

**Action Plan**  
**Responding to Recommendations in the Prison and Probation Ombudsman Investigation Report into the Death of Mr Oscar Okwurime, a detainee at Heathrow Immigration Removal Centres on 12 September 2019.**

Recommendation	Person to complete & Timescale	Action to be taken	Action status
<p><b>The Head of Healthcare should develop a clear pathway for the management of patients with hypertension in accordance with NICE guidance 136.</b></p>	<p>CNWL Head of Healthcare / NHS England</p>	<p>A range of procedures have now been put in place and a clear pathway developed for patients with hypertension;</p> <ol style="list-style-type: none"> <li>1. SystemOne (electronic health record system) amended to trigger an alert if detainees present with a blood pressure (BP) reading that is 140/90</li> <li>2. Templates amended so that staff cannot complete a healthcare screening without taking a second blood pressure reading</li> <li>3. Detainee to be referred to GP for next day appointment if BP remains high</li> <li>4. GP refers to hospital for further review.</li> </ol>	<p>Complete and Ongoing</p>
<p><b>The Head of Healthcare should revisit the Homely Remedy Protocol to ensure that healthcare staff are prompted to consider further discussion and review of symptoms.</b></p>	<p>CNWL Head of Healthcare / NHS England</p>	<ol style="list-style-type: none"> <li>1. Homely remedy policy to be reviewed</li> <li>2. SystemOne amended to ensure staff supplying homely remedies are recording their actions in same place</li> <li>3. Staff reminded to record reason for homely remedies to be prescribed.</li> <li>4. Ratified policy circulated to all staff and discussed in team meetings.</li> </ol> <p>All healthcare staff have received a tracked email on the homely remedy protocol which confirms it has been delivered and read.</p>	<p>Complete &amp; ongoing</p>

<p><b>The Director should initiate an investigation into the DCO's failure to carry out the roll check on the morning of 12 September 2019, and his refusal to be interviewed by the PPO investigator, with a view to considering whether disciplinary proceedings are appropriate.</b></p>	<p>MITIE Centre Director</p>	<p>An investigation into the DCO's actions and conduct have been undertaken and concluded. Appropriate disciplinary action has been taken.</p>	<p>Complete</p>
<p><b>The Director should initiate an investigation into a DCO's failure to check on Mr Okwurime during unlock on the morning of 12 September 2019, with a view to considering whether disciplinary proceedings are appropriate.</b></p>	<p>MITIE Centre Director</p>	<p>An investigation into the actions of a DCO has been undertaken and concluded. Appropriate disciplinary action has been taken.</p>	<p>Complete</p>
<p><b>The Director should ensure that all IRC staff are made aware of and understand DSO 4/2018 and their responsibilities to carry out roll checks and welfare checks on detainees at the appropriate times.</b></p>	<p>MITIE Centre Director</p>	<p>All staff were issued with and received a briefing on 'Notice To Staff 56-2019' which provides guidance on carrying out roll counts and welfare checks. This was issued on 19 September 2019 and re-issued again on 28 February 2020. This will be re-issued on a regular basis and/or when necessary.</p>	<p>Complete</p>
<p><b>The Director and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including:</b></p> <ul style="list-style-type: none"> <li>• <b>the meaning of medical emergency codes;</b></li> <li>• <b>an ambulance is called immediately when a medical emergency code is called; and</b></li> <li>• <b>ambulance staff are escorted to the emergency scene without delay.</b></li> </ul>	<p>CNWL Head of Healthcare / NHS England And MITIE Centre Director</p>	<p>MITIE staff receive bi-weekly written reminders setting out the definitions and meaning of the medical emergency response codes in use at the centre.</p> <p>MITIE managers and duty directors undertake random testing of staff on duty during visits to the centre.</p> <p>Clear signage is also displayed throughout the centre on the Emergency Medical Response Codes for staff reference.</p> <p>Ambulance staff will always be escorted from the gate to the scene as soon as possible. MITIE staff have been reminded of this requirement through local communications and as part of MITIE Local Procedures.</p>	<p>Complete and Ongoing</p>

		<p>CNWL have re-issued the guidance on the use and response to emergency medical response codes to all healthcare staff.</p> <p>CNWL have also put in place measures to deliver training on these codes and their use to MITIE staff during ITC presentations on healthcare.</p> <p>CNWL have completed an internal audit of the emergency medical response codes and their use in the Heathrow IRCs to measure compliance.</p>	
<p><b>The Director and Head of Healthcare should ensure that:</b></p> <ul style="list-style-type: none"> <li>• all IRC staff have received training in basic life support and first aid; and</li> <li>• feel confident in putting that training into practice when necessary.</li> </ul>	<p>MITIE Centre Director And CNWL Head of Healthcare / NHS England</p>	<p>All DCOs are trained in first aid as part of their initial training course (ITC). The training plan for refresher training is currently being reviewed to ensure all staff training in first aid remains current.</p> <p>All Band 5 to 8 nursing staff undertake mandatory Trust training in immediate life support. For nurses at Bands 3 and 4, this requirement is for basic life support training. Refresher training for all bands is undertaken at regular intervals. This level of training supersedes first aid training for healthcare professionals.</p>	<p>Complete and Ongoing</p>
<p><b>The Head of Healthcare should initiate an investigation into the acts and omissions of a Nurse, with a view to considering whether further action is required.</b></p>	<p>CNWL Head of Healthcare / NHS England</p>	<p>This matter has been referred to the Service Director to consider and take appropriate action. Any decision will take into account the CNWL clinical review undertaken in this case.</p>	<p>Ongoing</p>
<p><b>The Head of Healthcare should ensure that local guidance on the appropriateness of resuscitation is aligned to the Royal College of Nursing document ‘Guidance to support the</b></p>	<p>CNWL Head of Healthcare / NHS England</p>	<p>The CNWL emergency medical response policy for the Heathrow IRCs is being updated to include the relevant guidance from the Royal College of Nursing on the</p>	<p>Ongoing</p>

<p><b>decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centres’.</b></p>		<p>decision- making process for cardiopulmonary resuscitation.</p> <p>Once complete the updated policy will be shared with all CNWL staff and regularly discussed at team meetings.</p>	
<p><b>The Director should ensure that prompt arrangements are made to remove other detainees from the scene of a medical emergency.</b></p>	<p>MITIE Centre Director</p>	<p>Contingency plans are in place setting out the requirements to clear the scene in the event of a medical emergency. These plans have been reviewed in light of this recommendation. MITIE have purchased additional privacy screens to be used by staff as a means to ensure that events of this nature are handled sensitively and privately while the scene is being cleared.</p>	<p>Complete</p>
<p><b>The Director and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage.</b></p>	<p>MITIE Centre Director And CNWL Head of Healthcare / NHS England</p>	<p>The PPO fatal incident investigation report has been shared with all the MITIE staff named in the report.</p> <p>A process for sharing this report with named CNWL healthcare staff who are no longer part of the healthcare team at the Heathrow IRCs is being considered.</p>	<p>Complete  Ongoing</p>
<p><b>The Head of Operations in Detention and Escorting Services in the Home Office should satisfy himself that effective action is taken in response to the concerns identified in this report.</b></p>	<p>Head of Operations And Head of Risk and Assurance Detention and Escorting Services</p>	<p>Both the local Detention and Escorting Services (DES) Compliance Team and the DES Audit and Assurance Team (DESAAT) undertake regular and robust assurance of all third-party recommendations to satisfy themselves that action is being implemented and appropriate evidence provided to support reported progress.</p> <p>In March 2020 DESAAT are scheduled to undertake a thematic review on the progress of third-party recommendations made in respect of deaths in detention, with a report expected in April 2020. This will include the recommendations made in this report.</p>	<p>Complete and Ongoing</p>