

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Kevin Crehan a prisoner at HMP Bristol on 27 December 2016

**A report by the Prisons and Probation Ombudsman**

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To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

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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 Kevin Crehan died on 27 December 2016 of a drug overdose at HMP Bristol. Mr Crehan was 35 years old. We offer our condolences to Mr Crehan's family and friends.

Mr Crehan had overdosed previously on 23 December and had spent three days in hospital. When he was discharged back to Bristol, staff failed to conduct a reception health screen. We are concerned that no consideration was given to monitoring Mr Crehan overnight, despite him telling staff that same day that he did not feel able to stop his illicit drug taking.

Mr Crehan had reported to staff previously that he was struggling with his dependency on illicit substances in prison but little action was taken to address this.

We found deficiencies in the unlock procedures and in the emergency response on the morning of 27 December. We also found that staff attempted resuscitation inappropriately given there were clear signs Mr Crehan had died.

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

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

**February 2018**

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# Summary

## Events

1. In July 2016, Mr Kevin Crehan was sentenced to twelve months imprisonment for a racially aggravated public order offence and was sent to HMP Cardiff. He had a history of opioid dependence, for which he was prescribed methadone.
2. Mr Crehan was transferred to HMP Guys Marsh in August. Over the next two months, staff obtained intelligence to suggest that Mr Crehan was involved in the prison's illicit drugs market and that he was illicitly using pregabalin (a prescription-only medication which can enhance the euphoric effects of other drugs, such as opiates).
3. On 30 November, Mr Crehan was transferred to HMP Bristol. Five days later, he told a substance misuse worker that he had been taking illicit pregabalin at Guys Marsh and was suffering withdrawal. Although the substance misuse worker created a care plan, there is no record of a follow-up appointment.
4. On 23 December, Mr Crehan was taken to hospital following an overdose. Around an hour later, a nurse found an appointment request made by Mr Crehan on 21 December, stating that he felt suicidal and asking for gabapentin (a prescription-only medication which has similar effects to pregabalin).
5. On 25 December, the prison Governor visited Mr Crehan in hospital and concluded that he had not intended to overdose. Mr Crehan was discharged back to Bristol the following afternoon. When he collected his medication later that day, he told the healthcare assistant that he was buying illicit pregabalin and gabapentin and needed help. Around 5.45pm, a nurse went to see Mr Crehan in his cell to check he was okay. She took his clinical observations, which were normal. She did not speak to him about his substance misuse.
6. At around 9.15am, on 27 December, prisoners found Mr Crehan unresponsive in his cell and alerted staff. An officer called for assistance over the radio network, before calling a medical emergency code shortly afterwards. Staff started cardiopulmonary resuscitation (CPR) while Mr Crehan was on his bed but then moved him onto the floor. They noticed he was stiff but continued CPR. At 9.26am, a paramedic confirmed that Mr Crehan was dead.

## Findings

7. We consider that Mr Crehan should have had a medical assessment when he was discharged back to Bristol following his overdose and that staff should have considered observing him overnight. We agree with the clinical reviewer that the overall care Mr Crehan received at Bristol was not equivalent to that which he could have expected to receive in the community.
8. We are not satisfied that the prison properly supported Mr Crehan when he disclosed to staff that he was struggling with dependency on illicit medication.
9. We found deficiencies in the unlock procedures on 27 December and in the emergency response, although the delays would not have affected the outcome

for Mr Crehan. Staff's attempts at resuscitation were inappropriate given he was dead when discovered.

10. We are concerned that another prisoner, who had access to an illicit mobile phone, notified Mr Crehan's family of his death before prison staff had the opportunity to do so.

## **Recommendations**

- The Head of Healthcare should ensure that prisoners returning from hospital following an overdose receive an appropriate assessment and that consideration is given to additional monitoring.
- The Head of Healthcare should ensure that there is a consistent process for reviewing applications to see healthcare, and that urgent cases are acted upon promptly.
- The Head of Healthcare should ensure that there is an appropriate procedure for the management of withdrawal from illicit medication, including pregabalin and gabapentin.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the use of an appropriate emergency code which triggers the control room to call an ambulance immediately.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Crehan's prison and medical records.
13. The investigator and an Assistant Ombudsman interviewed seven members of staff at Bristol on 25 July 2017. The investigator interviewed a prisoner at HMP Erlestoke on 26 July. He also interviewed three members of staff from Bristol by telephone on 8 August.
14. NHS England commissioned a clinical reviewer to review Mr Crehan's clinical care at the prison.
15. We informed HM Coroner for Avon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Crehan's father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Crehan's father raised the following issues:
  - He wanted to know what happened when Mr Crehan was taken to hospital on 23 December 2016.
  - He was concerned about the care Mr Crehan received when he returned to prison on 26 December.
  - He asked if Mr Crehan was monitored overnight and whether he pressed his cell bell.
  - He wanted to know what happened the morning Mr Crehan died.
17. Mr Crehan's family received a copy of the initial report and indicated that they were satisfied with the findings.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

# Background Information

## HMP Bristol

19. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health provides primary healthcare services and Medco Secure Health Services provide GP services. Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health services and substance misuse services. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty at night.

## HM Inspectorate of Prisons

20. The most recent inspection of Bristol was in March 2017. Inspectors reported that clinical record keeping was generally good but formal care planning for those with complex health needs was underdeveloped. They reported that joint working between clinical nurses, psychosocial workers and the regular GP prescriber for prisoners with substance misuse issues, was impressive.
21. The inspectors found that the prison had a proactive and coordinated approach to drug supply reduction but this had yet to lead to reduced availability. They found that the range of psychosocial interventions for prisoners with substance misuse issues was good but they were often unable to attend due to a lack of escorts.

## Independent Monitoring Board

22. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its latest annual report for Bristol, for the year to July 2016, the IMB reported that priority and routine healthcare services are offered on the wings daily, and include the delivery of medication. The Board noted that nurses reported occasional diverting of prescribed medication when officers were not present to oversee the process.

## Previous deaths at HMP Bristol

23. Mr Crehan was the seventh prisoner to die at Bristol since January 2016. There have been three deaths at Bristol since Mr Crehan died. In a recent investigation into a previous death at Bristol, we found that although the prisoner died of natural causes, the post-mortem showed that prior to his death, he had taken medication that had not been prescribed to him.

## Key Events

24. On 20 July 2016, Mr Kevin Crehan was sentenced to twelve months imprisonment for a racially aggravated public order offence and was sent to HMP Cardiff. At an initial reception screen, a nurse noted that Mr Crehan had a history of opioid dependence, for which he was prescribed methadone. The next day, a prison GP prescribed Mr Crehan 5mg diazepam (used to treat anxiety) and 110ml methadone daily. On 9 August, a nurse recorded that Mr Crehan had agreed to reduce his methadone dose by 5mls a week until he reached 40ml daily.
25. Mr Crehan was moved to HMP Guys Marsh on 10 August. At an initial reception screen, a nurse noted that Mr Crehan had reported difficulties outside prison and wanted to talk to someone about anxiety and depression. He made a referral to the prison's primary mental health team and a prison GP agreed to prescribe 5mg diazepam until they reviewed him. The mental health team discussed Mr Crehan's referral on 16 August, but considered there was no evidence of a mental illness. Mr Crehan experienced difficulty reducing his methadone dose by 5ml a week and on 29 September, a nurse prescriber agreed for him to remain on 60ml daily until release.
26. Over the next two months, while at Guys Marsh, staff obtained intelligence indicating that Mr Crehan was involved in the prison's illicit drug market and that he was taking pregabalin (a medication used to treat epilepsy and nerve pain which can be used to enhance the euphoric effects of other drugs, such as opioids). On 22 November, a substance misuse worker recorded that he had attended the medication hatch stating that he had been taking pregabalin and needed to stop. However, there is no record that this was followed up or that healthcare or substance misuse staff saw Mr Crehan for a review.
27. On 30 November, Mr Crehan was transferred to HMP Bristol and a nurse conducted an initial reception screen. She noted that he reported no thoughts of self-harm and she made a referral to the prison's substance misuse team. Prison staff assigned Mr Crehan a cell on the detoxification wing and a prison GP prescribed him 60ml methadone daily. On 5 December, a substance misuse worker saw Mr Crehan for an assessment and he reported taking illicit pregabalin at Guys Marsh. He said that he was suffering from withdrawal symptoms and that he had accidentally overdosed three times in the past. The substance misuse worker created a care plan indicating that Mr Crehan required relapse prevention support, but there is no record of a follow up appointment.

### Events from Friday 23 December to Tuesday 27 December

28. At around 10.25am on 23 December, another prisoner, a friend of Mr Crehan's, went to his cell to request a cigarette and started to shout and bang on the door when he failed to respond. Mr Crehan's friend told the investigator that he asked an officer to open Mr Crehan's cell a number of times before he eventually unlocked the door. The officer noticed that Mr Crehan had difficulty breathing. His friend pressed the general alarm to alert prison staff and the officer used a radio to request medical assistance. Within minutes, a nurse arrived and noticed Mr Crehan lying unresponsive on his bed with liquid running down his chin.

Shortly afterwards, another nurse arrived and instructed prison staff to request an ambulance and to move Mr Crehan into the recovery position. Healthcare staff treated Mr Crehan for a suspected overdose until paramedics arrived and took him by ambulance to Southmead Hospital, Bristol. He was escorted by two officers, without restraints.

29. About an hour after Mr Crehan was taken to hospital, healthcare staff found a medical application he had written on 21 December stating that he was on the verge of suicide and requesting gabapentin (a medication used to treat epilepsy and nerve pain, which has similar effects to pregabalin). According to the electronic medical record, a nurse liaised with the prison's safer custody department about starting suicide and self-harm prevention measures (known as ACCT), as she was concerned Mr Crehan may have deliberately taken an overdose. However, the nurse recorded that she was advised not to open an ACCT while he was outside the prison. She spoke to a mental health nurse, Nurse A, about an urgent referral, but was informed that a standard referral would be sufficient as Mr Crehan had gone to hospital.
30. Hospital staff admitted Mr Crehan to intensive care and kept him sedated while they treated him for an overdose. On 24 December, a nurse contacted the hospital for an update and recorded that Mr Crehan was awake and talking. The prison Governor visited him in hospital the following day and noted that despite being conscious, he remained very drowsy. In his statement the Governor said that Mr Crehan told him that he used pregabalin and gabapentin outside prison and 'often took more than he had' (taken to mean an excessive amount). He did not report any thoughts of self-harm or suicide and the Governor concluded that his actions were an unintended consequence of drug misuse.
31. On 26 December, Mr Crehan was discharged from hospital and he arrived back at Bristol mid-afternoon. When he went to collect his medication later that afternoon, he told the healthcare assistant who was administering the medication that he spent £50 per week on illicit pregabalin and gabapentin and that he needed help because he was scared about what might happen if he continued. The healthcare assistant reported this to Nurse A, who, having established that Mr Crehan had not been seen by the reception nurse, decided to see him herself to check he was fit to be back in custody. She did not see the hospital discharge summary.
32. At 5.45pm, Nurse A recorded that she had seen Mr Crehan, that he was in good spirits and that his clinical observations were normal. However, she did not speak to him about illicit substance misuse or thoughts of self-harm. She told the investigator that she was aware Mr Crehan had reported using illicit pregabalin to a member of staff that afternoon but she felt it was inappropriate to enquire further when she saw him in his cell because it was not a confidential environment. She also said that she did not refer Mr Crehan to the substance misuse team as it was a bank holiday and nobody was on duty.
33. Mr Crehan's friend told us that when he saw Mr Crehan following his return from hospital, he was staggering around and could not maintain a conversation. He said that he told healthcare staff that something was wrong and that he asked an officer to check on Mr Crehan overnight. He said staff told him that Mr Crehan

was fine and would feel better after a night's sleep. Shortly before locking Mr Crehan in his cell for the night, Officer A escorted him to get some hot water. He told the investigator that Mr Crehan did not report any issues and that he had no concerns about his presentation. There is no record that Mr Crehan reported any concerns to night staff or that he pressed his cell bell.

34. Shortly before 9.15am on 27 December, Officer B unlocked Mr Crehan's cell. She told the investigator that she looked through the observation hatch before opening the door and saw Mr Crehan lying on his bed with a cup in his hand. She could not remember whether she said "good morning", but said this is something she would normally do. After unlocking two more cells, the officer heard a prisoner shout, "He's dead, he's dead" and made her way towards Mr Crehan's cell with Officer C. When they arrived, a number of prisoners were in the cell and Officer B used a radio to call for assistance, at 9.15am. Around 30 seconds later, she called an emergency code blue (which indicates that a prisoner is unconscious or has difficulty breathing) and the control room immediately called for an ambulance.
35. Officer A arrived and checked Mr Crehan's vital signs, but could not find a pulse. He started cardiopulmonary resuscitation (CPR) and a prison manager arrived to assist. In the meantime, Nurse A put the controlled medication away and made her way to Mr Crehan's cell. When she arrived, she asked a healthcare assistant to go and collect the emergency equipment. The prison manager noticed Mr Crehan's bed was absorbing the compressions and staff moved him onto the floor so that CPR could continue. While doing so, the prison manager and Nurse A noticed that Mr Crehan's body was very stiff. Additional healthcare staff arrived and attached a defibrillator, but it did not find a shockable heart rhythm. At 9.25am, paramedics arrived and advised staff to stop CPR due to the presence of rigor mortis and at 9.26am, a paramedic pronounced that Mr Crehan was dead.

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

36. At 11.40am, a prison family liaison officer and the Governor attended Mr Crehan's parents' address to break the news of their son's death. When they arrived Mr Crehan's father was already aware of what had happened as another prisoner had contacted him by mobile phone. They apologised for him finding out that way and offered their condolences and support.
37. The family liaison officer remained in contact with Mr Crehan's family until shortly after his funeral, which took place on 20 January 2017. The prison contributed towards the cost, in line with national policy.

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

38. After Mr Crehan's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.
39. The prison posted notices informing other prisoners of Mr Crehan'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 Crehan's death.

## Post-mortem report

40. The post-mortem report found that Mr Crehan had died from the toxic effects of methadone and diazepam. It found that the level of methadone in Mr Crehan's blood was in excess of what would be expected during maintenance therapy and that the level of diazepam was towards the upper end of therapeutic range. Gabapentin and pregabalin were also identified at levels considered to be within the therapeutic range. The report noted that diazepam and methadone would act together to produce central nervous system depression with a risk of sudden death.

# Findings

## Clinical care

41. Mr Crehan's death from a drug overdose on 27 December was his second overdose in four days and occurred within 24 hours of his discharge from hospital. We are concerned that a full medical assessment was not carried out on Mr Crehan when he was returned to Bristol on 26 December. Prison policy (set out in PSI 07/2015 Early Days in Custody – reception in, first night in custody, and in induction to custody) states that where a prisoner is returning to prison after a temporary absence, a medical assessment is required where the prisoner falls into one of several categories or where reception staff have any other concerns about their health. We consider that Mr Crehan fell into at least one of these categories, given that he had drug dependency and had very recently overdosed, resulting in a hospital admission.
42. Nurse A conducted a review of Mr Crehan but this consisted only of taking his clinical observations. No one discussed with Mr Crehan the request he made on 21 December for gabapentin and his statement that he was on the verge of suicide. Nor did anyone discuss with him his disclosure on 26 December that he was taking illicit pregabalin and gabapentin and needed help as he feared what might happen to him if he continued.
43. Mr Crehan's friend told the investigator that Mr Crehan was staggering around before he was locked up for the night on 26 December. Nurse A and Officer A both said that Mr Crehan appeared fine and they had no concerns about him. We have been unable to verify Mr Davies' account as Bristol was unable to provide us with any CCTV footage. Despite a number of requests, Bristol told us that the CCTV footage could not be retrieved.
44. We consider that the assessment of Mr Crehan's health upon his return to Bristol from hospital on 26 December was inadequate. Given his history of drug dependency and his recent overdose, he should have had a full medical assessment and his disclosure that he continued to take illicit substances should have been discussed with him. Given the circumstances, we consider that staff should have considered observing Mr Crehan overnight. The clinical reviewer found that Mr Crehan's clinical care in this respect was not equivalent to that which he could have expected to receive in the community.
45. Healthcare staff did not realise until after Mr Crehan had been taken to hospital on 23 December that he had applied for a healthcare appointment on 21 December, in which he said he was on the verge of suicide. We agree with the clinical reviewer that healthcare staff should have identified and acted upon this information more quickly. Had they done so, it is possible that Mr Crehan may have received appropriate substance misuse intervention prior to overdosing.
46. We make the following recommendations:

**The Head of Healthcare should ensure that prisoners returning from hospital following an overdose receive an appropriate assessment and that consideration is given to additional monitoring.**

**The Head of Healthcare should ensure there is a consistent process for reviewing applications to see healthcare, and that urgent cases are acted upon promptly.**

### Substance misuse

47. The post-mortem gave Mr Crehan's cause of death as the toxic effects of methadone and diazepam. Gabapentin and pregabalin were also found in Mr Crehan's blood. Mr Crehan was never prescribed diazepam, gabapentin or pregabalin at Bristol and we consider it likely that he obtained these drugs in prison.
48. Mr Crehan had a history of dangerous drug taking and had overdosed accidentally on several occasions prior to his death. Although Mr Crehan stated in his healthcare application on 21 December that he was on the verge of suicide, there was little indication that he had serious suicidal thoughts and we consider it likely that his primary aim in making this statement was to try to get a prescription for gabapentin. We consider that Mr Crehan's fatal overdose was probably accidental rather than a deliberate act.
49. We are concerned however, that more was not done to support Mr Crehan when he told staff on 5 December that he had been taking illicit pregabalin at Guys Marsh and was struggling with withdrawal after being transferred to Bristol. Although a substance misuse worker created a care plan, there was no follow up appointment. We make the following recommendation:

**The Head of Healthcare should ensure that there is an appropriate procedure for the management of withdrawal from illicit medication, including pregabalin and gabapentin.**

50. In a recent investigation into a previous death at Bristol, we found that the deceased in that case had also taken medication that had not been prescribed to him. We noted that Bristol's Substance Intoxication Strategy did not cover the risks arising from diverting prescribed medication and that there was no separate policy to cover this. As a result of our recommendation made in that case, aimed at reducing the availability and use of illicit drugs and diverted medication, Bristol agreed to review its Substance Misuse Strategy. We therefore make no recommendation.

### Unlock procedures

51. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

52. Additionally, Prison Service Instruction 75/2011 states that “there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process”.
53. When interviewed, Officer B told the investigator that she generally shouted “good morning” when unlocking cells but would not wait for a response. She remembered seeing Mr Crehan lying on his bed but could not remember if he responded when she unlocked his cell. In fact it is clear that Mr Crehan was already dead when Officer B unlocked his cell and that she failed to notice this.
54. While the failure to follow the correct unlock procedure did not affect the outcome for Mr Crehan given it appears he had been dead for some time, it is important that staff identify if a prisoner’s life is at risk at the earliest opportunity. We make the following recommendation:

**The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.**

### Emergency response

55. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Bristol’s local policy instructs staff to use a medical code blue 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, and for healthcare staff to attend with the appropriate emergency equipment.
56. On 27 December, Officer B called for further assistance over the radio network shortly after a prisoner alerted her of Mr Crehan’s condition. This meant that Nurse A did not immediately respond and there was a delay before the control room called an ambulance. Officer B told us that the cell was full of prisoners and her initial reaction was to ask for help securing the cell. Although we recognise that there was only a one minute delay, we consider that prisoners reporting a death should have prompted the calling of a code blue.
57. When she heard the code blue, Nurse A continued to put the controlled medication away before making her way to Mr Crehan’s cell. While the security of controlled medication is important, we consider that she should have responded to the code blue immediately and found alternative means of securing the medication, such as asking the healthcare assistant to put the medication away. Nurse A did not take the appropriate emergency medical equipment to Mr Crehan’s cell, as dictated by Bristol’s local emergency response policy, causing a further delay. While we consider the delay issuing and responding to the code blue would not have changed the outcome for Mr Crehan, in other circumstances, it could be crucial. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during**

**medical emergencies, including the use of an appropriate emergency code which triggers the control room to call an ambulance immediately.**

58. When Officer A arrived at the scene, he checked for breathing and immediately started CPR. When Nurse A arrived, she helped officers move Mr Crehan onto the floor and noted that his body was stiff and his lips were blue. Nurse A told us that she initially thought it would be futile to attempt resuscitation, but continued with the attempt out of instinct, and because there was no guidance at that time about what to do.
59. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but consider staff should understand that they should not undertake CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. While the clinical reviewer considered that it was reasonable for staff to start CPR because Mr Crehan was young and his death was unexpected, we consider that there were signs that rigor mortis was present in Mr Crehan's body and that CPR should not have commenced because he was already dead. In September 2016, Professor Sir Bruce Keogh, National Medical Director at NHS England wrote to prison Heads of Healthcare introducing new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.**

**Access to mobile telephones**

60. We are concerned that a prisoner was able to notify Mr Crehan's family of his death by mobile telephone. This is likely to have been very distressing for the family. In a recent investigation into a previous death at Bristol, we found that in that case too, a prisoner had telephoned the family of the deceased from an illicit mobile telephone to tell them of the death. We made a recommendation in that case, which the prison accepted. The Head of Security told the investigator that the prison has introduced handheld mobile phone detectors and that mobile phones are included on the prison's risk register. Although we are concerned at the evident weaknesses this demonstrates, given we have been assured that steps have been taken to address this, we do not repeat that recommendation.

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