



## **Guidance to support the decision making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centre (IRC)**

### **1. Introduction**

1.1. This guidance is designed to address the issue of inappropriate resuscitation following a sudden death in a prison, IRC or residential short term holding facility in the absence of a signed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) document. It is designed to support prison, detention and healthcare staff in making a decision as to whether resuscitation would be futile and therefore not required

1.2. This guidance has been taken from the European Resuscitation Council Guidelines for Resuscitation 2015<sup>1</sup> which supports current national guidance from the British Medical Association, Royal College of Nursing, National Offender Management Service and the Home Office and decision making in the prison or IRC setting.

1.3. Full current guidance is available at [www.erc.edu](http://www.erc.edu) and [www.resus.org](http://www.resus.org) and includes a decision making framework to enable health care professionals and patients to make decisions before a resuscitation situation occurs. Full guidance relating to DNA CPR can be found at [www.resus.org.uk/dnacpr/decisions-relating-to-cpr/](http://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/)

1.4 The above guidance also places greater emphasis on the importance of effective communication and recording of CPR decisions. This is of particular significance in the prison and immigration removal centre setting where health care, prison and custody / detention staff are responsible for the care of prisoners/detainees.

### **2. Initiating and Continuing Cardiopulmonary Resuscitation (CPR)**

2.1. Evidence from Prison and Probation Ombudsman investigation reports following deaths in custody/detention reveal that there have been incidents where prison and healthcare staff have tried to resuscitate someone who is already dead and has no chance of survival. Resuscitating someone who is dead is inappropriate, very distressing for staff and undignified for the deceased. Additionally, in some cases resuscitation has not been attempted where it is possible that the person was not dead.

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<sup>1</sup> European Resuscitation Council Guidelines for Resuscitation 2015 - <http://www.cprguidelines.eu/>

2.2. In most cases CPR is an unplanned event and will not have been discussed or planned in advance. In these circumstances, CPR will be commenced immediately whilst more information is obtained to help with any further decision making. If any information arises which is relevant to advance decisions or treatment refusal, continuing with CPR is deemed inappropriate.

2.3. Resuscitation must be started on all patients who are found not breathing and/or pulseless UNLESS certain conditions exist. The European Resuscitation Council Guidelines for Resuscitation 2015; Section 11: The ethics of resuscitation and end-of-life decisions states that '*Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile*'. The guidelines go on to provide clear exceptions where CPR would be futile and are listed at appendix A.

2.4 In the prison and IRC estate the primary judgment to be made is whether rigor mortis is present. The answer to this will inform the decision about commencing CPR. Rigor Mortis is the stiffening of the body after death and normally appears within the body around two hours after the deceased has died. Once the contracting of all the body's muscles has taken place this state of rigor - technically referred to as the Rigid Stage - normally lasts anything from eight to twelve hours after which time the body is completely stiff; this fixed state lasts for up to another eighteen hours

2.5 The ERC guidelines state that in such cases, a non-clinician might be making a diagnosis of death but is not verifying or certifying death. CPR that has no chance of success in terms of survival is pointless and may violate the right for dignity in death.

2.6 If resuscitation is not carried out, a full explanation of the circumstances and reasons must be given, and documented appropriately.

2.7 Staff who are not able to recognise rigor mortis should start resuscitation until advised otherwise by a competent member of staff. When the decision NOT to resuscitate a prisoner or detainee has been made by a competent, qualified nurse or other healthcare professional, it is inappropriate for them to be overruled by a senior prison or IRC manager. Nursing staff should always exercise their own clinical judgment in their practice, and are supported to do this through the Nursing and Midwifery Council Code of Practice<sup>2</sup>.

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<sup>2</sup> The Nursing and Midwifery Council Code of Practice - <http://www.nmc.org.uk/standards/code/>

## Further Resources

British Medical Association: [www.bma.org.uk](http://www.bma.org.uk)

European Resuscitation Council: <https://www.erc.edu/>

Nursing and Midwifery Council: [www.nmc-uk.org](http://www.nmc-uk.org)

Prisons and Probation Ombudsman: [www.ppo.gov.uk](http://www.ppo.gov.uk)

Prison Service Instructions: [www.justice.gov.uk/offenders/psis](http://www.justice.gov.uk/offenders/psis)

Resuscitation Council UK: [www.resus.org.uk](http://www.resus.org.uk)

Royal College of Nursing: [www.rcn.org.uk](http://www.rcn.org.uk)

Royal College of General Practitioners: [www.rcgp.org.uk](http://www.rcgp.org.uk)

## Paper informed by:

Dorset Healthcare University NHS Foundation Trust (2015) *Cardiopulmonary Resuscitation Policy, Reference Number IN-185*

Nottinghamshire Healthcare NHS Trust (2014) *Resuscitation, Recognition of Physical Health Deterioration & Emergency Oxygen Use in Adult Patients, Policy 1.20*

## Appendix A:

Definitions of the seven conditions that are unequivocally associated with death and resuscitation **SHOULD NOT** be attempted:

**Hypostasis/Lividity:** *The pooling of blood, which settles in direct response to gravity, as a result of absent blood flow. Often referred to as 'mottling' or the skin having a mottled appearance. Initially seen as small round patches mimicking bruises. Above the hypostatic engorgement (pooling of the blood) there is obvious pallor of the skin. The presence of hypostasis is a diagnosis of death – the appearance is not present in a live subject.*

**Rigor Mortis:** *Rigor Mortis is the stiffening of the body after death. Rigor normally appears within the body around two hours after the deceased has died. Once the contracting of all the body's muscles has taken place this state of rigor - technically referred to as the Rigid Stage - normally lasts anything from eight to twelve hours after which time the body is completely stiff; this fixed state lasts for up to another eighteen hours..*

Signs of rigor mortis include:

- the limbs and joints of the deceased are stiff (rigid) and difficult to move or manipulate. This usually affects the smaller muscles first, such as those in the face, neck, arms and shoulders making the insertion of an intubation tube difficult or impossible.
- the body holds its position when moved

**Decapitation:** *self-evidently incompatible with life.*

**Massive cranial and cerebral destruction:** *where injuries to skull and brain are considered by attending healthcare professional to be incompatible with life, such as catastrophic head injury*

**Incineration:** *the presence of full thickness burns with charring of greater than 95% of the body surface*

**Traumatic Hemicorporectomy:** *the body is completely cut across below the shoulders and above the hips through all major organs and vessels. The spinal column may or may not be severed.*

**Decomposition/Putrefaction:** *where tissue damage indicates that the patient has been dead for some hours, days or longer.*

These definitions have been based on [Recognition of Life Extinct for Ambulance Clinicians \(2006\)](#)

www2.warwick.ac.uk/fac/med/research/hsri/emergencycare/prehospitalcare/jrcalcstakeholderwebsite/guidelines/recognition\_of\_life\_extinct\_by\_ambulance\_clinicians\_2006.pdf recognition of life extinct by ambulance technicians