Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Conway, a prisoner at HMP Isle of Wight, on 25 June 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. If my office is to best assist HM Prisons and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Mark Conway died in hospital of lung cancer, which had spread, on 25 June 2023 while a prisoner at HMP Isle of Wight. He was 57 years old. We offer our condolences to those who knew him.

4. The clinical reviewer concluded that the clinical care Mr Conway received at Isle of Wight was equivalent to that which he could have expected to receive in the community. The clinical reviewer made four recommendations which were not relevant to Mr Conway's death but which the Head of Healthcare will need to address.

5. There were a number of issues relating to the escort risk assessment process and we found no evidence that the decision to restrain Mr Conway on 30 April was justified.

Recommendations

The Governor should ensure that all staff undertaking risk assessments:

- **understand the legal position on the use of restraints and make evidence-based decisions which are reflected in the documentation;**
- **carry out fresh risk assessments for each escort when/if the prisoner's condition changes to establish the appropriate level of restraints when travelling to and from hospital; and**
- **securely retain risk assessment documentation.**

The Head of Healthcare should ensure that healthcare staff complete the medical risk assessment in full, including signing and dating the form.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Conway's clinical care at HMP Isle of Wight.

7. The PPO investigator investigated the non-clinical issues relating to Mr Conway's care.

8. Mr Conway did not have a named next of kin.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Isle of Wight

10. Mr Conway was the twenty-eighth prisoner to die at HMP Isle of Wight since 25 June 2020. Of the previous deaths, twenty-two were from natural causes, four were self-inflicted and the cause of one is currently unknown. While our previous reports issued in January and May 2022 raised concerns about the use of restraints, the circumstances of this case are different.

Key Events

11. In March 2020, Mr Mark Conway was convicted of sex offences and was later sentenced to 10 years in prison. He was transferred to HMP Isle of Wight on 12 December 2020. He was a category B prisoner.

12. On 9 November 2022, a nurse examined Mr Conway. He told her that he had been experiencing shortness of breath, fatigue and chest pain on exertion. She carried out clinical observations and calculated a NEWS2 score of four. (NEWS2 is a tool to detect and respond to clinical deterioration. A score of one to four requires a prompt clinical assessment to decide on a change to the frequency of monitoring or an escalation of clinical care.)

13. The nurse discussed Mr Conway's clinical observations and symptoms with a GP operating at the prison. Mr Conway was given antibiotics and an appointment was made for Mr Conway to see a GP the next day.

14. On 10 November, a prison GP examined Mr Conway. He made an entry in the medical records to say that recent blood tests had shown raised inflammatory markers. The GP said he would arrange for a chest X-ray and repeat blood tests.

15. On 13 November, Mr Conway reported feeling unwell. A nurse carried out clinical observations and calculated a NEWS2 score of one. Later that day, the hospital contacted the prison's healthcare team about the blood test results and decided that Mr Conway should be admitted to hospital.

16. On 14 November, a hospital doctor told the healthcare team that Mr Conway had a possible chest infection and lesion on his lung which needed investigation. Mr Conway was discharged back to prison the same day.

17. On 22 November, Mr Conway attended hospital for a bronchoscopy (a procedure to examine the lungs).

18. On 26 January 2023, a prison GP made an entry in the medical records to say that Mr Conway has been diagnosed with rapidly advancing lung cancer. (It is not clear exactly when Mr Conway was told he had cancer, or who by.)

19. On 30 January, a nurse spoke to Mr Conway. She told him that there was a bed available for him in the prison's inpatients unit and they discussed the option of early release on compassionate grounds. Mr Conway told her that he did not wish to be considered for early release.

20. On 2 February, Mr Conway was moved to the inpatients' unit.

21. On 31 March, Mr Conway went to hospital for an oncology appointment. Before he left, staff completed the escort risk assessment and decided that he should not be restrained due to his condition and the treatment he was receiving.

22. Between 3 and 11 April, Mr Conway attended hospital for chemotherapy on five occasions. On each occasion, staff completed the risk assessment and decided not to restrain Mr Conway because he was receiving treatment for cancer.

23. On 11 April, Mr Conway was admitted to hospital for chemotherapy. The security risk assessment completed for this appointment concluded that Mr Conway posed a high risk to the public, hospital and escort staff. However, the authorising manager concluded that no restraints should be used as Mr Conway was an enhanced prisoner, with no history of escape or abscond, and was receiving chemotherapy.

24. Mr Conway had been scheduled to attend hospital on 12 April and the escort paperwork had been completed in advance. On this occasion, the authorising manager concluded that restraints were not required when travelling to hospital or undergoing treatment. However restraints should be applied for the return journey.

25. Mr Conway remained in hospital, without restraints, until 30 April. On his return to the prison's inpatients unit, he was restrained using 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) in line with the assessment completed for 12 April.

26. The Head of Safer Custody told the investigator that he was contacted on 30 April and told that Mr Conway was to be discharged. He said that he had decided that an escort chain was appropriate and decent as there were no medical objections to using restraints, Mr Conway was a category B prisoner who had been assessed as a high risk to the public, hospital and escort staff and due to the length of the journey.

27. Following Mr Conway's discharge from hospital, healthcare staff carried out regular clinical observations.

28. At approximately 12.45am on 3 May, a nurse calculated a NEWS2 score of five. (A score of five to six indicates the need for an urgent clinical review.) Mr Conway was taken to hospital by ambulance at 1.57am, restrained using an escort chain. The authorising custodial manager noted that Mr Conway had lung cancer and restraints could be removed if a medic requested or in an emergency. The escort risk assessment indicated no medical objections to using restraints and Mr Conway was identified as posing a normal level of risk. The overall security assessment did not contain any specific intelligence information and the healthcare section was not fully completed.

29. Mr Conway returned to the prison at 5.33am. Later that day, Mr Conway attended a hospital oncology appointment. The escort risk assessment noted no medical objection to using restraints. The security assessment recommended that Mr Conway should be restrained. However, the form was not signed and Mr Conway's person escort record (PER) recorded that he was not restrained.

30. On 4 May, a nurse carried out clinical observations on Mr Conway and calculated a NEWS2 score of ten (a score above seven indicates the need for an emergency response). Mr Conway was taken to hospital by ambulance and admitted. The prison was unable to find the escort risk assessment for this admission. The PER indicated that Mr Conway was restrained but did not specify the type of restraint used.

31. On 9 June, the prison's family liaison officer visited Mr Conway in hospital to discuss his end-of-life wishes.

32. At approximately 3.50pm on 23 June, a paramedic carried out clinical observations on Mr Conway and calculated a NEWS2 score of 7. He was sent to hospital, unrestrained, at 4.58pm with suspected sepsis. A Supervising Officer (SO) completed his escort risk assessment. It was dated 3 May 2023, with the security assessment and medical section signed and dated 27 and 28 April respectively. Both signatures and dates were crossed out and replaced with the SO's signature and dated 23 June 2023.

33. At 2.09pm on 25 June, Mr Conway died in hospital.

Post-mortem report

34. The post-mortem report concluded that Mr Conway died of carcinomatosis (where cancer has spread to other parts of the body) caused by lung cancer. He also had COPD and pulmonary fibrosis (due to cigarette smoking) which did not cause but contributed to his death.

Inquest into Mr Conway's death

35. The inquest into Mr Conway's death was held on 3 November 2025 and a verdict of natural causes was recorded.

36. The coroner concluded that Mr Conway's death was due to carcinomatosis caused by lung cancer. He also had COPD and pulmonary fibrosis due to cigarette smoking.

Non-Clinical Findings

Restraints, security and escorts

37. 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.

38. 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 he has a serious medical condition. 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.

39. Mr Conway attended multiple hospital appointments for cancer treatment in March and April, appropriately unrestrained. However, there were three occasions when Mr Conway was restrained despite no evidence that his risk had increased.

Return to prison on 30 April

40. When Mr Conway was admitted to hospital on 11 April, the risk assessment concluded that restraints should not be applied. The risk assessment completed on 12 April mirrored this decision but the authorising manager decided that restraints should be used for Mr Conway's return journey to the prison. When Mr Conway returned to the prison on 30 April, he was restrained using an escort chain.

41. We were told that the decision to restrain Mr Conway was based on there being no medical objection to the use of restraints and that Mr Conway was considered high risk and a category B prisoner. We were not provided with the rationale as to why Mr Conway's risk was considered greater when traveling back from hospital. We have also not seen any evidence which indicates that a new medical assessment was sought when Mr Conway was discharged on 30 April, eighteen days after the risk assessment was completed. Mr Conway had a terminal illness and there was no evidence that his risk had increased. There is no evidence that the decision to restrain him on his return to prison was justified.

Emergency admissions on 3 May and 4 May

42. The medical risk assessment completed for Mr Conway's emergency admission on 3 May was not completed in full and the name of the person who completed it was not recorded. The only question answered was that there were no objections to the use of restraints. The risk assessment shows that the authorising manager was aware that Mr Conway had lung cancer but he had not had access to his security file. He concluded that Mr Conway posed a normal level of risk and that an escort chain should be used.

43. On 4 May, Mr Conway was sent to hospital when his health deteriorated. The PER indicated that Mr Conway was restrained using an escort chain. The prison was unable to provide us with a copy of the medical or security risk assessment and we are therefore unable to review why he was restrained on this occasion. We make the following recommendations:

The Governor should ensure that all staff undertaking risk assessments:

- **understand the legal position on the use of restraints and make evidence-based decisions which are reflected in the documentation;**
- **carry out fresh risk assessments for each escort when/if the prisoner's condition changes to establish the appropriate level of restraints when travelling to and from hospital; and**
- **securely retain risk assessment documentation.**

The Head of Healthcare should ensure that healthcare staff complete the medical risk assessment in full, including signing and dating the form.

Governor to note

44. The documentation provided for Mr Conway's admission to hospital on 23 June was of a poor quality. The prison advised the investigator that the dispatching officer (the SO) used an old risk assessment and had not changed the date on the first sheet. It is not clear if the information in the document reflected the situation on 23 June or 3 May.

Adrian Usher
Ombudsman **March 2024**

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