

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Paul Clawson a prisoner at HMP Wayland on 18 May 2017

**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*



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Clawson died of hypertensive heart disease on 18 May 2017 while a prisoner at HMP Wayland. He was 55 years old. We offer our condolences to his family and friends.

Mr Clawson had high blood pressure, angina and obesity, which put him at risk of heart disease, and we agree with the clinical reviewer that healthcare staff managed these conditions in line with national guidance. We are satisfied that Mr Clawson received a good standard of clinical care at Wayland, equivalent to that which he could have expected to receive in the community.

In the month before his death, Mr Clawson refused food and said he was doing so to cope with his personal problems. Healthcare and prison staff began monitoring some of his clinical observations and his food intake, and mental health staff reviewed him twice. However, we are concerned that his mental capacity was not assessed regularly and that healthcare staff did not measure his full clinical observations, including signs of muscle wastage.

We are also concerned that officers restrained Mr Clawson when he went to hospital on the day of his death, despite a nurse noting that he had a life-threatening condition.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**February 2018**

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# Summary

## Events

1. On 10 June 2009, Mr Paul Clawson received an indeterminate sentence for public protection for threatening behaviour and possession of an offensive weapon, with a minimum tariff to serve of two and a half years in prison. On 7 January 2016, Mr Clawson was transferred to HMP Wayland.
2. Mr Clawson had had a minor heart attack in 2002, was noted to be obese and had a family history of hypertension (high blood pressure) and cardiovascular disease. He had also gone on hunger strikes at previous prisons and shortly after arriving at Wayland, during which he developed high blood pressure.
3. On arrival at Wayland, healthcare staff measured Mr Clawson's blood pressure and found it was often high. On 13 January, a prison GP referred Mr Clawson for a blood test, which showed that his renal function was mildly impaired and he had a low HDL level. (HDLs transport cholesterol to the bile to be removed from the body.) Mr Clawson did not attend a scheduled GP appointment on 28 January to discuss the results.
4. On 16 March, a prison GP examined Mr Clawson, who had experienced regular headaches and chest pain. The GP considered that hypertension could have caused his headaches so referred Mr Clawson for a blood test and prescribed him glyceryl trinitrate spray. A week later, another prison GP reviewed the blood test results and noted that Mr Clawson's renal function and cholesterol levels were normal but decided to prescribe him atorvastatin (used to lower cholesterol) and bisoprolol (used to treat heart disease) because he had a family history of heart disease.
5. On 23 September, a prison GP examined Mr Clawson and replaced his bisoprolol prescription with atenolol (used to treat high blood pressure) to help with his ongoing headaches.
6. On 18 November, a prison GP examined Mr Clawson after he felt pressure in his chest and tingling in his left arm. The GP diagnosed Mr Clawson with angina and prescribed amlodipine (used to treat high blood pressure), aspirin and an increased dose of atenolol. The GP sent Mr Clawson to hospital but they did not change his treatment plan.
7. On 8 April 2017, Mr Clawson began to refuse food as a response to personal problems. From 15 April, healthcare and prison staff began to measure his blood pressure and pulse regularly and to monitor his food intake. On 18 April, a nurse began suicide and self-harm prevention procedures (known as ACCT). Mr Clawson asked for ACCT monitoring to be stopped as it worsened his mood, and staff stopped monitoring him. That day, another nurse examined Mr Clawson but decided that he did not require input from the mental health team.
8. On 16 May, a mental health social worker examined Mr Clawson after prison staff were concerned that he was having a "mental breakdown". Mr Clawson said that he was not on a hunger strike but was avoiding putting on weight. The social worker explained the risks this presented, which Mr Clawson understood.

The mental health social worker felt that Mr Clawson had the mental capacity to make this decision.

9. At approximately 8.40am on 18 May, an officer found Mr Clawson unresponsive in his cell and called a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). Two nurses responded, placed him in the recovery position and took his basic observations, though Mr Clawson was agitated and tried to resist treatment. At 9.00am, paramedics arrived and gave Mr Clawson intravenous fluids to raise his blood pressure. The paramedics took him to hospital and officers restrained him for the journey to the hospital. Mr Clawson's condition deteriorated and he died at 8.20pm.

## Findings

### Clinical care

10. Prison GPs diagnosed Mr Clawson with high blood pressure and angina, and noted he was obese. Healthcare staff monitored him with blood pressure checks, blood tests and treated him with appropriate medication. We agree with the clinical reviewer that healthcare staff appropriately treated his conditions in line with National Institute for Health and Care Excellence guidelines, and that the care he received was equivalent to that which he could have expected to receive in the community.

### Food refusal

11. Mr Clawson stopped eating on 8 April and prison and healthcare staff started a log to monitor Mr Clawson's food intake, regularly measured some of his basic observations and started ACCT procedures. While we are satisfied that the overall clinical care that Mr Clawson received was equivalent to that which he could have expected to receive in the community and we recognise that prison and healthcare staff took some positive steps to manage Mr Clawson's food refusal, we are concerned that they did not fully comply with the Department of Health's guidelines about the management of prisoners who have refused food. We found that healthcare staff did not regularly review his mental capacity and only reviewed his mental health twice in the 40 day period that he refused food. We are also concerned that healthcare staff did not check all his clinical observations or for signs of muscle wastage and loss of subcutaneous fat.

### Restraints, security and escorts

12. When Mr Clawson was taken to hospital on 18 May, officers restrained him with an escort chain. While we appreciate that Mr Clawson was restrained for less than an hour, we are concerned that he was restrained at all as he had a life-threatening condition.

## Recommendations

- The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with the Department of Health guidelines for the clinical management of people refusing food in prison. This should include:
  - regular mental capacity assessments;

- regular mental health assessments; and
- measurement and assessment of a prisoner's full clinical observations, including signs of muscle wastage or loss of subcutaneous fat.
- The Governor and Head of Healthcare 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 the prisoner and are based on the actual risk the prisoner presents at the time.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Clawson's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Clawson's clinical care at the prison.
16. The investigator and clinical reviewer interviewed six members of staff at Wayland on 25 September. Another investigator took over the investigation in November 2017.
17. We informed HM Coroner for Norwich of the investigation. Our investigation was suspended for a month until we received the post-mortem report from the coroner. We have sent the coroner a copy of this report.
18. The investigator contacted Mr Clawson's ex-partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to consider what action prison staff took when Mr Clawson stopped eating, including whether they assessed his mental health and responded to his weight loss, and whether Mr Clawson received appropriate medication.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
20. Mr Clawson's ex-partner received a copy of the initial report. She did not make any comments.

# Background Information

## HMP Wayland

21. HMP Wayland is a medium security prison, near Thetford in Norfolk, holding over 1,000 men in thirteen residential units. Virgin Care provides healthcare services.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Wayland was in June 2017. Inspectors reported that following the eight deaths in custody since the previous inspection, a healthcare action plan had been put in place and the majority of recommendations had been satisfactorily implemented. Hospital referrals were generally well managed.

## Independent Monitoring Board

23. 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 May 2017, the IMB reported that despite staff shortages, appointment waiting times were shorter than in the previous reporting period. They found that prisoners not attending healthcare appointments, due to patient choice, not receiving appointment slips or being locked in their cells during a restricted regime, continued to be a problem. Not having medically trained staff available out of hours was an issue. At any time, there were about 320 offenders between 40 -75 years but no nurses to manage prisoners with long-term conditions.

## Previous deaths at HMP Wayland

24. Mr Clawson was the second prisoner to die from natural causes at Wayland since January 2016. There were no significant similarities between the investigations.

## Key Events

25. On 30 January 2009, Mr Paul Clawson was remanded to HMP Lewes, charged with threatening behaviour toward his ex-partner and possession of an offensive weapon. On 10 June 2009, Mr Clawson was sentenced to an indeterminate sentence for public protection, with a minimum time to serve of two and a half years in prison. After spending time at Lewes and HMP Swaleside, Mr Clawson was transferred to HMP Wayland on 7 January 2016.
26. Mr Clawson had had a minor heart attack in 2002 and was noted to be obese. He had also been diagnosed with a personality disorder, had a history of self-harm and had gone on hunger strikes at previous prisons and shortly after arriving at Wayland. During these previous hunger strikes, healthcare staff found that Mr Clawson developed high blood pressure and a high pulse.
27. During Mr Clawson's initial health screen on arrival at Wayland, a nurse noted that he was physically well. The nurse measured his blood pressure, which was pre-high (a normal reading is between 90/60 and 119/79, pre-high is between 120/80 and 139/89 and high is above 140/90), and his pulse, which was normal (a normal reading is between 60 and 100 bpm and high is above 100 bpm). The next day, Mr Clawson told another nurse that his family had a history of hypertension (high blood pressure) and cardiovascular disease. The nurse measured Mr Clawson's blood pressure and pulse, which were still high.
28. On 11 January, a nurse examined Mr Clawson because he had refused food since arriving at Wayland in protest about not moving to the Psychologically Informed Planned Environment (PIPE – a specifically designed environment for prisoners diagnosed with personality disorders). The nurse measured Mr Clawson's blood pressure and pulse, which were slightly raised, though he said that he had not had blood pressure issues in the past. The nurse planned for healthcare staff to monitor Mr Clawson's blood pressure.
29. The next day, a nurse measured Mr Clawson's blood pressure, which was high. Mr Clawson said that he had ended his hunger strike because the prison planned to move him to the PIPE wing, which had not previously happened due to a miscommunication from staff at Swaleside. He moved there on 1 February.
30. On 13 January, a prison GP examined Mr Clawson due to his high blood pressure readings. Mr Clawson reiterated that he had had a heart attack in 2002 and had been taking statins (to lower cholesterol levels) for a while. He said that he had not had any other symptoms or concerns. He referred Mr Clawson for a blood test and an electrocardiogram (ECG – a test to check the heart's rhythm and electrical activity).
31. Healthcare staff took the blood test and ECG on 25 January. That day, a prison GP reviewed the blood test results and noted that they showed Mr Clawson's renal function was mildly impaired and he had a low HDL level. (HDLs transport cholesterol to the bile to be removed from the body.) He planned to discuss the results with Mr Clawson, but he did not attend a GP appointment on 28 January.
32. On 9 March, a healthcare student measured Mr Clawson's blood pressure, which was high, though his pulse was normal and regular.

33. A week later, a prison GP examined Mr Clawson, who said that he had had headaches for the last two years and had experienced mild chest pain in the left side of his chest. She considered that hypertension could have caused his headaches so referred Mr Clawson for a blood test. She also prescribed him glyceryl trinitrate spray (GTN spray – used to relieve chest pains).
34. Healthcare staff took the blood test on 17 March. Six days later, a prison GP discussed the results with Mr Clawson. She explained that Mr Clawson's renal function and cholesterol levels were normal but that, due to his family history, he needed to be on a statin. She felt that Mr Clawson needed to take a beta blocker (used to treat heart conditions by making it beat more slowly and with less force). She prescribed Mr Clawson atorvastatin and bisoprolol, and referred him for remedial gym sessions.
35. On 27 April, a prison GP examined Mr Clawson, who said that he had not had any side effects from his medication. He said that he had used the GTN spray on three occasions and it had been effective. She measured Mr Clawson's blood pressure, which was pre-high, and decided that he needed to be reviewed in three months' time with another blood test before that appointment.
36. Healthcare staff performed the blood test on 27 July. That day, a prison GP reviewed the blood test results and noted that they were normal, though his HDL level remained low.
37. On 3 August, a prison GP examined Mr Clawson, who said that he used his GTN spray when he had mild panic attacks. He said that he experienced discomfort in his chest though it did not radiate, that his diet was not good despite cutting out crisps and chocolate, and that he continued to have headaches. She calculated Mr Clawson's QRISK2 cardiovascular disease 10 year risk score at 24.34% (a score over 10% indicates a need for further intervention) and warned him about gaining weight. She also diagnosed him with migraines and prescribed medication to treat them.
38. On 23 September, a prison GP examined Mr Clawson, who said he still had headaches. He replaced Mr Clawson's bisoprolol prescription with atenolol to help with his migraines.
39. On 14 November, a prison GP examined Mr Clawson, who continued to experience mild headaches. He measured Mr Clawson's blood pressure, which was high, and prescribed amitriptyline to help with his headaches.
40. On 18 November, a prison GP examined Mr Clawson, who said that two days earlier, he felt pressure in the left side of his chest and tingling in his left arm so had used his GTN spray twice. He measured Mr Clawson's blood pressure, which was high, and diagnosed him with angina. He also referred Mr Clawson for an ECG, prescribed him amlodipine and aspirin to treat his angina, and increased the dose of atenolol. Later that day, he examined Mr Clawson's ECG result and noted that the T waves were flattened (a potential indicator of not having enough blood in the coronary arteries) so sent him to hospital as an emergency. The next day, the hospital discharged Mr Clawson without changing his treatment plan.

41. Between November 2016 and March 2017, healthcare staff saw Mr Clawson regularly as part of a wellbeing service. Mr Clawson did not raise any concerns about chest pain and he continued to take his prescriptions without incident.
42. On 31 March 2017, Mr Clawson told a nurse that he felt lightheaded and had numbness in his left arm. She measured his blood pressure and pulse, which were both high, and she advised him to use his GTN spray if his symptoms continued.
43. On 12 April, a prison GP examined Mr Clawson, who said that he had used his GTN spray on four occasions in the last ten days, though it did not always have an effect, and that his pulse felt fast. She measured his blood pressure, which was high, but did not change his treatment plan.
44. On 14 April, prison staff told a nurse that Mr Clawson had not eaten since 8 April. He said he was not eating to cope with personal problems, rather than as a form of protest. She planned for healthcare staff to take Mr Clawson's physical observations regularly to monitor his health.
45. The next day, a nurse examined Mr Clawson, who said that he was not on a hunger strike but was just not hungry. He said that he had drunk lots of fluids. She measured his basic observations, including his blood pressure, which was pre-high. She asked healthcare staff to continue to monitor him. Meanwhile, prison staff began to monitor Mr Clawson's food intake and noted that he refused his main meals. He also continued to order malted drinks, juices and milk from the prison canteen.
46. On 18 April, prison staff told a nurse that Mr Clawson was eating small amounts as he was snacking at the servery. She saw Mr Clawson and encouraged him to drink fluids and milk to prevent harm to his kidneys. She also began ACCT procedures.
47. Later that day, staff held an ACCT case review with Mr Clawson, who said that he was working through childhood trauma and that his lack of appetite was not a deliberate form of self-harm. He said that ACCT monitoring might worsen his mood and trigger his paranoia. On that basis, a Senior Officer (SO) assessed that Mr Clawson's risk of suicide and self-harm was low (on a scale of low, raised and high) and decided to stop ACCT monitoring immediately.
48. On the same day, a nurse examined Mr Clawson and noted that he did not show any evidence of formal thought disorders or perceptual abnormalities. She decided that Mr Clawson did not require input from the mental health team.
49. On 21 April, a nurse examined Mr Clawson, who said that he had drunk at least 700ml of fluids since his last meeting with her. She measured Mr Clawson's basic observations. His blood pressure was high, and she referred him for a blood test.
50. On 24 April, a nurse performed the blood test and measured Mr Clawson's basic observations, finding that his blood pressure and pulse were both high. That day, a prison GP reviewed the blood test results and noted that they were normal.

51. Between 25 April and 1 May, healthcare staff assessed Mr Clawson's blood pressure and pulse on six occasions but did not always take his other basic observations. His blood pressure was mostly pre-high, while his pulse was mostly normal.
52. On 2 May, a prison GP examined Mr Clawson, who said that he had not eaten but was drinking fluids, including tea and coffee with sugar. She encouraged Mr Clawson to eat soups in order to stimulate his taste buds. She also measured his basic observations. His blood pressure was high, and she planned to review him in three weeks.
53. Between 6 May and 16 May, healthcare staff measured Mr Clawson's blood pressure and pulse on seven occasions but did not always take his other basic observations. His blood pressure varied between normal and high, while his pulse was normal each time.
54. On 16 May, a mental health social worker examined Mr Clawson after prison staff were concerned that he was having a "mental breakdown". Mr Clawson said that he seen his mother in a visual hallucination but the social worker was unable to confirm whether it was a vivid dream, a hypnagogic hallucination (the period of consciousness between being awake and asleep) or a stress induced psychosis. Mr Clawson also reiterated that he was not engaged in a hunger strike but that he was limiting his food intake to avoid putting on weight. The social worker explained the risks this presented, which Mr Clawson understood. When interviewed by the investigator, the social worker said that he assessed Mr Clawson's mental capacity during the examination and decided that he had the capacity to refuse food, though this was not recorded in his entry in Mr Clawson's medical record. He planned to review Mr Clawson in a week to assess his mental state.

### **Events of 18 May 2017**

55. On the morning of 18 May, Mr Clawson left his cell and had a shower.
56. At approximately 8.40am, an officer visited Mr Clawson's cell as part of a roll check, and found him on the floor of his cell. He noted that Mr Clawson was breathing and his eyes were open, though he did not respond when spoken to. He tried to radio a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing), but it did not transmit because the signal was poor. He shouted for assistance from a colleague. He then successfully called a code blue. When the investigator interviewed his colleague, she said that the code blue was called within one minute of finding Mr Clawson unresponsive. The officers could not move Mr Clawson into the recovery position due to his agitated state but they protected his head, checked his airway and kept him warm.
57. Two nurses responded to the code blue within five minutes. They placed him in the recovery position and took basic observations, though Mr Clawson was agitated and tried to resist treatment. At 9.00am, paramedics arrived with a paramedic doctor and gave Mr Clawson intravenous fluids to raise his blood pressure. They checked Mr Clawson's level of impairment three times, using the

Glasgow Coma Score, and found that he scored four, five and seven (a score of eight or below indicates a severe brain injury).

58. At 10.27am, paramedics took Mr Clawson to hospital. A nurse confirmed that Mr Clawson had a life-threatening condition, but did not object to the use of restraints. A senior manager used this information and authorised officers to restrain him with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). At 11.00am, when he arrived at hospital, officers removed the escort chain on the request of hospital staff.
59. Shortly after arriving at the hospital, hospital staff sedated Mr Clawson and then moved him to the Intensive Care Unit. Mr Clawson's condition continued to deteriorate and a hospital doctor declared his death at 8.20pm.

### **Contact with Mr Clawson's family**

60. When he was taken to hospital, a senior manager telephoned Mr Clawson's ex-partner. When he died, he telephoned her again and offered his condolences. The next day, the prison appointed an officer as the family liaison officer. He visited Mr Clawson's ex-partner that day to offer his condolences and support.
61. Mr Clawson's funeral was held on 16 June 2017 and the prison contributed to the funeral costs in line with national policy.

### **Support for prisoners and staff**

62. After Mr Clawson's death, the senior manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
63. The prison posted notices informing other prisoners of Mr Clawson'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 Clawson's death.

### **Post-mortem report**

64. The post-mortem examination concluded that Mr Clawson died of a fatal dysrhythmia (an abnormal heart rhythm), secondary to hypertensive heart disease (heart disease caused by high blood pressure). The post-mortem examination noted that there was no food present in Mr Clawson's stomach, though there was no evidence of a fatty change in his liver to suggest prolonged starvation.
65. The toxicology report concluded that there were concentrations of prescribed medications, consistent with therapeutic use.

# Findings

## Clinical care

66. While at Wayland, prison doctors diagnosed Mr Clawson with high blood pressure and angina, and they noted that he was obese. Healthcare staff treated him with regular blood tests and regular monitoring of his blood pressure and pulse rate. They also prescribed him appropriate medication including a GTN spray, atenolol, atorvastatin, aspirin and amlodipine. We also note that Mr Clawson was mindful of his own health and wellbeing as he was aware that he had put on weight during previous bouts of depression and that if he repeated this, it would put additional pressure on his heart.
67. We agree with the clinical reviewer that healthcare staff appropriately treated Mr Clawson's hypertension and angina in line with National Institute for Health and Care Excellence (NICE) guidelines 'Hypertension in adults: diagnosis and management (CG127)' and 'Stable angina: management (CG126)'. We agree that the care Mr Clawson received was equivalent to that which he could have expected to receive in the community.

## Food refusal

68. Chapter 10 of Prison Service Instruction (PSI) 64/2011 on safer custody confirms that the refusal of food and fluids is not considered in law to be a form of self-harm and that a person has the right to do this if mentally capable. It also states that the use of the ACCT process is a useful way of recording the care offered to a prisoner.
69. A Department of Health report on 'Guidelines for the clinical management of people refusing food in immigration removal centres and prisons' says that a thorough assessment of a person's mental capacity and nutritional status should be undertaken immediately and that there should be regular reviews. It says that when assessing the person's nutritional status, healthcare staff should record their basic observations, including their body weight, temperature, pulse, blood pressure and respiration rates, and examine them for the presence of muscle wastage and loss of subcutaneous fat.
70. Mr Clawson said that he stopped eating on 8 April but did not tell prison staff until 14 April. From 15 April, prison and healthcare staff started a log to monitor Mr Clawson's food intake, regularly measured some of his basic observations and placed Mr Clawson on an ACCT. We also note that a nurse and a mental health social worker assessed Mr Clawson's mental health on 18 April and 16 May respectively, and the social worker told us that he assessed his mental capacity on 16 May, although he did not make a record of this at the time.
71. We are satisfied that Mr Clawson's clinical care was equivalent overall to that which he could have expected to receive in the community. Despite this, while we recognise that prison and healthcare staff took some positive steps to manage Mr Clawson's food refusal, we are concerned that healthcare staff did not regularly review his mental capacity and only reviewed his mental health twice in the 40 day period that he refused food. We are also concerned that healthcare staff generally only measured Mr Clawson's blood pressure and pulse.

We would have expected them to have taken all of his basic observations. There is also no evidence that they checked him for muscle wastage and loss of subcutaneous fat in line with the Department of Health's guidelines. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with the Department of Health guidelines for the clinical management of people refusing food in prison. This should include:**

- **regular mental capacity assessments;**
- **regular mental health assessments; and**
- **measurement and assessment of a prisoner's full clinical observations, including signs of muscle wastage or loss of subcutaneous fat.**

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

72. 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 prisoner's risk of escape, his risk to the public and his 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 he has 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.
73. When Mr Clawson was taken to hospital on 18 May, healthcare staff noted that he was conscious but unresponsive, while paramedics found that he had a severe brain impairment. When completing the medical section of the escort risk assessment, a nurse recorded that Mr Clawson had a life-threatening condition but did not raise any medical objection to the use of restraints. Due to the lack of objection, a senior manager authorised officers to restrain Mr Clawson with an escort chain.
74. While we appreciate that Mr Clawson was restrained for less than an hour and that officers permanently removed the escort chain at the request of hospital staff, we are concerned that he was restrained at all as he had a life-threatening condition. Security measures must be proportionate to a prisoner's circumstances, and must be fully considered and balanced against the actual risk they pose. We are concerned that staff restrained Mr Clawson despite him being unresponsive and impaired, and despite the consequent reduction in his escape risk. We make the following recommendation:

**The Governor and Head of Healthcare 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 the prisoner and are based on the actual risk the prisoner presents at the time.**

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