Prisons &
Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Royden Pritchard, a prisoner at HMP Cardiff, on 23 April 2020

**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.

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 Royden Pritchard was found hanged in his cell at HMP Cardiff on 23 April 2020. He was 48 years old. I offer my condolences to Mr Pritchard's family and friends.

Mr Pritchard had been at Cardiff for less than 48 hours when he was found hanged. The investigation found that when Mr Pritchard arrived at Cardiff, staff failed to assess his risk of suicide and self-harm fully and missed an opportunity to put suicide prevention measures in place.

Mr Pritchard arrived at Cardiff with a letter saying that he was required to 'shield' because he was vulnerable to COVID-19 due to a serious lung condition. Staff correctly allocated him a single cell. However, no one considered the potential risks of placing Mr Pritchard in a cell on his own, given his risk factors for suicide.

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

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **April 2021**

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# Summary

## Events

1. On 21 April 2020, Mr Royden Pritchard was remanded in custody, charged with domestic abuse offences against his mother and her partner, and sent to HMP Cardiff.

2. The Person Escort Record (PER - a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) noted that Mr Pritchard was a recovering alcoholic with a history of self-harm as recently as May 2019. He also had post-traumatic stress disorder (PTSD), depression and anxiety. Mr Pritchard told the reception officer that he had no current thoughts of suicide or self-harm.

3. Mr Pritchard had chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases) and arrived at the prison with a letter from his GP advising him to 'shield' due to COVID-19. He was allocated a single cell.

4. On 22 April, a prison GP prescribed inhalers for COPD and asthma and a nurse carried out a medication assessment. The nurse recorded that there were no concerns about suicide or self-harm.

5. At 11.07am, an officer who knew Mr Pritchard from a previous sentence and wanted to say hello, looked into Mr Pritchard's cell. He saw him sitting on a chair facing the television, but his face was obscured by the bed. He did not go in as there was an isolation sticker on the door saying Personal Protective Equipment (PPE) must be worn. He said he had no concerns about Mr Pritchard and decided to see him at lunchtime instead.

6. At 11.54am, another officer walked past Mr Pritchard's cell. He said he noticed an isolation sticker on the door and considered looking in to see if Mr Pritchard was alright, but then decided not to as the sticker said PPE must be worn.

7. At 11.56am on 23 April, while staff were delivering Mr Pritchard's lunch to his cell, they found him sitting in a chair with a ligature around his neck, which was tied to the window. Staff called a code blue and started cardiopulmonary resuscitation (CPR). Healthcare staff attended and noticed clear signs that Mr Pritchard was already dead, but staff continued CPR. Paramedics arrived shortly afterwards and told staff to stop CPR. They confirmed Mr Pritchard's death at 12.18pm.

## Findings

8. Mr Pritchard arrived at Cardiff with several risk factors for suicide and self-harm. However, no one considered starting suicide and self-harm prevention monitoring (known as ACCT). The healthcare assistant who carried out Mr Pritchard's reception healthcare screening failed to identify or consider Mr Pritchard's risk factors, even though he had access to the PER. Two other officers involved in the reception and induction process based their risk assessments on Mr Pritchard's presentation and what he said to them, rather than his known risk factors.

9. The healthcare assistant who carried out the reception healthcare screening failed to carry out an alcohol audit or refer Mr Pritchard for a mental health medication review.

10. The nurse who completed Mr Pritchard's medication assessment failed to record that Mr Pritchard had risk factors for suicide and self-harm.

11. Staff were unfamiliar with the prison's COVID-19 policy and how to interact with clinically vulnerable prisoners who were shielding. We found there were missed opportunities to check on Mr Pritchard's welfare.

12. Although the emergency response was prompt, we found that staff attempted to resuscitate Mr Pritchard when there were obvious signs that he was already dead.

## Recommendations

- The Governor and Head of Healthcare should ensure that reception and induction staff:
    - are aware of all known risk factors for suicide and self-harm;
    - identify prisoners' risk factors from the information and documents available to them;
    - record the risk factors they have considered and the reasons for decisions;
    - sign and date relevant documentation where required to do so.
- The Head of Healthcare should ensure that reception staff carry out comprehensive health assessments and use screening tools to assess mental health and substance misuse.
- The Head of Healthcare should ensure that staff always record all risk information in a prisoner's medical record fully and accurately, regardless of the type of assessment being carried out.
- The Governor should ensure that, in line with national guidance, all staff are fully aware of the COVID-19 management policy, including how to monitor prisoners who are shielding and the appropriate use of PPE.
- The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.
- The Governor should share a copy of this report with Officers A and B and arrange for a manager to discuss the Ombudsman's findings with them.
- The Head of Healthcare should share a copy of this report with the reception HCA and Nurse A and discuss the Ombudsman's findings with them.

# The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Pritchard’s prison and medical records.

15. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Pritchard’s clinical care at the prison.

16. The investigator interviewed eight members of staff between June and October 2020. Due to coronavirus restrictions, all interviews were conducted by telephone.

17. We informed HM Coroner for South Wales Central of the investigation. The Coroner provided us with a copy of the post-mortem and toxicology reports. We have given the Coroner a copy of this report.

18. We contacted Mr Pritchard’s mother and his ex-wife to explain the investigation process and to ask if they had any matters they wanted the investigation to consider. They wanted to know whether he had any bruises on him when he went into prison, whether he was being monitored under suicide and self-harm prevention procedures, and the exact time that he took his life. We have addressed these issues in the report.

19. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

20. We sent copies of our initial report to Mr Pritchard’s mother and his ex-wife. They found no factual inaccuracies.

# Background Information

## HMP Cardiff

21. HMP Cardiff holds around 800 men, mostly from South East Wales. Many of the prisoners come on remand from local courts. Cardiff and Vale University NHS Health Board provides primary, physical and mental health services at the prison. Healthcare staff are on duty 24 hours a day.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Cardiff was in July 2019. Inspectors found that reception was relatively busy, but staff were generally relaxed and reassuring, and prisoners were positive about their treatment on arrival. Inspectors noted that in the first night centre prisoners were seen by an induction peer representative (a prisoner) and had a private first night interview with an officer, which they found were generally good and focused on safety. Inspectors found that the first night centre was clean and bright, and cells were appropriately equipped. Inspectors noted that significantly more prisoners than in other local prisons felt safe on their first night. Inspectors noted that around 51% of new arrivals reported substance misuse problems.

## 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 31 August 2019, the IMB reported that self-harm remained a major concern although it acknowledged that the number of incidents of self-harm were skewed by a number of prolific self-harmers. The IMB noted that assurance checks of the process for supporting prisoners deemed at risk of suicide or self-harm highlighted that there were both areas of good practice and areas that needed improvement.

## Previous deaths at HMP Cardiff

24. Mr Pritchard was the seventh prisoner to die at Cardiff since April 2018. Of the previous deaths, one was self-inflicted and five were from natural causes. Although the previous self-inflicted death also occurred in the induction unit, there were no other similarities between the findings in our investigations into the previous deaths and Mr Pritchard's death.

## Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

26. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As

part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

27. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

### COVID-19 (coronavirus)

28. COVID-19 is an infectious disease that affects the lungs and airways. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

29. COVID-19 can make anyone seriously ill, but the risk is higher for some people. People at high risk include those who have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

30. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

31. On 13 March, PHE's National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation.

32. On 31 March HMPPS, in consultation with Public Health England (PHE), issued an order to significantly reduce transfers between prisons and other measures were implemented. These measures were designed to be implemented at local level, depending on the needs of each individual establishment and known as 'compartmentalisation' which included:

- Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.

- Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of biosecurity including dedicated staff;
- Reverse Cohorting Units (RCUs): to accommodate new receptions or transfers in for a period of 14 days to detect any emergent infectious cases before entering general population.  These units could also accommodate anyone returning from hospital.

## Key Events

33. On 21 April 2020, Mr Royden Pritchard was remanded in custody charged with actual bodily harm and criminal damage. His mother and her partner were the victims of his offences. He was sent to HMP Cardiff. Mr Pritchard had previously been released from Cardiff in October 2019.

34. The Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) noted that Mr Pritchard had previously attempted suicide, most recently in 2019, and that he was a recovering alcoholic with a history of violence and domestic abuse. The PER also said that Mr Pritchard suffered from post-traumatic stress disorder (PTSD), anxiety, depression and chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases).

35. The reception officer noted in the comments section of the Cell Sharing Risk Assessment (CSRA) form that Mr Pritchard had no injuries, no thoughts of self-harm, had anxiety, depression and PTSD, was allergic to ibuprofen, and had a history of self-harm.

36. A healthcare assistant (HCA) completed Mr Pritchard's healthcare reception screening. He noted that Mr Pritchard had PTSD, anxiety, depression, COPD and asthma. Mr Pritchard said that he had previously used medication for anxiety and depression, but he did not think it worked for him. He also said that he had started drinking alcohol again, although he said he was not drinking as much as before so he did not want to be referred to the substance misuse team. The HCA made a referral to the mental health team as Mr Pritchard said he would like counselling following the death of a friend.

37. Mr Pritchard arrived at the prison with a COVID-19 'shielding' letter from his GP advising him to self-isolate for 12 weeks because he had COPD. The HCA told the investigator that he discussed this with a senior nurse, who advised that Mr Pritchard should be allocated a single-occupancy cell as he was shielding. He signed Part 2 (healthcare assessment) of the CSRA form, advising a single cell on medical grounds. He said he did not remember seeing the comments made by the reception officer on the front of the CSRA form. Although he saw the PER and medical record, he said he was not aware that Mr Pritchard had a history of attempted suicide or self-harm.

38. The HCA also completed the first night suicide and self-harm assessment form. He noted on the form that there were no concerns about mental health or detoxification. He recommended that Mr Pritchard should have a single cell on medical grounds. He then passed the form to prison staff to complete the rest of the induction process.

39. Officer A completed Part 1 of the CSRA form, noting that healthcare staff advised a single cell on medical grounds. He did not sign the form to show he had completed the assessment. He also completed the second section of the first night suicide and self-harm assessment form, comprising of ten questions. He indicated that Mr Pritchard had been charged with domestic violence offences and had been charged with violent offences against a family member. He marked that there was no suicide/self-harm warning form available and that Mr

Pritchard had no current thoughts of suicide or self-harm. He told the investigator that he had access to the PER and Mr Pritchard's NOMIS record (electronic prison record) but he could not recall seeing anything that alerted him to a risk of suicide or self-harm. He said he asked Mr Pritchard if he had any thoughts of suicide or self-harm and he said no.

40. A custodial manager subsequently authorised a single cell for Mr Pritchard on medical grounds.

41. Officer B completed Mr Pritchard's first night induction interview and the remainder of the induction process. He had access to Mr Pritchard's NOMIS record, the PER, the CSRA form and the information completed by the HCA and Officer A on the first night suicide and self-harm form. He told the investigator that he repeated the questions asked by Officer A and he was satisfied that Mr Pritchard was not at risk of suicide or self-harm. He noted that Mr Pritchard declined a telephone call to his family and said he was happy to be in a cell on his own. Staff then moved Mr Pritchard into a single cell on the induction unit.

42. On 22 April, a prison GP prescribed Mr Pritchard inhalers for COPD and asthma. The GP did not see Mr Pritchard. Nurse A subsequently made a note in Mr Pritchard's medical record to say that he was suitable to have his medication in his possession. He recorded in his assessment that there were no concerns about substance misuse, suicide or self-harm. He told the investigator that he did not see Mr Pritchard but completed the paper assessment based purely on his suitability to have inhalers in his possession. He said he would have assessed risk factors differently if Mr Pritchard was receiving tablets or higher risk medication.

### Events of 23 April

43. At around 6.05am on 23 April, an officer carried out the early morning roll count. She provided a statement saying that Mr Pritchard was asleep on his bed at that time. She said that if he had been out of bed, she would have spoken to him.

44. At 7.11am, an officer checked on Mr Pritchard. He told the investigator that his checks involved making sure that all prisoners were in their cells and that there were signs of movement or breathing. He said he could not remember if Mr Pritchard was on his bed or on the chair at that time. Although he did not speak to him, he had no concerns and was satisfied that Mr Pritchard was alive at the time of his check.

45. At 11.07am, Officer C looked into Mr Pritchard's cell. He was not carrying out a formal check at the time. He told the investigator that he remembered Mr Pritchard from a previous sentence and wanted to say hello. He said that he looked through the observation panel and saw someone sitting on a chair facing the television, which was on. He said he could not see the person's face as it was obscured by the bed. He told the investigator that he did not go into the cell as there was an isolation sticker on the door telling staff to wear personal protective equipment (PPE). He said he did not have any concerns about Mr Pritchard but decided to go to see him during lunchtime instead.

46. At 11.54am, an officer walked past Mr Pritchard's cell while helping with lunch duty. He noticed an isolation sticker on the door so considered checking to see if the prisoner inside was okay. However, he told the investigator that he decided not to open the observation flap as the isolation sticker stated that PPE must be worn by staff and he was not wearing any.

### Emergency response

47. At 11.56am on 23 April, Officer C opened the door to Mr Pritchard's cell so that a colleague could deliver his lunch. Staff found Mr Pritchard sitting in the chair with a ligature around his neck which was tied to the window. He immediately called a code blue (a medical emergency code used when a prisoner is unresponsive or is having difficulty breathing which alerts healthcare staff and tells the control room to call an ambulance immediately) and staff cut the ligature. Other prison officers arrived and started cardiopulmonary resuscitation (CPR).

48. Nurse A and a healthcare assistant arrived shortly afterwards. The nurse said that he arrived to find two prison officers carrying out CPR. He told the investigator that there were visible signs that Mr Pritchard had already died. He described him as cold to touch with signs of rigor mortis. (Rigor mortis is the stiffening of the body after death. It normally occurs around two hours after death, which means that Mr Pritchard almost certainly died some time before 10.00am.) Nurse A said that, as prison staff had started CPR, they had to continue until either a doctor or a paramedic confirmed that Mr Pritchard was dead. Paramedics arrived at 12.15pm and told staff to stop CPR. The paramedics confirmed Mr Pritchard's death at approximately 12.18pm.

49. Mr Pritchard left a note to his ex-partner which indicated that he had planned his offence so that he would be sent to prison and would be free to take his life. He also left a note for staff saying that he knew he would be placed in a single cell due to shielding. He said that he had planned his death and that staff were not to blame.

### Contact with Mr Pritchard's family

50. At 2.00pm on 23 April, the prison's family liaison officer contacted Mr Pritchard's mother by telephone to tell her that her son had died. (Due to COVID-19 restrictions in place at the time, the prison was unable to break the news to Mr Pritchard's mother in person.) The prison contributed to the cost of Mr Pritchard's funeral in line with national instructions.

### Support for prisoners and staff

51. A prison manager debriefed the staff who were involved in the response when Mr Pritchard was found. The staff care team also offered support.

52. The prison posted notices informing other prisoners of Mr Pritchard'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 Pritchard's death.

### Post-mortem report

53. The post-mortem report concluded that Mr Pritchard’s death was due to pressure on the neck (incomplete hanging). Toxicology reports showed that no illicit drugs or alcohol were present in his body.

# Findings

## Assessment of Mr Pritchard's risk of suicide and self-harm

54. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, lists the risk factors for suicide and self-harm. These include violent offences against family members, previous suicide attempts, mental health issues and substance misuse issues, all of which applied to Mr Pritchard.

55. The reception officer identified Mr Pritchard's mental health issues and history of self-harm in the comments section on the front sheet of the Cell Sharing Risk Assessment (CSRA) form. He recorded that Mr Pritchard had no thoughts of self-harm.

56. Despite having access to the PER and Mr Pritchard's medical record, the healthcare assistant (HCA) in reception said he did not see any information about his previous suicide attempts. Although the reception officer had noted that Mr Pritchard had a history of suicide and self-harm on the front sheet of the CSRA form before the healthcare reception screening, the HCA could not recall seeing it and said he thought the form was blank when he received it. He said that, if he had seen this information, he would have considered starting suicide and self-harm prevention monitoring (known as ACCT). We found evidence that information about Mr Pritchard's risk of suicide and self-harm was readily available to him, but he was unable to explain how he missed it.

57. Officers A and B completed the remainder of Mr Pritchard's reception and induction process. They both said they were aware of Mr Pritchard's risk factors but did not consider that he was at risk of suicide or self-harm because of how he presented and what he said to them.

58. Neither officers considered starting ACCT procedures, despite knowing the risk factors and the additional risk of Mr Pritchard being allocated a single cell. We are concerned that neither officer seemed to acknowledge that they had failed to adequately assess Mr Pritchard's risk, both saying at interview that they would not have done anything differently.

59. We accept that it was necessary for staff to allocate Mr Pritchard a single cell for medical reasons. However, if his risk had been appropriately assessed, it is likely that staff would have considered starting ACCT procedures, resulting in closer monitoring during his early days in custody. In the event, due to COVID-19 management and his need to shield, staff had minimal interaction with Mr Pritchard, and he was easily able to carry out his plan to take his life.

60. We are concerned that staff based their assessments on Mr Pritchard's presentation and what he said to them, rather than the obvious risk factors for suicide and self-harm that were present when he arrived at Cardiff. We therefore consider that Mr Pritchard's reception and induction screening was inadequate. We recommend:

    **The Governor and Head of Healthcare should ensure that reception and induction staff:**

- **are aware of all known risk factors for suicide and self-harm;**
- **identify prisoners' risk factors from the information and documents available to them;**
- **record the risk factors they have considered and the reasons for decisions; and**
- **sign and date relevant documentation where required to do so.**

### Healthcare assessments

61. During the reception healthcare screening, Mr Pritchard told the HCA that he had started drinking again. He also said that he had previously taken medication for anxiety and depression but felt it did not work for him. Although the HCA recorded this information, he did not carry out an alcohol audit screen or make a referral to the GP for a mental health medication review. We recommend:

    **The Head of Healthcare should ensure that reception staff carry out comprehensive health assessments and use screening tools to assess mental health and substance misuse.**

62. We are concerned that when Nurse A carried out the medication review on 22 April, he recorded that he found no concerns in relation to substance misuse, mental health, or risk of suicide and self-harm. While we accept that this assessment was carried out to approve the use of inhalers for asthma and COPD, we consider that all risk factors should be accurately recorded, regardless of the reason for the assessment. We recommend:

    **The Head of Healthcare should ensure that staff always record all risk information in the prisoner's medical record fully and accurately, regardless of the type of assessment being carried out.**

### COVID-19 management policy

63. On 24 March, HM Prison and Probation Service issued an instruction to all prisons, in line with Government advice, to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation. The instruction stated that '*prisoners on a shielding unit should have access to the best possible healthcare support due to their vulnerability. They should be monitored regularly*' and that '*establishments should consider a system of welfare checks for newly received prisoners and determine how this will operate in line with social distancing procedures*'.

64. We found no evidence of a local COVID-19 management policy at Cardiff. Mr Pritchard was a newly arrived prisoner with significant risk factors for suicide and self-harm who was required to shield due to his vulnerability to COVID-19. He was rightly given a single cell for medical reasons, but he had little interaction with prison or healthcare staff during his short time at Cardiff. We found evidence that staff were unfamiliar with the guidance around prisoners who were shielding and the use of PPE. For example, Officer C was confident to look

through the observation panel without PPE, while another officer said that he would not. We consider this uncertainty made staff more cautious about their interactions with Mr Pritchard. As a result, opportunities to check on Mr Pritchard's welfare were missed. We recommend:

**The Governor should ensure that, in line with national guidance, all staff are fully aware of the COVID-19 management policy, including how to monitor prisoners who are shielding and the appropriate use of PPE.**

### Emergency response

65. European Resuscitation Council Guidelines 2015 say that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines give examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) have also issued guidance about making appropriate resuscitation decisions. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.

66. When staff found Mr Pritchard unresponsive in his cell, there were visible signs that he was already dead. Despite this, staff attempted to resuscitate him. Nurse A said that he thought Mr Pritchard was dead as rigor mortis was present. However, as prison staff had already started CPR, he said that he had to continue until a doctor or paramedic pronounced Mr Pritchard dead. We consider that it was not necessary to attempt to resuscitate Mr Pritchard and that he should have been confident to tell staff to stop CPR. We consider that the presence of a doctor or paramedic to confirm death is not the same as making the decision to stop CPR when it is futile to continue. We recommend:

**The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.**

### Learning from this report

67. We consider it important for staff to learn the lessons from this report. We recommend:

**The Governor should share a copy of this report with Officers A and B and arrange for a senior manager to discuss the Ombudsman's findings with them.**

**The Head of Healthcare should share a copy of this report with the reception HCA and Nurse A and discuss the Ombudsman's findings with them.**

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