Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Hill a prisoner at HMP Isle of Wight on 22 November 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 Mark Hill died of pneumonia caused by a malignant brain tumour on 22 November 2018 while a prisoner at HMP Isle of Wight. He was 55 years old. I offer my condolences to his family and friends.

I am satisfied that the healthcare that Mr Hill received at Isle of Wight was good and equivalent to that which he could have expected to receive in the community.

Prison managers allowed Mr Hill's family to be with him during the last two weeks of his life. This was an example of good practice.

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 **June 2019**

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Summary

Events

1. On 22 August 2016, Mr Mark Hill was sentenced to 28 years in prison for sex offences. On 24 November 2016, he was transferred to HMP Isle of Wight.

2. On 20 November 2017, a nurse saw Mr Hill because he had pain in his left shoulder, arm and lower back and was unable to use his legs. A prison GP diagnosed lower back pain and a possible trapped nerve, and sent him to hospital where he had an MRI scan, which was normal.

3. On 17 January 2018, a prison GP noted that Mr Hill had double vision, headaches, slurred speech and reduced cognition. The GP thought that Mr Hill may have a brain tumour and arranged for him to go to hospital for an urgent CT scan of his brain. Mr Hill decided that he did not want to have the scan because he did not want to know "what was going on in his head". The scan never took place as Mr Hill was assessed as having the mental capacity to decide. Mr Hill remain remained fairly well physically after this for several months.

4. On 16 October, a nurse saw Mr Hill in his cell after he was found on the floor in a "vague and vacant" state. Mr Hill then had an epileptic seizure. He went urgently to hospital by ambulance. Hospital staff did a CT scan of his brain which identified a large tumour. Mr Hill remained in hospital until 19 October, when he returned to Isle of Wight, and was given a cell in the prison's inpatient unit.

5. On 30 October, Mr Hill attended a hospital outpatient appointment. He had an MRI brain scan and saw a consultant neurosurgeon, who diagnosed him with a malignant brain tumour and told him that he had a life expectancy of months. (The neurosurgeon did not specify how many months.)

6. On 17 November, Mr Hill's condition deteriorated and a prison GP considered that he might have a bleed on the brain.

7. On 19 November, a palliative care consultant saw Mr Hill, healthcare staff, his mother and sister and discussed with them his medication, treatment and care. Mr Hill's medication was adjusted. Nursing staff frequently gave him bed baths and mouth care and made him comfortable.

8. At 4.26pm on 22 November, Mr Hill died of pneumonia caused by a brain tumour. His mother and sister were with him when he died.

Findings

9. I am satisfied that the healthcare that Mr Hill received at Isle of Wight was good and equivalent to that which he could have expected to receive in the community.

10. When Mr Hill first had symptoms of a brain tumour, prison GPs appropriately sent him to hospital for tests. After his diagnosis, he was well cared for in the inpatient unit at Isle of Wight, where he had access to 24-hour nursing care.

11. Mr Hill's mother raised a number of concerns about the clinical care that Mr Hill received during the last two weeks of his life. However, the clinical reviewer has no concerns about the end-of-life care that he received.

12. When Mr Hill was diagnosed as being terminally ill, a prison manager promptly appointed family liaison officers. His family were with him each day for the last two weeks of his life.

13. When Mr Hill went to hospital for tests and treatment, prison staff appropriately assessed the risk that Mr Hill posed to the escorting officers, the public and to himself and followed an appropriate decision-making process to restrain him.

14. Mr Hill did not want to apply for compassionate release and therefore an application was never started.

15. We make no recommendations.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

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

19. We informed HM Coroner for Isle of Wight of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The investigator wrote to Mr Hill's mother to explain the investigation. She was concerned:

    - about how the healthcare department identified and treated pneumonia;
    - that it was undignified that nurses said that he should go to the toilet in his bed;
    - that his carbamazepine medication was reduced and stopped when he had been prescribed it for many years;
    - that he became very dehydrated because, for five or six days, he was only given water from a sponge on a stick; and
    - about his end-of-life care plan and why he had not been placed on a drip the day before he died.

21. We have addressed these questions in this report and by separate correspondence, and the clinical reviewer has also considered some of these issues in detail in her review of Mr Hill's clinical care.

22. We have assessed the main issues involved in Mr Hill'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.

23. We shared the initial report with the Prison Service. There were three reported factual inaccuracies and this report has been amended accordingly.

24. Mr Hill's mother received a copy of the initial report. She did not make any comments.

Background Information

HM Prison Isle of Wight

25. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany, and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs. The inpatient unit includes special facilities for end-of-life care.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Isle of Wight was conducted in June 2015. Inspectors reported that health services were good, the inpatient unit provided compassionate care to men with complex needs and prisoners with palliative and end-of-life needs received excellent care.

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 December 2017, the IMB said that, overall, the healthcare provided at the prison was at least as good as that provided to the wider population. However, there was an ongoing shortage of nurses, with bank and agency staff covering the shortfall.

Previous deaths at HMP Isle of Wight

28. There have been 17 deaths from natural causes and three self-inflicted deaths at Isle of Wight in the last three years.

Assessment, Care in Custody and Teamwork (ACCT)

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Findings

The diagnosis of Mr Hill's terminal illness and informing him of his condition

30. On 2 July 2015, Mr Mark Hill was remanded to HMP Bristol. When he arrived at Bristol, Mr Hill was noted to have a history of mental health issues and was monitored under ACCT procedures. On 20 July 2016, he was convicted of sex offences and on 22 August, he was sentenced to 28 years in prison.

31. Mr Hill had a long history of contact with mental health care providers, including stays in psychiatric wards in the community. He had been diagnosed with an Emotionally Unstable Personality Disorder and his mood was very volatile. This presented as physical and verbal aggression to others and physical harm to himself, usually by cutting his arm. He also isolated himself from others and sometimes refused food. As a result, he spent a significant amount of his time in prison being monitored under ACCT procedures.

32. On 24 November 2016, Mr Hill was transferred to HMP Isle of Wight. He was monitored continuously under ACCT procedures until 6 January 2017.

33. On 20 November 2017, a nurse saw Mr Hill in his cell because he was not able to walk to the healthcare unit. He told her that he had pain in his left shoulder, arm and lower back and was unable to use his legs. She asked for a GP to review him urgently. A prison GP, saw Mr Hill and diagnosed lower back pain and prescribed him pain relief medication.

34. Later that day, a prison GP reviewed Mr Hill again because he complained that his left leg and buttock were numb. The prison GP thought that he may have cauda equina syndrome (pressure on the nerves of the spinal cord, usually caused by a slipped disc) and sent him to hospital by ambulance. On 21 November, Mr Hill went back to Isle of Wight. A clinical team manager, noted that Mr Hill had had an MRI scan in hospital which was normal.

35. On 17 January 2018, a prison GP noted that Mr Hill had double vision, headaches, slurred speech and reduced cognition. The prison GP thought that Mr Hill may have a brain tumour and arranged for him to go to hospital for an urgent CT brain scan. The appointment was arranged but Mr Hill decided that he did not want to attend because he did not want to know "if anything is wrong in his head". The prison GP noted that Mr Hill had the mental capacity to decide but tried unsuccessfully to persuade him that it was in his interests to attend.

36. We are satisfied that prison GPs promptly sent Mr Hill to hospital for tests. We are satisfied that the prison GP assessed that Mr Hill had the mental capacity to decide not to have a CT brain scan and tried to persuade him that it was in his own interests to attend.

37. Mr Hill remained physically well for most of the year.

38. On 25 September, a consultant forensic psychiatrist reassessed Mr Hill to review his psychotropic medication (drugs which have an effect on the mind, emotions, and behaviour). Mr Hill was prescribed carbamazepine, which is normally used to prevent epileptic seizures but can also be used as a mood stabiliser in cases of

mental disorder. Although at times Mr Hill told doctors and medical staff that he had been prescribed carbamazepine for epilepsy, research of his records revealed that he had never had any epileptic seizures but had started carbamazepine as a mood stabiliser in about 2003.The consultant forensic psychiatrist felt that it was "time to try and reduce" his psychotropic medication. The plan was to reduce the dose by 200mg every week.

39. On 16 October, an officer started ACCT procedures because a nurse said that Mr Hill's mood was low and he was concerned about his behaviour. ACCT monitoring continued until 20 November. A prison GP noted that Mr Hill should be moved to the healthcare unit. (There was space in the healthcare unit and he was to be moved there later that day.)

40. Later that day, a nurse went to Mr Hill's cell to review him but found him on the floor, "vague and vacant". She noted that his vital signs were very erratic. He told her that he had a severe headache and neck pain. Mr Hill then had a seizure, which a prison GP diagnosed as a tonic-clonic (epileptic) seizure. Mr Hill went urgently to hospital by ambulance. Hospital staff took a CT scan of his brain and found a large tumour which they noted was about the size of a golf ball.

41. Hospital staff re-prescribed the higher dose of carbamazepine and prescribed a high dose of dexamethasone (a powerful steroid that can shrink tumour size in the early stages).

42. The clinical reviewer noted that the carbamazepine might have stopped Mr Hill from having seizures which the tumour may have caused at earlier stages in its growth. She said that, if Mr Hill had remained on the higher dose of carbamazepine, it may have taken longer for his tumour symptoms to manifest themselves, but reducing the dosage of carbamazepine did not have any bearing on his death.

43. On 19 October, Mr Hill returned to Isle of Wight and was placed in the prison's inpatient unit.

Mr Hill's clinical care

44. On 20 October, a nurse saw Mr Hill and created a palliative care plan. A prison GP reviewed Mr Hill and noted that he was coming to terms with his diagnosis. Mr Hill said that he wanted his baseball cap because he was sensitive to the lights. He said that he had lost some of his memory, had episodes of déjà vu and saw auras (a sensation, including seeing flashing lights or blurred vision, that precedes a condition affecting the brain, such as a migraine or epileptic seizure).

45. On 30 October, Mr Hill went to a hospital outpatient appointment. A palliative care nurse, went with him to the appointment. Mr Hill had an MRI brain scan and then saw a consultant neurosurgeon, who diagnosed him as having a malignant brain tumour. He told Mr Hill that he planned to complete a biopsy (an examination of a small sample of tumour tissue) and told him that he could have radiotherapy, chemotherapy or a combination of these treatments. He told Mr Hill that the treatment would not cure him and that his life expectancy was months. (He was not given a prognosis of a specific number of months.) Mr Hill said that he wanted to have the biopsy and treatment.

46. On 1 November, a prison GP reviewed Mr Hill and prescribed him medication for pain relief and to help him sleep. Healthcare staff frequently noted that Mr Hill's behaviour was unpredictable and that he became upset and worried about his condition. He threatened to discharge himself from the inpatient unit and to stop taking his medication. Mr Hill's biggest concern was that he was not able to vape in the inpatient unit. Prison staff arranged for Mr Hill to go to his old wing to vape, which he did on a number of occasions.

47. On 4 November, Mr Hill went to hospital for a biopsy and an MRI scan. On 5 November, he returned to Isle of Wight. Mr Hill later became physically and verbally aggressive and threatening towards officers because he was not allowed to vape. He started punching a wall in his cell, so the night manager (night orderly officer), decided not to allow anyone to go into his cell, except in a medical emergency. A prison GP noted that it would be helpful if Mr Hill could vape in his cell. When Mr Hill calmed down, he apologised for his behaviour.

48. On 7 November, a prison GP saw Mr Hill who said that he had his baseball cap and medication which helped him sleep. He complained to him that he was not able to go to his old wing to vape. The GP said that he would speak to the Head of Healthcare to ask if she could apply a flexible policy to allow Mr Hill to vape in his cell.

49. The Head of Healthcare, told the investigator that Mr Hill was not permitted to vape in the inpatient unit but great efforts were made for him to attend a standard wing to vape occasionally. As Mr Hill's health deteriorated, his requests to vape reduced and then stopped altogether. There were discussions between senior members of staff as to whether a flexible approach should be accommodated. She said that not everyone was in favour of doing so and she agreed to review the position if Mr Hill was too unwell to leave the inpatient unit but wanted to vape.

50. On 9 November, Mr Hill went to a palliative care meeting. The Head of Healthcare, a prison GP, a nurse and Mr Hill's mother and sister were present. The nurse noted that they discussed many issues, including that Mr Hill was religious and wanted a priest present when he died.

51. On 10 November, two nurses reviewed Mr Hill's palliative care plan and falls assessment and completed a nutritional review.

52. On 12 November, a prison GP saw Mr Hill who told him that he had had abdominal pain and bloating over the past two days. Mr Hill said that he had been to the toilet, had increased wind and belching and had previously had duodenal ulcers (sores on the stomach or small intestine). The prison GP prescribed medication for gastric pain.

53. On 12 November, Mr Hill signed an order to say that he did not want to be resuscitated if his heart or breathing stopped.

54. On 13 November, Mr Hill went to hospital and was told that the biopsy had shown that the tumour was malignant. Hospital staff told him what treatment he could have.

55. On 17 November, a prison GP saw Mr Hill because his condition had deteriorated significantly over night. He had severe pain in his head, neck, nausea, vomiting, was intolerant of light and was not able to take his medication orally. He believed that these symptoms might be caused by a bleed on the brain. He noted that Mr Hill should receive his medication by injection and prescribed levomepromazine (a palliative care drug for nausea and vomiting) and diamorphine for pain relief. A nurse put a cannula in his right upper arm. Prison staff kept Mr Hill's cell door permanently unlocked.

56. On 17 November, a nurse gave Mr Hill's family (who were visiting him) mouth sponges and lip salve to keep his mouth and lips moist because he could not swallow water.

57. On 18 November, a nurse noted that Mr Hill had not passed urine or taken fluids overnight. He declined to use a urinal (to pass urine in bed), sips of fluid and mouth care, but allowed his lips to be wetted with water and Vaseline to be applied. Two nurses washed Mr Hill because he was unsettled and hot. Mr Hill told the nurses that he had stomach pain and they saw that his stomach was swollen. A nurse put a bottle in place for him to go to the toilet but Mr Hill did not want to use it, so they applied an incontinence pad. The nurses gave him mouth care and sips of water.

58. A prison GP reviewed Mr Hill and spoke to his mother about his care. Because his condition had got much worse, the prison GP said that, rather than continuing to give Mr Hill his medication by injection, they would fit a syringe driver to give a steady continuous dose of pain relief, sedation and epilepsy treatment. A nurse fitted the syringe driver. Mr Hill's mother and sister told the prison GP that they thought that a syringe driver had been used too soon because he needed high levels of medication to control his symptoms. The prison GP told them that he thought that he had made the right decision. The clinical reviewer commented that Mr Hill's medication was not reduced when the syringe driver was fitted (as his mother may have thought).

59. Later that day, Mr Hill had a large bowel movement in the bed. A nurse cleaned him, changed his bedding and made him comfortable.

60. The clinical reviewer commented that where someone is in the last stages of life, decisions must be made about the safety of using equipment to hoist or asking a patient who is weak to stand or take weight to use a commode or bedpan. It is often neither safe nor possible to use such equipment. It is common practice to use incontinence and continence equipment to manage the bowel and bladder care. She said that while Mr Hill's incontinence incident on 18 November was regrettable, it may have been unavoidable.

61. A nurse updated Mr Hill's end-of-life care plan, which included half hourly observations, to ensure that his condition was stable, that he remained comfortable and pain-free by giving medication through the syringe driver, for nursing staff to attend to his personal needs and to check his skin for signs of pressure sores.

62. On 18 November, before Mr Hill's mother and sister left the prison, they told a nurse that they were concerned about Mr Hill's end-of-life care. They told her

that they thought that the syringe driver was used too soon, that he was not given anything to eat or drink, that he had no assistance in going to the toilet which resulted in him soiling the bed. The nurse told them that Mr Hill was unable to walk and would not be able to sit on a commode safely, even with nursing help. The nurse noted that Mr Hill's family was angry about his care and she suggested that they should put their concerns in writing for the doctor to answer in the morning.

63. On 19 November, a nurse noted that Mr Hill had a bed bath and his sheets were changed because he was incontinent of urine. She noted that he would only let healthcare staff wet his lips and apply Vaseline.

64. A consultant in palliative care from a hospice, reviewed Mr Hill. A prison GP, a nurse and Mr Hill's mother and sister were also present. The prison GP, nurse and the family liaison officer (FLO), met Mr Hill's mother and sister and discussed how his condition had changed over the past 48 hours. The prison GP supported the likely diagnosis that Mr Hill had deteriorated because of a bleed on the brain, but also felt this could be a result of a big epileptic fit, although the timing and pattern suggested a bleed. He explained there was some uncertainty over this diagnosis and added some ideas for actions to be taken if Mr Hill seemed to improve (which he might do if it was the result of a fit). Mr Hill's condition did not improve.

65. The prison GP confirmed that the doses of opiate used in the syringe driver were correct. On his suggestion, levetiracetam was added to the syringe driver to reduce and treat seizures and dexamethasone was added to try to reduce the size of the tumour.

66. The prison GP also suggested that a subcutaneous (under the skin) fluid infusion could be considered if fluid intake was a problem. He agreed for Mr Hill to receive fluids subcutaneously to increase his fluid intake for 24 hours.

67. The clinical reviewer commented that it is not common practice to use intravenous fluids in terminal care but from time to time subcutaneous fluids can be helpful if dehydration is causing distress. She said that subcutaneous infusions can be uncomfortable if the fluid does not absorb well. She also said that one of the main skills in terminal care is looking after the skin and that usually requires healthcare staff to move the patient regularly. Having more than one set of needles and tubing can make this more difficult and distressing for the dying person. It is therefore not a routine measure in terminal care.

68. A nurse told Mr Hill's family that they could be involved in his care as much as possible by giving him drinks and washing him. The prison GP discussed how nursing staff could feed Mr Hill because he was finding it difficult to swallow. Nursing staff frequently gave Mr Hill bed baths, mouth care, changed his incontinence pad and kept him comfortable.

69. On 21 November, a prison GP spoke to Mr Hill's mother and sister who asked him about his hydration and nutrition. He told them that because of his level of consciousness, it was unlikely that he would be able to swallow anything.

70. A prison GP also spoke to Mr Hill's mother and sister about his hydration and nutrition. He apologised again for the incident on 18 November when Mr Hill had

soiled his bed and explained to them the reasons why he was not able to get out of bed at the time.

71. Later that day, two nurses tried to give Mr Hill fluids subcutaneously in his left arm and both of his thighs but were not successful.

72. The clinical reviewer commented that oral fluids could not always be given safely because of Mr Hill's fluctuating level of consciousness. She noted, however, that he was regularly given mouthcare and offered sips of fluid to help with his mouth symptoms of dehydration, and that it is inaccurate to say his only fluid was from a sponge on a stick.

73. The clinical reviewer said that Mr Hill's mother was clearly hopeful that Mr Hill's recent deterioration may have been from a significant fit (which a GP had suggested as a possibility) rather than from a significant deterioration of his tumour. However, Mr Hill's condition did not improve as might have been expected if he had had a fit. The clinical reviewer said that Mr Hill was clearly at the end of his natural life and that increasing his fluids by any means would not have altered the fatal outcome of his brain tumour in these last days.

74. At 4.26pm on 22 November, Mr Hill died, with his mother, sister and a priest present.

75. The post-mortem identified the cause of his death as pneumonia caused by a malignant brain tumour.

76. Mr Hill's mother asked whether the prison's medical staff were aware that Mr Hill had pneumonia and, if so, why did they not inform his family? The clinical reviewer commented that pneumonia is a normal end of life phenomenon and is a very common finding at post-mortem in any death where there has been a period of several hours or days of dying. She said it would be an unremarkable finding and would need no treatment or intervention, as treatment would very likely prolong suffering without benefit. She said pneumonia in otherwise fit people is treatable; pneumonia at end of life is not. She also said it would not be normal to add this diagnosis or specifically share this news with the family once they had been told that death was near.

77. The clinical reviewer had no concerns about the end-of-life care that Mr Hill received. We are satisfied that the care that Mr Hill received at Isle of Wight was equivalent to that which he could have expected to receive in the community.

Mr Hill's location

78. When Mr Hill went to Isle of Wight, he lived in a standard cell. On 19 October 2018, when he went back to Isle of Wight from hospital, he went to the healthcare inpatient unit. This was important because he needed frequent monitoring, medication and nursing care.

79. Mr Hill was a smoker and was offered smoking cessation advice. When Isle of Wight became smoke-free, Mr Hill started vaping. He was not allowed to vape in the inpatient unit which upset him. Prison staff arranged for him to go to his old wing to vape but, when this was not possible, he considered discharging himself from the unit. He soon became too ill to leave the inpatient unit.

80. We are satisfied that when Mr Hill went back to Isle of Wight from hospital after his diagnosis, he was appropriately located in the prison's inpatient unit, where he had access to 24-hour nursing care.

Restraints, security and escorts

81. When prisoners travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as a prisoner's health and mobility.

82. When Mr Hill went to hospital on 16 October as an emergency, prison staff completed a risk assessment. The medical section was not completed. Prison staff said that he did not know why the section had not been completed but if there was a risk to Mr Hill's life, the ambulance would not be delayed waiting for the paperwork.

83. We consider that the prison staff's explanation that the medical section was not completed on 16 October because it was a medical emergency and the ambulance needed to leave the prison promptly is reasonable.

84. Mr Hill was considered a high risk to staff and the public. A Custodial Manager recorded that officers must use 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) which should be kept in place while receiving medical treatment. When Mr Hill had an x-ray and a CT scan, the escorting officers had permission to remove the escort chain, which they did. Mr Hill went to a ward in hospital, where he had an MRI scan and a further CT scan during which the escort chain was removed. On 19 October, the Head of Security reviewed the risk and noted that Mr Hill should remain on an escort chain. That day, Mr Hill went back to Isle of Wight.

85. On 30 October, Mr Hill went to hospital for an outpatient appointment. Prison staff completed a risk assessment. A nurse completed the medical section and noted that Mr Hill may need a wheelchair, may be unsteady on his feet but was still mobile. She noted that there were no medical objections to using restraints but that the restraints may need to be removed for a scan. The risk assessment noted that Mr Hill remained a high risk to the public and a high risk to staff. A Head of Operations, noted that Mr Hill should be restrained with a single cuff, which could be removed for treatment, because he had mobility issues. Mr Hill's restraints were removed for treatment and appointments.

86. On 13 November, when Mr Hill went back to hospital for an outpatient appointment, a nurse completed the medical section of the risk assessment. She objected to the use of restraints because Mr Hill risked having seizures due to his condition. She noted that he was now terminally ill and could become anxious and stressed. The prison's risk assessment noted that Mr Hill remained a high risk to the public and staff and a risk to children. It also noted that he had been found guilty of damaging property in a disciplinary hearing and that he was at risk of suicide and self-harm. The Head of Safety, noted that Mr Hill was terminally ill but, was prone to violent and confrontational behaviour. He noted that officers

should use an escort chain to restrain Mr Hill but that they should apply a double cuff and telephone the police if they had any concerns.

87. We are satisfied that when Mr Hill went to hospital in October and November 2018, prison staff appropriately assessed the risk that Mr Hill posed to the escorting officers, the public and to himself and authorised an appropriate level of restraint. We do not consider that it was unreasonable for restraints to have been authorised on 13 November even though Mr Hill was terminally ill at the time.

Liaison with Mr Hill's family

88. On 17 October, after Mr Hill had been diagnosed with a brain tumour and admitted to hospital, a Head of Operations, appointed an operational support grade, as the family liaison officer (FLO) and an officer as the deputy family liaison officer. At 11.00am, the FLO telephoned Mr Hill's mother to tell her that he was in hospital.

89. On 31 October, a nurse spoke to Mr Hill's mother by telephone and updated her about Mr Hill's condition and treatment. On 6 November, a prison GP spoke to Mr Hill's mother by telephone and updated her about his biopsy and prognosis.

90. On 9 November, Mr Hill's mother and sister visited him at Isle of Wight. They stayed nearby and were able to visit him daily between 11.00am and 5.00pm until he died. We are satisfied that the family liaison officers supported them well.

91. The FLO remained in contact with Mr Hill's mother. Mr Hill's funeral took place on 9 January 2019. The prison contributed to its cost in line with national instructions.

92. We are satisfied that Isle of Wight promptly appointed family liaison officers when they were aware that Mr Hill was terminally ill. The family liaison officer arranged for Mr Hill's family to be with him during the last two weeks of his life. Mr Hill's mother told us that she was very grateful for this.

Compassionate release

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

94. On 7 November, a prison GP asked Mr Hill if he wanted to apply for compassionate release. Mr Hill told the prison GP that he did not want to apply and that he wanted to remain at Isle of Wight.

95. We are satisfied that it was therefore appropriate that an application for early compassionate release was not started.

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