

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Christopher Swanson a prisoner at HMP Elmley on 25 February 2019

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2019

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Christopher Swanson died in hospital on 25 February 2019 of oesophageal cancer while a prisoner at HMP Elmley. He was 52 years old. I offer my condolences to Mr Swanson's family and friends.

I am satisfied that the care Mr Swanson received at Elmley was equivalent to that he could have expected in the community. Mr Swanson had no serious health concerns during his time at Elmley until, in February 2019, he reported feeling unwell. When his symptoms did not improve, he was sent to hospital four days later where he was unexpectedly diagnosed with oesophageal cancer. His condition deteriorated very rapidly and he died two weeks later. I am satisfied that staff could not have reasonably foreseen his illness or acted to prevent his death.

However, I am concerned that Mr Swanson was restrained when he was admitted to hospital two days before his death and continued to be restrained until 12 hours before he died, despite being seriously ill and in pain at that time. I am also concerned that we have repeatedly made recommendations about the inappropriate use of restraints at Elmley, and have previously escalated our concerns to the Prison Group Director for Kent, Surrey and Essex. These concerns must now be addressed effectively.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**September 2019**

## **Contents**

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Findings .....	5

# Summary

## Events

1. On 26 September 2018, Mr Christopher Swanson was sentenced to five years imprisonment for attempted burglary. His reception health screen revealed no significant health concerns. He received pain relief medication for carpal tunnel syndrome (compression of a nerve in his wrist) but otherwise reported no significant health concerns over the next few months.
2. On 4 February 2019, he told a nurse that he had had diarrhoea and vomiting for two weeks and could not keep food down. She diagnosed possible gastroenteritis and booked him a GP appointment for 8 February if his symptoms continued.
3. On 8 February, a prison GP sent Mr Swanson urgently to hospital for investigations. The investigations revealed that Mr Swanson had oesophageal cancer with secondary cancer in his liver. Hospital staff informed Mr Swanson of this diagnosis but were unable to give him an accurate prognosis. On 15 February, Mr Swanson returned to Elmley, at his own request.
4. On 23 February, a prison GP sent Mr Swanson back to hospital because his health had deteriorated significantly. He was accompanied by two officers and sent under restraints.
5. Mr Swanson's condition deteriorated rapidly in hospital. On 25 February, at 11.50am, his restraints were removed. At 11.45pm, the hospital pronounced Mr Swanson dead. His partner was with him at the time.

## Findings

### Mr Swanson's clinical care

6. Mr Swanson died two weeks after he was diagnosed with oesophageal cancer. He had only reported feeling ill for the first time four days earlier and the speed of his deterioration took everyone by surprise.
7. Oesophageal cancer often fails to display any symptoms until it is too late. The clinical reviewer is satisfied that prison healthcare staff could not reasonably have suspected Mr Swanson's condition and that he was sent promptly to hospital when the symptoms he had reported did not clear up.
8. Mr Swanson was informed about his terminal illness by hospital staff and felt he had not had time to ask questions. However, we are satisfied that healthcare staff at Elmley subsequently discussed his condition with him.
9. The clinical reviewer is satisfied that the care Mr Swanson received at Elmley after his diagnosis was equivalent to that he could have expected in the community. There were some concerns, but these were resolved promptly.
10. We are satisfied that Mr Swanson was appropriately located while he was at Elmley. Staff respected his decision to remain on a standard houseblock.

## **Restraints, security and escorts**

11. We are concerned that the prison restrained Mr Swanson on his final admission to hospital until 12 hours before his death, although he was terminally ill and in a lot of pain. We are also concerned that, despite making recommendations about the inappropriate use of restraints on several occasions in the past, this continues to be a problem at Elmley.
12. We are concerned that Mr Swanson and some of the bedwatch officers considered that he was not always dealt with professionally in hospital by nursing staff.

## **Liaison with Mr Swanson's family**

13. We are satisfied that the prison conducted its contact with Mr Swanson's family appropriately.

## **Compassionate release**

14. We are satisfied that the prison promptly began the process for applying for Mr Swanson to be released on compassionate grounds when he was diagnosed with terminal cancer. Unfortunately, he deteriorated and died very quickly before this process could be completed.

## **Recommendations**

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Prison Group Director for Kent, Surrey and Essex should write personally to the Ombudsman explaining what he is doing to ensure that effective action is taken on the inappropriate use of restraints at HMP Elmley.
- The Governor and Head of Healthcare should discuss the treatment of prisoners with managers at Medway Maritime Hospital to ensure that prisoners and escorting staff are treated professionally.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: Nurse A; Nurse B; Nurse C; Dr A; Dr B; Dr C; Supervising Officer A; and the managers who signed the escort risk assessment forms on 20 and 23 February 2018.

## The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator obtained copies of relevant extracts from Mr Swanson's prison and medical records.
17. NHS England commissioned a clinical reviewer to review Mr Swanson's clinical care at the prison.
18. We informed HM Coroner for Kent and Medway of the investigation. There was no post-mortem for Mr Swanson but the coroner provided his cause of death. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Swanson's partner, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked us to consider:
  - the issues surrounding Mr Swanson's decision about resuscitation;
  - whether he should have been assessed for gastroenteritis;
  - whether the Head of Healthcare took his condition seriously enough;
  - whether wing staff monitored him appropriately; and
  - whether healthcare staff should have chased the hospital for test results.
20. The investigation has assessed the main issues involved in Mr Swanson's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.
22. Mr Swanson's partner received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Swanson's partner also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## Background Information

### HM Prison Elmley

23. HMP Elmley serves the courts in Kent and holds up to 1,252 men, remanded and sentenced, in six houseblocks with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

### HM Inspectorate of Prisons

24. The most recent inspection of HMP Elmley was conducted in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort.

### Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 October 2018, the IMB reported that healthcare staff in the inpatient unit should be commended for their nursing care.

### Previous deaths at HMP Elmley

26. Mr Swanson was the eleventh prisoner to die from natural causes at Elmley since January 2017. We have raised the issue of the inappropriate use of restraints on several occasions over this period and in November 2018 we escalated the issue to the Prison Group Director for Kent, Surrey and Essex.

# Findings

## Diagnosis of Mr Swanson's terminal illness and informing him of his condition

27. On 26 September 2018, Mr Christopher Swanson was sentenced to five years imprisonment for attempted burglary. He had previously been held on remand at HMP Elmley and returned there.
28. Mr Swanson had a history of drug use and was diagnosed with carpal tunnel syndrome (the compression of a nerve in the wrist). On Mr Swanson's admission to Elmley, a prison GP renewed his prescription of gabapentin for his nerve pain. Mr Swanson remained on gabapentin until shortly before his death. Otherwise, he had no significant health concerns over the next few months.
29. On 4 February 2019, Nurse A saw Mr Swanson at his request after he became unwell. He said he had had diarrhoea for two weeks, was vomiting during the night, and was struggling to eat or drink. The nurse examined Mr Swanson and recorded that he had abdominal tenderness but nothing else abnormal. She suspected gastroenteritis and prescribed him rehydration salts. She booked Mr Swanson a GP appointment for 8 February if he did not improve.
30. On 8 February, Nurse B reviewed Mr Swanson in his cell at the request of officers. He said he had had constant abdominal pain for a month which became worse when he tried to eat or drink. The nurse arranged for Mr Swanson to be seen by a GP. Shortly afterwards, Dr A, a prison GP, examined Mr Swanson. She noted that his abdomen was very tender, his liver area was enlarged and his gastro-duodenal area was hard. She noted that Mr Swanson was in pain on touching and looked unwell, so she sent him to the Medway Maritime Hospital in Gillingham as an emergency.
31. On 14 February, Nurse C recorded that Mr Swanson had been diagnosed in hospital with oesophageal cancer with liver metastases (secondary malignant growths) and that he had been referred to the hospital's upper gastrointestinal team. She recorded that he was "eager to return to the prison" and was "fit for discharge". She noted that Mr Swanson was to be discharged the next day with a comprehensive discharge summary containing details of his medication.
32. We recognise that it would have been shocking and distressing for Mr Swanson and his family to be given the unexpected news that he had terminal cancer and had only a short while to live. However, the clinical reviewer is satisfied that Mr Swanson's cancer could not have been realistically detected earlier. The clinical reviewer said that oesophageal cancer often presents at a late stage and can spread before showing any symptoms. The clinical reviewer considers that although Mr Swanson would have had the disease for some time, it was without symptoms until a few weeks before his diagnosis. Mr Swanson only reported feeling ill on 4 February and said he had been feeling unwell for two to four weeks. He was sent to hospital four days later. The clinical reviewer is satisfied that there was no delay in diagnosing Mr Swanson and there had been no opportunities to detect his illness earlier.
33. In hospital, Mr Swanson was diagnosed with advanced oesophageal cancer, meaning it had spread to another part of the body – in Mr Swanson's case to his

liver. Most people with advanced oesophageal cancer live for between 3 to 12 months after their cancer is diagnosed.

34. Hospital doctors informed Mr Swanson of his diagnosis and that he had only a short while to live. He was reported to be shocked as he had thought he had an infection. Mr Swanson later said that he felt he had not had the opportunity to ask questions in hospital. However, prison healthcare staff spent time talking to him when he returned to Elmley.

### **Mr Swanson's clinical care**

35. Mr Swanson was discharged from hospital on 15 February and, after his condition deteriorated, he was readmitted on 23 February and died in hospital two days later. He spent only eight days in Elmley between these admissions and was seen by prison healthcare staff on most of these days.
36. On 16 February, Nurse A reviewed Mr Swanson in his cell following his return to Elmley. Mr Swanson told her that he had been informed about his cancer at the hospital but had not been offered any treatment. He said that his partner was present when he received his diagnosis.
37. Nurse A observed that Mr Swanson had swollen legs which he said was a new development. She examined him and recorded that there was visible swelling with a palpable mass in his upper abdomen and a pain score of 7/10 in this area. She noted that he had only been taking zomorph (a morphine-based pain killer) for three days so she was unsure whether this had helped.
38. On the same day Dr B, a prison GP, prescribed Ensure (a nutritious drink supplement) to be taken twice a day.
39. The following day, Dr C, a prison GP, reviewed Mr Swanson. She noted that the zomorph was not controlling Mr Swanson's pain and planned to add oramorph (a different morphine-based painkiller) to his prescription. She noted that Mr Swanson was angry that he had still not received any Ensure. She told him that the prescription had been issued and the prison pharmacy would provide Ensure. On 19 February, Dr B increased Mr Swanson's Ensure prescription to be taken three times a day. On 21 February, Mr Swanson told Supervising Officer (SO) A (his family liaison officer - FLO) that he had the drinks in his cell.
40. Pharmacies in prison, as in the community, do not keep every possible medication in stock and it may sometimes take a few days to order something new. Although we appreciate that Mr Swanson found the short delay in obtaining Ensure distressing, we are satisfied that the delay was no more than a few days. Mr Swanson was very ill by this point and the delay did not affect the outcome for him.
41. On 16 February, Nurse A recorded that Mr Swanson wanted to sign a DNACPR (which means that no attempt at resuscitation will be made in the event of cardiac or respiratory arrest). Mr Swanson's family disputed Nurse A's record about the DNACPR as they believed that he wanted to be given a "fighting chance" and wanted to wait for the results of a biopsy. The following day, however, Mr Swanson told Dr C that he did not want to sign a DNACPR and

- wanted to be resuscitated instead. She noted that he appeared angry and said that he had never discussed this with anyone.
42. On 18 February, Mr Swanson told his FLO that a GP had spoken to him about the DNACPR the day before, while he was on the landing within the hearing of other prisoners.
  43. It is clear that there had been some kind of misunderstanding about whether Mr Swanson wanted to sign a DNACPR. However, we are satisfied that this was resolved very quickly and that Mr Swanson's views were correctly recorded and respected.
  44. We note that discussion of DNACPRs is potentially distressing and should always be done sensitively and in private.
  45. Mr Swanson was also concerned that he had not received the endoscopy results from the hospital so did not know the full extent of his cancer. On 23 February, he was told that the prison had received the results, but he was readmitted to hospital before they could be explained to him.
  46. We consider that prison healthcare could have chased the endoscopy results up more quickly as Mr Swanson was anxious about them. It is possible that the results would have made it clear to him that that he had only a short time left - although it appears that hospital doctors did not know how widespread his secondary cancer was until he had a scan in hospital on the day he died. However, obtaining the endoscopy results more quickly would have made no difference to the outcome for Mr Swanson. His condition was terminal and his health deteriorated very quickly after his diagnosis and there was no treatment available that would have prolonged his life.
  47. On 19 February, Dr B reviewed Mr Swanson in his cell. Dr B observed that Mr Swanson had a leg oedema (a swelling of the skin and tissue) and referred him to the hospital with suspected deep vein thrombosis (DVT) for a scan. On 20 February, Mr Swanson went to hospital for a consultation and a hospital consultant asked him to return the next day for an ultrasound scan. However, on 21 February, a nurse noted that Mr Swanson had refused to attend hospital for the scan as he said he was too tired.
  48. On 22 February, Nurse C discussed Mr Swanson's healthcare expectations with him. He told her that he had had a very negative experience in hospital, with nurses openly discussing his criminal past. Mr Swanson told Nurse C that healthcare staff bothered him quite a lot, so they agreed they would only see him when he asked. Mr Swanson agreed to stop his gabapentin medication but to ask for additional pain relief when he felt he needed it. He also agreed to attend the hospital for a scan the following week.
  49. On 23 February, Dr C reviewed Mr Swanson in his cell. She noted that he had a worsening oedema, which was extending to his abdomen, and had ascites (an accumulation of fluid in the abdomen) and that recent blood test results were abnormal. He was later seen in his cell by a GP. As his condition had deteriorated, Dr C arranged for him to be admitted to hospital.

50. Mr Swanson's condition deteriorated rapidly in hospital and at 10.45pm on 25 February, the hospital telephoned the prison to report that Mr Swanson had experienced multi-organ failure. The hospital reported that Mr Swanson's life expectancy was very short.
51. A hospital doctor explained to Mr Swanson's partner that there was nothing further the hospital could do for him other than manage his pain relief. Mr Swanson's partner asked why Mr Swanson had not had any treatment following the endoscopy. The doctor explained that Mr Swanson's cancer was so advanced that there was nothing that could have been done for him.
52. At 11.45pm, the hospital pronounced Mr Swanson dead.
53. No post-mortem examination was carried out but the coroner recorded that Mr Swanson died from metastatic carcinoma of the oesophagus (oesophageal cancer that has spread).
54. We agree with the clinical reviewer that the care Mr Swanson received at Elmley was equivalent to that he could have expected in the community. The clinical reviewer concluded that the care Mr Swanson received following his diagnosis met the required palliative care standards. Healthcare staff provided him with the appropriate pain relief and care, and referred him to hospital when it was necessary.
55. The clinical reviewer considered the concerns about Mr Swanson's decision regarding resuscitation and obtaining his Ensure nutritional drinks but concluded that these problems were adequately resolved as they arose.

### **Mr Swanson's location**

56. Mr Swanson was resident on a standard houseblock prior to his hospital admission in February 2019. On 16 February, following his discharge from hospital, he told Nurse A that he wanted to remain on the same houseblock and did not want to move to the prison's inpatient unit. Mr Swanson said that he had good friends on the houseblock who could help him. He also declined the offer of someone to provide care for him and said that his friends would help.
57. On 18 February, Mr Swanson told his FLO that he wanted to stay on his houseblock for the time being but did not want to die in prison.
58. We consider that the prison appropriately respected Mr Swanson's wishes about his location.

### **Restraints, security and escorts**

59. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

60. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
61. When Mr Swanson went to hospital on 8 February 2019, his risk assessment recorded that he was mobile and that there were no medical objections to restraints. He was restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Mr Swanson was a relatively young man, he was still mobile and in reasonable health and had not yet been diagnosed as terminally ill, and we do not consider that the use of restraints was unreasonable.
62. On 20 February, Mr Swanson went to hospital for a consultation. His assessment recorded that there were medical objections to his being placed in restraints because he was under palliative care and had serious physical health concerns. His risk assessment, nevertheless, again authorised the use of restraints but allowed for these to be removed for emergency treatment. Mr Swanson was a category C prisoner and given the medical advice and the fact that he was seriously ill by this point, we do not consider that the use of restraints was justified.
63. On 23 February, Mr Swanson was taken to hospital for the final time and restraints (in the form of an escort chain) were again authorised. The escort chain remained in place until 11.50am on 25 February, when a handwritten note was made on Mr Swanson's risk assessment recording that a prison manager had authorised the removal of his restraints due to the deterioration in his health. The note added that restraints should be reapplied if his condition improved. They were never reapplied and Mr Swanson died later that day.
64. We are concerned that although Mr Swanson was extremely ill, in a lot of pain and unable to walk because of the fluid build-up in his legs, the prison continued to restrain him until 12 hours before he died. We accept that healthcare staff had recorded their objections to him being restrained when he was taken to hospital on 20 February, and make no criticism of them. We consider that any risk Mr Swanson posed at this stage could have been adequately managed by the officers on bedwatch duty and we remind the prison of their responsibility to assess the actual risk a prisoner poses. We recommend:

**The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

65. We have made recommendations to Elmley about the inappropriate use of restraints on several occasions over the past few years. In November 2018, we escalated our concerns to the Prison Group Director for Kent, Surrey and Essex. The prison told us then that they had revised their escort risk assessment form to make it clearer that assessments needed to take account of medical advice. In December 2018, the Prison Group Director also told us that his regional safer

custody team would carry out random checks of risk assessments to ensure the prison were complying with our recommendations, and that checks would also be made on the guidance issued to staff and all new managers responsible for signing off risk assessments, including the verbal handover provided to escorting staff.

66. Unfortunately, this does not appear to have resolved the issue, so we make a further recommendation.

**The Prison Group Director for Kent, Surrey and Essex should write personally to the Ombudsman explaining what he is doing to ensure that effective action is taken on the inappropriate use of restraints at HMP Elmley.**

67. We note that the Governor authorised the bedwatch officers to wear plain clothes on the final day of Mr Swanson's life and that his partner said that she appreciated this. This was good practice.

#### **Liaison with Mr Swanson's family**

68. Mr Swanson's next of kin was his partner. On 10 February 2019, the prison appointed SO A as his family liaison officer (FLO) when Mr Swanson was diagnosed with cancer. She called Mr Swanson's partner to tell her that Mr Swanson was in hospital and arranged for her to visit him. The next day, the FLO introduced herself to Mr Swanson's partner at the hospital when she came to visit. She continued to liaise with both Mr Swanson and his partner. She kept Mr Swanson's partner informed about his condition, and assisted Mr Swanson with any questions he had.
69. Early on 24 February, the FLO told Mr Swanson's partner that he had been taken to hospital and arranged for her to visit him. The bedwatch log records that his partner spent the day with him.
70. During the morning of 25 February, the FLO called Mr Swanson's partner and told her that his condition had deteriorated significantly. At 12.30pm, Mr Swanson's partner arrived at the hospital. The FLO met her there and spent the day at the hospital to provide support. Mr Swanson's partner was with Mr Swanson when he died.
71. Mr Swanson's funeral was held on 18 March. The prison contributed to the cost in line with national guidance.
72. We are satisfied that the prison conducted its contact with Mr Swanson's family appropriately. The FLO remained a reliable and caring point of contact throughout and assisted both Mr Swanson and his partner.

#### **Compassionate release**

73. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

74. On 11 February, Mr Swanson asked his FLO about compassionate release while she was visiting him at the hospital. On 20 February, Nurse A recorded that they “still await[ed] confirmed diagnosis/prognosis to be able to proceed with care goal identification”. On 22 February, Dr A noted that she needed to speak to the healthcare manager about Mr Swanson’s compassionate release. Nurse C later noted that the Head of Healthcare had started Mr Swanson’s compassionate release paperwork. No formal application for compassionate release was made before Mr Swanson died on 25 February.
75. We are satisfied that the prison acted appropriately in starting the process of compassionate release when it did. Unfortunately, Mr Swanson’s condition deteriorated very rapidly following his initial diagnosis, taking everyone by surprise, and his application could not be formally submitted in time to be considered before he died.

### Other matters

76. We are concerned that Mr Swanson said that nurses openly discussed his offending history when he was in hospital from 8 to 15 February, that the families of other patients were rude to him and that he felt he was treated less well than other patients. The FLO also recorded that some of the bedwatch officers felt that Mr Swanson was not dealt with professionally and said that they had also been spoken to rudely by the nurses.
77. The treatment Mr Swanson received in hospital is outside the Ombudsman’s remit, but we recommend:

**The Governor and Head of Healthcare should raise the treatment of prisoners with managers at Medway Maritime Hospital to ensure that prisoners and escorting staff are treated professionally.**

78. We consider that it is important for staff who were involved in Mr Swanson’s care to see the findings of our investigation and we therefore make the following recommendation:

**The Governor and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman’s findings: Nurse A; Nurse B; Nurse C; Dr A; Dr B; Dr C; Supervising Officer A; and the managers who signed the escort risk assessment forms on 20 and 23 February 2019.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations