Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Pinakinbhai Patel, a detainee at Yarl's Wood Immigration Removal Centre on 20 April 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Pinakinbhai Patel died from a heart attack caused by coronary artery arteriosclerosis and thrombosis at Yarl's Wood Immigration Removal Centre on 20 April 2015. He was 33 years old. I offer my condolences to his family and friends.

Mr Patel's death was sudden and unforeseeable. However, the investigation identified a number of areas for improvement. These include the need to use a telephone interpretation service when assessing those, like Mr Patel, who speak little English and improved access to a GP.

I am also concerned that emergency response arrangements were poor. There was confusion about two local policies, neither of which complied with national instructions, there was a delay in calling an ambulance and in admitting the ambulance once it arrived and staff were not confident in using emergency equipment. I have previously expressed concerns about emergency response at Yarl's Wood, and more generally across the immigration detention estate, and this issue needs to be addressed as a matter of urgency.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in the investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2015**

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Summary

Events

1. On 11 February 2015, Mr Pinakinbhai Patel and his wife arrived at Heathrow Airport and were refused leave to enter the United Kingdom. Neither spoke much English. On 12 February, they were taken to Yarl's Wood Immigration Removal Centre. A nurse assessed Mr Patel and recorded no health concerns. Mr Patel and his wife were held together in the centre's family unit. They appealed against the decision to refuse them leave to enter the country.

2. On 15 April, Mr Patel told a nurse he had leg pain and the nurse added him to the GP waiting list. At 9.30am on 20 April, Mr Patel suddenly collapsed in his room. Other detainees alerted the unit officer, who radioed an emergency. Unit staff cared for Mr Patel's wife and nurses arrived and began cardiopulmonary resuscitation. A member of staff in the control room waited six minutes to be directed to call an ambulance. Paramedics arrived, but were slightly delayed getting into the centre by a fault with the gate. Mr Patel did not recover and paramedics pronounced him dead at 10.26am. The cause of death was a heart attack caused by coronary artery arteriosclerosis and thrombosis.

Findings

3. The clinical reviewer found that Mr Patel's sudden death was not foreseeable and that the care he received before he collapsed was broadly equivalent with that available in the community. However, we are concerned that Mr Patel saw nurses twice and they did not use a telephone interpreting service. Mr Patel spoke and understood little English and it is unlikely that the communication was effective. A nurse referred Mr Patel to the GP on 15 April, but there was still no doctor's appointment booked when he died on 20 April.

4. We consider that the emergency response was not good enough. A national Detention Services Order, issued in 2014, requires control room staff to call an ambulance as soon as staff radio a medical emergency code. Yarl's Wood had two confusing and contradictory local policies, neither of which included this requirement. This led to a six-minute delay, while the control room officer waited for a manager to tell her to call an ambulance. The control room officer was alone during the emergency and there is no contingency plan to enhance the staffing during an emergency.

5. A problem with the gates led to a further delay admitting the emergency response vehicles to the centre. Nurses could not assemble the emergency equipment properly, which meant that Mr Patel was not given oxygen until the paramedics arrived. There was only one set of emergency response bags for the whole centre, which is not enough for an establishment the size of Yarl's Wood.

Recommendations

- The Head of Healthcare should ensure that staff use the telephone interpreting service for assessments when a detainee speaks little or no English.

- The Head of Healthcare should ensure that detainees have appropriate access to GPs for both routine and urgent appointments and, except in exceptional circumstances, should be able to see a GP within a week. Regular audits of waiting times should be conducted to ensure a satisfactory standard of service is maintained.

- The Director and Head of Healthcare should ensure that Yarl's Wood's local emergency contingency plans are in line with Detention Services Order 09/2014 and that:

    - Control room staff call an ambulance immediately an emergency code is called.
    - That there is a contingency plan for staffing the control room during an emergency.
    - The reception gates undergo a full maintenance check and that all control room staff can operate the override mechanism.
    - There is sufficient emergency response equipment and staff are trained and competent to use it.

The Investigation Process

6. The investigator issued notices to staff and detainees at Yarl's Wood Immigration Removal Centre informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

7. The investigator visited Yarl's Wood on 23 April. He obtained copies of relevant extracts from Mr Patel's detention and medical records and spoke to four detainees who had been present during the emergency.

8. NHS England commissioned a clinical reviewer to review Mr Patel's clinical care at the centre.

9. The investigator and the clinical reviewer interviewed eight members of staff at Yarl's Wood on 20 May. The clinical reviewer interviewed paramedics on 10 June.

10. We informed HM Coroner for the Bedfordshire and Luton area of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers tried to contact Mr Patel's wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Despite a number of telephone calls, he was unable to establish contact and sent a letter to her address instead. We have not had a response. The family liaison officer was also unable to establish contact by telephone or letter to arrange for Mr Patel's wife to see a copy of the draft report.

Background Information

Yarl's Wood Immigration Removal Centre

12. Yarl's Wood is operated by Serco and holds on average 350 detainees over the age of 18. Most are single women, but husbands and wives can live together in the Hummingbird family unit, and there is also a separate short term holding facility for single men. G4S has provided healthcare services at Yarl's Wood since September 2014. Reception health assessments are carried out by a nurse working alone. There is a GP surgery seven days a week.

HM Inspectorate of Prisons

13. The most recent inspection of Yarl's Wood was in April 2015, just after Mr Patel died. The inspectors found that the quality of healthcare had significantly deteriorated since their last inspection, with severe and chronic staff shortages. Access to most primary care services was good but improvements were needed to scheduling appointments. Detainees' perceptions of healthcare were overwhelmingly negative and they said that healthcare staff had a poor attitude. The inspectors had significant concerns about the inadequate management of physical health problems.

Independent Monitoring Board

14. Each immigration removal centre has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that detainees are treated fairly and decently. In their 2014 annual report, the IMB reported a serious deterioration in the quality of healthcare provision. For much of 2014, the healthcare department was under-staffed and lacked proper management. The IMB commented that new commissioning arrangements and the change in healthcare provider had not helped. Detainees frequently complained that healthcare staff had a dismissive attitude and that it was difficult to get a GP appointment. When G4S took over, they reduced the weekly GP hours from 48 to 38. The IMB found that the healthcare team were struggling to recruit permanent staff. At the time of this investigation, only seven of the 19 posts were filled by permanent staff.

Previous deaths at Yarl's Wood

15. We investigated the death of a woman from a pulmonary embolism at Yarl's Wood in March 2014. This was the only other death at the centre for nearly a decade. We recommended that the Director General of Immigration Enforcement should implement a medical emergency response code system at all immigration removal centres to avoid delays in calling an ambulance. The Home Office introduced a Detention Services Order, but this investigation found that Yarl's Wood did not implement the Order effectively.

Key Events

16. On 11 February 2015, Mr Pinakinbhai Patel and his wife arrived at Heathrow Airport on a flight from India. They both spoke Gujarati but very little English. They had Indian passports and visitors' visas. Immigration staff interviewed them and were not satisfied that they planned to return to India. They refused them leave to enter the United Kingdom and cancelled their visas. The couple appealed against the decision and were detained pending the appeal.

17. On 12 February, Mr and Mrs Patel were taken from Heathrow to Yarl's Wood Immigration Removal Centre. Immigration staff at Heathrow did not record any medical issues.

18. After the couple arrived at Yarl's Wood, a nurse saw Mr Patel for a reception health assessment. He did not record any concerns about Mr Patel's health. He did not use a telephone interpreting service for the assessment, despite noting that Mr Patel did not speak English well. Mr Patel did not report any existing medical problems and was not on any medication. Because he had arrived from abroad, he had no available medical records. Mr and Mrs Patel moved to a shared room in the Hummingbird Unit. This unit allows family members over the age of 18 to live together.

19. Immigration staff had originally arranged to remove Mr and Mrs Patel on 26 February, if they had not appealed. Mr Patel's appeal was apparently not communicated to Home Office Detention Services, because they did not cancel the planned removal and arrived to take him to the airport on 26 February. The mistake was recognised and Mr and Mrs Patel remained in Yarl's Wood waiting for their appeal to be heard. On 26 March, Mr Patel and his wife moved to Room 137 in the Hummingbird Unit.

20. On Wednesday 15 April, Mr Patel told a nurse at a triage clinic that he had been having pain in his calves for the last week. He said that the pain was not going away and was worse in bed at night. He also complained of lower back pain which got worse when he bent down and was radiating down his legs. He said that unit staff had given him paracetamol but that this was not helping. (Staff at Yarl's Wood are allowed to give detainees paracetamol, which they record in a log.) Mr Patel asked for stronger pain relief. The nurse said that he could understand Mr Patel, who was able to communicate that the pain was in his legs and back. He examined him, prescribed ibuprofen to be taken at night and added Mr Patel to the GP waiting list. However, there is no record that an appointment was ever scheduled.

21. A married couple lived in room 139. They told the investigator that Mr Patel was upset about being detained, but he had never reported feeling unwell. He played sport regularly with the other detainees. A married couple lived in room 140. They described Mr Patel as a jolly person who was very kind and never had any health problems. He was very active and played volleyball or cricket twice a day after lunch and dinner. They said that he had played cricket on Sunday 19 April and had appeared happy and well.

Monday 20 April

22. The couple who lived in room number 140 said that Mr Patel had breakfast as usual on the morning of 20 April. At 9.20am, Mr Patel went to the shop and bought an energy drink. He then smoked a cigarette and consumed the drink, before returning to his room.

23. Shortly after he got back to room 137, Mr Patel became unwell. His wife ran to room 140 to ask the woman for help. The woman went to room 137 and saw Mr Patel on the bed. He was struggling to speak and clutching his head and arms. The woman called her husband to come and help. Mr Patel then got up but fell backwards, closed his eyes and stopped breathing properly. The woman ran to the unit office and told a detention custody officer who was working on her own in the unit, that Mr Patel did not look well. The officer followed the woman to room 137. She asked other detainees, who were crowding around Mr Patel, to move out of the way. She put her ear to his mouth, observed his chest and did not see any rise and fall to indicate that he was breathing.

24. At 9.30am, the officer radioed a medical code blue emergency. (A code blue indicates that a detainee is unconscious or not breathing and should alert the control room to call an ambulance immediately.) An officer was working in the control room. She transmitted this message to the emergency response nurse, the orderly officer and the duty director who all acknowledged receiving the message. The officer did not call an ambulance because one of the two relevant local policies required control room staff to wait for advice from a manager or a nurse at the scene.

25. Mr Patel made occasional noises as if he was gasping for breath and blood started to trickle out of his mouth. The officer put him in the recovery position on the bed. She radioed two more requests for immediate assistance. A further officer arrived and the officer who was already in the cell asked her to get help. The officer went to the office and telephoned a further officer to ensure that healthcare staff were on their way. That officer radioed the nurse again.

26. A nurse and a healthcare assistant were in the healthcare centre when they heard the radio messages and took the emergency response equipment, which includes an oxygen cylinder and a defibrillator, to the Hummingbird Unit. The nurse estimated that it took between three to five minutes to reach the unit.

27. The orderly officer arrived at the Hummingbird Unit at the same time as the healthcare staff. They found the officer supporting Mr Patel in the recovery position on the bed. He was unresponsive, his eyes were fixed and he was bleeding from his mouth. The nurse told the orderly officer to request an ambulance and call the centre GP and other available healthcare staff.

28. The orderly officer radioed for an ambulance and an officer telephoned the control room. At 9.36am, a further officer requested an ambulance and gave the ambulance service operator a telephone number for the Hummingbird Unit. The operator called the orderly officer who gave more details.

29. When she arrived, the nurse immediately recognised that Mr Patel was not breathing. Two officers helped the healthcare staff to move Mr Patel to the floor and the nurse began chest compressions. A custodial manager and two officers then took turns with chest compressions and giving rescue breaths while the nurse attached the defibrillator. The orderly officer sent an officer to get a second defibrillator from the gym as a precaution and asked the assistant orderly officer to bring an extra oxygen cylinder. A nurse printed out Mr Patel's clinical record and brought it to the room.

30. A further nurse arrived and, with the emergency response nurse tried to assemble the bag valve mask used to give oxygen when a patient is not breathing. They could not assemble it. The emergency response nurse said that they were both shaky and stressed. They abandoned it and instead used a different type of oxygen mask, which was of no benefit to Mr Patel because he was not breathing. Nurses shocked Mr Patel repeatedly with the defibrillator. At 9.47am, the duty GP and the clinical lead arrived. The woman who was resident in room 140 took Mrs Patel to her room, where other detainees, a member from the chaplaincy team and an officer comforted her.

31. Yarl's Wood is on an industrial estate. There are two entrances to the estate, both blocked by mechanical barriers. Only one of these entrances is staffed by a security guard. The barriers at the other entrance can be operated remotely by the guard. The officer did not telephone the guard to warn him that an ambulance was on its way. In the past, ambulances have used both entrances, but fortunately this time the ambulance arrived at the staffed entrance and was admitted to the estate immediately. The guard later telephoned the officer to complain that he had not been told about the ambulance and would have had the gates open in readiness if he had been alerted.

32. There was a delay in getting the first response vehicle and the ambulance into Yarl's Wood. To allow rapid access to the centre, both the outer and inner reception gates can be opened simultaneously using an override mechanism. The officer had permission to use the override, but this did not function. A rapid response vehicle arrived at 9.44am. The outer gate opened about three feet before closing again. It opened fully at about 9.47am, by which time an ambulance had also arrived. The vehicles drove into the airlock together but then had to wait for the outer gate to fully close again behind them before the inner gate opened.

33. Paramedics arrived at Mr Patel's room at 9.54am. The clinical lead said that there were too many detention staff present who were not directly treating Mr Patel and the paramedics had to ask for the room to be cleared. Only the duty GP and the clinical lead stayed. The paramedics tried to revive Mr Patel for more than half an hour, giving oxygen, further shocks from the defibrillator and shots of adrenaline. The clinical lead assisted with chest compressions. However, Mr Patel did not recover and the GP pronounced him dead at 10.26am.

Contact with Mr Patel's family.

1. An assistant director told Mrs Patel that her husband had died, using other detainees to interpret. An officer and a member of the chaplaincy team stayed with Mrs Patel for the rest of the day. The officer used other detainees and the Big Word telephone interpreting service to communicate with her. The Director wrote a condolence letter to Mrs Patel, translated into Gujarati. Mrs Patel was released from Yarl's Wood on Wednesday 22 April and went to stay with relatives in London. The Home Office paid for Mr Patel's funeral, which was held at Golders Green crematorium on 5 May. When Mr Patel died, the Immigration Tribunal had not yet reached a decision about his appeal.

Support for detainees and staff

34. Managers checked all of the detainees who had been present during the emergency. The chaplaincy team spent time with detainees in Hummingbird Unit. A centre manager reviewed all detainees subject to suicide and self-harm prevention procedures in case they had been affected by the news of Mr Patel's death. The couple in room 140 said that they had been well supported by staff. After Mr Patel died, some of the detainees refused to eat lunch as a protest. A member of staff from the Home Office and the orderly officer spoke to detainee representatives at lunchtime on 20 April. The detainees resumed eating and Home Office staff held focus groups to help address any concerns. When the investigator visited on 23 April, there was no evidence of any disruption or a hunger strike.

35. At 1.35pm on 20 April, the Director held a debrief for staff involved in the emergency. The care team also offered support. A nurse manager from another immigration removal centre visited to offer one-to-one support to the nurses.

Post-mortem report

2. A post mortem examination found that Mr Patel had died from a heart attack caused by coronary artery arteriosclerosis and thrombosis.

Findings

Clinical care

3. The clinical reviewer noted that Mr Patel's heart attack was most likely to have resulted from an undiagnosed chronic condition. She thought it very unlikely that there would have been any evidence of coronary artery arteriosclerosis when the nurse assessed him on 12 February or when a further nurse saw him on 15 April. Neither nurse used the Big Word telephone interpreting service. The nurse that assessed him on 12 February knew how to access the service but maintained that he had been able to communicate with Mr Patel, even though he noted on the assessment that Mr Patel did not speak English well. The reception assessment asks about specific medical conditions, and it is hard to see how the nurse could have meaningfully asked these questions when Mr Patel spoke little or no English and his wife spoke none. The nurse that assessed him on 15 April also knew how to access the service but did not use it and said that Mr Patel was able to make himself understood and describe his pain. We make the following recommendation:

   The Head of Healthcare should ensure that staff use the telephone interpreting service for assessments when a detainee speaks little or no English.

4. When the nurse saw Mr Patel on 15 April, he added him to the GP waiting list. At the time, healthcare staff prioritised certain appointments, such as for new arrivals. When a GP was available, healthcare staff gave an appointment to a patient from the waiting list, such as Mr Patel. There is no standard timescale within which a patient has to see a GP either in Yarl's Wood or in the community, since a 48-hour target was abandoned. However, Mr Patel remained on the waiting list for the next five days and no appointment had been booked for him by the time he died.

5. The clinical reviewer considered this was not an acceptable standard. The Independent Monitoring Board's most recent report identified that detainees had trouble accessing GP appointments and HM Inspectorate of Prisons identified problems with the appointment system. The number of GP surgery hours was reduced last year when G4S took over the healthcare contract. The clinical lead had only been in post a few weeks when Mr Patel died. She told the investigator that she had serious reservations about the existing GP referral system. She said that she planned to stop using a waiting list and instead use a triage nurse to identify appropriate GP referrals and make the best use of the limited number of appointments. We make the following recommendation:

   The Head of Healthcare should ensure that detainees have appropriate access to GPs for both routine and urgent appointments and, except in exceptional circumstances, should be able to see a GP within a week. Regular audits of waiting times should be conducted to ensure a satisfactory standard of service is maintained.

6. Although he did not see a GP before he died, the clinical reviewer concluded that Mr Patel's care before 20 April was broadly equivalent with that available in the community and that his death was not foreseeable.

Emergency response

36. The clinical reviewer commented that there was only a very slim chance of Mr Patel surviving the heart attack. However, we consider that the emergency response after he collapsed was not good enough and in other emergencies could mean the difference between life and death. Several systemic failings led to unnecessary delays.

37. In our Learning Lessons Bulletin about Immigration Removal Centres published in March 2014, we highlighted a lack of learning from Prison Service emergency response procedures and the absence of a national instruction about emergency response. After the death of a woman at Yarl's Wood in March 2014, we recommended that the Director General of Immigration Enforcement should develop a national protocol to ensure that there were no delays in calling an ambulance at immigration removal centres. The Home Office introduced Detention Services Order (DSO) 09/2014 in October 2014, which included a mandatory requirement for control room staff to call an ambulance immediately they receive an emergency medical code.

38. On 28 November 2014, Yarl's Wood introduced a 'Post Order' (the local instruction system) entitled 'Procedure for calling a blue light emergency'. This local instruction states that there should never be a delay caused by staff waiting for permission to call an ambulance and that any member of staff can instruct the control room to make the call. However, the Post Order does not outline the two required emergency codes, code blue and code red, and does not state that control room staff should call an ambulance automatically as soon as staff at the scene radio one of the codes.

39. Yarl's Wood also had a different local Post Order, '1st and 2nd response', which was last updated in September 2014. This also contains emergency response procedures and requires staff to wait for advice from a manager or member of healthcare staff at the scene before calling an ambulance. This Post Order was not updated to reflect the requirements of DSO 09/2014 but it was not removed either. This means that Yarl's Wood had two confusing and contradictory local instructions when Mr Patel died, neither of which reflected the national policy.

40. The officer used the correct medical emergency response code when she found Mr Patel, but her colleague did not immediately call an ambulance. There was a six-minute delay while the officer waited for advice from the orderly officer and the emergency response nurse. Since Mr Patel died, we understand that the centre has updated both Post Orders, but confusingly emergency response instructions remain spread across two different orders.

41. An officer worked alone in the control room during the emergency. This situation became almost impossible to manage, as she was expected to:

- speak to staff in Hummingbird Unit on one telephone
- speak to the emergency services on another telephone
- continue to answer and relay radio messages

- speak to the guard at the barriers on the edge of the industrial estate where Yarl's Wood is located about the arriving ambulance
- check CCTV for the approaching ambulance
- operate the vehicle gates

42. Serco recently successfully rebid for the contract to run Yarl's Wood. An internal transition team changed the level of staffing to reflect the terms of the new bid, and reduced the number of staff in the control room from two to one. This might be sufficient for routine operations but there was no contingency plan to ensure that the control room officer receives additional support in an emergency.

43. The first response vehicle and the ambulance were delayed when they arrived at Yarl's Wood because the outer and inner reception gates did not open simultaneously as they should have done. Paramedics arrived at Mr Patel's room at 9.54am.

44. The facilities manager had reported a fault with the reception gates on 13 April. The on-site engineer looked at the gates and recommended that a specialist should check them. The specialist attended the same day, found a problem with the inner reception gate sticking, restarted the equipment and left the gates operational after checking with the control room. The officer then reported a further fault with the inner gate sticking open on 14 April. There is nothing recorded on the job sheet to show that any further maintenance was carried out on the gate between this date and the emergency on 20 April. The on-site engineer responsible for checking the gate no longer works for Serco. A different Serco engineer looked at the gates on 20 April (after Mr Patel's death) and could not find any faults.

45. This was the first time that the officer had ever tried to open both gates simultaneously using the override mechanism. It is not clear whether she made a manual error, given the pressurised situation she faced, but it is possible that a pre-existing fault with the gates contributed to the problem.

46. It took between three and five minutes for nurses to reach Mr and Mrs Patel's room. There was only one full set of emergency response equipment in Yarl's Wood, located in the healthcare centre, which the nurse and the healthcare assistant took to the Hummingbird Unit (and another defibrillator is kept in the gym). Although it made no difference on this occasion, the clinical reviewer commented that this arrangement was inappropriate for an establishment the size of Yarl's Wood

47. During the emergency, the two nurses failed to assemble the bag valve mask correctly to give oxygen. The emergency response nurse said that they were both shaky and stressed. They abandoned using the bag valve mask and tried to give Mr Patel oxygen using a mask which only helps if the patient is breathing. Mr Patel was not breathing and therefore did not receive any oxygen to his lungs until the paramedics arrived.

48. There were a series of errors during the response to Mr Patel's collapse. It seems likely that Mr Patel's condition was critical when he collapsed, and he

would only have had a slim chance of survival, even if he had been taken to hospital almost immediately. However, it is important that emergency procedures operate effectively to ensure the best chance of survival. In other emergencies, such delays and failures in procedures could be critical to the outcome. We make the following recommendation:

The Director and Head of Healthcare should ensure that Yarl's Wood's local emergency contingency plans are in line with Detention Services Order 09/2014 and that:

- **Control room staff call an ambulance immediately an emergency code is called.**
- **That there is a contingency plan for staffing the control room during an emergency.**
- **The reception gates undergo a full maintenance check and that all control room staff can operate the override mechanism.**
- **There is sufficient emergency response equipment and staff are trained and competent to use it.**

Action plan received from Yarl's Wood

Recommendation	Person to complete Timescale	Action to be taken	Date completed
The Head of Healthcare should ensure that staff use the telephone interpreting service for assessments when a detainee speaks little or no English	G4S	On admission all detainees who require an interpreter are offered the opportunity using Big Word or Language Line. If the patient has a relative in the centre with them then we will discuss with them if they wish to use the translation services or their relative. The electronic medical record will indicate when translation services have been used and in which format	Completed
The Head of Healthcare should ensure that detainees have appropriate access to GPs for both routine and urgent appointments and, except in exceptional circumstances, should be able to see a GP within a week. Regular audits of waiting times should be conducted to ensure a satisfactory standard of service is maintained	G4S	All patients are triaged when requesting a GP appointment to establish the priority.	Completed
The Director and Head of Healthcare should			

ensure that Yarl's Wood's local emergency contingency plans are in line with Detention Services Order 09/2014 and that:			
• Control room staff call an ambulance immediately an emergency code is called.	SMT	Post Order Updated stating - If a code blue first response is called by a member of staff then the control room must automatically call an emergency ambulance on the white phone in the control room. We now have a very clear policy (Operational and Medical Responses) for emergency repose codes and what to do in the event of a code red and code blue. Staff have been made aware and the there is a notice in the communications room to remind and guide staff in terms of what to do in a code red/blue emergency. There is now one clear Post Order.	16/07/2015
• That there is a contingency plan for staffing the control room during an emergency.	SMT	Amended our policy to ensure that an additional member of staff is deployed to the communications room in the event of a serious incident, including a death in detention. Staff have been made aware and the there is a notice in the communications room. Email has also been sent out to all staff.	June 2015
• The reception gates undergo a full maintenance check and that all control room staff	SMT/GA	A new policy has been set out - S0109 – Testing Vehicle gates which states 'The Vehicle Lock Gates in both Key Press and Reception must be tested once per week by a member of the Maintenance Team with a Serco member of Staff as witness. The	17/06/2015

can operate the override mechanism.		objective of this test is to ensure both gates can open at the same time effectively. The reason this may be required is that if a critical blue light is required this process will reduce waiting time and decrease risk to life.'	
There is sufficient emergency response equipment and staff are trained and competent to use it.	Serco/G4S	All Detainee Custody Officers complete first aid training as part of their initial training course which includes defibrillator training. They also undergo refresher training. G4S has ordered a further emergency bag. All healthcare staff are required to undertake advanced life support training which includes the use of defibrillators and other equipment. Healthcare assistants are required to undertake Basic Life Support training annually and compliance with this requirement is monitored. Nurses are required to undertake Intermediate Life Support training annually and compliance with this requirement is monitored.	Complete/ Ongoing