The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

'MR G'

AGED 51

WHILST ON RULE 27 (TEMPORARY RELEASE) FROM

MAGHBERRY PRISON

ON (DATE REDACTED)

[2nd October 2014]

[Published 15th October 2014]

Dates and names have been removed from this report, and redactions applied, solely to preserve the privacy of the deceased, their family and others who contributed to the investigation. All facts and analysis which are in the public interest have been retained.

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Glossary

CJI	Criminal Justice Inspectorate
ECR	Emergency Control Room
EMIS	Egton Medical Information System
HMIP	Her Majesty's Inspectorate of Prisons
IMB	Independent Monitoring Board
NIPS	Northern Ireland Prison Service
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust
SPAR	Supporting Prisoners at Risk

PREFACE

As Prisoner Ombudsman for Northern Ireland I have responsibility for investigating all deaths in prison custody in Northern Ireland. My investigators and I are completely independent of the Northern Ireland Prison Service (NIPS). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

I make recommendations for improvement where appropriate; and my investigation reports are published subject to consent of the next of kin in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for Prisoner Ombudsman investigations of deaths in custody are to:

- establish the circumstances and events surrounding the death, including the care provided by the NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust (SEHSCT);
- examine whether any changes in the NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. In this case, Dr Lloyd-Jones, General Practitioner at The

Newcastle Medical Centre, undertook a clinical review of the healthcare provided to Mr G in connection with the circumstances which led to his demise.

This report is structured to outline the cause of Mr G's death and the diagnosis and treatment he received whilst in prison.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. I first met with Mr G's next of kin in (date redacted), and contact has been maintained with them throughout the investigation.

Although this report will inform several interested parties, it is written primarily with Mr G's family in mind.

I am grateful to Mr G's family, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contributions to this investigation.

I offer my sincere condolences to Mr G's family for their sad loss.

Tom McGonigle.

TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
2nd October 2014

SUMMARY

Mr G died from cancer at Lagan Valley Hospital on (date redacted). He had been released from Maghaberry Prison under Prison Rule 27 two days earlier, in order that he would not die in custody, which was a humane and compassionate gesture that benefitted him and his family.

Mr G had a late and unexpected diagnosis just a fortnight previously, which came as a shock to him and his family. He had a variety of pre-existing conditions and had been in pain from (month redacted). The consultant physician in charge of Mr G's care advised that his condition would have been progressing for a number of months prior to his admission.

While earlier transfer to outside hospital would have assisted his pain relief, and there were differing opinions about some aspects of Mr G's medical care in prison, our clinical reviewer confirmed that a four day delay in sending him to hospital would not have made any difference to his prognosis.

The investigation has identified issues which, although they did not contribute to Mr G's demise, are important in relation to the future care of other prisoners. These include the review of prisoners' medication upon committal, alcohol withdrawal assessments, nursing attendance to prisoners during the night, and the application of Prison Rule 27.

I make seven recommendations for improvement one of which (Recommendation seven) has been previously been made and accepted by the SEHSCT on three occasions – once in March 2012 and twice in April 2012.

RECOMMENDATIONS

NIPS -

1. **ECR Occurrence Log Entries** – All contact by landing staff with the ECR in relation to the welfare of a prisoner should be recorded on the ECR occurrence log. (Pages 14-15)

2. **Prison Rule 27 (2) Temporary Release Procedures** – Clear guidelines should be provided for all staff about the procedures to be followed when a prisoner has been diagnosed with a terminal illness. These guidelines should promote a fully recorded, proactive process that reduces delay in consideration of Prison Rule 27 release. (Pages 16-18)

SEHSCT –

3. **Transfer to Outside Hospital** – Doctors should be reminded that urgent investigation is required and serious consideration should be given to prompt referral to outside hospitals when prisoners present with symptoms as Mr G did on 23rd July 2013. (Pages 11-12)

4. **Medication on Committal** – When prisoners advise Healthcare that they are no longer taking medication that was recently prescribed in the community; a record should be made on EMIS, along with the reasons provided. (Page 13)

5. **Alcohol Withdrawal Assessments** – All nursing staff should be reminded of the 'Guidelines for the Management of Alcohol Withdrawal' which clearly indicates what the procedure is for managing symptoms of alcohol withdrawal. (Pages 13-14)

6. **Nursing Attendance to Prisoners during the Night** – Nursing staff should be reminded of the requirement to assess prisoners directly at night time when necessary and that this decision should be based on the reported symptomatology and general presentation of the prisoner. (Pages 12, 14-16)

7. **EMIS[1] Reviews by Nursing Staff**: Nursing staff should once again be reminded of the need to adequately review a prisoner's EMIS record, especially when the nurse is using EMIS to base their decision on what, if any, healthcare assistance the prisoner needs. (Pages 15-16)

[1] EMIS – Egton Medical Information System, the database used to electronically store prisoners medical records.

MAGHBERRY PRISON

Maghaberry is a high security prison which holds male adult sentenced and remand prisoners. It was opened in 1987.

Maghaberry established a Prisoner Support and Safety Team (PSST) in 2011. The team comprises a governor and five members of staff. They have several responsibilities including a role to support vulnerable prisoners. Mr G was not engaged with PSST at the time of his death.

There has been one death from natural causes in Maghaberry since Mr G died.

The last CJI/HMI Prisons inspection of Maghaberry was conducted in March 2012 and published on 17th December 2012. Several of the 93 recommendations in that report are relevant to the healthcare provision.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. The 2012-13 IMB annual report did not make any recommendations that are relevant to Mr G's death.

FINDINGS

SECTION 1: CAUSE OF DEATH

On (date redacted) (five weeks after his committal to Maghaberry) Mr G was transferred to Lagan Valley Hospital for investigation of severely painful and swollen limbs, and a painful lower back.

On (date redacted) (five days later) following a series of tests and scans, Mr G was diagnosed with terminal cancer (lung cancer with metastatic liver and brain disease), and advised he may have two months to live. This was a late and unexpected diagnosis, which came as a shock to him and his family. The consultant physician in charge of Mr G's care advised that his condition would have been progressing for a number of months prior to his admission to hospital.

Bedwatch officers[2] remained with Mr G until (date redacted) when he was granted temporary release under Prison Rule 27[3]. Mr G's family were grateful that he was released under Rule 27 and they appreciated the compassion that was shown to him by the bedwatch officers. They said it was comforting that the officers kept him company, played cards with him and bought items from the shop on his behalf.

On (date redacted) (two weeks after diagnosis) Mr G passed away in Lagan Valley Hospital.

[2] Bedwatch officers are prison officers who escort prisoners to outside hospital, and remain with them if admitted.

[3] Prison Rule 27 allows for a prisoner to be temporarily released for any special purpose, including to enable him to receive healthcare.

SECTION 2: MR G'S DIAGNOSIS AND TREATMENT

On (date redacted) Mr G was committed to Maghaberry Prison and underwent a series of committal interviews, including one with a nurse. During this interview Mr G disclosed that he suffered from epilepsy; that he had a kidney removed in 1994; that he had mental health problems, and had been admitted to (name redacted) Hospital four weeks earlier. A withdrawal from alcohol assessment was also undertaken which showed that he had mild withdrawal symptoms. Mr G's medication on committal included propranolol[4], Epilim[5], citalopram[6], Librium[7], Vitamin B, and risperidone[8].

On the same day, a SPAR[9] was opened due to his refusal to eat food in protest against being incarcerated, and information from PBNI that he would have difficulty coping if sent to prison. The SPAR booklet remained open for nine days and was managed in accordance with SPAR procedures. During this period Mr G was assessed by the mental health team, and was seen by a member of healthcare staff almost every day.

A prisoner who knew Mr G said he started to complain about pains in his feet and lower back about a week after arriving in Braid House on (date redacted). The prisoner described Mr G's feet as being three times the normal size, and said that because they were too sore for him to walk, he only left the cell to collect his meals. The prisoner said Mr G did not always eat his meals because he felt nauseous.

Mr G first reported swollen feet to Healthcare staff on 14th (month/year redacted). He was advised to elevate his feet above heart level and told he would be seen the following morning by a nurse. There is no record of Mr G being seen by a nurse on 15th (month redacted), but the appointment tracker (slot notes) on EMIS shows a nurse booked him a doctor's appointment for 18th (month redacted) on 15th (month redacted). An earlier appointment subsequently became available, and Mr G was seen by a doctor on 16th (month redacted).

The doctor's examination concluded that Mr G's symptoms were likely to have been caused by his increasingly sedentary lifestyle, as he acknowledged spending most of the time in his cell. Mr G presented again to Healthcare on 21st and 22nd (month redacted) complaining of swollen feet. One nurse described his condition as extreme, and another noted it was causing slight redness on his right shin. There

[4] Propranolol is a beta-blocker used to treat a variety of conditions including high blood pressure, angina, some symptoms of anxiety and to protect the heart from a heart attack.
[5] Epilim is the brand name for sodium valproate and is used in the treatment for epilepsy.
[6] Citalopram is an antidepressant medication.
[7] Librium is the brand name for chlordiazepoxide and is used to treat anxiety and acute alcohol withdrawal.
[8] Risperidone is an antipsychotic drug used in the treatment of mental health problems including schizophrenia and bipolar disorders.
[9] **S**upporting **P**risoners **A**t **R**isk procedures and implemented when a prisoner becomes vulnerable and at risk of self-harm or suicide. These procedures are to support and observe the prisoner and allow for a multi-disciplinary care plan to be implemented.

were no doctors' appointments available on either of these days, but a prison doctor advised by telephone on 22nd (month redacted) that the nurse should monitor the area of reddening, and continue to monitor his temperature.

Medical opinions differed on the cause of the swelling: in his clinical review Dr Lloyd-Jones took the view that the swelling was not due to a sedentary lifestyle, and said that it would have been common and acceptable practice for the doctor to have checked Mr G's blood pressure, and listened to his heart and chest sounds.

However the prison doctor and the NIPS Clinical Director suggested it was a reasonable first impression, and not a definitive diagnosis, to consider Mr G's sedentary lifestyle as a causal factor, given his physically unfit appearance, history of alcohol dependence and the fact that he was not previously known to the prison doctor.

On 23rd (month redacted) Mr G was again seen by the doctor who had seen him on 16th (month redacted). The swelling was now described as severe, painful and tight, and the doctor queried whether there was swelling of his gastro-intestinal tract. The doctor prescribed Furosemide – a diuretic type drug that can increase fluid loss from the kidneys; and he also ordered a range of investigations including an urgent ultrasound scan, chest x-ray and further blood tests.

The following day Mr G had an x-ray in Maghaberry.

Dr Lloyd-Jones interpreted the doctor's prescription of Furosemide as having been prescribed for fluid retention on the basis of either poor renal function and/or heart failure. He suggested it would not be common or acceptable medical practice to prescribe this medication, and that Mr G should have been referred to outside hospital at this time.

On the other hand the prison doctor and the NIPS Clinical Director pointed out that Mr G's assessment was in line with both NICE guidance and the Guideline for Chronic Kidney Disease in Northern Ireland, which state that it would be common to treat patients with diuretics while awaiting urgent investigations to determine the cause of their complaint.

A nurse saw Mr G on 25th (month redacted) and recorded that his legs were less swollen and that he was feeling slightly better. Further blood samples were taken, along with his blood pressure and respiration saturation levels.

On the same day Mr G spoke to a family member on the phone and said that pain killers he received were not helping him.

In the early hours of 27th (month redacted) landing staff recorded that he was in extreme pain and requested extra painkillers. A nurse did not visit Mr G, but told landing officers that Healthcare staff were aware of his condition, and because he was already on painkillers (co-codamol 15/500) he would have to wait until the morning for his next issue and/or to see a doctor.

Later that morning, landing officers and a senior officer followed the matter up with Healthcare due to Mr G's continued pain and discomfort, and he was seen by a nurse at 10am.

The nurse recorded that Mr G had to stand up all night due to his pain. As a result of her assessment, the nurse ordered an ambulance and he was transferred to Lagan Valley Hospital.

Following a series of tests, on 1st (month redacted), Mr G was diagnosed with terminal cancer (lung cancer with metastatic liver and brain disease).

Dr Lloyd-Jones, whilst not an expert on causation, suggested the four day delay in sending Mr G to hospital would not have had a detrimental effect on his prognosis.

Earlier transfer to outside hospital would, however, have allowed better pain relief management for Mr G.

SECTION 3: OTHER ISSUES

The investigation has identified the following issues which, although they did not contribute to Mr G's demise, are important in relation to the future care of other prisoners.

Review of medication on Committal

In (date redacted) all newly committed prisoners who received medication in the community would have had these reviewed and renewed once their GP had faxed through a list of their medications. Medication reviews were generally done on the day of committal or the following day.

Despite Mr G seeing a doctor the day after his committal, and the prison being in receipt of the GP fax which listed his medications, Mr G did not receive them all. The doctor said that he did not issue all of his listed medications because Mr G said that he had not been taking them. There is however no record on EMIS[10] to support this account. Mr G complained daily to prison officers and nursing staff that he was not receiving his correct medication, and offered this as one of the reasons he was refusing to eat food - which had led to him being placed on a SPAR during the first nine days of his sentence. On (date redacted) (four days after committal) Mr G was seen by another doctor in order to review his medications. This resulted in three additional medications being prescribed: propranolol (beta-blocker), risperidone (antipsychotic) and mirtazapine (antidepressant).

The SEHSCT have previously advised that since introduction of a new Electronic Care Record (ECR), there is instant access to community medical records, and problems with confirmation of medications upon committal should be reduced. However the GP's fax of Mr G's medication had already been received and scanned onto EMIS, and was available for the doctor who saw him the day after his committal, to view.

Alcohol Withdrawal Assessments

Upon committal Mr G was assessed and treated for alcohol withdrawal. Part of that assessment included completion of a 'Clinical Institute Withdrawal Assessment for Alcohol (CIWA)' which asked a series of clinical questions and recorded clinical observations, leading to a figure that depicts whether the person has mild, moderate or severe withdrawal symptoms. The result of the CIWA helps the nurse/doctor decide about future medication and observation levels.

Mr G's first CIWA was carried out on 20th (month redacted) and resulted in a score of five, which sits within the mild category. A further test on 21st (month redacted)

[10] EMIS – Egton Medical Information System. The database used to store medical records electronically.

resulted in an increased score of eight, which was two points away from the moderate category. Despite Mr G being seen by healthcare staff on 22nd, 23rd, 25th and 26th (his withdrawal medication stopped on 26th (month redacted)) and contrary to the SEHSCT's protocol for carrying out CIWAs, no further CIWAs were undertaken to assess his withdrawal symptoms.

Nurse Attendance to Prisoners during the Night

In the early hours of 3rd (month redacted) Mr G's cell alarm was raised on two separate occasions in order to inform night guard staff that he required medical attention. He reported to officers at 01.35 that he had vomited blood; and at 02.45 his cell mate raised the alarm because Mr G was shaking profusely.

Night guard staff contacted the Emergency Control Room (ECR) in order for them to relay the message to the nurses. However the ECR did not record these requests.

There are three different ways for requesting Healthcare intervention during the night:

Option 1: Landing officers contact the ECR and inform them that a prisoner has asked to see a nurse. The ECR then contacts Healthcare and asks them to phone the landing to discuss the medical complaint, following which Healthcare decide whether they need to visit the prisoner.

Option 2: Landing officers contact the ECR and tell them that the prisoner has requested a nurse because of specific symptoms. The ECR contacts Healthcare and informs them of the prisoner's complaint. Healthcare then decide whether they need to attend the prisoner, and relay their decision to landing staff via the ECR.

Option 3: Landing officers contact Healthcare directly and discuss the prisoner's medical concerns.

During the 01.35 report of Mr G vomiting blood, the night guard officer said that he used 'Option 2' as his means of reporting Mr G's medical concern. The Night Guard Officer's journal entries support his account that he did not speak with the nurse directly, and that he only spoke to the ECR.

Based on the information provided by the ECR officer to the nurse, and questions asked by the nurse of the ECR officer about Mr G's presentation, the nurse decided there was no requirement to visit him as she had been advised there was no evidence that Mr G had vomited blood, nor were there any other symptoms of him being in discomfort or distress.

The nurse's EMIS entry about this phone call described what she had been told by the officer who contacted her. It was recorded that Mr G's pallor was unremarkable, his respiratory rate was normal and that he had an upset stomach over the past week. The night guard officer said that whilst he could not recall the specific conversation with the ECR officer, he would have only informed them of what he had recorded in the journal – that Mr G had reportedly vomited blood. This illustrates how indirect triage by phone can lead to a misrepresentation of the prisoner's symptoms.

The advice that was recorded as having been provided to officers was that Mr G should increase his intake of clear fluids, stop smoking, rest on the bed, implement breathing exercises and engage in relaxation strategies. The nurse elaborated that officers were to advise Mr G to lie on the bed and try to relax and breathe normally if he was feeling concerned. She concluded her entry by stating that Mr G should be reviewed if his current presentation changed. Otherwise he was to see the nurse in the morning if he wished.

The journal entry written by the night guard officer stated the following:

> *01.40 ECR contacted house, medic told them the prisoner is to drink plenty of fluids and see the doctor in the morning.*

This journal entry does not reflect the advice recorded on EMIS as having been given to the staff, further reflecting the challenges in ensuring accurate communication with prisoners via the telephone triage process.

At 02.45 on 3rd (month redacted), a further call by the night guard officer to the ECR was made after Mr G's cell mate raised the alarm because he was shaking profusely. A different nurse spoke with the ECR, and despite her colleague's indication that Mr G should be reviewed if his current presentation changed, she did not attend him. She recorded that he was shaking profusely because he was withdrawing from alcohol for which he was already receiving medication. However Mr G had last taken medication for alcohol withdrawal on 26th (month redacted), and his last reported withdrawal symptoms – two weeks earlier on 21st (month redacted) - were mild.

In relation to Mr G's medication for alcohol withdrawal, the second nurse said that when she checked EMIS she saw two prescriptions for this medication, and calculated that he should still have been taking it. Without accessing the hardcopy medication administration record, which was kept in the medical room in Braid House, this nurse was unaware that Mr G was no longer taking alcohol withdrawal medication.

The nurse also acknowledged that she only scanned Mr G's EMIS record to seek possible reasons for why he was shaking. She did not read the most recent entry, made by her colleague only 70 minutes earlier, which indicated he was vomiting

blood, and clearly noted that if Mr G's presentation changed, then he was to be reviewed.

At the conclusion of this night shift the first nurse who answered the call from the ECR at 01.35 updated Mr G's medical records stating that at 07.10 she had contacted staff for an update on Mr G, to be told that he was settled and in bed. There is no entry in the landing journal to corroborate this. The landing officer said that whilst he could not recall the specifics of that particular morning, if the ECR or nurse had contacted him for an update he believed he would have made a record of it.

There is also evidence of night duty nurses not attending Mr G on 27th (month redacted) when he pressed his cell alarm on three occasions (04.37, 05.20 and 05.26) due to his level of discomfort. On the first occasion the night guard officer recorded that he would leave things for an hour and return to check how he was feeling. At 05.20 the landing journal and ECR log record that Mr G was having difficulty breathing, in extreme pain and that Healthcare were informed. At 05.26 a nurse contacted the landing and informed them that she was aware of Mr G's condition, and that he would have to wait until the morning to receive his medication and see a doctor.

Mr G was not seen by a nurse until 10.00, at which stage immediate arrangements were made to transfer him to outside hospital.

Night guard officers have previously advised that it is common for nurses not to attend these types of medical requests at night. Healthcare staff advised that while the SEHSCT encourages nurses to limit the amount of triage carried out by phone at night, there is an operational understanding between nurses and prison officers that they will try to limit the requirement to unlock prisoners at night due to limited number of staff on duty. However there are no actual restrictions on nurses who wish to have a prisoner unlocked in order them make an assessment; and they can also consult with, and/or observe a prisoner through the cell door, in order to make an assessment.

Prison Rule 27 Procedures and Records

In the case of a terminally-ill prisoner, Rule 27 is a compassionate gesture which spares him and his family the indignity of dying in prison. While it is positive that Mr G was ultimately released under Rule 27, better communication could have expedited the process, allowed a longer period of privacy for Mr G's family, and reduced the major resourcing pressures that bedwatches cause for prison managers.

Mr G was informed of his diagnosis and limited life expectancy on 1st (month redacted). Eleven days later he was granted temporary release under Prison Rule 27, and the hospital bedwatch officers were stood down.

Staff on bedwatch duties believed - incorrectly - that any decision about release under Rule 27 would have to be granted by the courts, rather than by the prison Governor. In this instance there was no documentary evidence available to outline the deliberations that led to Mr G's release under Rule 27.

The routine process for granting Rule 27 release in the case of a terminally ill prisoner is:

1. Duty Governor informed by bedwatch officers, or prison Healthcare Department, of the prisoner's diagnosis and prognosis;
2. Action is only initiated when medical confirmation is provided;
3. Prison senior managers and/or the PSS Team undertake a risk assessment and examine whether the prisoner is suitable for release under Rule 27; whether a compassionate bail application should be advised, or an application should be advised for the Royal Prerogative of Mercy to be applied;
4. The PSS Team consider the prisoner's practical needs beyond palliative care, such as family contact, visits, personal belongings etc;
5. If Rule 27 is to be granted, documentation is prepared and bedwatch officers are stood down;

Timeline of Rule 27 implementation in Mr G's case:

1st (month redacted)	Bedwatch officer informed duty governor that Mr G had terminal illness and had two months to live; The Duty Governor permitted Mr G a phone call with his family to inform them of his news. This information was not passed to Healthcare or the PSS Team to follow-up and the Duty Governor began annual leave the following day; Unaware of the information provided to the Duty Governor, Maghaberry Healthcare Department contacted the hospital for an update, but were only advised that he was in a comfortable state, and were not made aware of his diagnosis or prognosis.
2nd (month redacted)	Mr G's prognosis was not discussed at the daily management team meeting, as the Duty Governor who had received the information was on leave.
6th (month redacted)	EMIS entry stating that Healthcare had now been informed of Mr G's diagnosis, but given a life expectancy of six to nine months;

	Healthcare informed the PSS Governor who was to advise Mr G on the procedure for applying for release under Royal Prerogative of Mercy.
7th (month redacted)	Healthcare informed by the hospital that Mr G's life expectancy was potentially weeks. Healthcare suggested to a residential governor that consideration should now be given to releasing Mr G under Rule 27.
7th – 8th (month redacted)	Maghaberry received a letter from Mr G's solicitor requesting the bedwatch officers be stood down; In response to this letter and the information from Healthcare, a residential governor began examining the options to release Mr G. A risk assessment was undertaken and the Rule 27 document was prepared.
9th (month redacted)	PSS Governor contacted the bedwatch officers for an appraisal of Mr G's condition, and advised there should be no restrictions on him receiving visits.
12th(month redacted)	The Rule 27 document was completed and approved by Maghaberry governor. A governor then visited Mr G in hospital to release him and return his possessions.

Once the Maghaberry governor authorised Mr G's release, the bedwatch officers were swiftly removed.

Given that Mr G's diagnosis and prognosis were shared with Maghaberry on 1st (month redacted), subsequent internal communication between Maghaberry managers and Healthcare Department and between Maghaberry Healthcare Department and the outside hospital could have been clearer and more prompt.