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

Mr David Over on 10/06/2021 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 Advance Care Plans (ACP) are discussed with patients where it has been identified that they are suffering from long term chronic health conditions.	Accepted	All ongoing care plans are discussed through the Dying well in custody meeting and then a member of the team will discuss the plan with the patient. Given the location of the Palliative care suite it would not be feasible to have the MDT discussion with the patient. The MDT process is ongoing and therefore the patient's wishes are fed back into this. This is evidenced in this case, however, as no site interviews took place the evidence could not be offered. Although the information was available via the minutes from the Dying Well in Custody Meeting notes, during the internal investigation, it was recognised that the information should also be recorded on SystmOne. As a result, the process was amended in August 2021 and discussions from the Dying Well in Custody Meetings are now also recorded on patients SystmOne records.	Head of Healthcare	Complete

2	The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.	Accepted	Head of Security has been made aware of the need for paperwork to be submitted within time frame. All departments were also reminded that documentation should be sent direct to Safer Custody.	Head of Safety HMP Wakefield	December 2021