

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Oscar Okwurime, a detainee at Heathrow Immigration Removal Centre, on 12 September 2019

**A report by the Prisons and Probation Ombudsman**

## 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*



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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 Oscar Okwurime died of a spontaneous subarachnoid haemorrhage (bleeding in the brain) on 12 September 2019 while being detained at Heathrow Immigration Removal Centre. He was 36 years old. I offer my condolences to Mr Okwurime's family and friends.

Mr Okwurime was at the IRC for three weeks before he died. The investigation found that during his initial health screen, Mr Okwurime was noted to have raised blood pressure, but that healthcare staff did not investigate this further. Healthcare staff also failed to investigate why Mr Okwurime requested paracetamol for recurring headaches on eight occasions between 28 August and 10 September.

I am concerned that staff failed to carry out an early morning roll check on 12 September, or to check on Mr Okwurime when his room was unlocked that morning. Mr Okwurime was later found unresponsive on the floor of his room and it is likely that he had been dead for some hours.

Healthcare staff who attended failed to check for a pulse or to assess Mr Okwurime's level of consciousness, and, although he was cold and stiff to the touch, they made prolonged and inappropriate attempts at CPR.

I am not satisfied that the healthcare Mr Okwurime received at Heathrow Immigration Removal Centre was equivalent to that which he could have expected to receive in the community.

This is not the first time my office has raised concerns about clinical care and emergency responses at Heathrow IRC and I am therefore escalating these concerns to the Head of Operations in Detention and Escorting Services in the Home Office.

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

**Sue McAllister, CB**  
**Prisons and Probation Ombudsman**

**June 2021**

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# Summary

## Events

1. On 22 August 2019, Mr Oscar Okwurime, a Nigerian national, arrived at Heathrow Airport. He was refused entry into the UK and was taken to Heathrow Immigration Removal Centre (IRC) pending removal to Nigeria.
2. Mr Okwurime did not report any medical conditions during his initial health screen, apart from a minor pain in his right side. A nurse noted his body temperature was lower than normal and that his blood pressure was significantly raised. He was not given any further blood pressure tests and was not referred to a GP for further review.
3. Between 28 August and 10 September, healthcare staff gave Mr Okwurime two paracetamol tablets on eight occasions. On seven of those occasions, Mr Okwurime said that he needed them because he had recurring headaches. There is no evidence in Mr Okwurime's medical records that healthcare staff tried to establish the cause of those headaches.
4. On the evening of 11 September, Mr Okwurime's room was locked for the night. The night patrol officer was expected to carry out an early morning roll check at 7.00am on 12 September as part of his duties, but he failed to do so. At 8.00am, the officer responsible for unlocking Mr Okwurime's room also failed to check on him as required.
5. At 11.11am, the officer returned to Mr Okwurime's room to carry out routine security checks. She found Mr Okwurime lying face down on the floor of his room. She called a colleague for assistance. Her colleague arrived and checked Mr Okwurime for a pulse but could not find one. They attempted to put him into the recovery position but were unable to do so. Her colleague then made a code blue emergency radio call.
6. An IRC nurse responded quickly. He did not bring an emergency grab bag. Because Mr Okwurime would not move his arms when the nurse asked him to, the nurse decided that Mr Okwurime was resisting so he did not check for a pulse but assumed that Mr Okwurime was conscious and breathing.
7. A second nurse arrived shortly afterwards and together they moved Mr Okwurime from his room onto the landing. Despite noting he was stiff and cold to the touch, healthcare staff began CPR until paramedics arrived. Paramedics told healthcare staff that rigor mortis had set in and Mr Okwurime had probably been dead for some hours.
8. At 11.37am, paramedics confirmed that Mr Okwurime had died.
9. The coroner gave Mr Okwurime's cause of death as spontaneous subarachnoid haemorrhage (bleeding in the space between the skull and the brain).

## Findings

### Clinical care

10. The clinical reviewer concluded that, although it was not possible to predict Mr Okwurime's death, the healthcare he received at Heathrow IRC was not equivalent to that which he could have expected to receive in the community.
11. Healthcare staff identified that Mr Okwurime had raised blood pressure, but they failed to investigate this any further.
12. Although Mr Okwurime reported headaches on seven occasions between 28 August and 10 September, there is no evidence that healthcare staff made any further enquiries or referred him to a GP for review.

### Roll checks/welfare checks

13. We are concerned that on the morning of 12 September, a Detainee Custody Officer (DCO) failed to carry out a roll check in line with local policy.
14. We are also concerned that another DCO failed to carry out the correct checks when unlocking Mr Okwurime's room.
15. We cannot say whether these failings affected the outcome for Mr Okwurime, but they could be crucial in other cases.
16. A DCO refused to be interviewed by the PPO investigator, contrary to Detention Services Order 8/2014.

### Emergency response

17. When the first ambulance paramedic arrived, they were not escorted to the resuscitation scene promptly.
18. We are not satisfied that all staff understand the significance of a medical emergency code.
19. The first nurse to respond failed to check Mr Okwurime for a pulse or to carry out a structured assessment of his level of consciousness and wrongly assumed that he was conscious and breathing.
20. We are concerned that healthcare staff carried out CPR on Mr Okwurime even though it was clear that he had been dead for some hours.
21. Other detainees were not removed from the scene promptly and were able to witness the inappropriate and undignified attempts to resuscitate him.

## Recommendations

- The Head of Healthcare should develop a clear pathway for the management of patients with hypertension in accordance with NICE guidance 136.
- 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.

- The Director should initiate an investigation into a Detainee Custody Officer'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.
- The Director should initiate an investigation into Detainee Custody Officer'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.
- The Director should ensure that all IRC staff are made aware of and understand DSO 4/2018 Management and Security of Night State and their responsibilities to carry out roll checks and welfare checks on detainees at the appropriate times.
- The Director and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including:
  - the meaning of medical emergency codes;
  - an ambulance is called immediately when a medical emergency code is called; and
  - ambulance staff are escorted to the emergency scene without delay.
- The Director and Head of Healthcare should ensure that:
  - all IRC staff have received training in basic life support and first aid; and
  - feel confident in putting that training into practice when necessary.
- The Head of Healthcare should initiate an investigation into the acts and omissions of a healthcare nurse, with a view to considering whether further action is required.
- 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 decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centres*'.
- The Director should ensure that prompt arrangements are made to remove other detainees from the scene of a medical emergency.
- 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.
- 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.

## The Investigation Process

22. The investigator issued notices to staff and detainees at Heathrow IRC informing them of the investigation and asking anyone with relevant information to contact him.
23. The investigator obtained copies of relevant extracts from Mr Okwurime's IRC and medical records.
24. NHS England commissioned a clinical reviewer to review Mr Okwurime's clinical care at Heathrow IRC.
25. The investigator visited Heathrow IRC with the clinical reviewer on 30 September 2019 and carried out two interviews. He visited again on 19 November and interviewed one further member of staff and interviewed another at the Prisons and Probation Ombudsman's office on 25 November.
26. Solicitors acting on behalf of number of detainees contacted the investigator and provided written submissions.
27. We informed HM Coroner for Western London District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
28. We wrote to Mr Okwurime's next of kin to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
29. The initial report was shared with the Home Office Immigration Enforcement Team. They pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

# Background Information

## Heathrow Immigration Removal Centre (IRC)

30. Heathrow IRC is an immigration removal centre in west London and holds about 1065 detainees. It consists of two separate sites: Harmondsworth (where Mr Okwurime was detained) and Colnbrook. Mitie Care and Custody run the centre under contract from the Home Office. Central and North-West London NHS Foundation Trust (CNWL) provides physical and mental health services. There is a 20-bed Enhanced Care Unit.

## HM Inspectorate of Prisons

31. The most recent inspection of the Harmondsworth site at Heathrow IRC was conducted in October 2017. Inspectors noted that detainees were often critical of the healthcare services available to them at the centre. However, inspectors considered that the healthcare provision was adequate. They noted that detainees had good access to a range of primary care services and that patient needs were largely met.
32. Inspectors noted that detainees received a thorough reception health screen following their arrival at the centre, which was routinely followed up by a GP review within 24 hours. There was also a health services leaflet available in a wide range of languages. They found the 20-bed Enhanced Care Unit to be clean and well maintained, with healthcare staff being available 24 hours a day.

## Independent Monitoring Board

33. Each IRC 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 its latest annual report for the year to December 2018, the IMB noted that there have been significant improvements in the provision of healthcare at the centre. They also noted that there had been an increase in staffing levels within the healthcare centre leading to a reduction in primary care appointment delays.

## Previous deaths at Heathrow Immigration Removal Centre

34. We have investigated two previous deaths at Heathrow (Harmondsworth site) since 2017. One death was from natural causes and the other death was self-inflicted. In those investigations we raised concerns about the emergency response and clinical care provided to the detainee.

## Key Events

35. On 22 August 2019, Mr Oscar Okwurime, a Nigerian national, was stopped at Heathrow Terminal 2 while trying to enter the United Kingdom from Nigeria. Mr Okwurime had a visa which allowed him to visit the UK for six months, but when Immigration Officers questioned him, he admitted that his work identity card was forged. As a result, Mr Okwurime was refused entry into the UK and taken to the Harmondsworth site of Heathrow Immigration Removal Centre (IRC) pending removal to Nigeria.
36. When he arrived, a nurse carried out a reception health screen. He noted that Mr Okwurime did not require an interpreter. He recorded Mr Okwurime's height, weight and body mass index – he was overweight - and asked if he had any pre-existing medical conditions. Mr Okwurime said that he had none, apart from some pain in his right side.
37. The nurse noted that Mr Okwurime's temperature was slightly lower than normal at 36°C (normal body temperature is between 36.5-37.5°C). He also checked his blood pressure which was raised at 168/113 mm/hg (normal blood pressure is around 120/80 mm/hg). His other observations were within normal limits. The nurse did not repeat the blood pressure test and did not arrange for any further reviews to be carried out. Mr Okwurime had no further significant contact with healthcare staff.
38. Following the health screen, Mr Okwurime was taken to Gorse House Harmondsworth, one of the residential units in Heathrow IRC. He shared a double room until the morning of 11 September, after which, he occupied the room alone.
39. On 28 August, Mr Okwurime asked for some paracetamol. A nurse gave him two 500mg paracetamol tablets. A nurse did not record why Mr Okwurime had requested the tablets in his medical records.
40. Between 28 August and 10 September, healthcare staff gave Mr Okwurime two 500mg paracetamol tablets on a total of eight occasions. On seven of those occasions he told healthcare staff that he was experiencing headaches. There is no evidence that healthcare staff referred Mr Okwurime for a review by a GP to try and find out the cause of his headaches.

### Events of 11/12 September

41. At 8.59pm on 11 September, Mr Okwurime's room was locked for the night. A Detainee Custody Officer (DCO), who was the night patrol officer, was required to carry out a roll check at 7.00am on 12 September, before the day staff came on duty. However, he failed to do so.
42. At approximately 8.00am on 12 September, another DCO unlocked Mr Okwurime's room. She did not look into Mr Okwurime's room when unlocking the door as she should have done.
43. At 11.11am, the DCO returned to Mr Okwurime's room to carry out routine daily security checks. She entered the room and saw that Mr Okwurime was lying

- face down on the floor with his head towards the room door and his arms tucked underneath him. She noted there was a pool of vomit by his head. She went to the room next door to summon help from another DCO.
44. The two DCOs went back into Mr Okwurime's room. One of the DCOs checked for a pulse but she was unable to find one. She also noted he felt cold and stiff to the touch. They attempted to move him into the recovery position but were unable to do so.
  45. The radio log records that the DCO called a code blue emergency over her radio at 11.12am. The control room staff called an ambulance at 11.16am. The DCO told the investigator that she also pressed her personal alarm more than once and that they also pressed the intercom in Mr Okwurime's room.
  46. At 11.14am, the Duty Shift Manager (DSM) and a DCO arrived and went into Mr Okwurime's room. In their statements the DSM said he responded to a code blue and the DCO said he responded to a request for a 'medical response'. The DSM could not move Mr Okwurime and could not find a pulse and thought that he was not breathing.
  47. A nurse arrived in response. He said that he had not heard a code blue call, just a call for medical assistance. As a result, he did not collect the emergency grab bag. Instead he took a basic first aid bag to the room. (Emergency grab bags are equipped with emergency equipment in line with UK resuscitation guidelines.)
  48. The nurse said that when he arrived at the room, he was not given a clear handover from either of the DCOs and was not able to establish when Mr Okwurime had last been seen alive. One of the DCOs told him, incorrectly, that Mr Okwurime was called 'Abdul' and that she thought he was known to smoke psychoactive drugs. She has not been able to explain this confusion.
  49. The healthcare nurse attempted to gain a verbal response from Mr Okwurime and shook him by the shoulder, but Mr Okwurime did not respond. The nurse said that he thought Mr Okwurime was deliberately resisting and not complying with his instructions and concluded that he must, therefore, be breathing and conscious. He did not check Mr Okwurime for a pulse.
  50. At 11.20am, Body-Worn Video Camera (BWVC) footage begins.
  51. At 11.21am, the nurse manager arrived to assist the nurse. The nurse manager's role did not require her to carry a radio and she did not hear if a code blue or a call for medical assistance had been put out but was asked to attend by an officer. The nurse told her that Mr Okwurime was resisting. He also told her that he thought he had witnessed shallow breathing.
  52. The nurse manager asked two DCOs to help her to get Mr Okwurime out of the room and onto the landing to give them more space. As they moved him from the room, the nurse manager was heard (via BWVC footage) to say that Mr Okwurime was stiff and not breathing.
  53. A DCO left the room to get the emergency grab bag from the healthcare room on the wing and she returned within a minute. The nurse manager, assisted by other staff, turned Mr Okwurime onto his back. As they turned him, his arms

stayed in place and he appeared to be rigid. The nurse manager checked Mr Okwurime's inner thigh for a femoral pulse, but she could not find one. She cut his shirt off and began chest compressions.

54. At 11.26am, the nurse manager used a nasal airway to deliver air into Mr Okwurime's lungs (they could not use an oral airway as Mr Okwurime's jaw was clenched shut). They continued with CPR until paramedics arrived at 11.27am.
55. The nurse manager told the paramedics that the policy of Heathrow IRC is that staff should attempt resuscitation in all circumstances. However, the nurse manager was asked to stop attempts at resuscitation by the paramedics as it was clear to them that rigor mortis (stiffening of the body which usually occurs four to six hours following death) was present. They concluded that Mr Okwurime had clearly been dead for some hours.
56. At 11.37am, the paramedics confirmed that Mr Okwurime had died.

### **Post-mortem report**

57. The coroner gave Mr Okwurime's cause of death as spontaneous subarachnoid haemorrhage (SAH, bleeding in the space between the skull and the brain).
58. The clinical reviewer said that a SAH is most often caused by a burst blood vessel in the brain (a ruptured brain aneurysm) and is a type of stroke. It is not known exactly why brain aneurysms develop in some people, although smoking, uncontrolled high blood pressure, excessive alcohol and a family history of the condition are known to be risk factors. A SAH can cause sudden and severe headache, which is often accompanied by nausea, vomiting, neck stiffness and sometimes collapse, seizure and loss of consciousness. The mortality rate is very high with death rates of around 50%. Successful resuscitation following an unobserved collapse would have been unlikely.

### **Contact with Mr Okwurime's Family**

59. At 11.48am on 12 September 2019, a family liaison officer (FLO) on behalf of the Home Office.
60. In line with Home Office policy, the Home Office FLO requested information on the next of kin's address from the police prior to visiting (for reasons of personal safety). However, despite repeated attempts he was unable to contact the relevant police department, and decided to contact Mr Okwurime's next of kin by telephone.
61. At 3.29pm, the Home Office FLO telephoned Mr Okwurime's uncle, who he had listed as his next of kin. He informed him of Mr Okwurime's death and offered support and advice. At his request, the Home Office FLO then contacted members of Mr Okwurime's family in the United Kingdom. The next of kin declined an offer by the Home Office FLO to inform members of Mr Okwurime's family in Nigeria, preferring instead to inform them himself.
62. The following day, the Home Office FLO, accompanied by the Home Office FLO co-ordinator, visited Mr Okwurime's uncle at his home address. They spent time

with the family explaining the circumstances of his death and answering any questions they had.

63. The Home Office FLO continued to offer the family support. He visited the family again on 18 September and stayed in regular contact both in person and by telephone, offering support and advice.
64. Mr Okwurime's brother visited Heathrow IRC to collect Mr Okwurime's property on 22 October.
65. On 5 December, Mr Okwurime's body was repatriated to Nigeria. His funeral was held the following day. In line with national guidance, the Home Office offered a financial contribution towards Mr Okwurime's repatriation and funeral.

### **Support for prisoners and staff**

66. After Mr Okwurime's death, an IRC manager debriefed the staff who were involved giving them the opportunity to discuss any issues arising, and to offer support. The two DCOs who first saw the death were not present. The staff care team also offered support.
67. The IRC posted notices informing other detainees of Mr Okwurime's death and offering support. Staff reviewed all detainees assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Okwurime's death.

# Findings

## Clinical care

68. The clinical reviewer concluded that, although Mr Okwurime's death could not have been predicted, the clinical care Mr Okwurime received at Heathrow IRC was not equivalent to that which he could have expected to receive in the community.
69. The clinical reviewer noted that Mr Okwurime had a high blood pressure reading during his initial health screen. Unlike prisons, health screening in IRCs does not include a secondary screen. However, the clinical reviewer considered that Mr Okwurime's elevated blood pressure reading should have been rechecked.
70. The National Institute for Health and Care Excellence (NICE) guideline 136, says that if a blood pressure reading of 140/90 mm/Hg is noted, a second measurement should be taken during the consultation. If the reading remains high, arrangements should be made for a third reading to be taken. Depending on Mr Okwurime's blood pressure results, arrangements should then have been made to follow up and monitor the level, along with a referral to a GP. This might have informed a diagnosis of hypertension and treatment to control his blood pressure. Healthcare staff failed to do this in Mr Okwurime's case.
71. Between 28 August and 10 September 2019, Mr Okwurime was given two 500mg paracetamol tablets on eight separate occasions. There are no entries in his medical records noting why he had requested them other than he had said he was experiencing headaches. There is no evidence that healthcare staff made any further enquiries into the duration, severity or site of his headaches, or any investigation into the possible links between his raised blood pressure and continuing headaches.
72. CNWL's protocol says that healthcare staff should record any advice they give and record a set of baseline observations. Healthcare staff failed to do this in Mr Okwurime's case. The actions of healthcare staff were also not in line with the Homely Remedy Policy (a protocol giving guidelines on the management of medications that can be purchased over the counter) which says that the maximum amount of treatment that can be given without review is three days. The clinical reviewer did, however, note that Mr Okwurime would have been able to buy this number of paracetamol tablets in the community without restriction.
73. We make the following recommendations:

**The Head of Healthcare and the Lead GP should ensure that they develop a clear pathway for the management of patients with hypertension in accordance with NICE guidance 136.**

**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.**

74. The clinical reviewer has made a number of additional recommendations about a review of CNWL's protocol in relation to emergency response and cardiopulmonary resuscitation, which we do not repeat here but which the Head of Healthcare will wish to address.

### Roll checks and detainee checks

75. Detention Service Order (DSO) 04/2018, *Management and security of night state*, requires IRC Directors to ensure that the local security strategy contains clear guidance on the hand-over procedures that must take place before the IRC can come out of night state, which includes a requirement for night staff to carry out a full roll check (to check that all detainees are present in their rooms).
76. Mr Okwurime's room was locked for the night at 20.59pm on 11 September. As part of his duties, the night patrol officer, was required to carry out a full roll check of the unit at 7.00am the following morning before the day staff came on duty. He did not do so. If he had carried out the check, he might have seen Mr Okwurime lying on the floor of his room, given that Mr Okwurime had been dead for some hours when he was found at about 11.00am. We cannot say whether this might have changed the outcome for Mr Okwurime.
77. On 19 November, the investigator attended Heathrow IRC for a planned interview with a DCO. However, the DCO was advised against speaking to the investigator by his union representative, so the investigator was unable to hear his account of the events of 11 and 12 September.
78. DSO 8/2014, *Deaths in Detention*, says that the PPO is responsible for investigating all deaths in IRCs and that "all centre staff (supplier, HOIE, healthcare, etc) must comply with the PPO investigation. This may include attending interviews and providing witness statements if requested". Our information for interviewees makes it clear that they can be accompanied by a trade union representative or a friend if they wish, but the DCO did not request this and simply did not attend for the interview. We consider that his refusal to be interviewed by the investigator was unacceptable.
79. On the morning of 12 September, another DCO was tasked with unlocking the rooms on Gorse Unit at about 8.00am. As part of that duty, she was expected to open the room door and to check that the detainee was present. She failed to do so. Had she done so, it is likely that she would have seen Mr Okwurime lying on the floor of his room, given that he had been dead for some hours when he was found at about 11.00am.
80. When questioned about the events of 12 September, the DCO said that after she had unlocked Mr Okwurime's room, she had immediately moved onto the room of another detainee who she knew was on an ACDT (Assessment, Care in Detention and Teamwork, the care planning process for detainees identified as being at risk of suicide or self-harm) to check on his welfare.
81. While it is not possible to say whether the missed roll check and unlock check had an impact on the outcome for Mr Okwurime, in other cases any failure to

carry out the required checks on detainees could be crucial. We make the following recommendations:

**The Director should initiate an investigation into a Detainee Custody Officer'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.**

**The Director should initiate an investigation into the 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.**

**The Director should ensure that all IRC staff are made aware of and understand DSO 04/2018 and their responsibilities to carry out roll and welfare checks on detainees at the appropriate times.**

### Emergency Response

82. DSO 9/2014 requires IRCs to have a medical emergency response code protocol which ensures that an ambulance is called automatically in a life-threatening medical emergency. Heathrow's local policy instructs staff to use a code blue to indicate when a detainee is unconscious or having breathing difficulties, and a code red when a detainee is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
83. When the DCO discovered Mr Okwurime on the floor of his room, she did not make an emergency code blue radio call, instead she asked another DCO for assistance. This was not in line with the IRC's local policy and led to a short delay before the emergency code was called.
84. There was an unexplained delay of seven minutes between the arrival of the first ambulance service paramedic and them reaching Mr Okwurime. A DCO was aware that the ambulance staff were onsite at 10.22am, but they were not immediately directed to attend the resuscitation scene. We do not know why they were not sent up directly. Although in this case it would not have affected the outcome, in a different case it could make a crucial difference.
85. We are also concerned that staff who attended the incident were confused about whether a code blue or a call for medical assistance had been put out. The control room log recorded at the time of the incident that the only radio call made was a code blue. However, a nurse, who was the only member of healthcare who responded, said he heard a call for medical assistance and as a result he did not take the emergency bag (which contains resuscitation equipment) with him. If a code blue was called, other healthcare staff should also have responded, but none did. The DSM who attended said a code blue was called, while the DCO who attended at the same time said he heard a call for medical assistance.

86. We have been unable to establish whether these different accounts are due to the way different people describe and understand a code blue or whether more than one call was made. If a code blue was called, it is worrying that only one member of healthcare responded.

87. We make the following recommendation:

**The Director and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including:**

- **the meaning of medical emergency codes and**
- **an ambulance is called immediately when a medical emergency code is called;**
- **ambulance staff are escorted to the emergency scene without delay.**

88. When a DCO was unable to find a pulse, she and another DCO attempted to place Mr Okwurime into the recovery position. All DCOs at Heathrow IRC receive training in basic life support, but despite that training neither of the two DCOs present attempted to administer basic first aid or initiate CPR after they found Mr Okwurime unresponsive. We make the following recommendation:

**The Director and Head of Healthcare should ensure that:**

- **all IRC staff have received training in basic life support and first aid; and**
- **feel confident in putting that training into practice when necessary.**

89. When the nurse arrived at the room and attempted to move Mr Okwurime, he considered the stiffness caused by rigor mortis as Mr Okwurime actively resisting being moved. The nurse mistakenly concluded that if he was resisting, he must therefore be breathing and conscious, and his subsequent actions were dictated by that belief. He did not get down at face level to observe for breathing and he did not check Mr Okwurime's pulse. He did not carry out a structured assessment of Mr Okwurime's level of consciousness. He did not ask any of the two DCOs when Mr Okwurime had last been seen alive, nor did he try to establish whether he was breathing, or attempt to clear the vomit from Mr Okwurime's face and mouth.

90. We recommend:

**The Head of Healthcare should initiate an investigation into the acts and omissions of the nurse with a view to considering whether further action is required.**

91. When the nurse manager arrived to assist the nurse, he told her that Mr Okwurime was unconscious but breathing. The nurse manager's immediate actions were based on this assumption. She did not attempt to check Mr Okwurime for any signs of breathing for herself.

92. When Mr Okwurime was removed from his room onto the landing, healthcare staff began CPR. However, the attempt at resuscitation was started inappropriately and was not based on clinical findings. Mr Okwurime was already displaying rigor mortis in his head, arms and upper body. When asked about her actions, the nurse manager told the investigator that with hindsight attempts at CPR should not have been made and that it was inappropriate.
93. We agree that the attempt to resuscitate a man in well-established rigor mortis was inappropriate and undignified. The lack of dignity and respect afforded towards Mr Okwurime was exacerbated by the lack of a clear and prompt plan to ensure that the landing was cleared of detainees while attempts at CPR were made.
94. NICE guidelines for pre-hospital resuscitation says that CPR should not be attempted if there are signs of rigor mortis. There can be little doubt from the assessment of the paramedic who confirmed life extinct, and the visual condition of Mr Okwurime's body when he was found, that he had died some hours earlier. We make the following recommendation:

**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 decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centres*'.**

**The Director should ensure that prompt arrangements are made to remove other detainees from the scene of a medical emergency.**

95. We consider it important that the findings of this investigation are shared with the staff involved. We therefore recommend:

**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.**

96. As this is not the first time we have expressed concerns about healthcare and the emergency response at Heathrow IRC, we are drawing this report to the attention of the Head of Operations in Detention and Escorting Services in the Home Office. We recommend:

**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.**





**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations