

Action Plan in response to the PPO Report into the death of Mr Paul Ashley on 19/02/2021 at HMP Wakefield

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should ensure that decisions about resuscitation are effectively communicated, so that staff do not attempt to resuscitate a prisoner with a DNACPR order.	Accepted	<p>DNACPR are reviewed on a weekly basis by the Primary Care Clinical Lead; the In-patient clinical lead will also be involved in this process once in post in November 2021. The weekly review is to ensure that they are up to date and that a list of those with an active DNACPR in place is shared. The DNACPR list is being revised on a monthly basis at the Dying Well in Custody Meeting. Patients who are located in the In-patient unit now have a copy of the DNACPR in their rooms in a confidential folder.</p> <p>Patients based on the wing are given a copy of their DNACPR and encouraged to display in cell however this cannot be enforced.</p> <p>As patients do access activities outside of their living area there is always a possibility that CPR would commence until the DNACPR can be confirmed. Emergency response should</p>	Head of Healthcare	Complete



		always be initiated if in doubt and healthcare maintain this position. However as detailed, the documentation has been made more easily accessible.		
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