

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Gayle a prisoner at HMP Oakwood on 8 December 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

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 Matthew Gayle died on 8 December 2016 at HMP Oakwood. He was 31 years old. I offer my condolences to Mr Gayle's family and friends.

I am concerned that Mr Gayle died while attempting to consume illicit drugs. He was suspected of being a frequent user of such drugs and, despite significant efforts, the prison was unable to prevent him from doing so.

It is also troubling that, despite being seen uncovered on the floor of his cell during the morning roll check, staff did not raise the alarm until after his cell was opened some two hours later.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

August 2017

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Summary

Events

1. Mr Matthew Gayle was convicted of drug offences on 12 August 2015 and was sentenced to five years imprisonment. He spent time at a number of prisons before arriving at HMP Oakwood on 24 March 2016.
2. Mr Gayle admitted smoking 'Mamba' (a New Psychoactive Substance, or NPS) in July. He said he did this unknowingly after sharing a joint with another prisoner. Mr Gayle was suspected of taking illicit drugs on a number of occasions, and was referred for mandatory drug testing three times. He never tested positive and no adjudications were upheld while he was at Oakwood.
3. At 5.22am on 8 December, an officer did the morning roll check but did not notice anything unusual when she checked Mr Gayle's cell.
4. At 7.38am, Mr Gayle's cell was unlocked and he was found unresponsive. An officer said that Mr Gayle was lying on his side on the floor of his cell, facing the window. His bed was made and was very neat.
5. An emergency was called, and Mr Gayle was moved from his cell to the landing. An officer noted that Mr Gayle remained rigid as they carried him out, but he started cardiopulmonary resuscitation (CPR). Shortly afterwards, a healthcare assistant arrived and took over CPR, despite recognising clear signs of Mr Gayle being dead. A nurse then arrived on the scene, and took over CPR despite later observing that it was clear Mr Gayle had rigor mortis. The Head of Healthcare arrived at 7.46am, and CPR was stopped after consultation with the healthcare professionals present.
6. While CPR was being performed on Mr Gayle, an officer removed an asthma inhaler from Mr Gayle's clenched hand. This inhaler had burnt foil over the mouthpiece, containing a residue of some substance. It was placed in an evidence bag and taken for testing by the police.
7. Paramedics arrived and pronounced Mr Gayle's death at 8.09am.

Findings

Clinical care

8. The clinical reviewer concluded that the care Mr Gayle received at Oakwood was not equivalent to that he could have expected to have received in the community. However, this was in respect of Mr Gayle's sleep hygiene problems (such as sleep walking and sleep apnoea) and asthma monitoring, so while this is noted, we do not find this relevant to Mr Gayle's death and make no recommendation.

Illicit drugs

9. The post-mortem report concluded that Mr Gayle died from choking on his own vomit, but could find no direct explanation for this, and no natural cause was identified. A toxicology report found no traces of illicit substances in Mr Gayle's blood or urine, but the substance found on the burnt foil tested positive for New

Psychoactive Substances (or NPS). Further comments in the post-mortem report, concluded that the whole scenario taken together indicated that Mr Gayle's death was related to an attempt to inhale illicit drugs, and that this caused an adverse reaction which may have involved convulsion, causing him to choke on his vomit while in a semi-conscious state.

10. Mr Gayle was suspected of being a user of illicit substances while at Oakwood, was referred for mandatory testing on three occasions (none of which proved positive), and had his privileges removed on two occasions due to suspicions of drug activity. He was seen by the substance misuse team in July 2016 when he admitted to having mistakenly smoked 'Mamba' (a type of NPS).
11. We acknowledge that Oakwood has a comprehensive drug strategy which is regularly reviewed with the input of all disciplines at the prison. Intelligence is gathered on prisoners suspected of using drugs, and adjudications are used to discourage such activity. Further efforts have been put in place since Mr Gayle's death however we find that continuing effort remains necessary to address the risk posed by NPS.

The events of 8 December

12. When Mr Gayle's cell was checked at 5.22am, the officer did not notice anything unusual, despite the fact that Mr Gayle was very likely to have been dead at that time. The officer said that she only checks to make sure someone is in the cell and that it was not unusual for prisoners to sleep on the floor. Although we cannot say whether a more thorough check on Mr Gayle at this point would have prevented his death, we find that had the officer obtained a clear view of his face, as the local instruction for Oakwood directs, there is every chance the emergency response would have been triggered sooner.
13. When Mr Gayle was found at 7.38am, the emergency response was prompt and healthcare staff were on scene quickly. However, we are concerned that an officer and then two members of healthcare staff performed CPR despite clear and recognised signs that Mr Gayle was already dead. The impact of this on staff cannot be understated, and we find that better information must be given to all staff to ensure they are aware of the guidelines regarding CPR. We also consider that better clarification should be given to healthcare professionals to ensure they have the confidence and support to make better resuscitation decisions.

Recommendations

- The Director should ensure there is effective implementation of the prison's substance misuse strategy to help reduce the availability of, and demand for, New Psychoactive Substances.
- The Director should ensure that staff are given clear guidance as to what is expected of them when conducting roll checks, and the extent of their responsibilities.
- The Director and head of healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate, in line with national guidelines.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact him. No one responded
15. The investigator visited HMP Oakwood on 13 December 2016. He obtained copies of relevant extracts from Mr Gayle's prison and medical records. The investigator interviewed four members of staff at HMP Oakwood on this visit, and another member of staff by telephone on 26 January 2017.
16. NHS England commissioned a clinical reviewer to review Mr Gayle's clinical care at the prison. The investigator and clinical reviewer interviewed a further five members of staff and a prisoner at Oakwood during January.
17. We informed HM Coroner for Staffordshire South of the investigation and he gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Gayle's mother, to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. Mr Gayle's mother asked us to consider the roll checks performed on Mr Gayle and whether he had any medical conditions detailed in his health records, or whether he had raised any issues with anybody. Mr Gayle's mother also requested that we obtain copies of his prison records and medical notes on her behalf.
19. Mr Gayle's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
20. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Oakwood

21. HMP Oakwood opened in 2012. It is near Wolverhampton and managed privately by G4S. Oakwood is one of the largest prisons in England and Wales, providing places for up to 1,605 Category C male prisoners.
22. Care UK provides healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs. There are no in patient facilities.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Oakwood was conducted in December 2014. Inspectors reported that health services had improved considerably since the last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well-equipped and staff created appropriate care plans.
24. Inspectors noted that there was a significant threat of drugs, including New Psychoactive Substances (particularly 'black Mamba') and diverted medication. They reported an overuse of strip searching, and closed visits (in which a glass pane separates prisoners and their visitors). They reported that, despite a comprehensive and robust supply reduction strategy, prisoners said that it was easy to acquire drugs at the prison.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board made up of unpaid volunteers from the local community who help to help ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2016, the IMB reported that, due to the uncertainty arising from the change of healthcare provider, there were a high number of vacancies and the use of agency staff had hindered continuity of care. There was no nurse cover during the night.

Previous deaths at HMP Oakwood

26. Mr Gayle was the sixth prisoner to die at HMP Oakwood since January 2016. We have previously made recommendations relating to New Psychoactive Substances.

New Psychoactive Substances (NPS)

27. New Psychoactive Substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for

precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
29. HMPPS (formerly NOMS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continues to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

30. Mr Matthew Gayle was convicted of drugs offences on 12 August 2015. Although he was sentenced to five years and ten months imprisonment, this was subsequently reduced to five years imprisonment following an appeal. Mr Gayle spent time at a number of prisons before arriving at HMP Oakwood on 24 March 2016.
31. When he arrived at Oakwood, a nurse reviewed Mr Gayle at a reception health screen. Mr Gayle said he did not drink or misuse drugs and had no concerns about his physical health. He was on prescribed medication for asthma, and a repeat prescription was set up for salbutamol (to relieve asthma attacks) and clenhil modulite (taken by way of an inhaler to prevent asthma attacks).

Illicit drugs

32. On 15 April, prison staff searched Mr Gayle's cell following reports he was selling 'Mamba' (a NPS) on his wing. Officers found drug paraphernalia in the form of an asthma inhaler covered with foil, which later tested positive for NPS. Mr Gayle claimed this makeshift pipe belonged to another prisoner, who admitted that it did belong to him. Mr Gayle and the other prisoner were both placed on report and referred for mandatory drug testing.
33. On 4 July, prison staff suspected that Mr Gayle was under the influence of an illicit substance and referred him for mandatory drug testing. A worker from the substance misuse team was unable to see Mr Gayle two days later, because he was being treated in his cell by healthcare staff as he was believed to be under the influence of an unknown substance. Prison staff told her that Mr Gayle had recently been under the influence in this way numerous times. The next day a worker from the substance misuse team saw Mr Gayle for a review. Mr Gayle told her that he had unknowingly taken NPS after sharing "a spliff" believing it to contain only tobacco. She advised Mr Gayle about the negative effects of NPS but Mr Gayle said he did not want to engage with the service further. On 26 July, an officer noted on Mr Gayle's prison notes that he had been under the influence of some substance the previous day.
34. In early September, prison staff received intelligence that Mr Gayle was the main supplier of drugs and mobile phones on his wing. On 6 September, staff searched Mr Gayle's cell and found two unknown tablets hidden in a bag of protein powder. This matter was dismissed at an adjudication hearing the next day, but Mr Gayle lost his privileges for about three weeks. Privileges are awarded to prisoners for good behaviour, but are removed if they are deemed to have misbehaved.
35. On 1 October, an intelligence report recorded that Mr Gayle had obstructed the observation panel in his door during the night. The report further observed that Mr Gayle appeared to be under the influence of an unknown substance when he removed this obstruction, and that he was referred for mandatory drug testing.
36. Later that month, one of Mr Gayle's visitors was suspected of having something in his mouth, which he swallowed when challenged. When told he would be

searched by a dog, the visitor declined to complete the visit and was banned from visiting the prison for three months.

37. Oakwood started testing for NPS in September 2016, and although subject to Mandatory Drug Testing on three separate occasions, Mr Gayle never tested positive while he was there. The team leader for substance misuse at Oakwood confirmed in interview that prior to this healthcare staff concluded that prisoners were using NPS by observing their symptoms and monitoring medical signs such as blood pressure.

Clinical care issues

38. In early May, Mr Gayle was added to the sleep clinic waiting list, although there is no record of any prior discussion of this. On 27 May, Mr Gayle saw a prison GP with sleep hygiene problems, and was given a two week prescription of amitriptyline (an antidepressant which also helps with sleep problems). Between September and November, Mr Gayle was seen by GPs and healthcare staff several times for insomnia, sleep walking and sleep apnoea (a disorder involving pauses or shallow breathing during sleep).
39. In early September, prison GP advised Mr Gayle to attend the prison sleep clinic and doubled his dosage of amitriptyline. Later that month, he reviewed Mr Gayle for his sleep problems, and on 12 October he issued a three day course of zopiclone (a hypnotic drug used to treat insomnia).
40. On 25 October, a prison GP referred Mr Gayle to the ear, nose and throat (ENT) clinic at the hospital to be assessed for sleep studies. He also gave Mr Gayle a seven day prescription for promethazine (an antihistamine with a strong sedative effect) to assist with his sleeping. An appointment was confirmed for the ENT clinic on 7 December, but later changed to 29 December.
41. On 3 December, Mr Gayle collected a prescription for both the salbutamol and clenil modulite inhalers. This was the first time he had collected asthma medication since the middle of September. Mr Gayle had not been reviewed for his asthma since arriving at Oakwood.

The events on 8 December

42. On 7 December, at around 7.00pm, Mr Gayle was locked into his cell. Officer A conducted a roll check on Mr Gayle's cell at 8.55pm that evening and did not notice anything wrong at this time. She confirmed in interview that she could not recall what Mr Gayle was doing, but would have noticed if anything had been wrong. She also recalled that although Mr Gayle often had his observation panel covered, he did not on this occasion.
43. On 8 December, at 5.22am, Officer B conducted a roll check on Mr Gayle's cell. She did not observe anything unusual during this check, and confirmed in interview that she would only go so far as to check to make sure someone was in the cell. She further stated that she might look a little longer if "there was any blood or anything like that", but that it was not uncommon for people to sleep on the floor because of the under-floor heating. She further confirmed that she would not need to identify the prisoner; only to see that a prisoner was there.

44. Officer C opened Mr Gayle's cell at 7.38am. She saw him lying on the floor with his feet under the bed and his head facing away from the door towards the window. She asked her colleague, Officer D to call a code blue (an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance). Mr Gayle did not respond when both officers shouted, so Officer D shook him by the shoulder. He said he was cold to the touch. At this point, both officers noticed blood on Mr Gayle's face and vomit on the floor. Officer C then called the code blue on her radio herself, but when there was no response to this, she pressed her personal alarm and repeated the code blue call. Officer D then went to get the defibrillator, while she stayed with Mr Gayle.
45. Officer E arrived at the scene, quickly followed by Officer F. Officer C left the scene soon after, shaking and very distressed.
46. Officer F went into Mr Gayle's cell and noted that the bed was made and very neat. He observed that Mr Gayle was lying on his side on the floor, facing the cell window, with his feet under the bed with his body curved in the foetal position. Mr Gayle's arms were bent at the elbow and tucked in towards his chest, with his hands clenched into a fist shape. He described Mr Gayle as being somewhat flushed and cold to the touch. He could find no pulse and observed what seemed to be congealed blood around his nose and mouth.
47. Officer F and two other officers lifted Mr Gayle from his cell to the landing. He stated in interview that Mr Gayle retained the same shape and his arms did not straighten up as they carried him. Once Mr Gayle was on the landing he began performing CPR.
48. A healthcare assistant arrived at the scene while Officer F was performing the first set of chest compressions on Mr Gayle. She confirmed in interview that Mr Gayle had his hands raised in the air and had pooling down one side. However, she said she did not feel qualified to take the decision to stop CPR. She took over chest compressions, while the officer tried to deliver breaths into Mr Gayle through a face shield, but was unable to do so. As this was happening, Officer E had returned with the defibrillator and was attaching the pads to Mr Gayle's chest.
49. Officer F then noticed a blue plastic inhaler in Mr Gayle's right hand, and asked an officer to remove it while he recorded this on a body camera. The cartridge had been removed from the inhaler, and it had burnt foil over the mouthpiece containing a residue of an unknown substance. The inhaler was sealed in an evidence bag and taken away by the police for testing.
50. A nurse arrived on the scene shortly afterwards, and was then the most senior nurse on duty. She took over chest compressions, while the healthcare assistant tried to insert an airway. In interview, she confirmed that it was clear Mr Gayle had rigor mortis, but she refrained from taking the decision to stop CPR because she had never done so before. She was also aware that the Head of Healthcare was not far behind her and said that she preferred to wait for him.
51. The Control Room Occurrence Log records that an ambulance was called at 7.42am.

52. The Head of Healthcare arrived on the scene at 7.46am and immediately indicated that CPR was futile. After a quick consultation between the healthcare professionals present, CPR was stopped shortly afterwards. At 8.09am, paramedics pronounced Mr Gayle dead.

Contact with Gayle's family

53. Shortly after Mr Gayle's death, the prison appointed a senior manager as the family liaison officer, with an officer as his deputy. Mr Gayle's next of kin was his mother.
54. The senior manager and officer arrived at the home of Mr Gayle's mother, at 10.35am. Mr Gayle's mother was not at home, so they waited in the car for her to return. When Mr Gayle's mother returned, the senior manager informed her of Mr Gayle's death and offered support.
55. The officer supported Mr Gayle's mother with funeral arrangements and visiting Mr Gayle's cell, which she did on 15 December. Mr Gayle had recently converted to Islam, and a Muslim funeral was held on 16 December. The prison contributed to the costs in line with national guidance. The officer continued to offer support to Mr Gayle's mother following the funeral, and visited her on 11 January 2017 to return his belongings.

Support for prisoners and staff

56. After Mr Gayle's death, the Deputy Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
57. The prison posted notices informing other prisoners of Mr Gayle'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 Gayle's death.

Post-mortem report

58. The post mortem report concluded that the immediate cause of death was aspiration of gastric contents (Mr Gayle choked on own vomit). The cause of this was unascertained, but no natural cause was identified.
59. A toxicology examination on Mr Gayle revealed modest levels of alcohol, and traces of morphine – neither were deemed likely to have endangered his health. No traces of NPS were detected in Mr Gayle, but the substance found on the burnt foil on the asthma inhaler did test positive for NPS.
60. Further comments in the post-mortem report, suggest that the whole scenario taken together indicated that Mr Gayle's death was related to an attempt to inhale illicit drugs, and that this caused an adverse reaction which may have involved convulsion. The toxicologist revealed that one of the synthetic compounds found has been known to induce asphyxia, due to vomiting under low-consciousness levels, following inhalation.

Findings

Clinical care

61. The clinical reviewer concluded that the level of care Mr Gayle received for his sleep hygiene problems and asthma monitoring was not equivalent to that he would have expected to have received in the community. As neither of these relate to Mr Gayle's death, we make no recommendation. However, the clinical reviewer made a number of recommendations which the Head of Healthcare and the Director will need to address.

Illicit drugs and NPS

62. At the time of Mr Gayle's death, Oakwood had a drug and alcohol strategy which relies on input from all sectors in the prison, including security, healthcare and operational staff. A number of tactics are employed by staff to control the supply of, and demand for, drugs in Oakwood. These include drug detection dogs, the searching of visitors and the targeted searching of prisoners based on intelligence and random tests. Intelligence reports are generated when there is a suspicion that prisoners have used illicit substances. However, the Head of Security confirmed that this was often a judgement call on the part of individual officers. Prisoners who are suspected of using illicit substances are referred to the substance misuse team. Mandatory drug testing was extended in September to include NPS. Prisoners are subject to a loss of privileges and segregation if they are found to have taken illicit substances.
63. Mr Gayle was suspected of taking illicit substances a number of times while at Oakwood and was subject to a loss of privileges on two occasions. He was referred for mandatory drug testing on three separate occasions, none of which were positive, albeit Oakwood did not test for NPS prior to September 2016. In July, Mr Gayle admitted smoking "Mamba", but claimed he did this unknowingly. He declined an offer to engage further with the substance misuse team. Oakwood banned one of Mr Gayle's visitors in October, because he refused to be searched when suspected of having something suspicious in his mouth.
64. We accept that Oakwood have taken steps to counter the problem with NPS, are updating their strategy to cope with fresh challenges and have extended their drug prevention measures further since Mr Gayle's death. Netting has been installed to prevent people throwing over packages. Modified missile detectors and fast moving digital cameras are also being trialled, to detect and track drones. However, we find that continuing efforts need to be made to combat the problem of NPS, and make the following recommendation:

The Director should ensure there is effective implementation of the prison's substance misuse strategy to help reduce the availability of, and demand for, New Psychoactive Substances.

Roll checks

65. Roll checks are performed each evening after prisoners are locked up, and again in the morning prior to unlock. At Oakwood, a local instruction states that night staff must obtain a clear view of a prisoner's face during roll check, including by waking him if necessary.
66. It is highly likely that Mr Gayle had died some time before the morning roll check on 8 December. Officer B can be seen on CCTV checking Mr Gayle's cell at 5.22am, and confirmed in interview that she did not see anything unusual. She also stated that it was not unusual for prisoners to sleep on the floor of their cell.
67. Mr Gayle was lying facing the window away from the observation panel, but he had blood on his face and vomit beside him on the floor. Officer B stated in interview that if she saw something unusual such as blood, she would check more carefully. We cannot say whether a more thorough check on Mr Gayle at this stage would have affected the outcome, but had she obtained a clear view of Mr Gayle's face during the morning roll check, as she should have, and seen the blood, there is every chance that an emergency response would have been triggered sooner.

The Director should ensure that staff are given clear guidance as to what is expected of them when conducting roll checks, and the extent of their responsibilities.

Emergency response and CPR

68. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two code medical emergency response system in place. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.
69. On establishing that Mr Gayle was unresponsive, Officer C attempted to call a code blue on her radio. There was no response to this, so she immediately pressed her personal alarm and repeated the code blue call. This was picked up by other officers and healthcare staff who arrived on the scene promptly. An ambulance was also called without undue delay. While noting that the emergency code did not initially register, we accept that the initial emergency response was appropriate.
70. Officer F started CPR as soon as Mr Gayle had been moved onto the landing. He observed that Mr Gayle was rigid as he was moved. The healthcare assistant observed that Mr Gayle had pooling (blood collating in parts of the body after death) down one side, and had one hand fixed in the air, but took the decision to continue CPR. She said she did not feel qualified to make a judgement on the appropriateness of this. A nurse arrived at the cell shortly afterwards and observed that Mr Gayle clearly had rigor mortis. She also took the decision to continue with CPR as she had never had to discontinue resuscitation before.
71. We agree with the clinical reviewer that Mr Gayle showed clear signs of death prior to CPR being started. We accept that Officer F made a reasonable decision

to start CPR, given that he was not a qualified healthcare professional. However, both the healthcare assistant and the nurse were trained in basic life support and recognised that continuing CPR was probably futile. In interview, the healthcare assistant said that it was “a very grey area” and it was not clearly specified what should be done in such situations. The nurse added in interview that she felt further clarification was needed as to when such a decision should be taken.

72. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. In September 2016, NHS England issued formal guidance entitled: ‘Guidance to support decision making for when not to perform CPR in prison and IRCs’. This guidance adopted the European Resuscitation Council Guidelines of 2015, which states: “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...”, such as the presence of rigor mortis. In 2016, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued revised guidance about making appropriate resuscitation decisions. The guidance states that every decision should be made on the basis of a careful assessment of each individual’s situation. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not necessary or appropriate, in line with national guidelines.

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