

Action Plan

Responding to Recommendations in the Prison and Probation Ombudsman Investigation Report into the Death of Mr Tarek Chowdhury a former detainee at Colnbrook Immigration Removal Centre on 1 December 2016.

Recommendation	Person to complete & Timescale	Action to be taken	Action status
<p>The Home Office should ensure that healthcare providers and staff in the immigration detention estate share information about risks relating to detainees' mental health when they move between immigration removal centres.</p> <p><u>Recommendation accepted</u></p>	<p>Head of Operations, Detention and Escorting Services</p>	<p>Detention and Escorting Services will work with its service and health care providers and partners to consider how the existing provisions in place for information sharing in the detention estate (Person Escort Records, Detainee Transferrable Documents and healthcare to healthcare referrals) can be enhanced to improve the management of detainee risk when transferring between facilities.</p>	<p>Ongoing</p>
<p>The Head of Healthcare at Heathrow IRC should ensure that healthcare staff review the SystemOne records thoroughly during reception to guarantee continuity of healthcare for detainees and the identification of their mental health needs.</p> <p><u>Recommendation accepted</u></p>	<p>Primary Care lead (Central and North West London NHS Foundation Trust for Heathrow IRCs)</p>	<p>During the reception screening healthcare staff are required to retrieve and review as much pertinent medical information as possible from all available sources. In addition a routine assessment to determine any immediate mental health needs is conducted.</p> <p>The information obtained at the reception screening is further explored and added to during an individual's follow up appointment with a doctor – usually within 24 hours of their admission to the centre.</p> <p>If the detainee refuses to see the GP an assessment of their health needs is undertaken and if there is no clear indication that an appointment is needed then their refusal is documented. If however there are concerns, contact would be made with the detainee to discuss his refusal and attempts would be made to re-engage and get agreement to attend an appointment.</p>	<p>Completed and ongoing</p>

		Reports are generated daily from SystmOne which highlights if the detainee has any Long Term Conditions registered on the quality outcomes framework register which would highlight any healthcare needs that may not have been disclosed at the initial screening. If this is highlighted an appointment is made to see the GP to discuss this and ongoing reviews would be instigated.	
<p>The Home Office and HMPPS should agree a consistent approach to the sharing of Mercury intelligence reports between prisons and all detention centres, including those that are not run by HMPPS, in order to provide staff in detention centres with the information they need to help them assess the risk that detainees pose to themselves and others.</p> <p><u>Recommendation accepted</u></p>	<p>Detention and Escorting Services, Head of Security</p> <p>October 2018</p>	<p>A project is underway to introduce the Mercury intelligence database into all immigration removal centres by October this year.</p>	Ongoing
<p>The Centre Manager of Colnbrook IRC should ensure that staff respond effectively to anti-social and violent behaviour by detainees in line with the Centre's violence reduction policy and anti-bullying strategy.</p> <p><u>Recommendation accepted</u></p>	<p>Safer Community Manager, Mitie Care & Custody</p>	<p>New bullying investigation forms have been developed and regular management reviews of these investigations have been implemented to ensure that risks and challenges are being properly identified by staff.</p> <p>Where these reviews identify learning points these will be published to all supplier staff at the Heathrow IRCs via Learning Bulletins to ensure continuous improvement. Any significant failings will be formally investigated.</p>	Complete and ongoing
<p>The Head of Healthcare at Colnbrook IRC and Central and North-West London NHS Foundation Trust (CNWL) must ensure that all healthcare staff undertake Immediate Life Support (ILS) training</p>	<p>Head of Healthcare & team leads</p>	<p>There is a requirement for all healthcare staff to complete Immediate Life Support Training every two years. All staff are currently compliant.</p>	Completed and ongoing

<p>which covers quality CPR, airway management and the recognition of clinical deterioration.</p> <p><u>Recommendation accepted</u></p>		<p>Compliance is monitored monthly by Healthcare Senior Managers.</p>	
<p>The Centre Manager and the Head of Healthcare at Colnbrook IRC should ensure that all staff are made aware of and understand DSO 09/2014, <i>Medical Emergency Response Codes</i>, and their responsibilities during medical emergencies as outlined in the Local Medical Emergency Response Code Protocol, so that staff efficiently communicate the nature of a medical emergency and there is no delay in calling ambulances.</p> <p><u>Recommendation accepted</u></p>	<p>Head of Operations, Mitie Care & Custody</p> <p>July 2018</p> <p>Head of Healthcare</p>	<p>Staff will now be reminded of the medical emergency response codes and their use through quarterly notices. The most recent notice was issued in June 2018. Where staff are found not to have used the appropriate codes this will be escalated to the Deputy Centre Manager for appropriate action to be taken.</p> <p>All staff computers will have screensavers installed about emergency medical response codes to ensure the importance of their use is visible daily.</p> <p>New staff will receive training on the use of emergency response codes during their initial training course.</p> <p>All healthcare staff are familiar with process for Medical Response Codes and as a reminder of the process, DSO 09/2014 has been re-circulated to all healthcare staff. This will be circulated every 6 months and all new starters will be made aware of this as part of their induction.</p> <p>Emergency ambulances will only be stood down once the situation has been fully assessed and deemed there is no immediate threat to life.</p>	<p>Completed and ongoing</p> <p>Completed and ongoing</p>
<p>The Centre Manager should ensure that all relevant mandatory actions in DSO 08/2013, <i>Death in Detention</i>, are completed after a prisoner's death. In particular, staff involved in an emergency response</p>	<p>Centre Manager, Mitie Care & Custody</p>	<p>Mitie Care & Custody provide an established range of support to staff who are affected by a death in detention. This includes individual and group support, access to a</p>	<p>Completed and ongoing</p>

<p>should be adequately supported and debriefed by a senior member of staff.</p> <p><u>Recommendation accepted</u></p>		<p>helpline supported by the employee assistance programme and specialist counselling.</p> <p>Staff debriefs are also undertaken immediately following a death and also a short period afterwards to ensure that staff are able to discuss the emergency response and, where appropriate, learn lessons.</p>	
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