

Action Plan in response to the PPO Report into the death of Mr Barry Keay on 13 September 2022 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 all healthcare staff, including agency workers know how to process non-resuscitation orders.	Accepted	The actions of the agency nurse in regards to escalation of the DNACPR was highlighted during the PPG internal Clinical Case Review held on 5 th October 2022. Following this review, the process for recording & escalating DNACPR instructions was discussed at the healthcare daily handover, and was also followed up by way of email to all healthcare staff. The Head of Healthcare is confident that healthcare staff are aware of the process for recording DNACPR instructions, and this is evident by the subsequent DNACPR instructions that have been implemented since this issue was highlighted.	Head of Healthcare PPG	Completed
2	The Head of Healthcare should ensure that all healthcare staff complete the medical risk assessment in full so that the authorising manager has sufficient information to make an informed decision about restraints.	Accepted	The initial PPO report with this recommendation is dated November 2023. But in response, completion of the medical risk assessment is continuously monitored to ensure healthcare staff are including relevant information. Where there have been concerns regarding the quality of information provided, healthcare staff have	Head of Healthcare PPG	Completed



			received one to one feedback from the security team or Head of Healthcare.		
3	The Governor should ensure that prison staff understand that medical information about a prisoner must be properly considered when deciding whether to use restraints and in cases where a medical objection is disregarded, the reason is documented.	Accepted	HMP Wakefield have amended the local risk assessment document to address this issue. A Governor will confirm the quality of the assessment once Healthcare has submitted their contribution to the risk assessment and complete a restraint flowchart to ensure the appropriate restraint level is set based on the information received. Local training has been delivered and will be ongoing with regards to escort risk assessment.	Head of Safer Custody HMPPS	Completed
4	The Governor should satisfy himself that: <ul style="list-style-type: none"> • decisions to apply restraints are justifiable at all times in line with the Graham judgment and the rationale for those decisions is correctly documented; and • relevant staff are regularly trained on the Graham judgement in order to challenge the culture of risk aversion that exists at the institution and so as to be empowered to raise any concerns. 	Accepted	Formal training on all aspect of escorting and cuffing arrangements was delivered to the Wakefield SMT in November 2023. A focus on the Graham judgement was incorporated into this training. Additional bi-monthly training on the Graham judgement has been scheduled for relevant staff at HMP Wakefield with a focus on delivery to the custodial and operational managers.	Head of Safer Custody HMPPS	Completed

