

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Robert Evans, a prisoner at HMP Swansea, on 14 January 2018**

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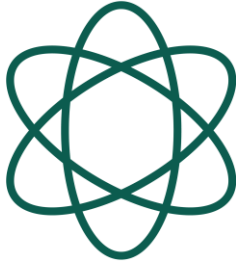
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To carry out independent investigations to make custody and community supervision safer and fairer



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**OGI**

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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 Robert Evans was found hanged in his cell on 14 January 2018 at HMP Swansea. He was 32 years old. I offer my condolences to Mr Evans's family and friends.

Although Mr Evans had some risk factors associated with suicide and self-harm, we found little to indicate to prison staff that he was at heightened or imminent risk in the period before his death. Mr Evans left a letter in the wing post box in which he said that he had given up because his medication had been stopped. Medical records did not support this, but CCTV showed that Mr Evans appeared upset and angry when he returned to the wing from the afternoon medication round. The officers he spoke to did not remember the conversation and we have been unable to establish why Mr Evans was upset or when the letter was put in the wing post box.

There was a significant delay in the prison calling an ambulance and the ambulance being dispatched. Although this did not affect the outcome for Mr Evans, such a delay might have serious consequences in other cases of emergency. Following a death in at Swansea in April 2016, we repeated a recommendation for the fourth time about delays in calling an ambulance and it is very disappointing to be revisiting the issue in this case.

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**

**December 2019**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings .....	10

# Summary

## Events

1. Mr Robert Evans had a history of alcohol addiction and had served several short sentences in HMP Swansea. He was recalled to prison on 11 January 2018 and arrived at HMP Swansea at 5.00pm on 12 January.
2. Mr Evans was given diazepam and symptomatic relief for alcohol withdrawal. He appeared cheerful and calm. Mr Evans was given a single cell on B Wing, the first night and induction unit.
3. Mr Evans showed signs of mild alcohol withdrawal on 13 January. He saw a nurse three times at assessments and medication rounds during the day and, according to staff, did not raise any concerns. CCTV showed that Mr Evans appeared upset and angry when he returned to the wing from the afternoon medication round.
4. The night nurse found Mr Evans hanging in his cell at about midnight. Other night staff responded to an emergency radio code and tried to resuscitate him. Paramedics attended but Mr Evans was pronounced dead at 00.40am.
5. The next morning, an officer found a letter Mr Evans had written to a friend in the Wing post box. Mr Evans said in the letter that he had had enough because his medication had been stopped.

## Findings

6. Mr Evans had a number of risk factors including alcohol addiction, licence recall, anxiety, depression and some historical self-harm. While we would have preferred to have seen more recognition of these by staff who assessed him, we recognise that there was little to indicate that the level of risk was such that suicide and self-harm prevention measures (known as ACCT) should have been started.
7. The day he died, Mr Evans's letter to a friend indicated he thought his medication had been stopped and that this was a factor in his death. Mr Evans arrived in Swansea on a Friday and was not prescribed the medication for anxiety or depression which he said he received in the community, pending confirmation from his GP. He appeared only to have mild symptoms of alcohol withdrawal and had received appropriate doses of diazepam and other medications since his arrival in police custody four days previously.
8. The officers Mr Evans spoke to after afternoon medication round did not remember the conversation or that he was upset. We have been unable to establish why Mr Evans was upset or when the letter was put in the wing post box.
9. Mr Evans did not have a formal assessment of his alcohol withdrawal symptoms in Swansea as he should have done.
10. There was a significant delay between Mr Evans being found and the control room calling an ambulance and another significant delay before an ambulance was dispatched. There was no delay in Mr Evans receiving CPR and the delays did not affect the outcome for Mr Evans.

11. The night nurse who found Mr Evans said he had signs of rigor mortis but attempted resuscitation because she thought that she had no choice in the absence of someone with the ability to pronounce death.

## **Recommendations**

- The Head of Healthcare should ensure that all newly received prisoners have baseline observations during their initial health assessment and that prisoners withdrawing from alcohol are assessed using the CIWA tool.
- The Governor should ensure that all staff understand their responsibilities during medical emergencies so that they efficiently communicate the nature of a medical emergency in line with national and local instructions.
- The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Swansea informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator visited Swansea on 6 February 2018. She obtained copies of relevant extracts from Mr Evans's prison and medical records, visited his cell and watched CCTV from 14 January.
14. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr Evans's clinical care at the prison.
15. The investigator and clinical reviewer jointly interviewed 14 members of staff at Swansea on 6 February, 20 and 21 March. An officer attended for interview on 6 February but said he had not met Mr Evans at all. His interview was not proceeded with. The clinical reviewer spoke to one nurse on the telephone. Statements from three staff who were on leave from work at the time of interviews were obtained from the police. The investigator obtained further information from the Welsh Ambulance Service.
16. The investigator returned to the prison in September 2018 to watch CCTV from 13 and 14 January 2018 after the prison made representations about the timing of the response at the initial report stage. CCTV confirmed the initial report was factually correct. She asked to see footage from earlier on 13 January. As a result, two officers were spoken to again.
17. We informed HM Coroner for Swansea and Neath of the investigation who 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 Evans's mother, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Evans's mother wanted to know how another death at Swansea had been allowed to happen. She was concerned about her son's medication because he referred to this in the letter found in the post after his death. She asked whether the timing of the doses was sufficient to hold alcohol withdrawal symptoms all night.

## Background Information

### HMP Swansea

19. HMP Swansea is a local category B prison holding up to 503 adult and young adult men. Healthcare is provided by Abertawe Bro Morgannwg University Health Board (ABMU).

### HM Inspectorate of Prisons

20. The most recent inspection of HMP Swansea was in August 2017. Inspectors reported that, at the time of the inspection, Swansea held 458 men in accommodation certified in normal circumstances to hold 268. Inspectors were disappointed that the prison had slipped to a 'poor' rating in three of the four healthy prison tests since the previous inspection in 2014. Four self-inflicted deaths between the 2014 and 2017 inspections had occurred within a week of arrival. Despite this, significant and highly relevant recommendations made by the PPO about early days procedures had not been implemented. Self-harm levels had tripled.

### Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2017, the IMB reported that, although PPO recommendations were discussed in Safer Custody meetings they were not always implemented in a timely manner. Several changes of senior personnel had impacted on continuity.

### Previous deaths at HMP Swansea

22. There were four self-inflicted deaths between 2014 and 2017 and, like Mr Evans, they all occurred within a week of the prisoner arriving at Swansea. In our investigation into a death in April 2016, we repeated a recommendation for the fourth time about delays in the prison calling an ambulance. In our investigation into a death at Swansea in October 2016 we suspected a similar delay in the ambulance service dispatching an ambulance to the prison in response to a 999 call. We recommended that Swansea review their protocol with the Welsh Ambulance Service to clarify when an ambulance should be dispatched. In two of the investigations, we found that the standard of care for prisoners detoxifying from alcohol was not equivalent to that which they could have expected to receive in the community.

## Key Events

23. Mr Robert Evans had a history of alcohol misuse. He often lived on the streets and had served several short custodial sentences at HMP Swansea for offences related to his addiction. He was released on licence from Swansea on 29 December 2017, after serving 12 weeks for shoplifting. He suffered from depression and anxiety and was briefly monitored under Prison Service suicide and self-harm monitoring procedures in 2014.

### Police custody 10 -12 January 2018

24. On Wednesday 10 January, Mr Evans was arrested for breaching the terms of his licence and was taken to Aberystwyth police station. Mr Evans said he was prescribed salbutamol (for asthma), propranolol (for anxiety) and mirtazapine (for depression). He said he had last taken his medication “days ago” and did not have an asthma inhaler with him. Mr Evans said during the day he had drunk two bottles of vodka, a couple of shots of rum and about two or three bottles of cider. He said he had last self-harmed about 12 years ago when he took an overdose but had no current suicidal thoughts. The police custody officer described Mr Evans as calm and compliant but intoxicated.
25. Late that evening, the police saw Mr Evans coughing and beginning to suffer withdrawal symptoms. A police medical officer authorised him to take two puffs of Salbutamol via inhaler. In the early hours of 11 January, police officers took Mr Evans to a hospital because he was short of breath. He was examined in accident and emergency and was passed fit to return to police custody.
26. On 11 January, another police medical officer examined Mr Evans at 11.20am. He noted Mr Evans was an alcoholic who had been in police custody for 13 hours and had developed moderate signs of withdrawal. The police medical officer prescribed diazepam 10mg and paracetamol and said Mr Evans should be monitored for further symptoms of withdrawal. At 8.30pm, another police medical officer authorised two further doses of diazepam 10mg. Mr Evans took the second dose at 10.15pm. Mr Evans’s licence was revoked the same day.
27. A police nurse examined Mr Evans at 9.00am on 12 January. Mr Evans scored one on the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scale, which indicated mild alcohol withdrawal. He appeared alert, oriented and communicative.
28. Later the same morning, Mr Evans appeared at a magistrates court and was remanded to Swansea. He arrived at the prison at about 5.00pm. Mr Evans’s personal escort record (PER, which accompanied him from the court) showed previous periods of monitoring for suicide and self-harm from 2014, asthma, diabetes, alcohol withdrawal, depression, anxiety, his prescription of diazepam in police custody and the fact that he had not taken his prescribed medication for several days.

### 12 January 2018

29. An officer said he recognised Mr Evans when he saw him in reception as he had been in Swansea before. He did not know anything about Mr Evans’s history or

issues and did not remember ever having had a conversation with him but said he was a familiar face.

30. The officer completed Mr Evans's cell sharing risk assessment (CSRA) and first night sheet. The officer asked Mr Evans whether he felt suicidal or like harming himself and Mr Evans replied, "I'm only here for 28 days". The officer said that Mr Evans did not obviously appear to be suffering from withdrawal symptoms. A second officer said Mr Evans was very talkative with staff and seemed in a good mood. He appeared to be familiar with the process and was not at all agitated. He asked for and was given a shower.
31. The officer said that Mr Evans was adamant he did not want to share a cell and that he would rather go to the segregation unit than share. He was not aggressive and was quite calm. The officer tried to persuade Mr Evans to share a cell because this was the policy at Swansea. However, Mr Evans remained adamant he would not, so the officer asked a Custodial Manager (CM) to approve Mr Evans's move to a single cell on B Wing (the induction and first night centre). As there were spaces, the CM agreed but said he would review the situation the following day.
32. Mr Evans told a nurse at an initial health assessment that he had been moving around Wales via the rail network because he was homeless. The nurse said he knew Mr Evans to say hello to from previous sentences and knew he was addicted to alcohol. He thought Mr Evans appeared cheerful and relieved to be somewhere with a roof over his head. Mr Evans denied any thoughts of suicide or self-harm.
33. The nurse did not complete a formal alcohol withdrawal assessment, as he should have done. He said Mr Evans did not appear to be suffering severe withdrawal symptoms but he knew he was an alcoholic, so he gave him 15mg of diazepam.
34. An officer conducted Mr Evans's first night interview on B Wing. He said he only vaguely remembered speaking to Mr Evans. He registered Mr Evans so he could use the prisoner telephone system. Mr Evans did not make any calls at Swansea.
35. Mr Evans spoke to a Prison Insider (trusted prisoners trained to speak to all new prisoners and identify initial risk factors and concerns). The Insider check sheet indicated that Mr Evans had no thoughts of suicide and self-harm and no immediate concerns.
36. Mr Evans's first night check sheet showed that he was checked at 10.00pm, 2.00am and 6.00am. At the first check, he was watching television, and appeared asleep on the second and third.

## 13 January

37. At about 8.30am, Mr Evans told a Supervising Officer (SO) at his basic custody screening that he was homeless and unemployed due to his chaotic lifestyle and alcohol addiction. The SO said Mr Evans was lying in bed and was cooperative and engaging. Mr Evans looked "a bit fragile" but did not appear to be suffering serious withdrawal symptoms. He did not remember Mr Evans saying anything about his medication. If he had done, the SO said he would have told him that he was seeing the nurse next and to raise it with her.

38. At 10.17am, a nurse completed Mr Evans's second day health assessment. The nurse remembered Mr Evans from previous sentences and described him as a quiet and pleasant young man. She said Mr Evans admitted to continued heavy use of alcohol. He seemed very motivated to move away from his home area and get some support to help him stop drinking. She said they discussed where he could get support in the community. She advised him to speak to a member of the substance misuse psychosocial team and booked him in for blood tests and a clinic review. Mr Evans was sweating and a little bit shaky but did not seem anxious about his medication.
39. At 10.36am, a nurse gave Mr Evans 10mg of diazepam. After asking him about his symptoms she also gave him paracetamol, ibuprofen, mebeverine and metoclopramide (both for an upset stomach), vitamin B and thiamine. She said that their interaction was brief but Mr Evans appeared fine.
40. An officer said she spoke to Mr Evans at about 3.00pm when he collected his dinner. She did not remember the substance of the conversation but said Mr Evans appeared fine and she was not aware from his appearance that he was detoxifying from alcohol. She did not remember him asking about medication.
41. A nurse gave Mr Evans his evening medication at 4.01pm. She said Mr Evans appeared anxious to receive it. She gave him the same medication she had given him that morning, including 10mg of diazepam.
42. CCTV showed Mr Evans return to the wing after receiving his medication. He appeared agitated and walked up to two officers who were standing together on the wing. Mr Evans gestured with his arms and appeared to be speaking angrily. Mr Evans then walked towards his cell. The officers said they could not recall this incident and had nothing further to add.
43. An officer saw Mr Evans again at roll check after the prisoners were locked in their cells for the night between 4.00 and 4.30pm. She said that he was standing in his cell but did not remember if she spoke to him. A second officer took over from the officer at 5.00pm. The second officer said the prisoners were all locked in their cells and the first officer told her the wing was quiet. There were approximately 29 prisoners and five of them were being monitored under Prison Service suicide and self-harm monitoring procedures, known as ACCT.
44. After about 20 minutes, an officer called the second officer to A Wing because he had issues with prisoners in three separate cells. Two cellmates were fighting, one prisoner was in crisis and another was kicking his door and being verbally aggressive. The second officer remained on A Wing to help and only returned to B Wing to do the checks on the prisoners on ACCT and answer cell bells. The second officer said she did not go to Mr Evans's cell that night. The cell bell record showed Mr Evans did not press his bell that night and the officer said she did not have any reason to go to his cell.
45. At 7.30pm, the B Wing night patrol officer came on duty. The second officer briefed him and gave him the ACCT documents, the observation book and the wing radio. Almost immediately, the night patrol officer was told he needed to go to C Wing to do constant observations of a prisoner at high risk of harming himself. He said he in turn handed over B Wing to an Operational Support Grade (OSG).

46. The OSG said she was based on the centre of the wing. There was a board on the centre that showed when prisoners pressed their cell bell and she answered them as necessary. She did not know Mr Evans and did not go to his cell that night.

## **Emergency response**

47. The night nurse said that about midnight she saw Mr Evans hanging from his window bars when she went to do the first of three nightly checks on new prisoners. CCTV showed the night nurse arrived at Mr Evans's cell at 00.01am. She radioed a code blue emergency (indicating that a prisoner is unconscious, or having breathing difficulties), and went to get the emergency first aid equipment from the centre (as a nurse she did not have a cell key).
48. The night officer on A Wing, arrived at 00.02am followed by a Custodial Manager (CM) who was the night orderly officer. The CM opened the cell and he and the night officer cut Mr Evans down and laid him on the floor. The night officer started chest compressions. The CM said he radioed the control room to ensure an ambulance had been called.
49. The night nurse returned to Mr Evans's cell at 00.02am with the emergency equipment and arrived as Mr Evans was being put on the floor. She said that Mr Evans was not breathing, had no pulse and had a deep ligature mark around his neck. The night officer continued chest compressions while the night nurse set up the oxygen equipment and attached a defibrillator to Mr Evans. Mr Evans's jaw was stiff and it was difficult to insert an airway. She said she thought that Mr Evans was already dead with signs of rigor mortis but she thought that she had no choice but to continue resuscitation until paramedics arrived.
50. Two night officers from C and D Wings also attended. The defibrillator advised no electric shock, so the officers rotated chest compressions while the night nurse gave Mr Evans oxygen. Paramedics arrived at 00.22am. After a brief assessment they agreed that Mr Evans had died.

## **The 999 call**

51. The investigator calculated the actual times of the emergency response by comparing records obtained from the Welsh Ambulance Service, CCTV and the control room log. There was a 21-minute gap between the night nurse discovering Mr Evans and paramedics arriving at his cell. There was a 14-minute gap between the 999 call and the paramedics arriving at Mr Evans's cell. There was therefore a gap of about seven minutes between Mr Evans being found hanging and the 999 call being made. The prison was unable to provide us with the radio traffic from the incident.
52. There was a further seven-minute gap between the 999 call being made and the ambulance being allocated. Information provided by the Welsh Ambulance Service showed that the control room knew that a prisoner had been found hanging and an ambulance was required. The call handler needed to know whether Mr Evans was conscious and breathing in order to prioritise the call. After radio consultation with officers at the scene the control room officer put the call handler through to Mr Evans's wing. The call went to voicemail and disconnected the call. The ambulance call handler rang the prison again and repeated the process. This time

they spoke to an officer who confirmed Mr Evans was unconscious and not breathing and an ambulance was dispatched.

### **Mr Evans's letter**

53. A letter written by Mr Evans to a female friend was found in the B Wing post box at 9.40am on 14 January. Mr Evans had been given a letter sheet on arrival on B Wing and appears to have started writing it on his first night. He continued writing the letter the next day and said he intended to stay in his cell during this sentence and only talk to people who could help him change. He asked his friend to email him and to get his mother to email him. On the reverse side of the letter, Mr Evans wrote "They have stopped my meds. I quit".

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

54. An operational manager, who was duty governor the night Mr Evans died, arranged for staff from HMP Berwyn to inform Mr Evans's mother of Mr Evans's death. A member of staff acted as family liaison officer (FLO). The prison contributed to the cost of Mr Evans's funeral in line with national guidance.

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

55. After Mr Evans's death, the operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. He telephoned and paged the staff care team but was unable to contact them.
56. The prison posted notices informing other prisoners of Mr Evans'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 Evans's death.

### **Post-mortem report**

57. The pathologist issued a provisional cause of death as "ligature pressure to neck as a result of hanging". The toxicology report and final post-mortem was not available at time of writing this report.

# Findings

## Assessment of risk

58. Prison Service Instruction (PSI) 64/2011 lists a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. Mr Evans had some factors that increased his risk including alcohol addiction, licence recall, anxiety and depression. He had some history of thoughts of self-harm and said he had tried to kill himself 12 years previously by overdose. He was monitored briefly under ACCT in prison in 2014.
59. Staff described Mr Evans as very pleasant, calm and quite cheerful. A nurse thought Mr Evans was glad to be somewhere with a roof over his head and regular meals. A nurse said he seemed motivated to tackle his addiction issues and make a fresh start on release.
60. When assessing a prisoner's level of risk, all risk factors must be considered. Mr Evans had a number of risk factors, and we would have preferred to have seen more recognition of these by staff who assessed him. However, we recognise that there was little to indicate that the level of risk was such as to make it very clear that an ACCT should have been opened. Each member of staff who saw Mr Evans considered whether he was at risk of suicide and self-harm and decided that he was not. We cannot say that the weight of the risk factors was such that they should have outweighed staff perceptions of his mood and demeanour at the time, even though subsequent events proved otherwise. CCTV showed that Mr Evans appeared angry and agitated when he returned from collecting his medication and spoke to two officers. In his final letter he referred to having his medication "stopped". Neither officer on duty remembered the conversation and we were unable to find evidence that he did not receive his medication that day. We make no recommendation.

## Clinical care

61. A nurse recognised Mr Evans from previous sentences and knew he was an alcoholic. He prescribed Mr Evans diazepam for alcohol withdrawal based on his knowledge of him and observation. He did not complete either the CIWA tool or take baseline observations, both of which are in accordance with the National Institute of Clinical Excellence (NICE) guidelines and help recognise future clinical deterioration. We make the following recommendation:

**The Head of Healthcare should ensure that all newly received prisoners have baseline observations during their initial health assessment and that prisoners withdrawing from alcohol are assessed using the CIWA tool.**

62. Mr Evans's letter indicated that medication was a factor in his death. Because Mr Evans arrived on a Friday he had not received his medication for anxiety or depression. Although he told the police that he was prescribed medication for this in the community he also told them that he had not taken them "for days". He appeared only to have mild symptoms of withdrawal and had received appropriate doses of diazepam and other medications since arriving in police custody four days previously. Mr Evans saw either two nurses three times during the day leading up

to his death and did not raise any concerns about his medication. None of his medications had been stopped and the investigation found no evidence that he was told this in error.

63. The healthcare manager told the investigator and clinical reviewer that the delay in prisoners receiving medicine prescribed in the community over the weekend was an area of current concern and the prison was in discussions to be given access to the NHS portal, which contains current prescriptions, and would allow the immediate dispensing of medication. We welcome this and make no recommendation.

## Emergency response

64. Prison Service Instruction 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, Swansea use 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 code should automatically trigger the control room to call an ambulance.
65. We have identified a significant delay between Mr Evans being discovered and the prison calling an ambulance. In the absence of the radio traffic we are unable to say whether this delay was between Mr Evans being discovered and a code being called or between the code being called and the control room calling an ambulance. There was a further significant delay between the 999 call being made and an ambulance being dispatched because the control room were unable to tell the call handler whether Mr Evans was conscious and breathing.
66. Although we accept that there was no delay in Mr Evans receiving CPR and that the delay in paramedics arriving did not affect the outcome for Mr Evans, this might not be the case in other emergency situations. In our investigation into a death in Swansea in April 2016, we repeated a recommendation for the fourth time about delays in calling ambulances. It is therefore especially disappointing to be revisiting the issue again. We make the following recommendation:

**The Governor should ensure that all staff understand their responsibilities during medical emergencies so that they efficiently communicate the nature of a medical emergency in line with national and local instructions.**

67. Following our investigation into a death at Swansea in October 2016, the prison produced a draft memorandum of understanding with the Welsh Ambulance Service to ensure that ambulances were dispatched promptly when the prison calls 999 in response to a code blue or red. We made our recommendation in April 2017, but the protocol was not signed or implemented until 1 December 2018. Annex B of the draft protocol gives explicit instructions to prison staff about the information required by the Ambulance Service to identify the appropriate level of response. We therefore make no recommendation.

## Resuscitation

68. In September 2016, the 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”. The guidelines define examples of futility as including the presence of rigor mortis.

69. A nurse said in her clinical opinion Mr Evans was dead and there were signs of rigor mortis. She was not aware of the guidance to prison staff from NHS England and believed she had no choice but to try to resuscitate Mr Evans. The orderly officer was also under this impression. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.**

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