The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

PAUL MATTHEW HENDERSON

AGED 59

IN ALTNAGELVIN HOSPITAL

WHILE IN THE CUSTODY OF

MAGILLIGAN PRISON

ON 26 JANUARY 2009

18 November 2010

Please note that where applicable, names have been removed to anonymise the following report

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PREFACE

Paul Matthew Henderson was 59 years old when he died in Altnagelvin Hospital, in the late hours of 26 January 2009.

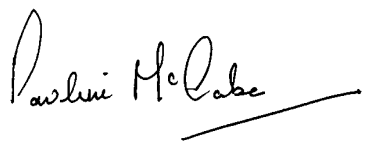
I offer my sincere condolences to Mr Henderson's wife for her sad loss. I have met with Mr Henderson's wife a number of times and I have shared the content of this report with her and responded to the questions and issues she has raised.

With the agreement of Mr Henderson's wife, I refer to him throughout the report as Mr Henderson.

During my investigation into Mr Henderson's death, I determined that there was a requirement to request input from an independent medical expert. I am grateful to Dr Peter Saul for carrying out a Clinical Review.

In the event that anything else comes to light in connection with the matters addressed in this investigation, I shall produce an addendum to this report and notify all concerned of my additions or changes.

As a result of my investigation, I make **five recommendations** to the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
18 November 2010

SUMMARY

Paul Matthew Henderson was committed on remand into Maghaberry Prison in 2004 and later given a sentence of 12 years. On 31 May 2007, having met the criteria to be moved, Mr Henderson was transferred to Magilligan Prison. In December 2008, Mr Henderson was diagnosed with cancer and subsequently died in January 2009.

When Mr Henderson was committed to Maghaberry Prison, the committal nurse recorded that Mr Henderson had previously had two myocardial infarctions[1], which had been treated by stenting, and suffered from angina. Mr Henderson was on a standard regime of medications to treat this condition, all of which were continued in prison.

Medical staff noted that Mr Henderson was significantly overweight and was a smoker. There is subsequently evidence that considerable support was given to Mr Henderson to encourage smoking cessation and weight reduction.

Mr Henderson went on to have a number of health problems during his time in prison and Mrs Henderson questioned whether her husband's cancer should have been diagnosed sooner. She also asked why, during Mr Henderson's time in prison, important hospital appointments were cancelled as a result of staffing and transport problems. The investigation addressed both of these questions.

On 18 May 2004, Mr Henderson complained of weakness in his left arm and coldness in his left hand. The prison doctor queried whether

[1] Myocardial Infarction Definition – Commonly known as a heart attack.

Mr Henderson had suffered a stroke and referred him to the Belfast City Hospital Accident and Emergency Department for an assessment.

The clinical reviewer, Dr Peter Saul, noted that *"the prison service staff acted promptly when the symptoms were reported."*

An appointment at a neurovascular clinic was subsequently arranged for 1 July 2004, but was cancelled by the prison and rescheduled for a later date. This was because the appointment letter had gone straight to Mr Henderson and, as Maghaberry is a high security prison, prisoners are not normally permitted to have advance knowledge of any outside medical appointments. In urgent cases, the prison may allow appointments to go ahead, but there is no evidence that this option was considered in respect of this appointment.

The rescheduled appointment took place on 24 August 2004 and Mr Henderson was diagnosed as having had a minor stroke.

Dr Saul said that *"there was a delay of nearly three months before Mr Henderson was assessed in the Neurovascular Unit. This delay is unacceptable and is outside both current stroke guidelines and those current at the time."*

Dr Saul also said, however, that the delay did not seem to have had any clinical significance in Mr Henderson's case.

On 24 August 2004, when Mr Henderson attended the neurovascular clinic, he also had a chest x-ray, the results of which were notified to the prison in a letter which was marked as typed on 22 September 2004.

This letter noted that Mr Henderson's carotid arteries (the main arteries in the neck) showed some mild plaque (internal thickening), but no significant thickening. The letter also noted that the x-ray showed *"vague circular density"* on Mr Henderson's left lung.

In his clinical review report, Dr Saul stated that *"this would have been worrying, particularly in view of the noted finger clubbing[2] and could have indicated lung cancer."*

Given the *"abnormal chest x-ray"*, a CT scan of Mr Henderson's brain, chest and upper abdomen was arranged by his consultant for 26 October 2004. The only concern arising from the scan was that his liver showed decreased attenuation[3]. An ultrasound examination subsequently confirmed that this was a simple cyst.

Whilst Mr Henderson was waiting to be seen by a neurovascular consultant in Belfast City Hospital in connection with the weakness in his left arm, he was seen, on 6 August 2004, by a prison doctor in relation to a testicular problem. Following the consultation, the prison doctor referred Mr Henderson to BCH for assessment. The hospital confirmed the referral and stated that there was approximately a 9-10 month waiting list for this type of appointment.

Mr Henderson was seen by the prison doctor on seven occasions between September 2004 and March 2006 in respect of this health concern. On 14 October 2004 and 2 March 2005, the prison doctor wrote further letters to the hospital in respect of the earlier referral

[2] Finger Clubbing Definition – It is a phrase doctors use to describe specific changes in the shape of fingers and fingernails. People with heart or lung problems sometimes have these changes. They usually develop in advanced disease.
[3] Decreased Attenuation - An area on the liver which was not as "bright" on the CT scan as the rest of the liver.

made, to try and speed up an appointment date for Mr Henderson to be seen by the urologist.

The urology appointment took place on 6 March 2006. Further tests were carried out on 4 April and 27 April and the Prison was notified that Mr Henderson had been added to the waiting list for a cystoscopy examination.

Mr Henderson's cystoscopy appointment was rescheduled on four occasions. On three occasions the appointment was cancelled due to problems with the Prisoner Escort Group and on the fourth occasion, the appointment was rescheduled by Belfast City Hospital.

The procedure took place on 11 June 2007 and the discharge letter records that there was no evidence of disease and the examination was normal.

On 24 May 2006, Mr Henderson was seen by a prison doctor in relation to a lump that he had found. The prison doctor diagnosed Mr Henderson as having a right inguinal hernia[4], and as a result Mr Henderson was referred to a surgeon for assessment. Mrs Henderson was particularly concerned that this lump may have been incorrectly diagnosed as a hernia. She was worried that the lump may have been the onset of her husband's cancer.

Mr Henderson was transferred to Magilligan Prison on 31 May 2007 and it was noted that Mr Henderson was still waiting to be seen by a surgeon in relation to his hernia. A further referral was made.

[4] Inguinal Hernia Definition – an inguinal hernia is a protrusion of abdominal content through the abdominal wall.

A letter, dated 28 September 2007, from the consultant in Belfast City Hospital, confirms that *"Mr Henderson has indeed got a small right inguinal hernia."* A further assessment by a visiting surgeon at Magilligan, in April 2008, also confirmed this diagnosis.

Dr Saul concludes that there was no question that the diagnosis of the three doctors was correct. He points out that the diagnosis of a hernia is not difficult.

On 29 July 2008, Mr Henderson complained of chest/upper abdominal pain. He was examined by the prison doctor and an x-ray was taken which was normal.

On 1 August 2008, Mr Henderson complained that the pain that he had been experiencing under his left rib cage had now moved to a more central position and that he felt that he had *"an object the size of a football inside him."* The nurse spoke with a prison doctor and he recommended that Mr Henderson take rantadine 75mg (a medication that inhibits stomach acid) and that he should be observed over the weekend. Mr Henderson's medical records show that he was seen on two more occasions that day because of the pain and that, on the second occasion, an ambulance was requested to take him to the accident and emergency department of the Causeway Hospital.

The discharge letter to Magilligan recorded a diagnosis of gastroenteritis, to be treated with protium tablets[5]. A

[5] Protium Definition - medications which is used in a number of conditions including gastrointestinal ulcers, indigestion and excess acid and gastro-oesophageal disease.

recommendation was given for an upper gastro intestinal endoscopy (OGD)[6] to be arranged by the prison doctor if symptoms persisted.

On 15 September 2008, Mr Henderson was again complaining of pain in his upper abdominal region. As a result, the prison doctor wrote to the Gastrin Ontologist at the Causeway Hospital requesting a review of Mr Henderson and noting that Mr Henderson has lost a stone in three months.

The following day, Mr Henderson reported to a nurse that the pain was getting worse and as a result, he was seen by the prison doctor who sent him to the accident and emergency department of the Causeway Hospital. In his referral letter, the prison doctor emphasised that Mr Henderson had a further exacerbation of upper abdominal pain and that he was in quite a bit of distress. It is further noted in his referral letter that, on examination, an upper abdominal mass was suspected, but that it was difficult to evaluate due to the rigidity of the area.

Mr Henderson was discharged later that evening. The discharge letter notes that Mr Henderson presented with very severe epigastric pain and that protium medication should be continued on an increased dose. Further arrangements were also to be made for an outpatient OGD appointment.

On 7 October 2008, Mr Henderson was again complaining of upper abdominal pain and was seen by the prison doctor who arranged for the Causeway Hospital to be contacted for an urgent OGD

[6] Gastrointestinal Endoscopy – When a doctor is able to see the inside lining of the digestive tract. This examination is performed using an endoscope-a flexible fiberoptic tube with a tiny TV camera at the end.

appointment. The following day the Causeway Hospital was contacted and an appointment was arranged for 17 October 2008.

The result of the OGD procedure is reported as normal but, in view of Mr Henderson's symptoms, he was listed for an urgent outpatient appointment. In the event, the appointment was to have taken place on 15 January 2009.

Dr Saul noted in his clinical review that the delay in performing the OGD was not consistent with good practice. He concluded, however, that these delays did not contribute to the final outcome for Mr Henderson.

Between 17 October 2008 and 14 December 2008, there are only routine entries noted on Mr Henderson's medical records. The only exception is a slightly abnormal liver function blood test result, which Dr Saul stated could have been due to a number of causes, though normal practice would have been to repeat the test in case the result was anomalous.

Dr Saul notes that the prison service did not receive the results of the OGD procedure until 22 November 2008 and would most likely have been working under the assumption that the main problem was in Mr Henderson's stomach.

On 14 December 2008, Mr Henderson was taken by a cardiac ambulance to Altnagelvin Hospital, suffering with chest pain. The hospital was contacted the following day and Magilligan healthcare staff were informed that Mr Henderson had a chest infection.

Mrs Henderson had been informed by staff at Magilligan that her husband had been taken to the Causeway Hospital, when in fact he had been taken to Altnagelvin Hospital.

It would appear that when Mr Henderson left Magilligan Prison, it was intended that he would be taken to the Causeway Hospital. The investigation confirmed that the Prison Service was informed, by the officers accompanying Mr Henderson that he had been taken to Altnagelvin Hospital. This information was not communicated to Mrs Henderson, who travelled to the wrong hospital.

Mr Henderson remained in hospital and further tests were carried out. On 19 December 2008, prison healthcare staff were informed that Mr Henderson had liver metastasis and that the hospital were trying to locate the primary site. It was thought that this was possibly in his bowel.

Mr Henderson was discharged from Altnagelvin Hospital on 23 December 2008 and returned to Magilligan Prison. It was intended that he should return to hospital on 5 January 2009.

Mrs Henderson said that her husband's health deteriorated significantly during this period. She asked why he was not referred back to Altnagelvin Hospital.

In a phone call on 23 December, Mr Henderson said that he was very happy to be back in prison, because he would rest better and have more people around him. Over the following days, however, his condition seemed to deteriorate.

At interview, Magilligan's healthcare manager said that when Mr Henderson was discharged from hospital, the hospital staff said that if Mr Henderson's condition should deteriorate, he could be sent back to hospital sooner. The healthcare manager said that this did not prove necessary. She said also that Mr Henderson was seen daily by a member of the healthcare staff to give him his medication and *"even just for a general chit chat."*

On his return to Magilligan prison, Mr Henderson initially sounded upbeat in his telephone calls with his family. However on 1 and 3 January 2009, in separate telephone conversations Mr Henderson had with family members, he told them that he was feeling terrible and that he thought that his condition was "*worse than they're letting on*". Mr Henderson also described how jaundiced he had become – *"getting yellower by the day"*, and the fact that he was down to 14 stone 1 pound. Mrs Henderson sounded very concerned and asked him if he could go back to hospital earlier, rather than waiting until the pre arranged date of 5 January 2009.

It is noted on EMIS[7] on 4 January 2009 that contact was made with Altnagelvin Hospital about the availability of a bed. The record shows that the bed manager there confirmed that there was no bed but that they would ring back later that day. There is no record of any calls from the prison to Altnagelvin Hospital on 5 January 2009. A day later than expected, on the morning of 6 January 2009, Mr Henderson was readmitted to Altnagelvin Hospital.

There is evidence in phone calls, as well as in Mr Henderson's medical file, that healthcare staff attempted to make Mr Henderson feel as

[7] EMIS – Egton Medical Information System used to keep a computerised record of each prisoners medical consultations and interventions with a nurse and doctor.

comfortable as possible by administering extra medicine when he felt sick and pain relief when he became more uncomfortable.

At Mr Henderson's request, he returned to Magilligan Prison on 20 January 2009 to deal with some personal matters. The healthcare manager said that on his return Mr Henderson was visibly weak and jaundiced.

That day, Mr Henderson telephoned his wife and it was apparent that he had shortness of breath. He said that he was very weak and that this made it difficult for him to walk around. Mrs Henderson expressed her and their families concern and said that they had not wanted him to return to prison. Mr Henderson assured her that as soon as he had sorted out what he needed to, he would return to hospital.

At interview, Mr Henderson's probation officer said that when she went to see Mr Henderson on 20 January 2009, he had accepted that he didn't have long to live and had wanted to return to Magilligan to sort out his personal effects. She said that Mr Henderson wanted to give his wife the valentine cards that she had sent him over the years and to gather up his personal belongings. She said that it was clear that he wanted to return to hospital.

At interview, the healthcare manager said that following a poor night, with increasing weakness and shortness of breath, Mr Henderson was returned to Altnagelvin Hospital on 21 January 2009.

In his clinical review, Dr Saul noted that "*it would appear that staff did all they could to make him comfortable in the period he was in their stay between hospital visits.* He also noted the "*strenuous efforts*"

made by the prison staff to maintain liaison with the hospital team and flagged this as an example of good practice.

On 23 January 2009, it is recorded in the bedwatch officer log that Mr Henderson's doctor had informed the officers supervising him that he was now bed ridden and that they were no longer required. Later on that day, a governor attended Altnagelvin Hospital in order to temporarily release Mr Henderson under Prison Rule 27(2).

Mr Henderson's family was concerned that he was asked to sign a release form when he was "on his death bed." It is regrettable that at such a sensitive and emotional time, this caused them to be upset.
Mr Henderson's family also asked why, when Mr Henderson's health was deteriorating rapidly, he could not have been transferred to Maghaberry where there is an in-patient health centre and where he would have been closer to the family home. This request was supported by a probation officer who felt it would have eased things considerably for his family. The probation officer asked the prison service to consider a transfer but the investigation found no evidence that any meaningful consideration was given to this possibility.

At 10.11 on 27 January 2009, Magilligan Prison was notified that Mr Henderson had passed away in Altnagelvin Hospital in the late hours of the previous night.

In his summary, Dr Saul noted that "*some delays characterised Mr Henderson's treatment*" but he concluded that Mr Henderson's medical treatment in prison was generally of a high standard and was entirely similar to the care that would be expected in a civilian setting. He said also that "*there is no evidence of an avoidable delay in respect to the prison staff in the diagnosis of Mr Henderson's liver cancer.*"

Acknowledgement

Following Mr Henderson's death, Mrs Henderson sent a thank you card to all the staff on H2 C and D wings who looked after her husband, and in particular nine officers whom she named. It is particularly difficult for a family to deal with the fact that a family member in prison is seriously ill and I would like to commend the officers for caring for Mr Henderson in a way that made his wife feel grateful and comforted.

RECOMMENDATIONS

In light of my findings and the observations of the clinical reviewer, I make **five recommendations** to the Northern Ireland Prison Service in co-operation with its South Eastern Health and Social Care Trust partners. These recommendations cover:

Recommendation 1

I recommend that the Prison Service and South Eastern Health and Social Care Trust (SEHSCT) take action to ensure that all hospitals in Northern Ireland are aware of the correct process for notifying prisoner appointments.

Recommendation 2

I recommend that the Prison Service and SEHSCT ensure that in any circumstances where, for whatever reason, consideration is being given to the cancellation of an appointment, full account is taken of NICE guidance and targets in respect of symptoms/investigations.

Recommendation 3

I recommend to the Prison Service and SEHSCT that they review their process for booking the Prisoner Escort Group to take prisoners to hospital appointments and ensure that current arrangements are fit for purpose.

Recommendation 4

I recommend to the Prison Service and SEHSCT that appointments that are missed/rescheduled are fully documented on EMIS, with reason.

Recommendation 5

I recommend to the Prison Service that they review arrangements and responsibilities for ensuring that family members are provided with accurate and timely information when a prisoner is transferred to hospital in serious circumstances.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. The Prisoner Ombudsman[8] for Northern Ireland has the responsibility for investigating the death of Mr Paul Henderson in Altnagelvin Hospital, on 26 January 2009. At the time of his death, Mr Henderson was in the custody of Magilligan Prison. The Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached at Appendix 1.

2. The Prisoner Ombudsman is independent of the Prison Service and her investigation provides enhanced transparency to the investigative process following any death in prison custody. It also contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. As required by law, the Police Service of Northern Ireland continues to be notified of all deaths in prison custody.

Objectives

4. The objectives for the investigation into Mr Henderson's death are:

    - to establish the circumstances and events surrounding his death, including the care provided by the Prison Service

[8] The Prisoner Ombudsman took over the investigations of deaths in prison custody in Northern Ireland from 1 September 2005.

- to examine any relevant healthcare issues and assess the clinical care afforded by the Prison Service
- to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in the future
- to ensure that Mr Henderson's family have the opportunity to raise any concerns that they may have and that these are taken into account in the investigation
- to inform the Coroner of the findings

Investigation Methodology

5. Details of the investigation methodology are included at Appendix 2.

Family Liaison

6. An important aspect of the role of Prisoner Ombudsman in dealing with any death in custody is to liaise with the deceased's family.

7. It is important for the investigation to learn more about a prisoner who dies in prison custody from family members, and to listen to any concerns or questions that the family may have.

8. The Prisoner Ombudsman is grateful to Mr Henderson's wife for meeting with her on 12 March 2009 and for the insight she gave into Mr Henderson's circumstances before his death.

9. The following concern's/questions were raised by Mrs Henderson:

- Why did it take so long to correctly diagnose her husband's cancer?

- Mr Henderson was diagnosed as having a hernia, and given a hernia belt. Was this lump misdiagnosed and actually cancerous?

- Why did her husband miss a number of important hospital appointments because of staffing and transportation problems?

- When Mr Henderson was taken to outside hospital on 14 December 2008, why was Mrs Henderson misinformed about which hospital her husband had been taken to?

- Between 24 December 2008 and 6 January 2009, Mr Henderson was discharged from hospital and sent back to Magilligan Prison. During this time his health deteriorated but he was not referred back to Altnagelvin Hospital. Why was this?

- A governor who attended Altnagelvin Hospital was rude to nursing staff and asked her husband to sign a release form while he *"was on his death bed"*.

- Why couldn't her husband have been transferred to Maghaberry Prison where there is better healthcare provision and where he would have been closer to the family home?

FINDINGS

SECTION 1: MR HENDERSON'S MEDICAL HISTORY

One of the questions asked by Mrs Henderson was why her husband had a number of important appointments cancelled during his time in prison as a result of staffing and transport problems.

Mrs Henderson also wanted to know why her husband's cancer was not found sooner.

Both of these questions are addressed in the chronology that follows.

1. Medical Conditions Identified at Committal

Mr Henderson was committed on remand into Maghaberry Prison on 3 March 2004 and later given a sentence of 12 years. As part of his committal to Maghaberry, Mr Henderson underwent an initial reception health screen where a nurse officer recorded that Mr Henderson had previously had two myocardial infarctions[9], which had been treated by stenting, and suffered from angina. Mr Henderson was on a standard regime of medications to treat this condition, all of which were continued in prison.

[9] Myocardial Infarction Definition – Commonly known as a heart attack.

The nurse also recorded that Mr Henderson was subject to anaphylaxis[10] triggered by latex and a variety of foods. Arrangements were made to alert staff to the need for these substances to be avoided and provision was made for access to an EpiPen[11].

Medical staff noted that Mr Henderson was significantly overweight and was a smoker. There is subsequently evidence that considerable support was given to Mr Henderson to encourage smoking cessation and weight reduction.

1a. On committal, it was noted that Mr Henderson had previously had two myocardial infarctions and suffered from angina and allergies.

[10] Anaphylaxis - An extreme and severe allergic reaction. The whole body is affected, often within minutes of exposure to the allergen but sometimes after hours.
[11] EpiPen Definition – An injection device used to treat severe allergies.

2. Referral to Hospital - 18 May 2004

On 18 May 2004, Mr Henderson was sent to Belfast City Hospital (BCH) Accident and Emergency department, by a prison doctor. In the referral letter, the doctor explained that Mr Henderson was complaining of weakness in his left arm and coldness in his left hand, which had been more noticeable over the previous two days.

In his clinical review report, Dr Saul noted, in respect of this referral, that Mr Henderson *"had been complaining of weakness in his left arm and a stroke was queried"* and that *"the prison medical staff acted promptly when the symptoms were reported."*

When Mr Henderson returned to Maghaberry, a discharge letter from BCH to the prison recorded that Mr Henderson had said that he had fallen down the stairs two days earlier and was complaining of back pain. A primary diagnosis of soft tissue injury to his back, called Neuropraxia[12] is recorded. There was no mention of the fall or back pain in Mr Henderson's prison medical records.

The discharge letter further records that in view of Mr Henderson's left arm symptoms, he should attend the neurovascular clinic. The letter was also sent to BCH's appointments office, so that Mr Henderson could be listed for the clinic.

[12] Neuropraxia Definition – Nerve definition in its mildest form where there is no disruption of the nerve.

2a. In May 2004, Mr Henderson was sent to outside hospital, having complained of weakness in his left arm and coldness in his hand.

2b. The discharge letter from Belfast City Hospital includes a referral to a neurovascular clinic.

2c. The discharge letter also notes that Mr Henderson was complaining of back pain which he said was caused by a fall.

3. Review at the Neurovascular Clinic - 1 July 2004

On 1 July 2004 Mr Henderson received an appointment letter to attend the BCH Neurovascular clinic on 6 July 2004 and gave the letter to prison staff. Mr Henderson did not attend this appointment and the prison rescheduled it for a later date.

In a statement from the healthcare manager at Magilligan Prison, she advised that the reason this appointment was rescheduled was because the letter had gone directly to Mr Henderson and, because Maghaberry is a high security prison, prisoners are not permitted to have advance knowledge of medical appointments.

The rescheduled appointment took place on 24 August 2004. At the Neurovascular Clinic Mr Henderson was diagnosed as having previously had a minor stroke. The discharge note from the consultant requested physiotherapy for Mr Henderson's upper left arm and left hand and recorded that his aspirin prescription should be stopped and changed to plavix[13].

In a more comprehensive discharge letter, marked as typed on 27 August 2004, the consultant noted that *"he [Mr Henderson] has some changes of his nail beds possibly suggestive of early finger clubbing[14]. Chest examination was clear. He has no respiratory symptoms, but says that he has lost weight, though*

[13] Plavix tablets contain the active ingredient clopidogrel hydrogen sulphate, which is a type of medicine called an antiplatelet (sometimes referred to as a 'blood-thinning' medicine). It stops blood cells called platelets from clumping together and forming blood clots.

[14] Finger Clubbing Definition – It is a phrase doctors use to describe specific changes in the shape of fingers and fingernails. People with heart or lung problems sometimes have these changes. They usually develop in advanced disease.

he attributes this to dieting, and he would appear to be on quite a restricted diet."

The consultant also notes in this letter that he would be grateful if the prison doctor *"would monitor his chest, his weight and arrange a repeat chest x-ray in two months' time and again in four months' time. Obviously if you find that his finger clubbing becomes more pronounced, or if he loses more weight then more detailed respiratory or other assessments would be necessary."*

Monitoring of Mr Henderson's weight and finger clubbing was arranged and repeat chest x-rays were carried out. Mr Henderson was referred to Maghaberry's physiotherapy and occupational therapy departments. His medication was changed as requested.

In his clinical review report, Dr Saul stated that the investigations undertaken at the Neurovascular Clinic *"were comprehensive and appropriate. There was, however, a delay of nearly three months before Mr Henderson was assessed in the Neurovascular Unit. This delay is unacceptable and is outside both current stroke guidelines, and those current at the time (Patients first seen in the community with TIA[15], or with a stroke but having made a good recovery when seen, should be assessed and investigated in a specialist service (e.g. neurovascular clinic) as soon as possible within seven days of the incident."*

Dr Saul also stated that patients who have had a stroke are at high risk of further strokes, so prompt assessment is advisable

[15] TIA Definition – Transient Ischaemic Attacks, an acute neurological event that are presumed to be vascular in origin and caused by cerebral ichaemia, cerebral infarction or cerebral haemorrhage. With TIA the symptoms and signs resolve in 24 hours.

in order to mitigate avoidable factors for recurrence. He felt, however, that the delay did not seem to have had any clinical significance in Mr Henderson's case.

In respect of the appointment that was cancelled by the Prison Service on 6 July 2004, the investigation established that it would be unusual for an appointment notified directly to a prisoner not to be re-arranged. It was however established that in urgent cases, consideration may be given to allowing appointments to go ahead. There is no evidence that this option was considered, in respect of this appointment.

Whilst it was the case that the Prison Service contributed to the delay in Mr Henderson's attendance at the neurovascular clinic by cancelling his appointment on 6 July 2004, other elements of the delay relate to Mr Henderson's care by the hospital and are not matters to be considered by the Prisoner Ombudsman investigation. The family are aware that they can raise any concerns they may have, about the healthcare received by Mr Henderson outside of prison, with the relevant Health Trust.

3a. As a result of Mr Henderson's left arm weakness, first assessed on 18 May 2004, he was referred to the Neurovascular Clinic for further assessment.

3b. Mr Henderson was due to attend a neurovascular clinic on 6 July but this was cancelled by the prison and the rescheduled appointment did not take place until 24 August 2004.

3c. Over three months after Mr Henderson presented with left arm weakness, on 24 August 2004, he was told that he had suffered a mild stroke.

3d. The application of Prison Service Policy in respect of advance notification of hospital appointments contributed to the delay.

3e. The clinical reviewer, Dr Saul, stated that the delay in Mr Henderson's attendance at the neurovascular was unacceptable and is outside both current stroke guidelines and those current at the time.

3f. Dr Saul concluded, however, that the delay did not have any clinical significance in this case.

4. Test Results and subsequent clinical investigations

On 24 August 2004, when Mr Henderson attended the neurovascular clinic, he also had a chest x-ray, the results of which were notified to the prison in a letter which was marked as typed on 22 September 2004.

This letter noted that Mr Henderson's carotid arteries (the main arteries in the neck) showed some mild plaque (internal thickening), but no significant thickening. The letter also noted that the x-ray showed *"vague circular density"* on Mr Henderson's left lung.

In his clinical review report, Dr Saul stated that *"this would have been worrying, particularly in view of the noted finger clubbing and could have indicated lung cancer."*

Given the *"abnormal chest x-ray"*, a CT scan of Mr Henderson's brain, chest and upper abdomen was arranged by his consultant for 26 October 2004.

The results of the CT scan of Mr Henderson's brain, chest and upper abdomen were notified to the prison in a letter which was marked as typed on 10 November 2004. The letter noted as follows:

- the brain scan showed mild cerebral atrophy[16]
- the chest CT scan did not show any abnormalities that were significant and the vague circular density noted

[16] Mild Cerebral Atrophy Definition – When the brain is smaller that expected for the persons age. Many people who don't have any neurological disease have such a finding.

adjacent to the left hillar point on the previous x-ray was not significant

- a CT scan of the liver showed decreased attenuation[17] in the left lobe and the kidneys, pancreas and liver were all found to be normal.

In view of the anomaly shown on the liver, it was also noted that an ultrasound had been booked.

Neurovascular Follow-Up Review

Mr Henderson attended a follow-up review with his neurovascular consultant on 23 November 2004. In the letter that was sent to the prison after this appointment, the consultant notes that no further episodes of left side weakness had occurred and that Mr Henderson was on appropriate secondary preventative treatment. He notes that the liver abnormality found at the CT scan may represent a simple cyst and states that an ultrasound has been booked, with a provisional date of 16 December 2004. He recommends a repeat chest x-ray towards the end of January 2005 and notes that this can be carried out in the prison. In light of the above, the consultant states in the letter that he does not plan any review.

In a further letter to the prison, marked as typed on 20 January 2005, it is noted that the ultrasound scan of the upper abdomen confirms the presence of a simple cyst in Mr Henderson's liver, as well as a stone in his gall bladder.

[17] Decreased Attenuation - An area on the liver which was not as "bright" on the CT scan as the rest of the liver.

Dr Saul stated that the ultrasound findings *"would not have been particularly unusual*". He notes that a further repeat x-ray was recommended. This was performed at Maghaberry on 6 March 2005. In relation to Mr Henderson's finger clubbing, Dr Saul notes that no pathological cause for this was found. Dr Saul states that some patients can have idiopathic clubbing where no cause is found and this appears to have been likely in Mr Henderson's case.

4a. Following an abnormal chest x-ray, Mr Henderson was sent for a CT scan.

4b. The only concern arising from the CT scan was that the liver showed decreased attenuation. This was subsequently confirmed to be a simple cyst and a gall bladder stone was also noted.

4c. The chest CT scan showed no significant abnormalities.

4d. On 23 November 2004, Mr Henderson's neurovascular consultant recommended a repeat x-ray in two months time and was content that as Mr Henderson was on appropriate secondary preventative treatment following his stroke, no further review was required.

5. Urology Problems

Whilst Mr Henderson was waiting to be seen by a neurovascular consultant in Belfast City Hospital (BCH) in connection with the weakness in his left arm, he was seen, on 6 August 2004, by a prison doctor in relation to a testicular problem. Following the consultation, the prison doctor referred Mr Henderson to BCH for assessment.

On 14 September 2004, BCH confirmed in a letter to the prison that Mr Henderson had been referred to the Urology department for a routine appointment. The referral letter stated that there was approximately a 9-10 month waiting list for this type of appointment.

Mr Henderson was seen by the prison doctor on seven occasions between September 2004 and March 2006 in respect of this health concern. On 14 October 2004 and 2 March 2005, the prison doctor wrote further letters to the hospital in respect of the earlier referral made, to try and speed up an appointment date for Mr Henderson to be seen by the urologist.

Whilst Mr Henderson was waiting to be seen by a urologist, the prison doctors prescribed him with antibiotics and pain relief medication.

The urology appointment took place on 6 March 2006.

Urology Results

On 6 March 2006, Mr Henderson attended Belfast City Hospital (BCH) for his assessment with a consultant uro-oncologist. A discharge letter, marked as typed on 20 March 2006, records that as a result of the consultation, an ultrasound scan, telescope test of the bladder and a dye test of the kidneys were to be arranged by BCH.

A letter to the prison confirmed that Mr Henderson attended BCH on 4 April and 27 April for an ultrasound scan and an intravenous urogram[18]. The prison was also notified that Mr Henderson had been added to the waiting list for a cystoscopy[19].

Rescheduled Cystoscopy Appointments

Mr Henderson's appointment to attend BCH for a cystoscopy was rescheduled on four occasions. The reasons given were as follows:

- **6 November 2006** - The senior officer of the Prisoner Escort Group (PEG) stated that this appointment had to be rescheduled because Mr Henderson had not been placed on their production list[20] by Healthcare, therefore, there was no staff available to take him to this appointment. The appointment was rescheduled for 13 November 2006.

[18] Urogram Definition - A radiograph of the urinary tract.
[19] Cystoscopy Definition – Where an endoscopy (camera) is used to assess the internal functions of the bladder.
[20] List of prisoners due to leave prison for medical, court or other appointments.

- **13 November 2006** - In her statement, the healthcare manager said that the reason this appointment was cancelled was because the Prisoner Escort Group (PEG) were unable to provide transport for Mr Henderson. The appointment was rescheduled for 15 January 2007.

- **15 January 2007** - Although Mr Henderson was on the PEG production list, the officers from the PEG who were detailed to take him to hospital were delayed in returning to Maghaberry with their morning prisoner and, said that as a result, there were no staff to transport Mr Henderson to the hospital. This appointment was rescheduled for 26 January 2007.

- **26 January 2007** - A handwritten note on the appointment letter indicates that BCH rang on 25 January 2007 to cancel the appointment. There was no reason recorded. The handwritten note further indicates that BCH would send out a new appointment.

On 15 May 2007 the prison was notified that Mr Henderson was to attend BCH on 11 June 2007 for the cystoscopy procedure.

On 31 May 2007, Mr Henderson was transferred in line with operational practice to Magilligan Prison, where the regime is more flexible.

Cystoscopy Procedure - 11 June 2007

A letter to the prison, marked as typed on 12 June 2007, confirms the results of Mr Henderson's cystoscopy. The letter states that there was no evidence of disease and the examination was normal.

5a. On 6 August 2004, Mr Henderson was referred to Belfast City Hospital in connection with a testicular problem.

5b. Mr Henderson attended the hospital on 6 March 2006 and had further investigation in April 2006.

5c. Mr Henderson was scheduled to have a procedure on 6 November 2006. It did not take place until 11 June 2007, having been cancelled by the prisoner escort group three times and rescheduled by Belfast City Hospital once.

5d. The results of Mr Henderson's urology investigations were normal. There was no evidence of disease.

6. Diagnosis of a Hernia - 24 May 2006

Mrs Henderson was particularly concerned that a lump that her husband discovered had been incorrectly diagnosed as a hernia. She was worried that the lump may have been the onset of her husband's cancer.

On 24 May 2006, Mr Henderson was seen by a prison doctor in relation to a lump that he had found. The prison doctor diagnosed Mr Henderson as having a right inguinal hernia[21], and as a result Mr Henderson was referred to a surgeon for assessment.

Mr Henderson's wife wanted to know who had supplied her husband with a hernia belt. A hernia belt, which is also known as a truss, is an elasticated belt that supports the abdomen and helps to prevent the hernia from protruding.

Whilst it was not recorded, it would appear that Mr Henderson was supplied with a truss, sometime between 24 May 2006 and 5 July 2006. On 5 July 2006, an entry in Mr Henderson's medical notes by a prison doctor refers to the truss.

There are no further medical notes in relation to Mr Henderson's hernia until 31 May 2007, when he transferred to Magilligan Prison.

[21] Inguinal Hernia Definition – an inguinal hernia is a protrusion of abdominal content through the abdominal wall.

An EMIS[22] entry of 31 May 2007 notes that while Mr Henderson was in Maghaberry he had been referred to a general surgeon, in connection with his hernia, but had not yet been seen by anyone. The entry records that a further referral is required.

On 2 July 2007, an EMIS entry records that Mr Henderson's name would be added to the visiting surgeon's list by Magilligan. This was followed up on the same day by a referral letter to a consultant in Belfast City Hospital.

Belfast City Hospital Surgeon's Assessment

A letter, dated 28 September 2007, from the consultant in Belfast City Hospital, who assessed Mr Henderson's suspected hernia, states, *"Mr Henderson has indeed got a small right inguinal hernia. It is not causing him much trouble. He is losing weight and he is finding his symptoms are eased. I have warned him that if we were to repair this he has a 5% chance of chronic pain. I don't feel it justified of surgery at the present time as it is easily reducible. He is happy with this. Obviously if symptoms change we will be in touch but we will leave well enough alone."*

Magilligan's visiting Surgeon's Assessment

On 16 April 2008, Mr Henderson was seen by a visiting surgeon in Magilligan Prison. The EMIS entry records:

"Referred with tenderness (in his) right groin…overweight. Quite sensitive over a small direct inguinal hernia (which is) developing.

[22] EMIS – Egton Medical Information System used to keep a computerised record of each prisoners medical consultations and interventions with a nurse and doctor.

Increased weight should be lost and review perhaps in 3 months."

On 21 May 2008, a further assessment was carried out by the same surgeon. The EMIS entry records:

"Was to be reviewed (in) 3 months but came back after a month. Now much more comfortable having given up cigarettes and lost some weight, feeling better. Only really sore when he sits because of the discomfort to his right groin. To come back for a review when he is below 15 stone. Then consider whether or not this could be fixed."

Mr Henderson was not seen by the visiting surgeon again until 8 October 2008 when it is recorded on EMIS that Mr Henderson was feeling much better having lost a stone and a half. It further states that he was feeling much more comfortable and that the hernia was less prominent.

In considering Mrs Henderson's concern that her husband's lump might have incorrectly been diagnosed as a hernia, the clinical reviewer Dr Saul, said that there was no question that the diagnosis by the three doctors was correct. He pointed out that diagnosis of a hernia is not difficult.

Dr Saul concluded that *"it seems perfectly reasonable that a 'watch and wait' policy was taken with respect to Mr Henderson's hernia and, there is evidence in the clinic letters that this was done after consultation and agreement with Mr Henderson."*

6a. Mr Henderson's hernia was assessed by a surgeon in Belfast City Hospital on 28 September 2007 who deemed surgery was not required at that time.

6b. Mr Henderson was seen three times by a visiting surgeon between 16 April 2008 and 8 October 2008 and it was felt that his condition was improving.

7. Episodes of Chest/Upper Abdominal Pain

On 6 June 2007, it is recorded on EMIS that a nurse was called to H2, where Mr Henderson was located, as he was complaining of chest pain. The nurse noted on EMIS that Mr Henderson had a long history of cardiac problems but that he advised her, on this occasion, that the pain was radiating from his left ribcage area. It is further recorded that the nurse discussed with Mr Henderson his cardiac history and, ascertained that he had not had a follow-up assessment since having a stent insertion in 2000. His blood pressure was taken and he was placed on the doctor's list to be reviewed the following day.

Mr Henderson was reviewed the following day by the prison doctor. It is recorded on EMIS that Mr Henderson was feeling better and had no further episodes of chest pain since the previous day. He was advised that, should his symptoms return, he was to inform a member of staff.

The next time that it is recorded that Mr Henderson complained of chest pain was thirteen months later on 23 July 2008.

From 23 July 2008, Mr Henderson complained of a similar pain and follow-up clinical investigations were carried out on the following dates:

- **23 July 2008** – An EMIS entry records that a nurse officer triaged Mr Henderson who had presented with pain below his lower left rib. It is noted that Mr Henderson was added to the doctor's list for him to be assessed.

- **29 July 2008** – Mr Henderson was seen by the prison doctor. The corresponding EMIS entry notes:

  "He gives a 3 week history of pain in the left hyperchondrium[23] (and) he has no other associated symptoms. He had (a) similar episode about 12 months ago which did resolve. O/E (On examination) he is remarkably obese; he has good entry and no added sounds (and) nil to feel on palpitation of his abdomen. I will arrange a chest X-ray."

  The results of the chest x-ray, which were notified to the prison in a letter marked as typed on 20 August 2008 came back as normal.

- **1 August 2008** - An EMIS entry records that a nurse officer was called out to see Mr Henderson. The record notes that Mr Henderson was complaining that the pain that he had been experiencing under his left rib cage had now moved to a more central position and that he felt that he had *"an object the size of a football inside him."* The entry further records that Mr Henderson had no appetite and that his stools were dark in colour. The nurse recorded that she was going to speak to the doctor and advised Mr Henderson to take Gaviscon in the meantime, and for him to rest. A prison doctor was spoken to and he recommended that Mr Henderson take rantidine[24] 75mgs and that he should be observed over the weekend. The prison doctor said that if Mr Henderson's symptoms got worse, a doctor was to be informed.

[23] Hyperchondrium Definition - The hyperchondrium is the upper part of the abdomen nearest to the lowest ribs of the thorax.
[24] Rantidine Definition – medication that inhibits stomach acid production.

The EMIS records show that Mr Henderson was seen on two more occasions that day because of his pain and that, on the second occasion, an ambulance was requested to take him to the Accident and Emergency department of Causeway Hospital.

- The discharge note from the Causeway Hospital to the prison recorded that Mr Henderson presented with a three week history of intermittent upper abdominal pain and an episode of passage of dark stools. The discharge note recorded a diagnosis of gastroenteritis and for him to be treated with protium[25] tablets. A recommendation was given for an upper gastro intestinal endoscopy to be arranged by the prison service doctor if the symptoms persisted.

- **15 September 2008** - An EMIS entry records that Mr Henderson was complaining of a reoccurrence of upper abdominal pain. It is recorded that he was assessed by a prison doctor and as a result the doctor wrote to the Gastrin Ontologist at the Causeway Hospital requesting a review of Mr Henderson. The letter refers to Mr Henderson as having been complaining of epigastric pain for the past three months. The letter also records that Mr Henderson has a history of weight loss and has lost approximately one stone in three months.

- **16 September 2008** - An EMIS entry records that Mr Henderson was seen by a nurse officer because his upper

[25] Protium Definition - medications which is used in a number of conditions including gastrointestinal ulcers, indigestion and excess acid and gastro-oesophageal disease.

abdominal pain was getting worse. Subsequently, Mr Henderson was seen by the prison doctor who sent him to the accident and emergency department at the Causeway Hospital and wrote a letter emphasising that Mr Henderson had a further exacerbation of upper abdominal pain and that he was in quite a bit of distress. It is further noted in the referral letter that, on examination, an upper abdominal mass was suspected, but that it was difficult to evaluate due to the rigidity of the area.

Mr Henderson was discharged from the Causeway Hospital later that evening. The discharge letter from the Hospital notes that Mr Henderson presented with very severe epigastric pain. It recommends that the protium medication Mr Henderson was already receiving should be increased. Further arrangements were also to be made for an outpatient OGD (Gastroscopy)[26] appointment.

- **7 October 2008** - Mr Henderson's was again complaining of upper abdominal pain. He was seen that day by the prison doctor and it is recorded on EMIS that *"this man is having further epigastric pain and discomfort. He is also losing weight. He is waiting for an OGD at Causeway (hospital), please contact and request an urgent appointment."* The entry further notes that Mr Henderson was receiving a semi soft diet of soups and yoghurts for one week which helped. It is noted also that the doctor requested that the kitchen be informed that Mr Henderson should receive this diet until he was seen at the Causeway Hospital.

[26] Gastroscopy Definition – This is a test where a flexible scope is passed down the oesophagus and into the stomach and duodenum.

An entry on EMIS records that the following day the Causeway Hospital was contacted by a member of healthcare and an OGD appointment was arranged for 17 October 2008.

Gastroscopy (OGD) Appointment - 17 October 2008

Correspondence from the Causeway Hospital to the prison indicates that Mr Henderson attended for his OGD procedure on 17 October 2008, however, in a letter from the hospital dated 22 November 2008, it indicates that the procedure took place on 31 October 2008. The reason for the confusion over dates is unclear. The result of the procedure is reported as normal but, in view of Mr Henderson's weight loss and previous dark stools, he was to be listed for an urgent outpatient appointment to further investigate these symptoms.

In the event, the urgent appointment referred to, was to have been arranged for 15 January 2009.

In his clinical review report, Dr Saul commented that, given Mr Henderson's symptoms, the delay in performing the OGD procedure was not consistent with good practice. He said that the guidance for management of such conditions would suggest that an endoscopy should have been recommended, irrespective of recurrence, when Mr Henderson left hospital. He noted that it was over one month later when prison health care staff then requested an endoscopy. He also noted, however, that prison healthcare staff made efforts to secure an urgent appointment, when Mr Henderson continued to have symptoms.

Dr Saul concluded that *"these issues did not, however contribute to the final outcome for Mr Henderson."*

7a. Mr Henderson first reported upper abdominal pain on 6 June 2007 to a nurse officer. He was seen the following day by a doctor and said that he felt much better.

7b. It was over one year later when Mr Henderson next reported upper abdominal pain.

7c. On 1 August 2008, Mr Henderson was sent to the Accident and Emergency Department at the Causeway Hospital and diagnosed as having gastroenteritis. The hospital recommended an upper gastro-intestinal endoscopy if his symptoms persisted.

7d. The prison healthcare team urgently referred Mr Henderson back to the Causeway Hospital on 16 September 2008 due to a further episode of upper abdominal pain and a suspected upper abdominal mass.

7e. Mr Henderson was discharged from the Causeway Hospital with a recommendation to increase his acid suppressing medication and an outpatient gastroscopy appointment was eventually arranged for 17 October 2008.

7f. The gastroscopy procedure took place on 17 October 2008 and was reported as normal. However, in the light of Mr Henderson's symptoms, a further urgent appointment was to be arranged.

SECTION 2: MR HENDERSON'S DIAGNOSIS OF CANCER AND SUBSEQUENT CARE

8. Admission to Altnagelvin Hospital – 14 December 2008

Between 17 October 2008 and 14 December 2008, there are only routine entries [such as medications administered and blood samples taken and results received] noted on Mr Henderson's medical records. The only exception is a slightly abnormal liver function blood test result, which the Clinical Reviewer Dr Saul states could have been due to a number of causes, though normal practice would have been to repeat the test in case the result was anomalous.

Dr Saul notes that the prison service did not receive the results of Mr Henderson's OGD procedure until 22 November 2008 and would most likely have been working under the assumption that the main problem was in his stomach.

On 14 December 2008, Mr Henderson was taken to Altnagelvin Hospital by a cardiac ambulance suffering with chest pain. The hospital was contacted the following day and Magilligan healthcare staff were informed that Mr Henderson had a chest infection.

Reason for admission to Altnagelvin Hospital rather than Causeway Hospital

Mrs Henderson asked why she had been told that her husband had been taken to the Causeway Hospital, when in fact he had been taken to Altnagelvin Hospital.

On 23 December 2008, in a telephone conversation Mr Henderson had with his brother, he told his brother that it was *"luck"* that he was taken to Altnagelvin Hospital. He said that whilst he was on route to the Causeway Hospital, the ambulance brakes weren't working properly and nearly caused an accident. Mr Henderson said that another ambulance, from Altnagelvin Hospital, picked him up and took him to Altnagelvin instead.

It would appear that when Mr Henderson left Magilligan Prison, it was intended that he would be taken to the Causeway Hospital. Mrs Henderson was informed that this was where her husband had been taken. The investigation confirmed that the Prison Service was informed, by the officers accompanying Mr Henderson that he had been taken to Altnagelvin Hospital. This information was not communicated to Mrs Henderson, who travelled to the wrong hospital.

Diagnosis of Cancer – 19 December 2008

Mr Henderson remained in hospital and further tests were carried out. On 19 December 2008, prison healthcare staff were informed that Mr Henderson had liver metastasis and that the hospital were trying to locate the primary site. It was thought that this was possibly in his bowel.

Mr Henderson remained in Altnagelvin Hospital until 23 December 2008.

8a. On 14 December 2008, Mr Henderson was admitted to hospital suffering from chest pain.

8b. Mr Henderson's family were not made aware that he had not, as originally communicated to them, been admitted to the Causeway Hospital.

8c. On 19 December 2008, Mr Henderson was diagnosed as having liver metastasis.

9. Period in Magilligan Prison between 23 December 2008 and 6 January 2009

Mr Henderson was discharged from Altnagelvin Hospital on 23 December 2008 and returned to Magilligan Prison.

Mrs Henderson said that her husband's health deteriorated significantly during this period and she wanted to know why he was not referred back to Altnagelvin hospital.

It would appear, from telephone conversations that Mr Henderson had with family members on 23 December 2008, that the reason that Mr Henderson was given for being returned to prison over the Christmas period was that the hospital would be short of staff, and the further tests that he needed couldn't, therefore, be carried out until after Christmas. In a telephone conversation with his wife, Mr Henderson said that he spoke with a hospital doctor before he returned to Magilligan so that he could talk through his options. Mr Henderson said that he was very happy to be back in prison, because he would rest better and have more people around him.

At interview, Magilligan's healthcare manager said that when Mr Henderson was discharged from hospital, the hospital staff informed Magilligan that they had a bed booked for him to return to hospital on 5 January 2009. They also said that if Mr Henderson's condition should deteriorate, he could be sent back to hospital sooner. The healthcare manager said that did not prove necessary. She said also that Mr Henderson was seen daily by a member of the healthcare staff to give him his medication and *"even just for a general chit chat."*

On his return to Magilligan prison, Mr Henderson initially sounded upbeat in his telephone calls with his family. Both he and his family sounded as though they were trying to remain positive about his situation until they had all the results back and they knew what type of cancer Mr Henderson had.

On 1 January 2009, in separate telephone conversations Mr Henderson had with his brother and wife, he told them that he was feeling terrible and that everything he ate or drank tasted like salt. He put this down to the steroids he was taking, saying that he was no longer going to take them.

On 3 January 2009, in a telephone conversation with his wife, Mr Henderson said that he thought that his condition was "*worse than they're letting on*". He told his wife that she would be very shocked when she came to visit him the following day. Mr Henderson described how jaundiced he had become – *"getting yellower by the day"*, and the fact that he was down to 14 stone 1 pound. Mrs Henderson sounded very concerned and asked him if he could go back to hospital now, rather than waiting until 5 January 2009.

Mr Henderson told his wife on the phone that the prison had been trying to get him back to Altnagelvin Hospital, but that there were no beds available. This was contrary to the information given to the investigation by the healthcare manager and EMIS records indicate that the first attempt to get a hospital bed was on 4 January 2009. The EMIS record shows that the bed manager there confirmed that there was no bed but that they would ring back later that day. There is no record of any calls from the prison to Altnagelvin hospital on 5 January

2009. A day later than expected, on the morning of 6 January 2009, Mr Henderson was readmitted to Altnagelvin Hospital.

There is evidence in phone calls, as well as in Mr Henderson's medical file, that healthcare staff, attempted to make Mr Henderson feel as comfortable as possible by administering extra medicine when he felt sick and pain relief when he became more uncomfortable.

9a. Mr Henderson appeared to be happy that he had returned to Magilligan Prison over the Christmas period.

9b. It is evident from telephone calls with his family members that his health and wellbeing deteriorated during this time.

9c. It appears to be the case, from a telephone call on 3 January, that Mr Henderson believed efforts were being made to have him returned to Altnagelvin hospital sooner than 5 January 2009.

9d. Prison staff tried to make Mr Henderson as comfortable as possible, whilst he wanted to return to hospital.

9e. Mr Henderson eventually returned to hospital on 6 January 2009, a day later than originally planned.

10. Mr Henderson's Future Care Plan

At interview, the healthcare manager said that on 13 January 2009, she spoke to Mr Henderson's consultant to discuss when he would be discharged from hospital and to discuss his future care plan. She said that Mr Henderson's consultant *"appeared to be under the impression that we would have the facility to care for him if Hospice care was not an option"*. The healthcare manager also said that the consultant *"requested that a guard would have to accompany Paul if he was admitted to a Hospice."* The healthcare manager admitted that she was not familiar with caring for prisoners in a hospice setting, but was of the opinion that it would not have been *"in-keeping with the hospice ethos*" for bed watch officers to accompany Mr Henderson.

The healthcare manager said that she requested to meet with Mr Henderson's consultant to discuss his future care plan but the consultant declined, saying that she was unable to meet because of work demands. Mr Henderson's consultant requested that the healthcare manager call back on 16 January 2009, for a further update.

The healthcare manager said that when she called back on 16 January 2009, the consultant was unable to talk with her as she was on her rounds. The healthcare manager did manage to speak to the ward sister and was informed that Mr Henderson would be staying in hospital over the weekend and she could, therefore, call back on Monday 19 January 2009, to speak with his consultant.

At interview, the healthcare manager said that when she contacted the hospital on Monday 19 January 2009, she spoke to the ward sister and was informed that Mr Henderson had made a request to return to Magilligan in order to sort out some *"loose ends"*. The healthcare manager said that she didn't know what *"loose ends"* Mr Henderson needed to sort out and neither did the ward sister.

In his clinical review, Dr Saul noted the strenuous efforts made by the prison staff to maintain liaison with the hospital team.

10a. Magilligan's healthcare manager made contact with Altnagelvin Hospital to discuss Mr Henderson's future care plan.

10b. On 19 January 2009 she was told that Mr Henderson wished to return to Magilligan to sort out some "loose ends".

11. Mr Henderson's Return to Magilligan Prison – 20 January 2009

At Mr Henderson's request, he returned to Magilligan Prison on 20 January 2009. The healthcare manager stated that on his return Mr Henderson was visibly weak and jaundiced.

That day, Mr Henderson telephoned his wife and it was apparent that he had shortness of breath. He said that he was very weak and that this made it difficult for him to walk around. Mrs Henderson expressed her and their families concern and said that they had not wanted him to return to prison. Mr Henderson assured her that as soon as he had sorted out what he needed to, he would return to hospital.

At interview, Mr Henderson's probation officer said that when she went to see Mr Henderson on 20 January 2009, he had accepted that he didn't have long to live and had wanted to return to Magilligan to sort out his personal effects. She said that Mr Henderson wanted to give his wife the valentine cards that she had sent him over the years and to gather up his personal belongings. She said that it was clear that he wanted to return to hospital.

At interview, the healthcare manager said that following a poor night, with increasing weakness and shortness of breath, Mr Henderson was returned to Altnagelvin Hospital on 21 January 2009.

In his clinical review, Dr Saul noted that prison healthcare records noted a high level of concern for Mr Henderson and said

that *"it would appear that staff did all they could to make him comfortable in the period he was in their stay between hospital visits".*

11a. On 20 January 2009, Mr Henderson returned to Magilligan Prison for one night so that he could gather up his personal belongings.

12. Temporary Release and the Removal of Bedwatch Officers

On 23 January 2009, it is recorded in the bedwatch officer log that Mr Henderson's doctor had informed the officers supervising him that he was now bed ridden and that they were no longer required.

Under Prison Rule 27(2), permission can be granted by the Governing Governor for prisoners to be temporarily released for the purpose of receiving medical attention. Factors to be taken into consideration before this can be granted included a risk assessment as to whether or not the prisoner is likely to escape or, in some instances, come into contact with their victims.

In his statement, the duty governor stated that he received a phone call from the officers on bedwatch to say that Mr Henderson's health was deteriorating at such a rate that they felt they were no longer needed.

The healthcare manager said that, after discussion with the governor, she attended Altnagelvin Hospital on 23 January 2009 to confirm that the bedwatch officers were no longer required. She said that, having spoken with hospital staff and Mr Henderson, it was evident to her that he was weak and drifting in and out of sleep. Having assessed Mr Henderson's deteriorating state, the healthcare manager said that she spoke to a governor on the phone to advise him that she supported the recommendation to remove the bedwatch officers and release Mr Henderson under rule 27(2).

Later on that day, a governor attended Altnagelvin Hospital in order to temporarily release Mr Henderson under Prison Rule 27(2).

Mrs Henderson said that she was concerned that the governor who attended was rude to nursing staff and, asked her husband to sign a release form while he *"was on his death bed."*

It was not possible to establish whether any conversation between the Governor and hospital nursing staff resulted in a number of hospital staff feeling that they had been spoken to rudely.

In his statement, the governor recorded that when he attended Altnagelvin Hospital for the purpose of formalising Mr Henderson's temporary release, he met only the two escorting officers and there were no visitors there at the time.

The governor further noted that Mr Henderson was propped up in bed with a hospital tray across the bed. He stated that he explained the reason why he was there and asked Mr Henderson if he understood the terms of his temporary release. He stated Mr Henderson fully understood, signed the form, shook his hand and wished him well.

At interview, one of the prison officers, who was on bedwatch duty at the time, said that when the governor arrived he was sensitive to the situation and spoke to Mr Henderson very professionally. The prison officer further said that Mr Henderson happily obliged in signing the form. He further said that Mr Henderson fully understood what he was signing and

thanked the prison staff. He said that Mr Henderson shook the governor's hand and shook the prison officer's hands before they left and became very emotional and *"quite weepy"*. One of the prison officer's recalled Mr Henderson shaking his hand with both hands and he felted touched by that as he didn't expect that from a prisoner. He said that Mr Henderson further thanked him for being a good officer to him throughout his time in Magilligan.

It is regrettable that Mr Henderson's family felt upset that he had to sign his release papers at such a sensitive and emotional time.

At 10.11 on 27 January 2009, Magilligan Prison was notified that Mr Henderson had passed away in Altnagelvin Hospital in the late hours of the previous night.

12a. Mr Henderson was temporarily released from prison custody under Rule 27(2) on 23 January 2009.

12b. Mr Henderson passed away, in hospital at 10.11 on 27 January 2009.

SECTION 3: OTHER ISSUES

13. Request to transfer Mr Henderson to Maghaberry Prison

With Mr Henderson's health deteriorating rapidly, Mrs Henderson said that she spoke with her husband's probation officer to ask for help in trying to move Mr Henderson from Magilligan to Maghaberry Prison.

Mrs Henderson requested this for two reasons. The first was that Maghaberry Prison has an in-patient healthcare centre which she felt would have been able to respond more effectively to her husband's healthcare needs than Magilligan Prison. The second reason was to try and ease the already distressing family situation, by removing the requirement for them to travel from Belfast to Londonderry to visit him.

In her statement, Mr Henderson's probation officer stated that it would have been better for Mr Henderson if he could have been transferred to Maghaberry Prison because in the last month of his life it would have eased things considerably for his family. The probation officer stated she spoke with a governor from Magilligan prison to put him in touch with Mrs Henderson to discuss the possibility of a transfer with her.

At interview, the governor recalled having two telephone calls with Mrs Henderson in January 2009, within the space of a week. The governor said that from his recollection, Mrs Henderson was asking for her husband to be transferred to either a clinic or a respite home. He said that he discussed with Mrs Henderson the fact that her husband couldn't simply be

moved, because there were a number of factors to take into consideration. He said that it was his impression that Mrs Henderson understood this but that she was still likely to push for a transfer to a respite home. The governor could not recall discussing a transfer to Maghaberry with Mrs Henderson but he said that "*if it was, I would have mentioned the possibility that the health care centre there was due for refurbishment.*"

The investigation found no evidence that any serious consideration was given to the possibility of moving Mr Henderson from Magilligan to Maghaberry other than by his probation officer.

The governor said that his conversations with Mrs Henderson happened within a week of Mr Henderson's death.

13a. Mrs Henderson raised the possibility of her husband being moved to Maghaberry with prison staff.

13b. Mr Henderson's probation officer agreed that it would be better for Mr Henderson to be moved to Maghaberry and she asked a governor to contact Mrs Henderson.

13c. The governor has no recollection of a discussion with Mrs Henderson about moving her husband to Maghaberry although he does recall speaking with her about the possibility of Mr Henderson being moved to a clinic or respite home.

SECTION 4: CLINICAL REVIEW

14. Findings of Dr Saul's Clinical Review Report

Reference to Dr Saul's findings has been included, at appropriate places, throughout this report.

Commenting on Mr Henderson's final illness, Dr Saul stated that primary liver cancer is difficult to detect. Risk groups, such as people with cirrhosis and those positive for hepatitis virus, would have regular medical reviews backed by blood tests.

Dr Saul concluded that *"Mr Henderson was not known to be in these risk groups and in particular there was no evidence of hepatitis infection, nor was he known to be a previous heavy drinker. Staff would have had no reason to suspect such a cancer. He was at risk of lung cancer but had repeated chest X-rays and scans during his time in custody. Colonoscopy and an OGD (gastroscopy) were carried out to exclude bowel tumours. There is no evidence that there was an avoidable delay with respect to Prison Staff in the diagnosis of Mr Henderson's liver cancer."*

In respect of Mr Henderson's medical treatment in prison, Dr Saul said this was generally of a high standard. The management of his cardiovascular disease was in line with current best practice, and he received regular reviews for his cholesterol and blood pressure, within target ranges. Dr Saul also noted that considerable support was given to encourage smoking cessation and weight reduction.

Dr Saul said that problems such as Mr Henderson's hernia and epididymal cyst were treated appropriately, with onward referral and investigation when this was appropriate.

In summary, Dr Saul stated that during the five years that Mr Henderson was in prison he had a number of serious medical conditions. The care that was given by Prison Health services was entirely similar to that which one would expect in a civilian setting and was generally of a high quality.

Dr Saul did state that some delays characterised Mr Henderson's treatment and that these may have affected the timeliness of his diagnosis. He said, however, that these findings, in the main did not lie with the Prison Service. He concluded, however, that these delays did not contribute to the final outcome for Mr Henderson.

Response from the South Eastern Health and Social Care Trust

The Trust accepted the findings of Dr Saul's review and had no further comments to make.

Mr Henderson's Care in Outside Hospitals

Many aspects of Mr Henderson's care and diagnosis relate to his management in outside hospitals. It is not the role of the Prisoner Ombudsman to investigate Mr Henderson's care outside of prison. Mr Henderson's family are, however, aware that they may request an investigation into any complaints about Mr Henderson's care in outside hospital by contacting the relevant healthcare trust.

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

   - **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.
3. The aims of the Ombudsman's investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.

- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising 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 action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure.

The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Secretary of State for Northern

Ireland (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

16. Annex 'A' contains a more detailed description of the usual reporting procedure.

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.
3. The Service responds within 28 days. The response:
   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

APPENDIX 2

INVESTIGATION METHODOLOGY

Notification

1. On 28 January 2009 the Prisoner Ombudsman's Office was notified by the Prison Service about Mr Henderson's death in Altnagelvin Hospital.

Notices of Investigation

2. The investigation into Mr Henderson's death began on the following morning of the 29 January 2009 when a request was made to Magilligan Prison for them to supply information surrounding the circumstances of Mr Henderson's death. Following a review of the material received, along with the concerns Mr Henderson's wife raised, the decision was made to carry out a full investigation into the circumstances surrounding Mr Henderson's death. Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Magilligan Prison on 16 March 2009 announcing the investigation. The Notices invited anyone with information relevant to Mr Henderson's death to contact the Prisoner Ombudsman's investigation team.

Prison Records

3. All the prison records relating to Mr Henderson's period of custody, including his medical records, were retrieved and analysed.

Interviews

4. Investigators interviewed relevant prison and healthcare staff as part of the investigation.

Working together with interested parties

5. An integral part of any investigation is to work together with all interested parties involved. My investigation team worked closely with the PSNI and the Coroner's Service for Northern Ireland.

Magilligan Prison, Prison Service Policies and Procedures

6. Included at Appendix 3 is some background information describing Magilligan Prison along with Prison Service policies and procedures relevant to this investigation.

Clinical Review

7. As part of the investigation into Mr Henderson's death, Dr Peter Saul, GP Associate Postgraduate Dean at Cardiff University, was commission to carry out a clinical review of Mr Henderson's healthcare needs and medical treatment whilst in prison. Dr Peter Saul's clinical review forms an important part of the investigative report and it formed some of the findings and recommendations. I am grateful to Dr Peter Saul for his assistance.

Factual Accuracy Check

8. In line with my Terms of Reference, I submitted my draft report to the Director of the Northern Ireland Prison Service for the purposes of security and factual accuracy.

APPENDIX 3

BACKGROUND INFORMATION, PRISON RULES, POLICIES AND PROCEDURES

Magilligan Prison

Magilligan is a medium security prison housing sentenced adult male prisoners which also contains low security accommodation for selected prisoners nearing the end of their sentence. It was opened in 1972 and major changes were made in the early 1980s. Three H-Blocks together with Halward House and the low-security temporary buildings of Foyleview, Sperrin and Alpha make up the present residential accommodation. It is one of three detention establishments managed by the Northern Ireland Prison Service, the others being Maghaberry Prison and Hydebank Wood Prison and Young Offenders Centre.

The prison accommodates an average of 400 adult males who have between six years and one year of their sentence left to serve.

The regime in Magilligan focuses on a balance between appropriate levels of security and the Healthy Prisons Agenda[27] – safety, respect, constructive activity and addressing offending behaviour. Purposeful activity and offending behaviour programmes are a critical part of the resettlement process. In seeking to bring about positive change, staff develop prisoners through a Progressive Regimes and Earned Privileges Scheme (PREPS) as in other prisons.

[27] Healthy Prisons Agenda-The concept of a healthy prison is one that was first set out by the World Health Organization, but it has been developed by the HM Inspectorate of Prisons. It is now widely accepted as a definition of what ought to be provided in any custodial environment.

PRISON RULES, POLICIES AND PROCEDURES

The following is a summary of Prison Service policies and procedures relevant to my investigation. They are available in full from the Prisoner Ombudsman's Office upon request.

Prison Rules

Rule 27(2) A Prisoner may be temporarily released under this rule for any special purpose or to enable him to have medical treatment, to engage in employment, to receive instruction or training or to assist him in his transition from prison to outside life.

Rule 25(5) A prisoner having been removed from prison and detained in hospital shall remain under the control of the governor of that prison and may be kept in the custody of an officer, a police officer or any person to whose custody he may temporarily be committed with the approval of the governor.

Security Manual

Explains the primary task of security, the operational line and the various roles and inputs into the Prison Service security organisation.

Chapter 42 Sets out the procedures and guidance for escorting prisoners outside an establishment, including various roles and staff responsibilities.

Governor's Orders

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners.

Governor's Order No. F.4 'Prisoners in Outside Hospital on Rule 27/2' (date of issue 1 March 2007). This order refers to contact the Emergency Control Room must have with the hospital to ensure the prisoner is still there.

Governor's Order No. F.5 'Bedwatches in Outside Hospitals' (date of issue 1 March 2007). This order lays out the procedures officers on bedwatch duties must comply with, including the equipment that must be taken.