

Action Plan in response to the PPO Report into the death of

Mr Azroy Dawes-Clarke on 10 November 2021 at HMP Elmley

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should investigate the quality of and compliance with policy of ACCT management, including the use of alternative clothing and special accommodation, in the previous 12 months, identify any improvements required, and devise a robust plan to deliver those improvements.	Accepted	<p>Work has been done to identify and implement improvements to the ACCT process. All ACCT documents are subject to a mandatory quality assurance check which is completed by a Custodial Manager (CM) 72 hours after being opened. Each week, 10% of open ACCTs are checked by a member of the Senior Leadership Team (SLT). In addition, all open ACCTs for prisoners in the care and separation unit (CSU) and the healthcare inpatient unit (IPD) are checked by a member of the SLT at weekends.</p> <p>The findings from quality assurance checks are fed back individually to Case Coordinators and are discussed at the monthly safety strategy meeting to monitor compliance with policy.</p> <p>Work has been ongoing to improve healthcare attendance at ACCT reviews. Healthcare staff are now allocated to attend planned reviews each day and attendance has improved. Planned ACCT reviews are discussed at the weekly safety</p>	Head of Safety HMPPS	Completed

			<p>intervention meeting (SIM) which is a multi-disciplinary meeting. All agencies are asked to note the review date for prisoners they are involved with so that they can arrange to attend and contribute to the review.</p> <p>All instances where special accommodation is used are now subject to a quality assurance check of the paperwork by the Operational Manager of the CSU.</p> <p>Use of alternative clothing is reserved for the most exceptional circumstances where risk is deemed to be too high to manage in normal clothing. Decisions about the use of alternative clothing must be made as part of a multi-disciplinary ACCT review chaired by the Deputy Governor.</p>		
2	The Governor and Head of Healthcare should ensure that there is clear guidance and training for all staff on the safe use of force, in particular on all risk factors in relation to positional asphyxia, that they understand the circumstances in which force is reasonable and justified, and that they are empowered to intervene when they feel the need to do so.	Accepted	<p><u>HMP Elmley:</u></p> <p>Use of force basic refresher training is undertaken by all staff annually. The training covers when it is reasonable and justified to use force. The practical element of the course covers positional asphyxia and what staff should do in the event of a medical emergency.</p> <p><u>Oxleas NHS Foundation Trust:</u></p> <ul style="list-style-type: none"> • All healthcare staff are trained to Immediate life support as a minimum standard for the 	<p>Governing Governor HMPPS</p> <p>Head of Healthcare Oxleas NHS Foundation Trust</p>	Completed

			<p>nursing team, this is refreshed yearly for prison staff.</p> <ul style="list-style-type: none"> • Local in-house training is completed on a quarterly basis on Use of Force and the risks associated. • The Practice development nurse is completing quarterly simulation training on post ligature and restraint positional asphyxiation. The PDN is developing a training video for additional learning. 		
3	The Governor and Head of Healthcare should ensure that clinical staff are consulted whenever possible before a use of force and attend any unplanned use of force as soon as possible, especially where a prisoner has already experienced a medical emergency.	Accepted	<p><u>HMP Elmley:</u></p> <p>For planned use of force incidents, the incident manager ensures that a healthcare professional is present for the incident, including the briefing before the intervention, and the post incident debrief.</p> <p>When a use of force incident is spontaneous, the general alarm sounds to attract the presence of a registered nurse, as per incident procedures. In cases where the general alarm is not raised, a call over the radio advises that someone is under restraint and the control room staff will ask for Hotel 1 (registered nurse) to attend the scene of the restraint.</p> <p><u>Oxleas NHS Foundation Trust:</u></p> <ul style="list-style-type: none"> • All healthcare staff on induction are inducted into the general alarm process and protocol. 	<p>Governing Governor HMPPS</p> <p>Head of Healthcare Oxleas NHS Foundation Trust</p>	Completed

			<p>Alongside the Use of Force training as mentioned above.</p> <ul style="list-style-type: none"> Healthcare staff document all use of force incidents and post restraint follow ups if applicable. All staff on duty regardless of role are expected to support in a Use of Force incident in the absence of hotel 1 who may be engaged in another incident. All staff attend the Use of Force training as set out in point 2. 		
4	The Governor should commission the National Incident Management Unit to review the use of force on 25 October 2021, and implement any recommendations they make.	Accepted	The Deputy Governor wrote to the National Incident Management Unit in September 2024 to refer the use of force incident so that a review could be carried out.	Deputy Governor HMPPS	Completed
5	The Head of Healthcare should ensure that there is always a registered nurse or a GP present during a medical emergency. Guidance on the role of GPs and senior managers during an emergency should be developed, detailing guidance on leadership, handover and what staff must do before they return to their usual duties or leave the prison.	Accepted	<ul style="list-style-type: none"> The Nurse carrying Hotel 1 or equivalent emergency response radio is responsible for coordinating healthcare staff and delegation of actions in the event of an emergency. The nurse overseeing the incident must remain with the incident until it is fully resolved this includes supervision of paramedics if on site and overseeing the leadership of the incident. They will be the link between prison and paramedics to ensure a smooth transition of care and handover. 	Head of Healthcare Oxleas NHS Foundation Trust	Completed

			<ul style="list-style-type: none"> This is indicated in the Kent wide Standard Operating procedure for emergency responses. 		
6	The Head of Healthcare should ensure that all healthcare staff understand their role in an emergency response, including recognising and managing seizures or loss of consciousness in line with current clinical guidelines, and recording actions taken. A local protocol, in line with NICE Guidance should be developed and training provided to ensure staff at all levels understand what is required.	Accepted	<ul style="list-style-type: none"> Monthly training sessions incorporate emergency response and simulation training of emergency response. Oxleas NHS Trust provide mandatory immediate Life support training. NICE Guidelines (CG137) Eilepsies: Diagnosis and management has been shared with all staff in multiple forums such as team meetings, clinical governance and also the Microsoft Teams channel of sharing information. New or updated NICE guidelines are regularly shared by Oxleas NHS foundation trust through communication emails and the trust intranet. 	Head of Healthcare Oxleas NHS Foundation Trust	
7	NHS England and SECAmb should conduct an investigation into the circumstances surrounding Mr Dawes-Clarke's resuscitation, including the actions of paramedics in attendance.		The Deputy Governor wrote to the South East Coast Ambulance Service (SECAmb) to advise them of the recommendation addressed to them in October 2024.	Deputy Governor HMPPS	Completed
8	The Governor and Head of Healthcare should ensure that all staff involved in a death in custody, and those that are identified as	Accepted	<u>HMP Elmley:</u> The prison holds a hot debrief immediately after an incident to support staff from a welfare perspective. Following a death in custody support	Governing Governor HMPPS	Completed

	<p>significant to the deceased, should be offered support in line with Postvention procedures.</p>	<p>is offered to all staff by the Care team and the prison has trauma risk management (TRiM) practitioners who offer peer support to all staff involved in a death. This support is available in the immediate aftermath but can be accessed at any time.</p> <p>PAM assist sessions are also arranged for staff involved in a death in custody. A member of PAM assist will attend the establishment and speak with staff either as a group or individually and ongoing services are offered where appropriate, such as counselling, via PAM assist,</p> <p><u>Oxleas NHS Foundation Trust:</u></p> <ul style="list-style-type: none">• Oxleas and HMP Elmley work under the Patient Safety Incident response framework (PSIRF). <p><u>NHS England » Patient Safety Incident Response Framework</u></p> <ul style="list-style-type: none">• All staff are invited to attend a hot debrief following any serious incident or 1:1 session if more appropriate.• Ongoing support is provided through supervision.• During the upcoming months and as part of investigations, further cold debriefs and support sessions are put in place to support all staff• Staff can self-refer to talking therapy services through Occupational Health• Staff can also use the Care team within the prison.	<p>Head of Healthcare Oxleas NHS Foundation Trust</p>	
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