

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a young person, detained at HMYOI Cookham Wood, on 27 June 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.

The young person died of a brain haemorrhage on 27 June 2019 while a prisoner at HMYOI Cookham Wood. He was 16 years old. I offer my condolences to his family and friends.

The young person's haemorrhage was caused by a tangle of abnormal blood vessels in his brain which had probably been present since birth without showing symptoms. The investigation found that his clinical care was equivalent to that which he could have expected to have received in the community. He had a rare condition, with no history of problems with his brain, and I am satisfied that, given the information available to them, healthcare staff at Cookham Wood could not reasonably have predicted his death.

The young person used the gym several hours before staff found him unresponsive. Although it is unlikely to have affected the outcome, I am concerned that Cookham Wood could not provide evidence that he had received a gym induction and that staff supervision of the gym was inadequate

While it did not affect the outcome for the young person, there was also a delay in the emergency response which the Governor will need to address.

Sue McAllister CB
Prisons and Probation Ombudsman

March 2020

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Summary

Events

1. On 7 June 2019, the young person was remanded to HMYOI Cookham Wood, charged with murder.
2. At an initial reception screen, a nurse noted that the young person appeared relaxed and did not report any health concerns. On 8 June, a nurse conducted a secondary health screen and obtained his consent to request his community medical records. However, there is no evidence that staff requested this information.
3. At around 2.55pm, on 26 June, the young person went to the gym's weight training room. CCTV footage shows him holding the back of his head after a set of lifts and then sitting down on a piece of equipment. A physical education instructor (PEI 1) noticed that the young person appeared to be in discomfort and asked him if he was OK, but he said he was fine. Shortly afterwards, the young person told another PEI that he had a headache and he arranged for an officer to take him back to his cell.
4. At 4.23pm, an officer spoke to the young person through his cell door in response to his cell bell. The officer told the investigator that the young person reported a headache and asked to see the healthcare team. He said that he spoke to a nurse who said that she would see the young person but the nurse told us that healthcare staff were not told that he felt unwell.
5. At 5.48pm, an officer looked through the young person's cell observation panel to conduct a roll check. He could not remember much, but told us that he would have obtained a response from him. At 7.54pm, another officer opened the young person's observation panel to conduct a roll check. He told the investigator that although the young person did not respond verbally, he looked directly towards the door.
6. At 8.50pm, an Operational Support Grade (OSG) looked through the young person's cell observation panel to conduct a roll check. She found him lying unresponsive on the floor and called a medical emergency code blue. Officers arrived swiftly, entered the cell and started cardiopulmonary resuscitation (CPR). At 8.53pm, healthcare staff arrived with an emergency bag and assisted with the resuscitation effort.
7. At around 9.45pm, paramedics took the young person, unrestrained, to hospital escorted by two officers. At 12.12am, on 27 June, he was transferred by ambulance to another hospital. The young person did not respond to treatment and died at 4.10pm, with his family present.

Findings

8. The clinical reviewer concluded that the standard of healthcare the young person received at Cookham Wood was equivalent to that which he could have expected to receive in the community. However, we are concerned that healthcare staff did not obtain his community medical records.

9. There was no record that the young person had a gym induction and CCTV showed a PEI reading a magazine while supervising the gym. Although a gym induction and closer supervision is unlikely to have changed the outcome, it is important that all young people are shown how to use gym equipment by a competent person and that PEIs give young people their full attention
10. There was a delay of three minutes before prison staff called an ambulance after the medical emergency code had been called. This did not affect the outcome in this case, but it could be critical in future cases.

Recommendations

- The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners.
- The Governor should ensure that:
 - all young people receive a suitable gym induction and that a record of their induction is stored securely; and
 - staff supervising physical education observe and appropriately monitor young people at all times.
- The Governor should ensure that a copy of this report is shared with PEI 1 and that a senior manager discusses the Ombudsman's findings with him.
- The Governor should ensure that staff call an ambulance immediately when a medical emergency code is called and that the prison's local emergency response policy is revised to reflect this requirement.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMYOI Cookham Wood informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator visited Cookham Wood on 5 July 2019. He obtained copies of relevant extracts from the young person's prison and medical records and interviewed five prisoners.
13. The investigator interviewed six members of staff at Cookham Wood on 26 July.
14. NHS England commissioned a clinical reviewer to review young person's clinical care at the prison. She conducted joint interviews with the investigator on 26 July.
15. We informed HM Coroner for Mid Kent and Medway District of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted the young person's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She wanted to know:
 - whether he had reported headaches earlier in the day;
 - what time he went to play football and when he went to the weights area;
 - whether he had lifted weights and whether they were appropriate for his size;
 - if there were qualified trainers in the gym;
 - whether regular checks were completed when he returned to his cell;
 - whether healthcare staff reviewed him; and
 - why there was a delay notifying her that he had been found unresponsive.

We have addressed these points in this report

17. The young person's mother received a copy of the initial report. She pointed out some factual inaccuracies and this report has been amended accordingly.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMYOI Cookham Wood

19. HMYOI Cookham Wood is a young offender institution in Kent, for up to 188 boys between 15 and 18. Oxleas NHS Foundation Trust provide primary care services and Central and North-West London NHS Trust provide mental health services. Nurses are on duty from 7.30am until 9.00pm on weekdays and from 7.45am until 7.30pm at weekends.

HM Inspectorate of Prisons

20. The most recent inspection of HMYOI Cookham Wood was in December 2018. Inspectors reported that the quality of health services was very good, with age-appropriate health screening, primary care and vaccination services. However, they reported that access to health services continued to be hindered by delays in movements and frequent lockdowns.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to July 2018, the IMB reported that although healthcare was good, a shortage of officers had led to young people missing check-ups and appointments.

Previous deaths at HMYOI Cookham Wood

22. The young person was the first young person to die at Cookham Wood since July 2015. There were no similarities with the previous death.

Key Events

23. On 7 June 2019, the young person was remanded to HMYOI Cookham Wood, charged with murder.
24. At an initial reception screen, a nurse noted that he presented as relaxed and did not report any health concerns.
25. The Head of Safeguarding told us that the young person should have had his gym induction that day, but physical education (PE) staff could not find his induction record.
26. On 8 June, a nurse conducted a secondary health screen and noted that the young person did not have any health problems. She took his clinical observations, which were within the normal range for an adolescent, and obtained his consent to request his community medical records. However, there is no record that staff requested this information.
27. On 13 June, a senior psychologist conducted an initial mental health screen and recorded that the young person engaged well. She noted that he said that he had never suffered a head injury or a seizure and was not aware of any family history of neurological problems.
28. Over the next 12 days, the young person had frequent contact with staff and did not report any concerns about his health. Several young people who knew the young person told the investigator that he always presented as physically well and never complained about anything.

Events from 26 to 27 June

29. At 9.04am on 26 June, CCTV footage shows that the young person left the houseblock where he lived and went to the exercise yard for around 50 minutes. (CCTV footage provided by the prison was 10 minutes slow and we have adjusted the timings in this report accordingly.) At 10.01am, after he returned to his houseblock, his keyworker spoke to him. He recorded that the young person did not report any concerns and asked for a telephone number to be added to his contacts list.
30. At 1.51pm, Officer A unlocked the young person's cell so that he could go to the gym. He arrived at the gym at 1.56pm and played football for 40 minutes. Two PEIs told the investigator that the young person played in goal and did not present with any concerns.
31. At around 2.55pm, the young person went to the weight and cardiovascular training room. CCTV footage shows that he completed one set of 11 repetitions on a bench press machine, followed by one set of eight repetitions. Immediately after finishing the second set, CCTV shows that the young person placed both hands on the back of his head and his facial expression indicated that he was in discomfort. PEI 1 was present, sitting on a chair next to the machine the young person was using, reading a fitness magazine.
32. At 3.14pm, CCTV footage shows the young person sitting on an exercise bench, holding the back of his head with both hands and leaning backwards. PEI 2 told

us that he noticed that the young person appeared to be in pain and asked if he was OK but he said that he was fine. During the time that the young person was sitting on the exercise bench, CCTV shows that both PEIs used the gym equipment, alongside the young people.

33. At 3.23pm, the young person moved to a chair by the doorway and placed a hand on his forehead. PEI 1 told us that he asked the young person if he was OK and he said that he had a headache. He asked him if he wanted to go back to the houseblock but he said, "No, I just want to just chill out here". He told him that it would be best if he returned to the houseblock so that he could rest and ask healthcare staff for painkillers. He then used a radio to request an escort officer.
34. Shortly afterwards, Officer B arrived at the gym to escort the young person to the houseblock. He told us that he sat with him in the changing room while they waited for other movements to take place and that when he asked him if he was alright, the young person said, "I'm alright, just got a bit of a headache". At 3.37pm, the officer took the young person to the houseblock and locked him in his cell. Officer A told us that he noticed the young person return early but was not aware that he felt unwell.
35. At 3.55pm, Officer A looked through the observation panel on the young person's cell door. He could not remember why but he said that he normally checked on young people every so often to "keep an eye and have a look at them".
36. At 4.20pm, a young person spoke to the young person through his cell door. At interview, one of young person's friends told us that he spoke to him after he returned from the gym and he said that his chest felt tight. It is not clear if this was the same person.
37. At 4.21pm, CCTV shows that the young person's emergency cell bell light came on. At 4.23pm, Officer A turned the cell bell off and spoke to him through his door. He said that the young person looked hot, reported having a headache and asked to see the healthcare team. CCTV footage shows the officer walking to the area where healthcare staff were located. At interview, he said that he spoke to a nurse and that she said that she would see the young person. However, she told us that healthcare staff were not told that he felt unwell. At 4.26pm, Officer A returned to the young person's cell and told him that someone from the healthcare team would come to see him.
38. At 5.14pm, Officer A entered the young person's cell to collect his dinner plate and bowl and put them outside his door. He said that he asked him if he was OK and he said, "I'm not feeling too well, apart from that I'm OK". At 5.35pm, a SO (Specialist Officer) asked the young person through his cell door if he wanted any vegetables and said that he grunted a response before saying "no" in an agitated voice. At 5.36pm, she entered the young person's cell and noticed him lying in bed, dozing. She told us that she put his meal on his desk and he thanked her, but did not get out of bed.
39. At 5.48pm, an officer looked through the young person's cell observation panel to conduct a roll check. He told us that although he could not remember much, he would have got a response from him and alerted staff if he had concerns.

40. At 7.54pm, an officer opened the young person's cell observation panel to conduct a roll check. He told the investigator that he saw him lying on his left side, facing the wall adjacent to his bed. He said that he called out, "Hi, you alright, mate? You good?" and he turned his head.
41. At 8.50pm, an Operational Support Grade (OSG) turned on the young person's cell night light and looked through the observation panel to conduct a roll check. She noticed the young person lying on his back on the floor and tried to obtain a response by calling his name and kicking the cell door. The young person did not respond and, at 8.51pm, she called a medical emergency code blue (which indicates that a young person is unconscious or has breathing problems).
42. Within 35 seconds, an officer arrived at the young person's cell, followed by 10 members of staff. He looked through the observation panel, unlocked the door and entered the cell, with several other officers. They tapped the young person on the shoulder and called out his name, but he did not respond. At that point, the officer noticed that he had stopped breathing and started cardiopulmonary resuscitation (CPR).
43. In the meantime, a Custodial Manager (CM) had heard the code blue over the radio network and made her way towards the cell. En route, she came across healthcare staff leaving the prison and asked them to attend. At 8.43pm, a nurse and a recovery support worker arrived at the young person's cell with an emergency medical bag. They took over CPR, issued oxygen and applied a defibrillator. The defibrillator advised not to shock and to continue with CPR. Healthcare staff requested a second device to make sure that the first one was working correctly but it also advised not to shock.
44. An ambulance arrived at the prison at 9.00pm and the first paramedic reached the young person's cell at 9.04pm. Prison staff moved the young person onto the landing for easy access and paramedics took over resuscitation efforts. They got the young person's heart beating and placed him on a ventilator, as he could not breathe on his own. At around 9.45pm, paramedics took the young person to hospital. Two officers went with him and did not use restraints. Hospital staff conducted an emergency computerised tomography (CT) scan which showed that he had had a brain haemorrhage.
45. At 12.12am on 27 June, the young person was transferred by ambulance to another hospital for specialist treatment. He arrived at 12.55am and was taken for surgery at 1.15am. At 2.20am, hospital staff moved him to an intensive care unit (ICU). The young person did not respond to treatment and died at 4.10pm, with his family present.

Contact with the young person's family

46. At 10.25pm, a prison manager phoned the young person's next of kin to tell her what had happened. She did not answer, so he left a voicemail. At 10.35pm, the young person's next of kin phoned the prison and he told her that the young person had been taken to hospital. He asked her to go there urgently, but she said that the trains had stopped running. He offered to arrange a taxi to take her to the hospital and she asked him to keep her updated. Shortly afterwards, he

told her that the young person was being moved to another hospital, and she said that she could get there.

47. At 4.40am on 27 June, a prison family liaison officer met the young person's family at the hospital and offered his support. At 9.20am, two officers and a prison manager arrived to take over the escort. They liaised with hospital staff and offered support to the young person's family and friends.
48. At 11.11am on 1 July, the family liaison officer phoned the young person's mother to arrange a home visit. At 10.30am on 2 July, the family liaison officer and a colleague visited his family and offered support. Following the visit, they continued to provide ongoing support to the young person's family.
49. On 7 August, the young person's family visited Cookham Wood and met the Governor. They also attended a memorial service with staff and young people. On 16 August, two members of prison staff attended the young person's funeral. The prison contributed towards its cost, in line with national policy.

Support for prisoners and staff

50. After the young person's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
51. The prison posted notices informing other prisoners of the young person's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the young person's death.

Post-mortem report

52. The post-mortem report found that the young person died of a subarachnoid haemorrhage (bleeding on the surface of the brain) and intraventricular haemorrhage (bleeding into the brain itself) caused by an arteriovenous malformation (AVM) in the brain. The pathologist said that the degree of bleeding was incompatible with life. He also said that there was no evidence of trauma (injury) and no evidence of third party involvement in the young person's death.
53. A brain AVM is a tangle of abnormal and poorly developed blood vessels connecting arteries to veins. AVMs are rare and occur in less than 1% of the population. It is thought that in most cases they are formed before birth or shortly afterwards, although it usually takes some time before they cause problems or symptoms and most are discovered between the ages of 20 and 40.
54. Bleeding in the brain is the most serious complication of an AVM. (The blood vessels in an AVM are weaker and so have a higher risk of bleeding than normal ones.) Symptoms include a sudden onset of severe headache, often with nausea and vomiting, stroke-like symptoms or a decreasing level of consciousness.

Findings

Clinical care

55. The clinical reviewer considered that the care the young person received at Cookham Wood was equivalent to that which he could have expected to receive in the community. There were no records to indicate that the young person had any long-term physical health conditions or that he reported any health issues to staff or prisoners. The clinical reviewer noted that although the young person told staff that he had a headache and felt unwell on 26 June, he did not disclose any symptoms that would have indicated a need for urgent healthcare intervention, such as seizures, impaired vision, muscle weakness or difficulty speaking.
56. Healthcare staff did not review the young person on 26 June. A nurse told us that no one informed her or any other member of healthcare staff that he was unwell. CCTV footage shows that Officer A entered the healthcare area, but there is no evidence that he spoke to a nurse. We therefore do not make a finding or recommendation about whether healthcare staff should have conducted a review.
57. The clinical reviewer considered that based on the description of symptoms that the young person gave staff, it is likely that healthcare staff would have suggested mild pain relief medication and encouraged him to drink fluids.
58. She also noted that staff started CPR appropriately when they noticed that the young person had stopped breathing.
59. There was however, one aspect of the young person's care that fell short of expectations, namely that healthcare staff did not request his community medical records. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that, when a new prisoner arrives in reception, prison staff try to obtain relevant information from the prisoner's GP or other relevant health services with whom the prisoner has recently been in contact. While we recognise that the young person did not report any health problems healthcare staff should have obtained his community medical records.
60. We are satisfied that, overall, the young person received a good standard of clinical care at Cookham Wood and that healthcare staff could not have reasonably predicted or prevented his sudden death. However, we make the following recommendation:

The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners.

Physical education

61. Prison Service Instruction (PSI) 58/2011 on PE for prisoners says that PE departments must deliver an induction programme which should include instruction on basic weight training, the safe use of equipment and an explanation of the rules and regulations. PSI 58/2011 also states that it is good practice to have a PE compact (a document that sets out what is expected of a prisoner) signed by PE staff and prisoners.

62. PEI 2 told the investigator that PE staff typically visit young people on the induction landing every Friday afternoon to complete a gym compact and health questionnaire. The next morning, PE staff take the same young people on a tour and show them how to use the equipment in the cardiovascular and weight training room. However, there is no record that the young person signed a gym compact or had a gym induction. He did not arrive at Cookham Wood until 7.20pm on 7 June. Therefore, we consider it likely that he arrived on the induction landing after PE staff had left. Although he was still on the induction landing the following Friday, there is no record that PE staff saw him then either.
63. Both PEIs told us that they were not aware of a specific weight limit that young people can lift. They said they obtained a British Weightlifting Association (BWLA) qualification as part of the national physical education training course and that all young people are advised to start off with light weights and increase them to find a comfortable weight. However, we are concerned that the young person might not have received this advice if he did not have an induction.
64. CCTV footage on 26 June shows the young person holding the back of his head with both hands after lifting weights. He was using a machine next to the chair on which PEI 1 was sitting reading a magazine. Although the PEI told us he did not see anything untoward while the young person was using the machine, we are concerned that his attention was focussed on the magazine. When PEI 2 noticed the young person was in discomfort, he asked if he was OK. When the young person told him that he had a headache, he arranged for an officer to take him back to the houseblock. While we are satisfied that this was appropriate, PE staff should ensure that young people are monitored at all times.
65. While having a gym induction and closer supervision is unlikely to have changed the outcome for the young person, it is important that a trained member of staff instructs all young people how to use gym equipment and monitors them appropriately. We therefore make the following recommendation:

The Governor should ensure that:

- **all young people receive a suitable gym induction and that a record of their induction is stored securely; and**
- **staff supervising physical education observe and appropriately monitor young people at all times.**

The Governor should ensure that a copy of this report is shared with PEI 1 and that a senior manager discusses the Ombudsman's findings with him.

Roll checks

66. The purpose of a roll check is to ensure that all young people are accounted for, but also to check that there are no immediate concerns. CCTV shows that staff conducted roll checks when required and that they looked into the young person's cell. Although one officer said that he could not remember what he saw, he said that he would have notified staff of any concerns. Another officer told us that the young person did not respond verbally but looked directly at the door. He said that he was lying on his bed and looked as if he was watching television. We are satisfied that staff conducted roll checks as required and we have no

reason to doubt their statements that they saw nothing to indicate that the young person required medical attention.

Emergency response

67. PSI 03/2013 on medical response codes requires prisons to have a two-code medical emergency response system. Cookham Wood's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties. Calling an emergency medical code should automatically trigger the control room (or the gate, if outside the core working day) to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
68. The PSI says local procedures must ensure that staff understand they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called. It also says, "It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required".
69. We are satisfied that the OSG responded quickly when she found the young person unresponsive and appropriately called a code blue. Officers arrived promptly and immediately entered the cell and began CPR. Healthcare staff attended with the correct medical equipment and appropriately took over the resuscitation effort.
70. However, we are concerned that an ambulance was not called immediately. In his prison statement, an OSG said that he heard the emergency code over the radio network at around 8.50pm and, minutes later, was asked to call for an ambulance. Ambulance records show that he called it at 8.53pm, indicating a delay of around three minutes. A CM told us that staff wait for confirmation that an ambulance is needed before calling 999.
71. Cookham Wood's local policy states that staff should call an ambulance, provide the ambulance control with as much detail as possible and ask them to 'stand by'. It states that once healthcare staff have arrived at the scene, they will either ask prison staff to stand the ambulance down or to confirm that an ambulance is required. This is not in line with PSI 03/2013 and creates an unnecessary delay.
72. While calling an ambulance immediately would not have changed the outcome for the young person, in other emergency situations, it could be critical. We therefore make the following recommendation:

The Governor should ensure that staff call an ambulance immediately when a medical emergency code is called and that the prison's local emergency response policy is revised to reflect this requirement.

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