Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Bartholomew a prisoner at HMP Swaleside on 20 December 2018

A report by the Prisons and Probation Ombudsman

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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*

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 we oversee can improve their work in the future.

Mr Ronald Bartholomew died of a ruptured artery in his pelvis on 20 December 2018, while a prisoner at HMP Swaleside. He was 70 years old. I offer my condolences to Mr Bartholomew's family and friends.

The clinical reviewer said that the condition was difficult to detect in its early stages and concluded that, although Mr Bartholomew was in poor health, his imminent death could not have been anticipated.

The clinical reviewer did, however, find that some aspects of the care Mr Bartholomew received at Swaleside were not equivalent to that which he could have expected to receive in the community. When Mr Bartholomew arrived at Swaleside he had PVD and hypertension. Neither of these conditions were properly managed. However, the clinical reviewer did not make a direct link between the poor management of these conditions and the cause of death.

I am concerned that when Mr Bartholomew became unwell on 19 December 2018, there was a delay of around two to three hours from when he first reported he was bleeding to when an emergency ambulance was called. During that time, Mr Bartholomew told prison staff twice that his condition was getting worse but prison staff did not call for immediate healthcare assistance.

It is unlikely, given the seriousness of Mr Bartholomew's internal bleeding, that a quicker emergency response would have resulted in a different outcome. However, in other circumstances, it might prove critical.

Mr Bartholomew was inappropriately restrained when he was taken to hospital appointments between September and November 2018. Mr Bartholomew's risk of escape was assessed as low, and he used a walking stick and, later, a wheelchair to get around.

We have previously drawn our concerns about the use of restraints at Swaleside to the attention of the Executive Director for the Long-Term and High Security Estate. In October 2018, the Executive Director said that a Group Safety Team had been established to ensure compliance with PPO recommendations. I have asked the Executive Director to provide me with an update on specific actions taken by the Group Safety Team to address Swaleside's continued failure to comply with case law on the use of restraints.

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 **May 2019**

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Summary

Events

1. On 8 November 2016, Mr Ronald Bartholomew was sentenced to 19 years in prison for sexual offences. On 4 January 2017, Mr Bartholomew was transferred to HMP Swaleside.

2. In 2010, Mr Bartholomew received treatment for cancer of the oesophagus (food pipe). He also had a history of hypertension (high blood pressure) and peripheral vascular disease (PVD) diagnosed in 2008, but he was not taking any medication. Neither of these conditions was recorded at Mr Bartholomew's reception screening at Swaleside or discussed with him.

3. In January 2018, Mr Bartholomew was prescribed medication to manage his hypertension. Mr Bartholomew's compliance with his medication was poor.

4. On 8 February, a prison paramedic examined Mr Bartholomew after he reported some rectal bleeding. A colonoscopy undertaken on 23 April concluded that the rectal bleeding was likely to be coming from either a colonic polyp or diverticular disease of the colon, both common causes of rectal bleeding. However, as the bleeding had not reoccurred, and Mr Bartholomew was an older man with multiple health problems, it was decided that any intervention would outweigh the benefit.

5. On 29 November, a paramedic examined Mr Bartholomew because he reported watery diarrhoea and dark faeces. The paramedic thought this could be a sign of a gastrointestinal bleed so sent Mr Bartholomew to hospital by emergency ambulance. At hospital, no bleeding point could be found and he was diagnosed with gastric mobility disorder and prescribed medication to help his digestion. Mr Bartholomew was discharged from hospital on 5 December.

6. On 19 December, Mr Bartholomew was sent to hospital by emergency ambulance again due to heavy rectal bleeding. Mr Bartholomew was admitted for treatment.

7. On 20 December, at 4.50am, it was confirmed that Mr Bartholomew had died. The post-mortem gave the cause of death as an internal haemorrhage caused by a ruptured pelvic artery.

Findings

Clinical care

8. Aspects of the care that Mr Bartholomew received at HMP Swaleside were not equivalent to that which he could have expected to receive in the community.

9. Mr Bartholomew came to prison with a diagnosis of peripheral vascular disease and hypertension. There was a 10-month delay in organising routine blood tests for his hypertension. Treatment was then delayed for six months, in part because there was a failure by healthcare staff to issue a prescription.

10. There was also a delay in recognising and optimising cardiovascular risk reduction strategies for Mr Bartholomew. While Mr Bartholomew made the decision not to collect and take his medication, there were delays in hospital staff recognising that Mr Bartholomew had pre-existing cardiovascular disease (PVD) and treating his hypertension.

11. In August 2017, Mr Bartholomew missed an appointment for an urgent scan to for suspected colorectal cancer because there were insufficient escort staff to escort him to hospital. We are not satisfied that the prison has adequate contingency plans in place to ensure that prisoners do not miss important medical appointments due to staff shortages.

12. The clinical reviewer concluded that although he could not say that these failings contributed to Mr Bartholomew's death, this aspect of his care was not equivalent to that which he could have expected to receive in the community.

Emergency response

13. We are concerned that when a paramedic decided that Mr Bartholomew should go to hospital by taxi on 19 December, there is no evidence that a taxi was arranged to take him to hospital.

14. When Mr Bartholomew asked to see healthcare again at around 2.00pm, we have not been able to establish who contacted the healthcare unit for advice and when this occurred. We know that healthcare staff were called back to see Mr Bartholomew, but it is not clear if this call was made at around 2.00pm at an officer's request, or around an hour later when another officer checked on Mr Bartholomew.

15. When this officer checked on Mr Bartholomew, sometime between 2.30 and 3.15pm, they found him bleeding and in distress. They asked healthcare staff to attend but did not request immediate healthcare assistance. Although this probably made little practical difference in this case, it could be critical in future cases.

16. It took 18 minutes for ambulance paramedics to get from the prison gate to Mr Bartholomew on the wing. It has not been possible to establish why it took 18 minutes, but the delay was not acceptable.

Restraints

17. We are concerned that Mr Bartholomew was restrained six times between 23 September and 29 November 2018 when he was taken to hospital, even though he was an unwell man who had been assessed as posing a low risk of escape.

Cell bell records

18. As part of the investigation we requested the cell bell records for 19 December 2018, to see when Mr Bartholomew pressed his cell bell and how quickly the calls were answered. However, the cell bell recording system at Swaleside is faulty. It is not acceptable that the logging system has been broken more often than it has been working since September 2018.

Recommendations

- The Head of Healthcare should ensure that clinical staff review the healthcare needs of all new prisoners and ensure that those with pre-existing conditions are reviewed and managed in accordance with current NICE guidance.
- The Head of Healthcare should ensure that when a specialist recommends a treatment, there is a process in place that allows for this to be given and identifies any prisoner who fails to comply with the recommendations.
- The Governor should ensure that there are sufficient staff and transport available to escort prisoners to hospital appointments without delays.
- The Governor of Swaleside should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary.
- The Governor should ensure that prison staff contact healthcare staff promptly, when prisoners report pain or other symptoms suggesting they are unwell.
- The Head of Healthcare should ensure that all clinical staff have access to a watch or similar device to enable them to make a record of the time that an event took place, so that full and accurate records are maintained.
- The Executive Director for Long-Term and High Security prisons should provide this office with an update on the progress of the Group Safety Team in addressing the prison's continuing failure to comply with case law on the use of restraints.
- The Governor should ensure that the cell bell logging system is in proper working order.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

20. The investigator obtained copies of relevant extracts from Mr Bartholomew's prison and medical records.

21. The investigator interviewed two members of staff on 5 March and 10 April 2019.

22. NHS England commissioned a clinical reviewer to review Mr Bartholomew's clinical care at the prison.

23. We informed HM Coroner for Kent and Medway of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

24. We wrote to Mr Bartholomew's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

Background Information

HMP Swaleside

25. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men. IC24 Integrated Care provides primary healthcare services. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. Minster Medical Group provides GP cover on weekdays, Monday to Friday from 9.00am to 5.00pm, and Medoc provides an out of hours GP service.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Swaleside was conducted in December 2018. Inspectors reported that health services had improved and were reasonably good but a few areas were still concerning. The chronic healthcare staffing shortages had started to reduce, although there were still some vacancies. The management of patients with long-term conditions had improved considerably with the introduction of an advanced nurse practitioner, who ran clinics and implemented care plans. Healthcare assistants were being trained to undertake regular reviews of patients with these conditions. In the previous four months, one-third of external hospital appointments had been cancelled because of prison staffing issues. The monitoring of relevant PPO recommendations by the healthcare department was better.

Independent Monitoring Board

27. 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 30 April 2018, the IMB reported that although the prison was fully staffed, many staff members were young and inexperienced which caused issues relating to the control and discipline of prisoners. The IMB continued to receive complaints about the treatment and waiting times offered for healthcare services.

Previous deaths at HMP Swaleside

28. Mr Bartholomew is the thirteenth prisoner to die at Swaleside in the last two years and the eighth prisoner to die from natural causes.

29. We have previously made recommendations about the use of restraints at Swaleside. In June 2017, we raised the inappropriate use of restraints and we drew this serious and continuing failure to the attention of the Executive Director for Long-Term and High Security prisons. In October 2018, we raised the inappropriate use of restraints again, and asked that the Executive Director provide an update within four weeks on what had been done to address the prison's continuing failure to comply with case law on the use of restraints. It is, therefore, disappointing, to have to raise this subject again.

Key Events

30. On 8 November 2016, Mr Ronald Bartholomew was sentenced to 19 years in prison for sexual offences. On 4 January 2017, Mr Bartholomew was transferred to HMP Swaleside.

31. In 2010, Mr Bartholomew received treatment for cancer of the oesophagus. He no longer needed specialist follow-up treatment by the time he moved to Swaleside. He had a history of hypertension and peripheral vascular disease (PVD), diagnosed in 2008, but he was not taking any medication. Neither of these conditions was recorded at his reception screening at HMP Swaleside or discussed with Mr Bartholomew. Mr Bartholomew should also have had his blood taken and screened as part of the management of his hypertension, either at the reception screening or soon after, but this did not happen.

32. On 7 August 2017, a nurse took Mr Bartholomew's blood pressure and found that it was raised. His blood pressure was taken again on 15 August by a prison GP, and the results were lower. However, Mr Bartholomew said he had a six month history of intermittent rectal bleeding, which could indicate colorectal cancer. The GP bloods to be tested as a matter of priority and made an urgent referral to the colorectal team at Medway Maritime Hospital under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Bartholomew received an appointment for 25 August 2017.

33. On 24 August, the results of the blood tests showed that Mr Bartholomew had Chronic Kidney Disease (CKD). Mr Bartholomew was referred to the Department of Renal Medicine at East Kent hospital for further examination and treatment.

34. On 25 August, Mr Bartholomew's hospital appointment to explore his suspected colorectal cancer was cancelled. The reason recorded on the Escort Cancellation Authority was 'resources not provided for this escort, unable to curtail regime in line with RMP (risk management plan)'.

35. The appointment was re-booked for 8 September 2017. Mr Bartholomew attended the appointment. He was referred for a colonoscopy and CT scan. The appointment for the colonoscopy had to be re-booked four times due to Mr Bartholomew's failure to take the bowel preparation solution. When these procedures took place in November and December, nothing of concern was found.

36. On 24 October, a consultant nephrologist examined Mr Bartholomew at East Kent Hospital and recommended that Mr Bartholomew's hypertension should be treated with amlodipine (as patients with CKD are likely to develop significant cardiovascular disease). The prison received a letter from the hospital confirming this on 30 October.

37. On 24 January 2018, a prison GP prescribed amlodipine. It is not clear from Mr Bartholomew's medical records why there was a three-month delay before the drug was prescribed. On 29 January, a nurse reviewed Mr Bartholomew's blood pressure, but found Mr Bartholomew had not been collecting his medication. Mr Bartholomew's compliance with his hypertension medication continued to be

poor. Medical records show that healthcare staff spoke to Mr Bartholomew about the importance of taking his medication.

38. On 8 February, a prison paramedic examined Mr Bartholomew because he reported some rectal bleeding. They found no blood and took his observations, which were normal. They advised Mr Bartholomew to contact healthcare staff again if there was further bleeding.

39. On 23 April 2018, a colonoscopy concluded that the rectal bleeding was likely to be coming from either a colonic polyp or diverticular disease of the colon, both common causes of rectal bleeding. However, as the bleeding had not reoccurred since February, and Mr Bartholomew was an older man with multiple health problems, it was decided that any intervention would outweigh the benefit.

40. On 12 June, a prison GP examined Mr Bartholomew because he reported chest pains. Mr Bartholomew was sent to A&E. Mr Bartholomew was diagnosed with angina and was prescribed aspirin and trimethoprim to manage it.

41. On 23 September, Mr Bartholomew was again sent to A&E because he was experiencing chest pains. He was discharged with medication to help his angina. On 11 October, Mr Bartholomew was sent back to hospital and had an intervention procedure to open his blocked coronary arteries and restore blood flow to the heart. A scan showed a shadow on Mr Bartholomew's lung, and the hospital made an urgent two-week referral to establish if it was cancerous.

42. From September onwards, staff recorded that Mr Bartholomew looked increasingly frail and unwell and struggled to manage his personal hygiene.

43. On 5 November, Mr Bartholomew was reviewed by a hospital consultant and was referred for a PET scan and lung function tests. He was also referred for a biopsy of the mass on his lung, which was arranged for 5 December.

44. On 29 November, a prison paramedic examined Mr Bartholomew in his cell because he reported watery diarrhoea and dark faeces. They thought this could be a sign of a gastrointestinal bleed so sent Mr Bartholomew to hospital by emergency ambulance.

45. At hospital, no bleeding point could be found in Mr Bartholomew's stomach. He was diagnosed with gastric mobility disorder (where food passes through the stomach more slowly than normal) and was prescribed medication to help his digestion. Mr Bartholomew was discharged from hospital on 5 December and was sent back to Swaleside. Mr Bartholomew was too unwell to have the planned lung biopsy, and remained too unwell for the procedure to be re-booked.

46. On 13 December, Mr Bartholomew was moved to a disabled cell on the wing because of his poor health. He was temporarily moved out on 15 December because of a leak, but moved back in on 18 December.

Events of 19 December 2018

47. Between 12.30pm and 1.30pm, on 19 December, Mr Bartholomew pressed his cell bell and an officer responded. Mr Bartholomew told the officer that he needed to see a member of healthcare staff because he was bleeding from his

bottom. The officer told Mr Bartholomew he would call the healthcare unit, and Mr Bartholomew said that was fine.

48. At approximately 1.30pm, another officer escorted a prison paramedic to Mr Bartholomew's cell. Mr Bartholomew was bleeding bright red blood and clots from his rectum. All his clinical observations were normal and the prison paramedic could not find a cause for the bleeding. Because of his diagnosis of kidney problems and suspected cancer, the prison paramedic arranged for Mr Bartholomew to be taken to hospital by non-emergency escort.

49. The prison paramedic told the investigator that she returned to the healthcare unit and called for an ambulance, but she was told that there was a waiting time of six hours so she asked a prison officer to arrange for a taxi so Mr Bartholomew could go to hospital sooner. There is no evidence that a taxi was arranged to take Mr Bartholomew to hospital.

50. Approximately 20-30 minutes later, Mr Bartholomew pressed his cell bell again and an officer responded. Mr Bartholomew was lying on his back and told the officer he was in more pain and needed to see healthcare staff again. The officer went back to the wing office, explained what had happened to another officer (he could not remember who) and left that officer to call the healthcare unit while he continued with other duties. There is no evidence that the officer called the healthcare unit for assistance.

51. Around 30 minutes later, another officer went to check on Mr Bartholomew. They found Mr Bartholomew lying on his side with his trousers down and bleeding from his bottom. Mr Bartholomew said, 'Help me please, I'm dying.' The officer went to the wing office and asked a Senior Officer to call healthcare again.

52. About 15 minutes later, a prison paramedic attended Mr Bartholomew's cell. The prison paramedic pulled back Mr Bartholomew's sheets and saw there was a much larger quantity of blood than before, and he was pale and clammy. The prison paramedic asked the officers present to call for an emergency ambulance. Control room records show that an ambulance was called at 3.25pm.

53. The prison paramedic was unable to take Mr Bartholomew's oxygen saturation or pulse readings because his circulation had become very poor, causing the tips of his fingers and toes to turn blue. They administered 2 litres of saline via a cannula. Although his blood pressure improved, he still complained of severe abdominal pain.

54. According to the ambulance records, the paramedics arrived at the prison at 3.42pm, got to Mr Bartholomew's cell at 4.00pm and left at 4.33pm. Mr Bartholomew was admitted to Medway Maritime hospital with acute rectal bleeding.

55. On 20 December, at 4.50am, it was confirmed that Mr Bartholomew had died.

Contact with Mr Bartholomew's family

56. In December 2018, the prison appointed and officer as the Family Liaison Officer (FLO), as Mr Bartholomew had been placed on the End of Life register due to his complex medical conditions. Mr Bartholomew did not have any contact with his

family. On 18 December, he told the FLO that he would like them to contact his son. Due to the nature of his offence, the FLO needed to check with the Public Protection Unit if Mr Bartholomew could have contact with his son.

57. On 19 December, when Mr Bartholomew was taken to hospital by emergency ambulance, the FLO called Mr Bartholomew's son. They told him that Mr Bartholomew was very poorly and contact could be arranged. Mr Bartholomew's son was unsure if he wanted to speak to or see his father and said he would call the FLO in the morning once he had had time to think about it.

58. On 20 December, at 6.15am, the FLO called Swaleside control room and was informed that Mr Bartholomew had died at 4.50am. At 7.35am, while the FLO was arranging to visit Mr Bartholomew's son to break the news of his father's death in person, he called the prison and spoke to the Governor, and said that he wanted to visit his father. The Governor said that he had no choice at this point but to tell Mr Bartholomew's son over the phone that his father had died.

59. Later that morning, the FLO visited Mr Bartholomew's son, along with another officer. They told Mr Bartholomew's son what had happened and offered support and guidance on the next steps.

60. Mr Bartholomew's funeral was held on 17 January 2019. The prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

61. After Mr Bartholomew's death, the Governor debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

62. The prison posted notices informing other prisoners of Mr Bartholomew's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bartholomew's death.

Post-mortem report

63. The post-mortem report gave the cause of death as a rupture of the internal lilac artery (the main artery of the pelvis), caused by an atherosclerotic aneurysm (a swelling in the artery due to the build up of fatty deposits), with underlying cancer of the liver.

Findings

Clinical care

64. The clinical reviewer said that internal iliac artery aneurysms are a rare occurrence and their depth within the pelvis means they are difficult to diagnose. This means they often present late as a result of complications, including rupture of the aneurysm resulting in internal haemorrhage (as happened in Mr Bartholomew's case).

65. The clinical reviewer said that the CT scan Mr Bartholomew had in hospital in November 2017 had not identified a problem and that it was likely that the rectal bleeding Mr Bartholomew had in 2017 was not due to an internal iliac aneurysm. He said that, although Mr Bartholomew was in poor health and had recently been found to have a nodule in his lung, his imminent death could not have been anticipated.

66. The clinical reviewer did, however, conclude that the care Mr Bartholomew received at Swaleside was not equivalent to that which he could have expected to receive in the community. When Mr Bartholomew arrived at Swaleside he had PVD and hypertension. Neither of these conditions were properly managed. However, the clinical reviewer has not made a direct link between the poor management of these conditions and the cause of death.

67. Mr Bartholomew's PVD and hypertension were not identified or discussed at his reception screening to HMP Swaleside on 4 January 2017. Patients with PVD should normally receive treatment to minimise progression of the disease and the development of other associated cardiovascular diseases. This would normally include advice about diet, cholesterol and smoking cessation. Mr Bartholomew was a smoker but there is no documented evidence that smoking cessation support was offered to him.

68. There was a 10-month delay in organising routine blood tests for Mr Bartholomew's hypertension. When they were undertaken, he was found to have chronic kidney disease. Treatment for his hypertension was delayed for a further six months, in part because there was a failure on behalf of healthcare staff to issue a prescription following the recommendation of a specialist.

69. There was also a delay in recognising and optimising cardiovascular risk reduction strategies for Mr Bartholomew. While there might have been some reluctance on Mr Bartholomew's part to collect and take his medication, there were delays by healthcare staff in recognising that Mr Bartholomew had pre-existing cardiovascular disease (PVD) and treating his hypertension. We make the following recommendations;

The Head of Healthcare should ensure that clinical staff review the healthcare needs of all new prisoners and ensure that those with pre-existing conditions are reviewed and managed in accordance with current NICE guidance.

The Head of Healthcare should ensure that when a specialist recommends a treatment there is a process in place that allows for this to be given and identifies any prisoner who fails to comply with the recommendations.

70. In August 2017, Mr Bartholomew missed an appointment for a scan for suspected colorectal cancer because there were insufficient prison staff to escort him to hospital. This was an important appointment, an urgent referral under the NHS two-week cancer referral pathway. We are not satisfied that the prison has adequate contingency plans in place to ensure that prisoners do not miss important medical appointments due to staff shortages. We make the following recommendation:

The Governor should ensure that there are sufficient staff and transport available so that prisoners are able to attend hospital appointments.

Emergency response

71. On 19 December, Mr Bartholomew was taken to hospital by emergency ambulance because of bleeding from his rectum.

72. The investigation found it difficult to establish a concise timeline for that day. A prison paramedic told the investigator that after they saw Mr Bartholomew the first time at about 1.30pm, they asked prison staff to arrange for him to go to hospital by taxi but the investigation found no evidence that a taxi was arranged. It was clearly the prison paramedic's intention to send Mr Bartholomew to hospital for review promptly after they were told that it would take six hours for a non-emergency ambulance to arrive. The investigator asked the prison for the booking form to demonstrate that the taxi had been ordered but they could not find the record. If a taxi had been promptly booked, and escort officers arranged, Mr Bartholomew might have been taken to hospital much sooner than he was. We make the following recommendation:

The Governor of Swaleside should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary.

73. At around 2.00pm, Mr Bartholomew pressed his cell bell again and asked an officer to contact a member of healthcare staff. The investigation has not been able to establish if a call was made to healthcare at this time, who made the call, what was said, or why there was a delay in healthcare staff responding. What is clear, is that Mr Bartholomew's pain level had increased and he was becoming more distressed. If healthcare staff had attended to review him at this time, it might have resulted in an emergency ambulance being called sooner.

74. Every day a nurse is allocated as the first responder (known as Hotel 1). It is expected that any call to Hotel 1 will receive an immediate response. When an officer checked on Mr Bartholomew at around 2.30pm, they saw that he was bleeding. Mr Bartholomew asked for help and said that he was dying. In response, the officer asked a Senior Officer to call the healthcare unit. We accept that Mr Bartholomew was not bleeding sufficiently to justify staff calling a code red medical emergency. However, we consider that either the officer or Senior Officer should have called Hotel 1 over the radio for immediate healthcare assistance, after seeing that Mr Bartholomew was bleeding and given how

distressed he was. Although healthcare staff attended fifteen minutes later, failure to call Hotel 1 meant that healthcare staff did not attend immediately.

75. In her written statement, a prison paramedic said that they saw Mr Bartholomew for the second time at about 2.15pm. However, during interview, the prison paramedic said they think they got the time wrong and it could have been an hour later at 3.15pm. This fits with the statements of other prison staff. The prison paramedic said they cannot wear a normal watch due to prison rules, and does not have a plastic prison safe watch.

76. The clinical reviewer said that the mortality rate from a ruptured internal iliac aneurysm is very high and that given Mr Bartholomew's other medical problems (coronary heart disease and chronic kidney disease) and the blood thinning medication he was prescribed, it is unlikely that he would have survived. The delays in calling healthcare staff and taking him to hospital are therefore unlikely to have affected the outcome for Mr Bartholomew, but in other circumstances, any delay could be crucial. We recommend:

The Governor should ensure that prison staff contact healthcare staff promptly when prisoners report pain or other symptoms suggesting they are unwell.

The Head of Healthcare should ensure that all clinical staff have access to a watch or similar device to enable them to make a record of the time that an event took place, so that full and accurate records are maintained.

77. The prison paramedic told the investigator that when they saw Mr Bartholomew they asked an officer to call an emergency ambulance straight away and that this was done. The prison paramedic did not call a code red because they said they were confident that the officers understood that an emergency ambulance was needed.

78. It is clear from the recording of the 999 call that the control room understood that an emergency ambulance was needed immediately and communicated this clearly to the ambulance service. We are satisfied that there was no delay in calling an ambulance.

79. Ambulance service records show that the ambulance arrived at the prison at 3.42pm, and it took 18 minutes for the paramedic crew to reach Mr Bartholomew's cell.

80. To understand the procedures that Swaleside has in place to escort ambulance crew through the prison to a medical emergency, the investigator spoke to a Senior Officer. The Senior Officer said that they would expect it to take 10-15 minutes for an ambulance to reach H wing, closer to 10 minutes if all prisoners were locked in cells and there was no delay on the gate.

81. When the ambulance arrived at Swaleside, it was met at the gate by an Operational Service Grade officer (OSG). Prison records show he met the ambulance at 15.45, recorded the ambulance details and would have been the officer to escort the paramedics to H wing. The investigation has found nothing to indicate that there was a delay at the gate. The ambulance arrived at a time when prisoners would not have been on association, and therefore this would not

have slowed the progress of the paramedics. The OSG has now left Swaleside so he was not available for interview. The investigation has been unable establish why it took 18 minutes for the ambulance to get to the wing. We make the following recommendation:

The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.

Restraints, security and escorts

82. 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. 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.

83. When Mr Bartholomew was taken to hospital six times between 23 September 2018 and 29 November 2018, he was restrained using either a single cuff or an escort chain. All but one of the risk assessments said he presented a low risk of escape (this section was not completed on the assessment for the 23 September). There were no medical objections made by healthcare to the use of restraints on any of the risk assessments.

84. However, there is evidence in prison records that Mr Bartholomew's mobility was poor, and that as early as June 2018, he used a walking stick. The medical risk assessment for the escort on 23 September, recorded that Mr Bartholomew had 'poor mobility, walks with stick', although no objections were made to the use of restraints by healthcare staff. The escort risk assessments on 5 and 19 November, recorded that Mr Bartholomew was using a wheelchair, yet he was still restrained using a single cuff or an escort chain. We can see no justification for the use of any form of restraint on an elderly prisoner who needs a wheelchair and posed a low risk of escape, and we consider these actions were both unnecessary and undignified.

85. When Mr Bartholomew was taken to hospital on 19 December, the Head of Security reviewed his risk assessment and appropriately authorised two officers to escort him without using any restraints due to the seriousness of his condition and lack of mobility.

86. The risk assessments between September and November 2018, were based on the prison's view of his offence with little consideration of how his age, health and mobility affected his risk of escape, as the 2007 High Court judgement required. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity.

87. The Head of Security told the investigator that the escort risk assessment form had been updated in November 2018, with the following wording:

'The 'Graham Ruling 2007' makes the distinction between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit, and those risks posed by the same prisoner when suffering from a serious medical condition. Medical opinion regarding the prisoner's ability to escape must therefore be considered as part of the assessment process'.

88. It is positive that this wording has been included to help increase staff's understanding of the inappropriate use of restraints. We also acknowledge that when Mr Bartholomew was taken to hospital on 19 December, he was not restrained, which demonstrates a proportionate assessment of risk balanced with Mr Bartholomew's dignity.

89. We have previously made recommendations about the use of restraints at Swaleside. In June 2017, we raised the inappropriate use of restraints and we drew this serious and continuing failure to the attention of the Executive Director for Long-Term and High Security prisons. In October 2018, we raised the inappropriate use of restraints again, and asked that the Executive Director provide an update within four weeks on what had been done to address the prison's continuing failure to comply with case law on the use of restraints.

90. The Executive Director told us that he now has a Group Safety Team who liaise with Swaleside (and the other prisons he is responsible for) regularly and test the compliance of PPO recommendations. This team provides assurance to the Executive Director and Deputy Director who address failure to comply with the Governor. We make the following recommendation:

The Executive Director for Long-Term and High Security prisons, should provide the Ombudsman with an update on the progress of the Group Safety Team in addressing the prison's continuing failure to comply with case law on the use of restraints.

Cell bell records

91. As part of the investigation we requested the cell bell records for 19 December 2018. However, the information could not be provided because the system that logs the cell bell data was not working that day. Head of Operations told the investigator that this was not an isolated problem, and the system had only been working around 30% of the time since he took over as Head of Operations in September 2018. They told the investigator that it had started working again recently, but had broken again and they are waiting for an engineer to fix the problem.

92. Although efforts have been made to fix the problem, it is not acceptable that the logging system has been broken more often than it has been working since September 2018. We make the following recommendation:

The Governor should ensure that the cell bell logging system is in proper working order.

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