."

Ms A was then evacuated to the emergency department of RDH, where a scan confirmed that she was approximately 36 weeks pregnant. She was then returned to prison and a referral to RDH for antenatal care instigated. At this point, seven weeks had elapsed since she had submitted the first MRF.

The HCSCC was informed of Ms A's pregnancy.

The day after her visit to RDH, Ms A was seen at the PHS clinic by a nurse for antenatal observations and further blood and urine tests, and by a doctor who changed her medications, ceasing Ramipril and commencing Cephalexin and Elevit. The doctor records an appointment with "high risk anc", noting that Ms A's blood pressure should be observed over the following two days. She was referred to an obstetrician on this date, noting that she has had no antenatal care. The referral further notes that her blood sugar levels were 11 [mmol/L] the day prior and 12 mmol/L that day, with no indication of diabetes in the past.

Five days later, Ms A was admitted to the maternity ward at RDH, where she consulted a number of health professionals, including an endocrinologist, a diabetes team, midwife and obstetrician. She saw a consultant endocrinologist at RDH, who recommended that her Ramipril medication be

stopped in exchange for Metformin, and that her blood glucose levels be monitored. A diabetes nurse educator recommended monitoring her BGL four times per day "so we can adjust medication as needed as she didn't present with any BGL levels" and requested that these be faxed weekly.

The following day, Ms A was seen by the obstetrics team. She was booked for a caesarean section and discharged. The discharge notes state that her blood glucose levels (BGL) were within target range but needed to be reviewed four times per day. The notes of her return to prison check confirm this advice, however, a nurse's note states that she would be recalled for bi-daily monitoring as four times per day was "unable in this setting."

A note recorded two days later by an Aboriginal Health Practitioner states that Ms A presented for BGL monitoring, which she is supposed to do bi-daily but this has not occurred. The nurse notes the "BGL machine put into trolley so BGL can be done BD [bi-daily]." It does not appear that she was consistently monitored on a bi-daily basis.

Around two weeks after finding out she was pregnant, Ms A advised HCSCC that she would like to pursue the complaint against PHS. HCSCC's records state that Ms A reported that she did not know that she was pregnant and did not feel the baby move.

The following week, Ms A attended appointments at RDH.

She was then reviewed by a doctor at PHS, who noted that her BGL has been "well controlled with 2g of metformin daily" and that she feels well and is due for a caesarean section next week.

The following day she was reviewed by a doctor for lower back pain and evacuated to RDH. She was not found to be in labour and discharged. Two days later she was reviewed by a nurse who checked her BGL and noted she is "happily talking about going to RDH in a couple of days to have baby."

Ms A was transferred to RDH for a caesarean section on the scheduled date, and discharged and returned to prison five days later with the baby. At the time of giving birth, she had been incarcerated for 7 months.

6.2 INCIDENT REPORT AND REVIEW

A Riskman incident report was completed by a nurse on the day that Ms A was found to be pregnant. There is a record in Ms A's file by the Clinic Manager on the same date noting "extended review and discussions" of the incident with the clinic doctor. The incident report notes the four outstanding medical requests for the same symptoms, and states

> *direct result of staffing insufficiency, lack of continuity of care to women in prison. Incomplete reception, no capacity within current staffing levels to adequately follow up.*

It identifies insufficient staff and funding as systemic issues, but states that no preventative or corrective action is required. Given the potential gravity of the incident it is concerning that no follow up action was recommended at this point.

An internal review of the incident was undertaken by the Acting Strategic Manager of PHS almost five months later, after the complaint was referred for investigation to the HCSCC,. The internal review found that Ms A must have been about 8 weeks pregnant when she came into custody but was either unaware of the pregnancy or did not acknowledge it. It confirms that a blood sample was collected upon reception, but the message from the laboratory that the sample was not tested was either not received or not acted upon.

The internal review notes that although Ms A's first MRF was followed up (whilst she was at a work party), the following three MRFs were not. By way of providing some explanation as to how the pregnancy may not have been obvious to staff, it highlights Ms A's obesity and the fact her weight remained more or less the same. It states that Ramipril is contraindicated in pregnancy "due to possible foetal and neonatal morbidity and death" but there was no indication of an adverse effect on the child to date.

The internal review lists a number of actions taken in response to the incident:

- All nursing staff instructed to fill blood specimen tubes completely
- All nursing staff to attend a two week course in advanced clinical skills required for working within the primary health care model, noting that at the time of the incident a number of staff were relatively new or short term locum staff
- Staffing increases by an additional 6.4 full time nursing positions
- The move from Berrimah to the new DCC facility at Holtze to result in higher level of service to female prisoners, including daily access, a dedicated women's clinic and a nurse allocated to women's health portfolio

6.3 FURTHER EVIDENCE

Ms A was interviewed for the purposes of this investigation.

Ms A stated that from her perspective her requests for medical attention were ignored: "no one wanted to see me… nobody didn't want to really care." She reported that a friend, a white lady, helped her fill in the forms. She put in lots of forms and waited for them to call her name to go to the clinic but nothing happened.

Ms A stated that she was not aware that she was pregnant. When the doctor told her she felt shocked and started crying. She had been on a work party for the majority of her pregnancy, so she was worried that her baby could have been in danger. She felt herself lucky not to have miscarried given that she was doing manual labour including lifting heavy things, cutting branches and doing cyclone clean up. As soon as she was found to be pregnant she was not allowed on work parties.

She was alarmed that the Ramipril medication she had been receiving could have been harmful during pregnancy. She believes that she continued to receive Ramipril after her pregnancy was discovered at RDH, and she had to tell PHS staff to stop giving her the pill. From the records supplied by DOH it is unclear whether Ms A received Ramipril in the five days after the PHS doctor recorded that it be ceased and her first appointment at RDH.

Once they knew Ms A was pregnant she received a lot of attention from the PHS, however she says they "should have been running around before that." She stated that the pregnancy should have been detected when she was admitted into custody. She says that PHS should be doing full check-ups of patients, particularly women, and taking more care in seeing patients. In her words: "I need to tell them clinic mob, do your job properly."

The PHS Clinic Manager was interviewed in relation to the complaint. He managed the service at the time in question and was aware of the case, having communicated with HCSCC about the complaint.

The Clinic Manager explained that pathology results are sent to an off-site doctor who is not employed by PHS. The role of this doctor is to check the results and notify PHS of any concerns. The Clinic Manager stated that the service item on Ms A's record was witnessed by the off-site doctor, and therefore appears to have been done. Accordingly, the incomplete test would be difficult for PHS staff to identify. The Clinic Manager stated that since that time, nursing staff have been made responsible for following up the results of any tests that they request.

The Clinic Manager noted that Ms A had daily contact with nursing staff, who physically delivered her medications. He suggested that medication rounds allow nursing staff to supplement information from MRFs to undertake a "triage" assessment. In my view, this makes it all the more concerning that Ms A's condition was not investigated sooner.

The Clinic Manager reported that previously it was very difficult for PHS staff to gain access to the women's prison. He expressed that the PHS would be lucky to spend two hours per week seeing female patients and would shut down the men's clinic in order to do so. Since the relocation to the Holtze precinct, the PHS has a greater capacity to service women's needs because there are separate waiting areas that allow women and men to be seen concurrently. There is also consultation space available within the women's section of the prison that the PHS use for appointments.

7. THE SECOND COMPLAINT

7.1 CHRONOLOGY OF MS B'S TREATMENT

The second complainant shall be referred to as Ms B.

The following chronology incorporates evidence from Ms B's medical records for the time period in question, including MRFs, notes from consultations with PHS health staff and administrative documentation. In this period, Ms B submitted 45 MRFs. Around 18 of these related to wrist or shoulder pain; the remainder to a range of issues including mental health, suboxone treatment, dental and women's health. The information most relevant to this investigation is summarised below, though it is important to note that Ms B was in regular contact with the PHS for a range of concerns.

As part of the PHS' reception of new clients, Ms B was assessed by a nurse and a doctor. According to the reception record, Ms B had a history of injury to her shoulder for which she underwent surgery. In addition, Ms B presented with a number of other medical issues, including asthma and a previous CIN 3 result on a pap smear.

Five days after her admission into custody, Ms B was involved in a fight with two other inmates, where she alleged that she was the victim of an assault by two inmates.

Following the assault she was seen by a nurse and observed to have bruising to her lower right eye lid, a graze to the back of her left shoulder, redness in her left cheek, a small graze to left upper eye lid, swelling and a minor graze to her upper lip and pain in her right hip. She was prescribed analgesics and reviewed several hours later where she was reported to be settled and "feel[ing] much better."

However, she continued to experience pain in her shoulders and right wrist, which she raised with the PHS through MRFs and in consultations with nurses and doctors.

Two days after the assault, Ms B was seen by a nurse where she requested more analgesia for her shoulder pain. The notes state that the decision was deferred to a doctor due to her history of opiate addiction. On the same day, she submitted a MRF reporting worsening shoulder blade pain. She was seen by a doctor, whose notes make no reference to her shoulder pain, although a script for an anti-inflammatory medication was written.

Five days after the assault, Ms B submitted a MRF requesting an x-ray for her shoulder, and reported that she was in a lot of pain and believed a pin had come out, whilst her other shoulder was getting worse.

A week following the assault, she was again seen by a doctor who notes her history of shoulder injury and reduced range of motion. Following this consultation, the doctor completed a referral for the orthopaedic clinic at RDH. A letter from RDH confirms Ms B's appointment for a date three and a half months from the date of the alleged assault.

Two days later, Ms B signed a contract for suboxone treatment for her opiate addiction. The treatment commenced shortly thereafter and was administered by a nurse every two days. There appears to be no further action in relation to her shoulder pain in this time, although a doctor's note states that she has "BEEN ON OXYCODONE LARGE DOSES FOR LONG TIME." Oxycodone is an opiate used for pain relief.

Three and a half weeks from the date of the assault, Ms B submitted an MRF stating "I have got no circulation in my right arm from a broken wrist and its saw and it crunches and I am in a lot of pain." It appears that in response to this MRF, a nurse sent an update to a doctor stating "Color, warmth Movement and sensation all present. Radial pulse present. Eucalyptus cream given to apply."

She submitted another MRF three days later repeating that her two shoulder blades were in a lot of pain and requesting an x-ray. A note on the MRF states that she was already on the orthopaedic specialist waiting list. The following day she submitted a number of MRFs, one of which stated that her left shoulder was becoming more painful.

Three days later, Ms B was seen by a nurse, who made a physiotherapist referral for her shoulder pain. There is no evidence that Ms B saw a physiotherapist until over three months from the date of the alleged assault.

Around two weeks from the date of the physiotherapy referral, Ms B submitted a MRF stating she was very stressed and that her hair was falling out.

The following day, she saw a nurse who gave her eucalyptus rub for her shoulder and noted that she was depressed. She also saw a doctor who reported she was "weepy but positive."

Around a week later, Ms B saw a nurse who notes she was requesting a review of her long term shoulder injury. The nurse made a recall for the doctor to review and decide whether she needed an x-ray.

The following day, Ms B submitted a further MRF in relation to her shoulder blades, stating she was in a lot of pain and her medication was not working. She stated she would contact the "medical ombudsman" (HCSCC) if she was not x-rayed.

Five days later, she submitted a form stating she needed to see a doctor about "a lot of things" and again indicated that she would contact the HCSCC.

Two days later (and two months from the date of the assault), Ms B submitted a form stating she was still waiting for an x-ray for her shoulder blades and hand. She stated that she was getting up every night with pain and there was no blood circulation through her shoulder blades and hand. The request concludes: "This is the six form now. I'm sick of it and nothing been done."

Five days later, Ms B contacted the HCSCC, complaining that she had put in 9 MRFs for an x-ray of her shoulder but had not been seen. She reported that she last saw the doctor a month ago and mentioned this to him but nothing was done. She was advised that HCSCC would make enquiries on her behalf. PHS informed the HCSCC that Ms B had a referral to RDH.

Three days after contacting the HCSCC, Ms B submitted a MRF stating: "Dear Doctor, what is going on with my xray on my two shoulder blade and my hand is in alot of pain too. Know blood is going through my two shoulder blade and my hand right hand double from two women back in January."

Around a week later, Ms B was seen by a nurse for the administration of suboxone, where the notes state "due to time restraints Dr […] will follow up Clients shoulder blade issues tomorrow."

Five days after this reference, Ms B submitted a MRF stating "I still need to go to hospital for a xray on my two shoulder blade. Also my right hand it is still in alot of pain. After taking medication. This is my seven form now."

A week later, Ms B submitted a MRF stating she would like to see the Clinical Nurse Manager to complain about staff.

She did not receive a response to this request, and submitted a further MRF a week later stating that staff would not give her eucalyptus rub and a second form reiterating that she would like to see the Clinical Nurse Manager "ASAP about a lot of things now." A note by a nurse on the same date stated that Ms B had asked for eucalyptus rub on the medication round, but the nurse advised her

that the doctor had not prescribed it and she could not administer it as it was not covered in the CARPA manual. Ms B responded that other staff had provided it to her and she was dissatisfied.

Later that day, the Clinic Manager saw Ms B and discussed her medical issues. His notes record that she reported left shoulder pain and right shoulder pain and pins and needles in her right hand since the "double banging" assault. According to the notes, Ms B "agreed" that physio would be the best initial treatment. The Clinic Manager noted that he "commended" nurses for not providing eucalyptus rub, given its "limitations of use particularly around CARPA." They also discussed Ms B's suboxone treatment, mental health issues and request for a pap smear.

Around one week after her meeting with the Clinic Manager, Ms B was seen by a physiotherapist, who noted she had shoulder soreness, stress traps soreness, weak supraspinatus left hand side and possible scaphoid fracture of her right wrist. She requested an x-ray and discussed stretches with her.

Ms B was then due to attend the orthopaedic clinic at RDH. She did not attend due to a court video conference, and three days after the scheduled appointment she was reviewed by a doctor who noted:

> *Complaining of ongoing pain in right wrist ?fractured #scaphoid from self defense up to 4 months ago was booked to see Orthopedic surgeons […] but could not make appointment as had video conference. Will rebook appointment with outpatients.*

The doctor then completed a second referral form for the orthopaedic clinic at RDH.

A note on Ms B's file by an Administrative Officer states: "RDH Orthopaedic/ fracture clinic – did not attend." The Clinic Manager's evidence was that a visit scheduled for this date was cancelled due to lack of prison officer availability.

Two and a half weeks from the date of the missed appointment, Ms B attended the orthopaedic outpatient clinic at RDH. The x-ray report from this date states:

> *Evidence of prior scaphoid injury with advanced scapholunate and radiocarpal degenerative change. Widening of the scapholunate interval. Extensive resorptive change seen about the site of the proximal pole of the scaphoid. Negative ulnar variance noted.*

The specialist's notes describe the injury as follows:

> *Marked lunate-capitate sclerosis and arthritis*
> *Radial styloid sclerosis*
> *Scaphoid Consistent with SNAC (scaphoid non-union advanced collapse) grade 3 changes*

The specialist concludes that this is a "likely exacerbation of old injury" and "will progress to painful arthritis," with a prognosis that it may be amenable to surgery in later years. Ms B was advised to wear a splint "for comfort only" and review once out of prison.

Later that day, Ms B submitted a MRF stating she needed stronger pain relief for her broken wrist.

Around 10 days after her specialist appointment, she submitted a further MRF stating that her medication was not working and the pain was worsening.

Five days later, Ms B submitted a MRF stating that she was still in a lot of pain every night with her two shoulder blades and needed an x-ray.

Several days later she was reviewed by a doctor who noted that recent scans of her "old scaphoid fracture" were due for follow up at an orthopaedic appointment in two weeks' time. He also

suggested that she talk about the pain to her left shoulder at the appointment. She was scripted analgesics for pain relief.

On the date Ms B was due to attend the orthopaedic clinic appointment, an administrative note on her record states “ortho clinic rang and stated they did not need to see her again, seen [one month prior], she is to follow up when she gets out of prison.”

A report for a second x-ray completed the following day reiterated the findings of the first x-ray, and noted “There are no features to suggests a region of acute fracture. Again there is a negative ulna variance. No evidence of osteonecrosis.” Upon her return to prison on this date, she was reviewed by a nurse who reported that Ms B had wanted an x-ray of her shoulders, as her wrist had already been x-rayed. She further noted “Nil paperwork from RDH; Dr […] reports is due ortho r/v shortly.”

On the same day, an inbox message from Ms B’s physiotherapist to the doctor states:

> *As suspected [Ms B] has a well advanced scaphoid # as well as interruption of her proximal carpal row and her distal radio unar joint. I have just reviewed the x-ray and the next step is getting her to ortho so they can sort out this injury as it will not improve by itself, the radio scaphoid and radio lunate articulation is very important for wrist function so as it is disrupted there will continue to be instability in the wrist as well as swelling pain and poor function. This injury is a priority.*

The doctor’s response was that he was “well aware” of the injury and had Ms B scheduled to see an orthopaedic specialist the previous day. However, there is no reference to RDH’s cancellation of the specialist appointment, suggesting significant confusion about her treatment.

Ms B submitted an undated MRF stating “I would like to see [the Clinic Manager] because of the staff again, I’m really getting sick of it,” which was entered into her patient records around this time.

Ten days after the second x-ray, Ms B was released from prison.

She was returned to prison under arrest after 18 days.

About 12 days from her return to custody, she submitted a MRF stating “Ring the hospital for about my right hand for a operation.”

The following day she was seen by a nurse, who noted her concern about an old fracture to her right wrist. The nurse then emailed the doctors stating:

> *[Ms B] is saying that ortho were supposed to consider ORIF’ing her right wrist. She has an old fracture from early this year. I cannot find any ortho documentation on Jadecare regarding this. Could you please chase up with ortho whether anything is to be done.*

The doctor completed a third referral to the orthopaedic clinic at RDH for Ms B’s scaphoid fracture, stating “we are concerned that she received no treatment and was wondering if she requires further management.” A document on her medical file notes that a RDH outpatient wait list entry was created for an appointment.

Around one week later, Ms B saw a nurse and requested paracetamol for her hand injury. Ibuprofen was scripted and supplied.

Three weeks later, a PHS doctor’s note on Ms B’s file states that she was not seen, however “Good news [second] xray report from RDH Radiology shows no acute scaphoid #, She has anyways been to # Clinic referred by Dr […] 2 weeks ago.”

One week from this entry, Ms B submitted a MRF stating that her wrist pain was worsening. The same day, a nurse sent an inbox to a doctor stating that Ms B was complaining of "arthritic type pain to old fracture site in right arm" and requesting review and a script for Panadol osteo, which was actioned.

The following week, upon administration of her suboxone treatment, the nurse recorded Ms B's complaints of wrist pain.

Ten days later, Ms B submitted a MRF stating:

> *My right risk is in alot of pain. I had injury and damage the bone more it is a old break now I can feel burning in the break also I'm geting up every night to move my fingers around for blood flow.*

Around two weeks later, Ms B reported to the nurse administering her suboxone treatment that she wanted a splint for her wrist and was on a waiting list to have surgery. She noted that there was no evidence of this on her patient file, and completed a recall for the doctor to review.

Two days later, during administration of her suboxone treatment she reported that her wrist was "getting worse since having fight the other day, gets pins and needles when lying down at night."

Several days after that, Ms B completed a MRF stating that her arthritis was "playing up tremendously" since moving to the dorm where the air-conditioning was kept on all night. Ms B later followed up the issue of air-conditioning, but was told this was not a medical request and to take it up with prison staff.

Ms B was released from prison two weeks later, and returned a month and a half later.

A month from her return to custody, Ms B completed a MRF for pain relief for the pain in her two shoulder blades, requesting an x-ray as soon as possible.

One month later, she consulted with a doctor who noted her long standing injury to her left shoulder and reduced mobility. The doctor's notes state that it appears to be a rotator cuff issue to be reviewed when she is released from of prison.

7.2 OTHER TREATMENT ISSUES – WOMEN'S HEALTH

Ms B contacted the HCSCC in relation to her requests for a pap smear and "other problems."

The HCSCC was advised by PHS that Ms B had not submitted any MRFs in relation to a pap smear. At that time, HCSCC did not have access to Ms B's medical records. Having had an opportunity to now review the records, it is apparent that Ms B had in fact submitted three MRFs requesting a gynaecological consultation. Her first MRF requested assistance for "women's business for down below"; the second request stated she is "still waiting" for a women's check, and on the third form stated that her doctor from the outside has been sending her letters to have a pap smear, which she required on a yearly basis due to a previous result.

Around two weeks after Ms B contacted HCSCC, a PHS doctor made a referral for RDH's gynaecology clinic, noting that Ms B had a prior CIN 3 result and no follow up for 3 years.

Over one month later, a nurse sent an inbox message to a doctor asking Ms B's request for a pap smear to be followed up, as a previous referral to the gynaecology clinic was completed but she had not yet attended an appointment.

Ms B was seen at the RDH gynaecology clinic, over 6 months from the time of her first request.

7.3 FURTHER EVIDENCE

Ms B was interviewed for the purposes of this investigation.

Ms B confirmed that her wrist injury occurred as a result of the assault against her and her shoulder pain from a longstanding injury for which she had surgery. Ms B reported that she suffered a lot of pain as a result of delays to her treatment. She indicated that prisoners are powerless in the process of obtaining medical assistance from PHS. They are advised to fill in the form and wait, given no idea of when they will be seen "because we're not – in their eyes, we're not going nowhere, in other words. So "they can just wait", you know. But meanwhile, we're sitting there in pain." She believes that prisoners are treated as "just another number, just waiting, waiting." Ms B stated:

> *we've been waiting for months and months to go and get medicated and that, you know, or to be seen by a professional doctor, you know, or a nurse for simple little things. It's gotten worse here, you know, because if it's too busy, you know. You know, well, this is why we put in a form, so you can make a time when to see us and that, you know… "I am too busy. I've got 8,000 prisoners", you know. Or "I've got 400 prisoners to see", you know. Then you – you know, this is some of their attitudes. This is why I put a form, so you can make a time to see me. You know, and then I get seen two to three months down the track and I'm thinking, well, hang on, I'm only just here and you've got a clinic there. It's not hard to, you know, take 10 minutes out of your time to come and see me and that and just get me out of the way. And then you can see them 400 prisoners, you know.*

In Ms B's view, the uncertainty and lack of communication around medical treatment renders people "physically, emotionally, spiritually, mentally more worse. You know? And it brings their self-confidence down and self-esteem."

Ms B stated that Aboriginal prisoners in particular do not commonly stand up for themselves, and are therefore likely to suffer longer delays to their treatment. She believes that she was disadvantaged as a consequence of complaining about the PHS and labelled a "trouble maker".

The PHS Clinic Manager was also interviewed in relation to Ms B's treatment. The Clinic Manager was well aware of Ms B's case and had spoken to Ms B about her concerns in detail. According to the Clinic Manager, there were several attempts to get Ms B to be x-rayed and attend external appointments, which failed due to prison officer capacity.

The Clinic Manager mentioned that Ms B was a high security prisoner, who had "not made any friends amongst her officers." Further to this, the Clinic Manager stated that: "[t]here are prisoners who… nobody goes out of their way to assist them when they have systematically burnt bridges everywhere." Nonetheless, he stated that this did not affect the quality of care she received from PHS.

With regards to Ms B's missed appointment as a consequence of a court video conference, the Clinic Manager stated that PHS does not crosscheck prisoner movements with Corrections, and suggested that this was generally unnecessary given the low probability of a conflict. He stated that the second appointment scheduled was cancelled due to lack of correctional staff to escort Ms B to RDH.

The Clinic Manager noted that it is now much easier for patients to be x-rayed, as the clinic at the new prison has an x-ray machine.

The Clinic Manager stated that Ms B's third scheduled appointment was cancelled by RDH because her condition was not urgent, would not change and she could follow it up once out of prison. In the

Clinic Manager's opinion, she had an obligation to have it reviewed when she was released from prison and "[f]ailed to take personal responsibility for her own injury while she had the capacity to not be restricted by the nuances of the prison environment."

I note that Ms B was out of prison for a matter of 18 days.

The Clinic Manager was asked to explain the nurses' observations of "Color, warmth Movement and sensation all present. Radial pulse present. Eucalyptus cream given to apply," which followed Ms B's first MRF complaining of a broken wrist. The Clinic Manager explained that the nurse's observations were that Ms B did have motion, sensation and function in her wrist, which therefore proved her claim on the MRF as false. The Clinic Manager stated that based on this clinical finding and treatment plan there was nothing to indicate her concerns should have been escalated.

The Clinic Manager highlighted that Ms B saw nursing staff practically every day and was well known to PHS. He stated that if Ms B was in genuine pain, he would have expected her to approach nurses each time. As I have outlined in the chronology, there are documented instances where Ms B repeated her complaints to nursing staff directly, in addition to the multitude of MRFs she submitted.

In relation to the women's health issues, the Clinic Manager stated that at the time in question PHS did not have enough nurses qualified in women's health checks, which was compounded by difficulties in accessing the women's prison at DCC Berrimah. He again suggested that Ms B should have obtained a pap smear when she was out of prison, as primary health is the responsibility of the individual and "their lack of organisation… does not become our emergency."

Furthermore, the Clinic Manager defended his statements in relation to Ms B's "behaviour" and noted that he has made a significant contribution to the PHS over the last two years, which has led to "doubling of the health care service team FTE nursing staff numbers and vast improvements in both policy and practice."

The Clinic Manager noted that much of the time relevant to this dispute included the transition phase from Berrimah to Holtze, when there was high pressure on the clinic due to prison officer training for the new prison precinct.

8. RELEVANT LEGISLATION AND STANDARDS

8.1 LEGISLATIVE STANDARD OF CARE

Division 4 of the *Correctional Services Act 2014* (NT) contains provisions in relation to health care. This Act requires the Commissioner to arrange health care for prisoners that is of a standard "comparable with that available to persons in the general community in the same part of the Territory" (section 82(2)).

The PHS' *Prisoner Reception Health Assessment Policy*, approved on 1 December 2011, reflects this provision:

> *Prisoner patients will be provided with the same standards of medical and nursing care as that available to any other patient and medical decisions will be based on clinical interpretation of the patient's condition only with the preservation of confidentiality.*

This principle is equally reflected in the *Prisoner Patients NT Hospitals Policy,* which provides a mechanism for NT acute care facilities to work in partnership with Correctional Services to deliver healthcare to prisoners.

8.2 STANDARD GUIDELINES FOR CORRECTIONS IN AUSTRALIA

Paragraphs 2.31 – 2.47 of the *Standard Guidelines for Corrections in Australia* (Revised 2012) provide minimum standards, agreed to by each of the State and Territory Corrections departments in Australia, for the provision of health services in correctional institutions. The paragraphs most relevant to the present investigation are included below:

> *2.31 Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Notwithstanding the limitations of the local-community health service, prisoners are to have 24-hour access to health services. This service may be on an on-call or stand by basis.*
>
> *2.32 Every prisoner is to have access to the services of specialist medical practitioners and services relevant to their needs. Referral to such services should take account of community standards of health care.*
>
> *2.33 Every prisoner is to be medically examined by a suitably qualified health professional within 24 hours after being received into prison, and thereafter as necessary.*
>
> *2.36 All prisoners who have a medical complaint shall be seen by a health professional at intervals appropriate to the diagnosis and prognosis in each case, according to good medical practice.*
>
> *2.44 Where a prisoner enters or is released from prison and is under medical or psychiatric treatment, where appropriate, the prison health service should make arrangements with an appropriate agency for the continuation of such treatment after release.*
>
> *2.45 Pre-natal and post-natal treatment and accommodation should be made available to female prisoners, where practicable.*

8.3 RACGP STANDARDS FOR HEALTH SERVICES IN AUSTRALIAN PRISONS

The Royal Australian College of General Practitioners ("RACPG Standards") have developed *Standards for Health Services in Australian Prisons* (1st ed, April 2011). These standards provide a useful set of independent criteria upon which to evaluate the service provided by PHS. The most relevant points are summarised here.

Standard 1.1.1 Scheduling care in opening hours

Standard 1.1.1 provides that a prison health service should demonstrate a flexible system that accommodates patients with urgent, nonurgent, complex, planned chronic care, and preventive health needs. This can be shown through the following indicators:

- Documentation of a flexible system that can accommodate patients with a range of needs.
- Staff are able to describe how they identify urgent medical matters and procedures for obtaining urgent medical attention.
- Written policy for dealing with urgent medical matters.
- Patients can directly access the service by telephone, written request, in person or other direct method during normal opening hours.

This standard makes a number of points that are instructive to this investigation:

- Patients with urgent needs must be promptly and efficiently identified.
- A health service should have systems in place to anticipate urgent needs, such as an appointment system that includes reserving unbooked appointment times for urgent appointments.
- Staff should be able to describe how to deal with an urgent case when the health service is operating at full capacity.
- Patients should have an opportunity to see a clinician within a reasonable time for non-urgent and preventative matters.
- A prisoner should be examined by a qualified health professional within 24 hours of admission into custody in order to identify health concerns and any urgent action required.
- Prisoners should ordinarily have direct access to the health service to make an appointment, rather than having to rely on prison staff.
- Health services may need to have special strategies for prisoners to request an appointment, for example to take into account low levels of literacy.
- Health services should document in a patient's record any delay between a request for health care and the provision of the service, including the reason for the delay.

Standard 1.4.1 Consistent evidence based practice

Standard 1.4.1 provides that a health service should ensure that common and serious conditions are treated in accordance with best available evidence. This should be demonstrated through the following indicators:

- Access to a range of current reference materials relevant to primary care.
- Evidence in patient health records that health service provides care in accordance with best clinical practice.
- Staff can access guidelines for clinical care of patients for common and serious conditions, and specific resources for patients who identify as Indigenous.

Standard 1.5.1 Continuity of comprehensive care

Standard 1.5.1 requires that a prison health service provide "patient centred, continuing, comprehensive and coordinated primary care (including mental health and dental healthcare)," in which patients have the opportunity to develop a relationship with the service. It describes continuity as the "degree to which a series of discrete healthcare events is experienced by the patient as coherent and connected, and consistent with the patient's medical needs and personal context."

Continuity of care is evidenced by strategies or policies in place to support it. It notes that it is particularly critical given the limited ability of patients in prison to choose healthcare providers, and their reliance on the health service to coordinate their healthcare.

Standard 1.5.3 System to follow up tests and results

Standard 1.5.3 requires a health service to have a system in place to review and follow up tests and results, which can be indicated by:

- A practical system for reviewing results, including recall of patients with clinically significant results, which is supported by a written policy.
- Patient health records include evidence that pathology results, imaging reports, investigation reports and clinical correspondence have been reviewed by a GP, initialled and acted upon in a timely manner.
- Staff can describe how patients are advised of the process of following up results.

The standard notes that the level of follow up required will depend on what is reasonable in the circumstances, which might include the probability that a patient will be harmed, the likely seriousness of any potential harm and the burden of taking steps to avoid the risk of harm. It notes that reliance on patient memory or motivation rather than an effective system is inappropriate.

Standard 2.1.2 Patient feedback

Standard 2.1.2 provides that a service should have a system for seeking and responding to patient feedback. Indicators of this can include:

- A documented process for receiving and responding to feedback and complaints.
- Improvements are made as a result of feedback.
- Feedback sought includes information about whether
    - patients are happy with the process for contacting the service and scheduling appointments;
    - staff talk about health promotion/ illness prevention;
    - patients are treated with respect and in a culturally appropriate manner;
    - patients receive enough information about their treatment to enable them to make informed decisions;
    - patients are confident that their care will not be affected by providing feedback;
    - patients are asked for consent to allow a third person to be present;
    - patients are offered an interpreter;
    - patients understand the separation between the health service and prison, and think the health service makes provision for privacy and confidentiality.

9. INVESTIGATION FINDINGS

9.1 THE FIRST COMPLAINT – FINDINGS

I find that the PHS failed to provide an adequate health care service to Ms A, in particular:

9.1(i) The PHS failed to follow up Ms A's pathology results for her pregnancy test.

The pathology results ordered for Ms A were never adequately followed up by clinical staff. The PHS received a message from the laboratory, which should have adverted staff to the need to retake a blood sample from Ms A in order to complete a pregnancy test. A consultation with a nurse notes that Ms A's pregnancy status was not yet known, however no action was taken. A number of pathology tests were ordered, but a pregnancy test was not re-ordered. It appears as an unserviced item on her records and is again not followed up. She was identified as a possible "contact" for sexually transmitted diseases and pathology tests ordered, but no pregnancy test.

These failings indicate significant shortcomings in PHS' follow up systems.

9.1(ii) The PHS failed to exercise due care and skill in responding to Ms A's requests for medical assistance.

Ms A submitted four MRFs during a six week period. One attempt was made to see Ms A when she was at a work party. No further attempts were made to see or communicate with Ms A about her condition, although nursing staff had contact with her during this time in administering her medication. Notably, her first MRF reported that she felt ill after taking the medication, and there is nothing in the record to indicate that nursing staff asked her about this when administering the medication.

Ms A received no medical assistance until she approached a nurse directly and handed her a note, at which point she was referred to a doctor and ultimately evacuated to RDH and found to be 36 weeks' pregnant. This amounted to a 7 week delay to her treatment.

These circumstances depict a standard of practice which would be considered unacceptable in the community, where Ms A would have been able to consult with a GP in the first instance. It is representative of substantial systemic issues in relation to the management of requests for medical assistance, the identification of urgent medical needs, delayed follow up, unreasonable waiting periods and poor communication with patients.

9.1(iii) The PHS failed to provide adequate antenatal care to Ms A and her unborn child.

Ms A received antenatal care only in the final four weeks of her pregnancy. There are two critical points at which the PHS could have become aware of Ms A's pregnancy, and thus provided her access to antenatal care if due care and skill had been exercised:

- Directly after her admission into custody if the results of her pregnancy test had been adequately followed up; and,
- Subsequent to her submitting the first MRF if adequate investigations had been made into her condition.

These circumstances represent practices inconsistent with best clinical practice.

9.1(iv) The PHS administered a medication to Ms A which could have been harmful to her and her unborn child.

Ms A was administered Ramipril during her pregnancy, which would never have been administered if the PHS had taken reasonable care in treating Ms A, as per 9.1(iii) above.

Again, these circumstances are inconsistent with best clinical practice.

9.1(v) The PHS did not complete appropriate risk management procedures.

No preventative or corrective actions were recommended in the Riskman report, in spite of the systemic issues it identified.

9.2 THE SECOND COMPLAINT – FINDINGS

I find that the PHS failed to provide an adequate health care service to Ms B, in particular:

9.2(i) The PHS failed to diagnose Ms B's wrist fracture.

The PHS did not adequately investigate Ms B's complaints in relation to her wrist, which led to an unacceptable delay in diagnosis and treatment of her scaphoid fracture.

Ms B first made direct mention of a suspected broken wrist in an MRF submitted around 3 weeks after the alleged assault against her. At this time, Ms B was reviewed by a nurse who did not assess it as necessary to refer her to a doctor or investigate further. Even if this was reasonable based on her presentation at the time, Ms B continued to complain of pain in her wrist without it being adequately investigated. She submitted three further MRFs about her wrist, and another three MRFs complaining about a "lot of things" in the three months following the assault.

No substantive action was taken in relation to her wrist injury until she spoke with the Clinic Manager about three months from the date of injury, by which time she had spoken with HCSCC and was threatening to escalate her complaint. On this date, Ms B was referred to a physiotherapist. She was seen by a physiotherapist who immediately suspected a scaphoid fracture and requested an x-ray. Further delays ensued, and Ms B did not see an orthopaedic specialist until a month later, when she was x-rayed and diagnosed. This diagnosis came over 4 months from the time of her injury.

I find this to be an unacceptable delay to her diagnosis and treatment. Ms B was likely to have had a better treatment outcome had she been treated sooner. Ms B's treatment was inconsistent with best clinical practice, and points to substantial systemic issues in relation to the management of requests for medical assistance, the identification of urgent medical needs, lack of follow up, unreasonable waiting periods and poor communication with patients.

9.2(ii) The PHS failed to provide adequate treatment for Ms B's wrist injury.

Once her scaphoid injury was diagnosed, PHS did not provide adequate treatment for the injury. Namely, the PHS did not:

(a) Follow up the results of her two x-rays and orthopaedic specialist appointment
(b) Provide use of a splint for comfort as per the specialist's recommendation
(c) Formulate a plan in relation to pain relief
(d) Communicate with Ms B to address her pain or ongoing concerns
(e) Provide a suitable referral or discharge information for when Ms B was released from custody.

The records indicate significant confusion amongst PHS clinical staff about her treatment. There is no evidence that the specialist's diagnosis of Ms B's injury was explained to Ms B or acknowledged by PHS clinical staff.

The Clinic Manager expressed the opinion that during the 18 days that Ms B was out of prison, she should have taken responsibility for having her injury reviewed. There is nothing in her records to show that PHS attempted to facilitate this.

Soon after returning to prison, Ms B submitted a MRF requesting that the clinic call the hospital about a hand operation. She was referred to the RDH orthopaedic clinic, with the PHS doctor noting that Ms B "received no treatment and was wondering if she requires further management." This referral does not eventuate in a specialist appointment, and there is minimal discussion with Ms B about her concerns although she continued to complain of pain. A month after Ms B returned to prison, a PHS doctor reviewed her file, noting that previous x-ray reports show the "good news" of an absence of acute scaphoid fracture. A script for Panadol osteo was actioned a week later, and after a further week, a PHS nurse referred Ms B for review by a doctor. It does not appear that she saw a doctor until four months later, when her wrist was not discussed.

I find that Ms B was not provided with adequate information about her injury or treatment options by PHS, and that her needs were not properly addressed. As well as the systemic issues of triage and management of requests for medical assistance, the facts indicate systemic issues in relation to communicating with patients and ensuring adequate treatment takes place in accordance with accepted community standards.

9.2(iii) The PHS failed to coordinate Ms B's treatment of her wrist injury.

Ms B was initially referred to the RDH orthopaedic clinic a week after the assault on account of her shoulder injury. This referral received an appointment in three months' time. It is probable that Ms B's RDH appointment would have been re-triaged at higher priority if PHS clinical staff had revised the referral to include information about a possible acute wrist fracture.

Ms B was unable to attend the appointment at the orthopaedic clinic due to a court video conference scheduled at the same time. It appears that no efforts were made to avoid this conflict. At this stage, Ms B had waited more than three months for her orthopaedic appointment.

She was again unable to attend the rescheduled appointment due to lack of availability of a correctional escort. There is nothing in her records to indicate what steps were taken to secure an escort. Comments by the Clinic Manager suggest that the shortage of escorts to attend appointments with Ms B was due in part to her having "not made any friends amongst her officers." PHS staff interviewed have emphasised the lack of control they have over correctional escorts.

I find that there were problems in relation to the coordination of care between PHS and Corrections, as well as PHS and RDH.

9.2(iv) The PHS failed to provide adequate follow up and treatment of Ms B's shoulder injury.

There is little by way of documentation in Ms B's records to show that her shoulder pain was being addressed or that a treatment plan was communicated to Ms B. Ms B complained repeatedly of shoulder pain and there is nothing to show that it was reviewed or discussed in any detail with Ms B, other than the doctor's note stating that she should have it reviewed when she gets out of prison.

Ms B was referred to the physiotherapist for her shoulder pain, but no appointment resulted from this referral. The second referral to the physiotherapist resulted in an appointment one week later, largely to address her wrist pain. Stretches were recommended for her shoulder pain, but there was no follow up in spite of her repeated complaints.

The facts reveal poor systems in relation to the management of requests for assistance and follow up, as well as a standard of treatment not in line with accepted community standards.

9.2(v) The PHS failed to follow up Ms B's need for a pap smear in a timely manner.

Ms B's previous CIN 3 result on a pap smear was noted in her health reception records. She submitted three MRFs requesting to have a pap smear. She was not referred to the RDH's gynaecology clinic until some four months later, following her complaint to HCSCC. There is no explanation as to it took a further 3 and a half months for her to be seen by the RDH gynaecology clinic.

The delay in responding to Ms B's need for a pap smear is unacceptable. It highlights the pervasive problems in PHS' response to medical requests and coordination of care.

9.3 SYSTEMIC ISSUES – FINDINGS

9.3(i) PHS does not have satisfactory systems in place for the management of requests for medical assistance.

The PHS uses the term "triage" for the allocation of appointments. However, triage implies that patients are given a category of urgency. The PHS does not have a system for categorising degrees of urgency in clinical needs based on an overall assessment of the patient's presenting condition and history. There is no clear documented policy about how to prioritise requests or identify urgent requests other than issues related to suicide and/or self harm.

Patients who submit a MRF or are otherwise scheduled for a consultation, such as for follow up of tests or a chronic condition, are given an appointment time and have approximately 50% chance of being seen on their appointment date. There are substantial failings in the "recall" appointment system that make it all too possible for important needs to be missed with the potential for serious consequences. Patients who are not seen on the day of their scheduled appointment are at an unacceptable risk of becoming lost on the recall list. The system is overly dependent on a Team Leader's knowledge of a large number of patients.

There is no data available as to how long patients are expected to wait, and no systems in place to ensure that they are seen within a reasonable timeframe. Delays are not adequately documented or explained in a patient's health records.

Correctional officers have a duty to seek medical assistance for prisoners who they understand to be unwell. However, it is not reasonable for PHS to rely on non-clinically trained correctional officers to identify all urgent needs or play any significant role in triaging care.

Staff are largely required to make clinical decisions based on what patients are willing and able to write on a form. It is reasonable to presume that many of PHS' patients have low literacy levels and are reliant on others – fellow inmates and correctional officers – for assistance. There is potential for missing urgent needs. Even where needs are plainly articulated, significant clinical problems are being missed.

The Clinic Manager and District Manager expressed that they would expect persons in genuine pain to make repeated complaints to nurses and/or correctional officers. This statement is troubling for three reasons. First, in the two complaints under investigation, the complainants did make repeated reports and they were not investigated. Second, it implies that patients must complain repeatedly to be treated quickly. Third, it takes no account of the disadvantaged position of patients within a prison environment, who may not feel empowered to make repeated complaints.

The PHS does not offer a typical primary health care service. Prisoners are unable to attend an Emergency Department or a different primary health care provider. They have limited options when requesting assistance but to wait to be recalled, submit further forms or negotiate with correctional officers or health staff on medication rounds.

I find that the PHS does not meet the standard of specialist systems required to provide a health service which responds adequately to the diverse needs of its patients.

9.3(ii) PHS does not have satisfactory clinical follow up procedures in place.

The complaints demonstrate a number of instances where clinically significant events were not followed up, including Ms A's pregnancy test results and review of Ms B's wrist x-rays and specialist treatment. PHS clinical staff should have identified these as matters on the patient's record requiring follow up. In Ms A's case there was an issue with review of results by an offsite doctor not employed by PHS.

This problem is closely related to the absence of systems to manage requests for medical assistance explained in the previous finding, but also points to specific systemic issues in actioning follow up procedures. Overall, it is difficult to say whether the deficiencies relate to clinical skill or internal procedures. However, it is clear that the service is not meeting acceptable standards of clinical follow up.

9.3(iii) PHS does not have adequate processes in place to coordinate services with Corrections.

PHS is reliant upon correctional staff to deliver its services. The complaints are examples of the negative impact on patients of inadequate coordination with correctional staff. Ms B's complaint included an instance where she missed a specialist appointment due to a court video conference, and then missed the following appointment due to lack of correctional escorts.

PHS staff interviewed emphasised the "lack of control" they have over their environment (albeit much improved at Holtze), and how this affects their ability to recall patients to the clinic as well as ensure they can attend external appointments. PHS staff were unclear as to how many correctional officers were available to support the clinic's operations, and noted that some officers were more useful than others. Although this issue was not a focus of the investigation, and Corrections staff were not interviewed, there appears to be minimal documented policies or procedures in place setting out how Corrections and PHS will work together to deliver health services on an operational

level. Whilst a “lack of control” may be inevitable to a certain extent within a prison environment, there should be processes in place to secure cooperation in the delivery of essential health services to the highest possible degree. DOH’s current reliance on draft and outdated policy and procedure documents is a serious cause for concern.

9.3(iv) PHS does not have adequate processes in place to coordinate external services.

Ms B’s case shows a significant failure in the coordination of services with RDH, with respect to both her orthopaedic and gynaecological referrals. Poor coordination impacts on patient care in the form of delays as well as in the provision of important clinical information.

There is an overall concern about clinicians not following the progress of external referrals. As it is medical officers who make the referrals, it is expected that they should also be responsible for ensuring that their patient receives the service. This is particularly important given the lack of control prisoners have over information about their external care. Prisoners do not receive confirmation letters and are not told the date or time of appointments. They are therefore entirely reliant on PHS to manage external appointments. Equally, medical officers need to be aware of the outcomes of any external consultations for the purposes of planning future treatment and communicating with patients.

Finally, patients requiring treatment upon being released back into the community need to be given referral and discharge information, and linked to services appropriately. This is clearly not an established process at PHS.

The District Manager has reported that PHS staff will soon have access to a joint database which should improve access to RDH information, and plans to expand Telehealth. These are positive steps which need to be progressed.

9.3(v) PHS is not meeting its responsibility to communicate with patients about their health care.

The complaints under investigation evidence poor communication practices between PHS and their patients, which jeopardise clinical outcomes and lead to a negative patient experience.

Community standards dictate that patients have a right to receive information about their health and treatment, responsive to their needs, which allows them to make informed decisions about their care. Communication should be culturally sensitive and in language patients understand. Patients have a right to be seen within a reasonable timeframe, and to know how long they can expect to wait. Security measures that prevent specific disclosure of appointment times do not abrogate this responsibility. Furthermore, patients have a right to complain about services and to have their complaints responded to in a timely manner. I find that these standards were not met by PHS.

Some communication problems may be addressed through improvements relating to the systemic issues already outlined. In addition, it is necessary to invest in professional development and practical resources to help staff achieve best practice in patient centred care.

I note that the District Manager has outlined the recent implementation of a communications book, which is a positive step towards improving avenues for communication between patients and staff. The MRF has also recently been amended to include patient queries that might be responded to quickly and the option of submitting an internal complaint.

9.3(vi) Women's health

The complaints show substantial failings in access to women's health at PHS. Both complainants failed to receive critical healthcare services. I note that the situation at DCC Holtze has improved in relation to access due to better facilities and increased resources. However, it is critical that PHS remain responsive and accountable to women's health issues.

10. NATURAL JUSTICE

Section 67 of the *Health and Community services Complaints Act* states:

> *67. Adverse comments in reports*
> *(1) The Commissioner must not make any comment adverse to a person in a report under this Part unless –*
> *(a) the person has been given a reasonable opportunity to be heard in the matter; and*
> *(b) the person's explanation (if any) is fairly set out in the report.*

A draft report was provided to DOH, the (then) PHS Clinic Manager, Corrections and the complainants on 25 September 2015. All parties were given an opportunity to read and provide comments on the draft report, which have been incorporated into this final report as relevant. DOH and the PHS Clinic Manager were given an opportunity to respond to adverse comments.

In addition, on 24 December 2014 DOH provided the information set out below:[11]

a) What higher level systems, complexities of the prison environment, and roles and responsibilities of DoH and NTDS staff are not explained or explored in the report, which you believe should be included?

The draft investigation report is primarily based on two individual complaints rather than an overall review of the prison health service. The report provides a good platform for improvements, especially in relation to communication, booking of appointments and triage mechanisms. However, it does not present a detailed analysis of the services and complexities of providing broad spectrum health care in a correctional setting. The report does not provide any analysis of the operational setting, administrative controls and security restrictions imposed on the PHS or the impact of the operational aspects of the correctional facility on the ability of the PHS to deliver the services within the prison. The challenges faced by PHS around the security level of prisoners, difficulties around access and prison lock downs have not been considered. The duties and responsibilities of PHS staff and correctional officers and how they interact with each other have not been examined closely. The day to day operations of the clinic, including the interactions with visiting services such as forensic mental health and oral health are not covered by the investigation, resulting in the omission of detail around the complexities of arrangements with other services and the scheduling of appointments in the limited number of consulting suites or interview rooms.

b) What evidence-based data and comparisons across similar services would present a more 'balanced view' of PHS?

A comparison with similar services in other jurisdictions, using statistical data or review of reports, was not completed. There are no indicators of performance outlined in the report for the PHS, or any comparison of these to other prison or community-based health services.

11 Response to questions posed by the HCSCC (in bold) to DOH following their 27 October 2015 response to the Draft Investigation Report.

c) Please explain how the draft report may 'mislead the audience about the continuum of services' and how this might be addressed.

The report is a valuable tool that will assist the Top End Health Service in its continuing commitment to improve PHS. However, it does not provide sufficient contextual information around the key functions or operational setting of a PHS for consumption by the Members of the Legislative Assembly or the general public.

d) What efforts and improvements, not already noted in the report, have been made since the complaints?

The PHC service is actively working to improve access to health care by increasing the availability of onsite specialist health services and tele health services.

The Commissioner for NTDCS also took the opportunity to comment on the draft report, acknowledging that the availability of escorts has been an issue but that is "working with DOH with a suite of approaches in an attempt to improve this situation." He noted a belief that this situation has improved since the move to DCC Holtze. Furthermore, he highlighted that with the recent signing of the MOU there are regular meetings between the CEO of DOH and the Commissioner for Corrections, as well as a Stakeholder Reference Group and senior health management meetings that aim to continually review services and procedures.

I accept that this report is limited in its scope to the detailed examination of two particular cases, which had adverse outcomes for the complainants. However, as noted previously, the investigation was instigated as a consequence of the rising number of complaints about PHS. Although ranging in content and severity, complaints about PHS generally raised the same systemic issues that formed the basis for this investigation.

I have undertaken an analysis of PHS' operations and procedures, as set out in section 5, which is of broad relevance to PHS' service delivery and is not restricted to the two complaints examined in detail in this report. This analysis was based on the evidence gathered by HCSCC pursuant to section 55 of the Act. It included interviews completed under oath or affirmation with senior PHS staff and documentation provided under formal Notices to Produce. DOH have had multiple opportunities to respond to the issues raised in this report and their views including any supporting evidence, where provided, have been incorporated. I have provided an overview of the difficulties of delivering health services in a prison environment, including managing challenges associated with prison officer escorts and lockdowns.

I accept that a full investigation of the relationship between Corrections and DOH was outside of the scope of this investigation, as was a comparative study of other jurisdictions. Nonetheless, I have relied on relevant legislative and practice standards in assessing the quality of care provided to the two complainants and the systems in place to deliver services.

Of paramount importance is the principle that prisoners are entitled to expect the same standard of healthcare as individuals in the community. This standard has not been met. In my view, these concerns are serious enough to warrant publication of this report in the public interest.

I note that my recommendations have been accepted in full by DOH, and I commend the commitment the Department has shown to implementing the recommendations to date.

11. RECOMMENDATIONS

I recommend the following:

1. The complaint by Ms A be referred to conciliation with DOH for the purposes of discussing the complaint issues and any outcomes sought by the complainant, including any claims for compensation.

2. The complaint by Ms B be referred to conciliation with DOH for the purposes of discussing the complaint issues and any outcomes sought by the complainant, including any claims for compensation.

3. PHS develop an action plan for improving policies, practices and procedures in relation to the management of requests for medical assistance, which should include:
    a. A written policy on what constitutes an urgent request;
    b. Improving the assessment of health needs, including consideration of a system for categorising and prioritising urgent, non-urgent, complex, planned chronic care and preventative health needs;
    c. Strategies to address the limitations of information obtained from written Medical Request Forms and non-clinical correctional officers;
    d. Alternative means of access to PHS for patients with low levels of literacy;
    e. A system that ensures patients who are not seen on their appointment date are re-prioritised and seen in a timely manner;
    f. Estimated waiting periods to access PHS services, and procedures for documenting delays in patient records;
    g. Collection of data on waiting periods, and regular evaluation of data for quality improvement purposes;
    h. Professional development for staff on identifying and prioritising health needs in a correctional institution setting.

4. PHS develop an action plan for improving policies, practices and procedures in relation to follow-up, to ensure that clinically significant results and treatment plans are reviewed and acted upon in a timely manner. This should include an evaluation of procedures for medical officers to review and action pathology results, imaging reports, investigations reports and clinical correspondence.

5. PHS improve coordination of services with Corrections, including the facilitation of prisoner movement and the provision of escorts for internal and external appointments. This should include:
    a. A review of current practices and resourcing issues in relation to correctional officer escorts;
    b. A review of the roles and responsibilities of PHS and Corrections in recalling clients;
    c. A written agreement detailing the roles and responsibilities of DOH and Corrections in the overall delivery of health services;
    d. A strategy for improving communications between DOH and Corrections.

6. PHS improve coordination with external services, including:
    a. A system to ensure that referrals are actioned and tracked wherever necessary;
    b. Access for PHS staff to information systems used by other DOH agencies, particularly Royal Darwin Hospital (such as Jadecare);
    c. An implementation plan for Telehealth.

7. PHS improve communications with patients, including:
    a. Strategies and resources for engaging with patients on medication rounds;
    b. An evaluation of the effectiveness of the Communication Book recently implemented;
    c. Professional development for staff in providing patient centred, comprehensive and coordinated primary care.
    d. A mechanism for seeking patient feedback and regular evaluation of feedback for quality improvement purposes;
    e. A written internal complaints policy.

8. PHS develop a policy to ensure that patients being released back into the community requiring treatment are given referral and discharge information and linked to appropriate services.

9. PHS provide a report to the Commissioner on current and planned measures in relation to improving access to health services for women, including details of any obstacles affecting women's access to the PHS clinic, women's health checks and antenatal care.

Stephen Dunham
COMMISSIONER

26 February 2016