Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Child C, at Hillside Secure Children's Centre, on 25 February 2017

A report by the Prisons and Probation Ombudsman

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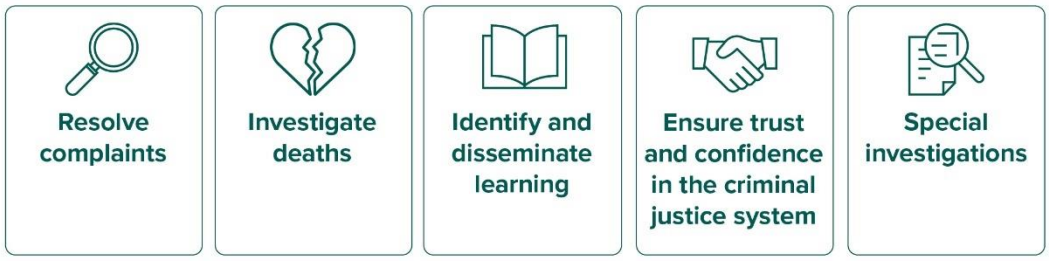
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Child C died on 25 February 2017 at Hillside Secure Children's Home. He was found dead in his room. The post mortem results were inconclusive but indicated that Child C's death might have been due to sudden arrhythmic death syndrome (SADS) when a disturbance to the heartbeat causes a person to die. He was 17 years old. We offer our condolences to Child C's family and friends and also recognise the grief felt by staff at Hillside.

While Child C was at Hillside he received a good level of clinical care. The clinical reviewer considered it unlikely that he had any obvious symptoms of a heart abnormality before he died.

Child C had a seizure around a month before he died. Staff responded appropriately, he underwent tests at hospital and was waiting for a follow up hospital appointment. The post-mortem found no evidence that this or any further seizures contributed to Child C's death.

After his seizure, staff should have checked Child C every three minutes when he was in his room. We have serious concerns about the way these checks were conducted. Staff were unclear about the frequency and purpose of the checks, they did not undertake checks when they should have done, and they falsified related documentation.

These concerns echo many of our concerns about well-being checks in an unrelated investigation into a death in another Secure Children's Home. We draw those concerns to the attention of the Department for Education and the Welsh Government, as well as the management of Hillside. We also have concerns about the way staff communicate, record and act on information about young people at Hillside in general.

When staff found Child C unresponsive in his bed, they reacted competently to a very distressing situation. Staff attempted cardiopulmonary resuscitation (CPR) and we consider this was the correct decision in the absence of clinical staff. We are, however, concerned that Hillside does not have a CPR policy, and we recommend that one is introduced.

We are also concerned that Hillside did not appoint a family liaison officer to support Child C's parents after his death.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **March 2018**

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Summary

Events

1. On 23 June 2016, Child C was sentenced to 30 months in custody and taken to Hillside Secure Children's Home. A nurse and a doctor assessed Child C on arrival and noted he had no outstanding medical conditions.

2. On 27 January 2017, Child C had a seizure while playing computer games. As a result, he fell off his chair, landing on his face and was unconscious for a number of minutes. Staff responded appropriately and he went to hospital in an ambulance. After a CT scan and facial X-ray raised no concerns, a hospital consultant referred Child C to a seizure clinic and he returned to Hillside. Child C was no longer allowed to play computer games to minimise the risk of any further seizure.

3. Staff constantly observed Child C until he went to sleep. After this, he was subject to checks every three minutes through his observation panel, and physical checks every 15 minutes which required staff to go into his room. Staff decided to stop these physical checks on 31 January, due to concerns that they were waking Child C up. His three minute checks continued.

4. Child C's behaviour changed after his seizure. He was frustrated at not being able to play computer games, became withdrawn and more resistant to staff direction. Staff also told the investigator that Child C seemed to have short blank episodes. The cause of these is not known and they were never referred to clinical staff at Hillside. Staff made several efforts to expedite Child C's appointment at the hospital seizure clinic but were told that there was a waiting list of 12 weeks.

5. On 25 February at 10.23am, a member of staff went into Child C's room, and found he was unresponsive. He had not moved position for a number of hours but staff had assumed he was sleeping. Staff started cardiopulmonary resuscitation (CPR) but when paramedics arrived, they pronounced Child C had died. Police informed Child C's parents of his death and his father went to Hillside to collect his belongings three weeks later.

Findings

Welfare Checks

6. Staff did not check Child C as often as required. On the night he died, he should have been checked 268 times but CCTV footage shows he was checked only 35 times. Staff were unclear how often Child C was supposed to be checked and they documented that they had checked him 90 times, falsifying records. Staff were also unclear about the purpose of these checks and how they should be carried out. As Child C had been dead for some time when staff finally entered his room to check on him, it is apparent that the previous visual checks had not provided an adequate means of checking his wellbeing. We note that Child C was recorded as having been in the same position for hours before staff entered his room to check him physically. There was virtually no management oversight of these checks.

7. We have made similar findings in another, unrelated death in a Secure Children's Home and are concerned that there appears to be no effective national oversight of this critical area.

Emergency response

8. The first two members of staff who went into Child C's room when he was found unresponsive were not first aid trained and did not initially realise the seriousness of the situation. As soon as a first aid trained member of staff got to Child C (around two minutes after he was first found) they started CPR. While we are not critical of this decision, there were signs of rigor mortis present and we are concerned that Hillside does not have a CPR policy, including situations in which it is not appropriate to attempt resuscitation.

Recording and sharing information

9. Staff at Hillside work within a multidisciplinary setting. We found ineffective communication both between and within teams. For example, clinical staff were not made aware of Child C's blank episodes after his fit and we found reference to information in meeting minutes which had not been documented and communicated elsewhere.

Family liaison

10. After Child C's death, Hillside should have appointed a family liaison officer to provide support and a point of contact to Child C's parents.

Recommendations

- The Director of Social Services should review the policies, procedures and actions of managers and staff at Hillside. They should determine whether they were sufficient to ensure that young people at Hillside were kept safe, and should report their findings and any actions they intend to take in response to the Prisons and Probation Ombudsman, the Welsh Government and the Department for Education within three months of receipt of the final version of this report.

- The Welsh Government and the Department for Education should review current practice and introduce a clear framework for delivering welfare checks on young people, to include:

    - clear instruction about the nature and purpose of checks
    - details of how to record checks accurately
    - details of who decides what checks are necessary and how these are communicated to staff
    - consideration of the frequency of checks required on young people, including whether it is necessary to check all young people throughout the night regardless of their risk
    - consideration of the number of staff needed to undertake checks
    - instruction about when staff should go into a young person's room
    - management oversight of checks.

- The Principal Manager should ensure there is an emergency response policy at Hillside, which includes details of when it is inappropriate to start CPR.
- The Principal Manager should ensure that relevant information about a young person's welfare is recorded and disseminated appropriately.
- The Principal Manager should ensure that whenever a young person dies, or is taken seriously ill, a family liaison officer is appointed to ensure the young person's next of kin are informed as soon as possible and to provide them with support and a point of contact.

The Investigation Process

11. On 17 March 2017, the Welsh Government invited the Prisons and Probation Ombudsman to investigate Child C's death using our discretionary powers. The Welsh Government had already asked the Prisons and Probation Ombudsman, through the Ministry of Justice, to extend its remit to cover investigations into any death of a child in secure accommodation in Wales. This was achieved by means of an amendment to the Children's Homes (Wales) Regulations which came into force on 1 April 2017. Child C's death occurred shortly before this and we therefore investigated his death on a discretionary basis.

12. The investigator contacted Hillside Secure Children's Home informing them of the investigation, requesting that her contact details were given to all staff and asking anyone with relevant information to contact her. No one responded.

13. An Assistant Ombudsman and the investigator met with the Youth Justice Board and Department of Education on 23 March 2017.

14. The investigator and an Assistant Ombudsman visited Hillside on 4 April. They obtained copies of relevant extracts from Child C's records and the Director of Social Services, Health and Housing in Neath Port Talbot and other senior staff from Hillside.

15. On 11 April, the Deputy Ombudsman and the investigator attended a multi-agency meeting with the local authority, Youth Justice Board, local police and Care and Social Services Inspectorate Wales (CSSIW) to review the scope of the respective investigations.

16. The investigator and the Assistant Ombudsman interviewed 16 members of staff in May and June.

17. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Child C's clinical care at Hillside. The clinical reviewer also attended interviews with clinical members of staff.

18. We informed HM Coroner for Swansea and Neath Port Talbot of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. We apologise for the delay in issuing this report. This was due to delays in receiving the post-mortem report on 1 September and the clinical review on 6 November.

20. One of the Ombudsman's family liaison officers contacted Child C's mother and father, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. His father asked:

    - What happened when Child C went to hospital following his seizure on 27 January? Was it appropriate that he was discharged back to Hillside a few hours later?
    - Why was there a delay in telling him that Child C had gone to hospital on 27 January?
    - What caused Child C's death and did negligence contribute to this?

- How was Child C being monitored after his first seizure and was this appropriate?
- Why had he not received any support or liaison from Hillside or the police after Child C's death?

His mother asked:

- Why was she advised not to contact Child C by the victim officer who worked for the Probation Service?
- What hospital did Child C go to on 27 January and what tests did they do?
- Why did Hillside not contact her when Child C was taken to hospital on 27 January?
- Why had she not been told about Child C's death until 9.30pm on 25 February?
- Had Child C been assaulted or taken drugs?
- Why had no one from Hillside contacted her after Child C died?

21. Child C's parents received a copy of the initial report. They did not make any comments.

22. The Welsh Government, Neath Port Talbot Social Services and Hillside also received a copy of the report. They accepted all the recommendations and their action plan is attached as an annex.

Background Information

Hillside Secure Children's Home

23. Hillside is a national Secure Children's Home, which opened in 1996. It accommodates up to 22 children and young people between the ages of 12 – 17 years. It is managed by Neath Port Talbot local authority. Young people are placed at Hillside either by the Youth Justice Board (as a result of being charged with or convicted of an offence) or by the local authority (due to the risk they are deemed to present to themselves or others).

24. Hillside has a Centre Manager, who was appointed on an interim basis after Child C died and on a permanent basis from June 2017. There are also two assistant managers, Ms L, who is responsible for the unit staff and Ms D, who is responsible for the clinical team.

25. A Nurse visits Hillside four days a week and a GP visits Hillside once a week. These services are provided by a local GP surgery. A mental health nurse also works at Hillside four days a week and a psychiatrist visits weekly.

Care and Social Services Inspectorate Wales (CSSIW)

26. CSSIW inspects Hillside annually. However, if they have particular concerns they will carry out an additional focused inspection. This occurred after Child C's death and they published their report in June 2017. Inspectors noted that young people had positive relationships with staff and there were a range of opportunities for residents. These included access to education, activities and maintaining contact with relevant people in their lives. They found that a multidisciplinary approach including clinical support was in place.

27. Inspectors concluded that systems for monitoring and checking young people's safety during the night were inadequate. They found that checks were not undertaken in line with risk assessments and planned care. Following this feedback, Hillside implemented an audit system to ensure checks were carried out as required. CSSIW noted that there had been some improvements in planned checks after this, but further improvements were necessary. Young people's documentation also did not clearly indicate the checks that had been undertaken. Inspectors found that further work was needed to ensure that records informed staff and accurately reflected the support provided to young people.

28. Inspectors also found that records of checks did not correspond with those actually undertaken evidenced by CCTV footage. They found that there was ineffective communication at Hillside and there needed to be improved oversight on compliance of procedures, integrity and the quality of record keeping.

29. CSSIW completed a further inspection of Hillside in August 2017 and published their report in October 2017. This noted that there was a quality assurance system in place to monitor bedroom checks and staff had received training in record keeping which had improved. They concluded that young people were being safeguarded more effectively.

Previous deaths at secure children's homes

30. Deaths in secure children's homes are extremely rare. There was one previous death at Hillside in 1998. There was a self-inflicted death at another children's secure home shortly before Child C's which the PPO has also investigated. That investigation has also found significant issues with the adequacy of the welfare checks conducted on young people.

Key Events

31. On 23 June 2016, Child C was sentenced to 30 months in custody and taken to Hillside Secure Children's Home, having been referred there by the Youth Justice Board (YJB). On arrival, a nurse and doctor at Hillside assessed Child C. He had no outstanding medical conditions.

32. Child C was allocated a key worker, a residential childcare officer (RCO). Each RCO is assigned one child for whom they are their keyworker. They are the young person's first point of contact and have regular keyworking sessions together. The RCO said Child C was a quiet, polite young person who was keen to work with her. He did not socialise much with other young people on the unit but got on well with staff.

33. On 3 October, Dr B, a clinical psychologist, assessed Child C's level of social and emotional development. This showed that both were well below the expected level for his age and intelligence.

34. On 10 October, Child C fell off a sofa and banged his nose causing a nosebleed. Nurse C assessed him and noted a slight bruise to his nose but had no other concerns.

35. Around this time, Child C also began offence-focused work with a caseworker from Barnado's, and a RCO. They met approximately weekly for the remainder of Child C's time at Hillside. The Barnardo's caseworker said that Child C was motivated to address his offending and made good progress during these often difficult sessions.

36. Ms D, assistant manager, chairs a weekly multidisciplinary team (MDT) meeting at Hillside during which every young person is discussed, including their care plan and risk. Clinical staff and staff representing each unit are present. Minutes of these meetings are emailed to assistant unit leaders who are responsible for communicating any pertinent information to unit staff. In the MDT meeting on 5 December, staff decided that Child C should be referred to the nurse due to his frequent nosebleeds (they were concerned that they may have arisen due to self-harm), his low mood over the last week and his threats to kill himself. Aside from staff recording this information in the MDT minutes, we have not seen this information documented elsewhere.

37. Nurse C assessed Child C later that day. She noted that other young people on the unit had become aware of the nature of Child C's offences and his behaviour had changed. He told the nurse that he had had six nosebleeds over the weekend but none so far that day (a Monday). The nurse noted that staff should monitor Child C's nosebleeds and she referred him to the doctor. The next day, the doctor prescribed Child C Naseptin (an antibiotic nasal cream) for his nosebleeds and referred him to the ear, nose and throat department at the hospital. He later received a hospital appointment for 14 March 2017 to have his nose cauterised.

38. Child C had some contact with his father while he was at Hillside, through telephone calls and visits. A victim officer for the National Probation Service, met with Child C's mother. They discussed possible written contact between Child C and his mother but the officer indicated this needed further consideration of the potential impact on the victims of the offences and Child C. Professionals discussed this at a

multi-agency public protection arrangement (MAPPA) meeting on 19 January. Those at the meeting agreed that contact between Child C and his mother would be inappropriate and possibly detrimental to Child C. The victim officer had arranged to visit Child C's mother, along with Child C's youth offending service officer on 3 March to explain this decision in detail.

39. On 23 January, staff in the MDT meeting referred Child C to the clinical psychologist at Hillside due to his anxieties in education and his low self-esteem. They also referred Child C to a student psychologist, Ms E, with the aim of improving Child C's social skills.

40. On 26 January, Child C was abusive to staff and refused to leave the common room. An RCO told the investigator that Child C then sat blankly for a number of minutes. The RCO and another member of staff linked arms with Child C and walked with him to his room. Child C remained in his room on his own for two hours as he refused to engage with staff. While in his room, staff observed him scratching his arms.

41. Nurse C later assessed these scratches, which were superficial. She told the investigator that she had no concerns about Child C but was shocked that he had self-harmed. Child C himself could not account for why he had done so. The nurse planned to see him again the next day since this behaviour was so out of character.

42. On 27 January, Ms E went to the common room to meet Child C. He was playing computer games and when Ms E spoke to him, he turned his head to her and stared at her but did not respond. Child C then turned back to the computer and started having a seizure. His head fell backwards, his body shook and he fell off the chair, landing on his face. He was unconscious. Ms E pulled the emergency alarm on her radio and shouted for assistance. All staff carry radios and when the emergency alarm is activated, it tells all staff the location of the emergency. Staff responded immediately, put Child C in the recovery position and requested an ambulance.

43. Paramedics arrived and assessed Child C who had recovered consciousness. They took him to hospital by ambulance with two members of Hillside staff. A unit leader said that she telephoned Child C's father as soon as she had contacted the YJB and found out hospital he had been taken to. X-rays showed that Child C had not broken any bones in his face. He refused a blood test due to his phobia of needles. Child C then vomited and hospital staff undertook a computerised tomography (CT) scan (which uses X-rays and a computer to create detailed images of the inside of the body). This showed Child C had no haemorrhage or tumour that might have caused his seizure.

44. The hospital consultant referred Child C to the First Fit clinic. This clinic investigates the possible causes for a single epileptic type fit and prescribes anticonvulsant medication if necessary. The consultant also recommended that Child C should not play computer games to minimise the risk of any further seizures.

45. Child C returned to Hillside at 9.30pm. To ensure Child C's safety, staff constantly observed him until he went to sleep. After this, staff checked him every three minutes through the observation panel. Staff also completed physical checks every 15 minutes, which required them to enter the room to check Child C was

responsive. The next day Child C's checks were reduced to every three minutes throughout the night, with physical checks every 15 minutes.

46. Child C found it very difficult not being allowed to play computer games. He remained fixated on being able to do so and was sometimes resistant to staff direction. Staff made concerted efforts to offer Child C alternative ways of keeping busy, such as playing board games or pool, going to the gym or doing art. In addition, Child C had considerable bruising and facial swelling as a result of the fall during his seizure. Staff said this caused him to feel uncomfortable and self-conscious.

47. On 30 January, during the MDT meeting, those present expressed concern that Child C's 15-minute physical checks were waking him up and therefore causing sleep deprivation. Staff were worried that this could increase the risk of Child C having another seizure. After the meeting, a unit leader telephoned Dr F, a GP, about Child C's nosebleeds. The doctor told her that these were not a concern. He instructed that staff should monitor Child C closely and he should return to hospital if his health deteriorated again.

48. Nurse C assessed Child C later that day. He told her that he felt "lousy" and his left eye was hurting (this was swollen after the fall). The nurse noted that she would ask the doctor to review his eye. On 31 January, Dr F reviewed Child C, who said he was feeling well. The doctor noted the bruising to Child C's face but had no other concerns. Dr F and Ms D, assistant manager, agreed that Child C's 15-minute physical checks should be stopped.

49. On 1 February, it was noted in the duty manager's log that Child C's three-minute checks should continue but the physical checks should only be completed if staff had particular concerns. The next day, Nurse C assessed Child C's facial injuries. Child C told her that he was in pain and struggling to breathe through his nose. The nurse noted that staff should monitor the injury and that the swelling should lessen over the next few days.

50. On 6 February, Child C asked to play computer games. When staff refused, he began to bang his head against a wall and did not stop when asked. Mr G, a RCO, placed his hand between Child C's head and the wall to try to stop Child C injuring himself. Along with another member of staff, he linked arms with Child C and they walked together back to Child C's room and sat down with him on the bed. Child C did not resist. Staff spoke to him and he calmed down. His forehead was slightly red. Child C refused to see a first aid trained member of staff so Mr G added him to the doctor's list for the next day. Child C told staff he had banged his head as he was bored. Mr G said Child C did not seem to understand the seriousness of the fit and the potential implications for him.

51. On 7 February, Ms D and a Community Psychiatric Nurse met Child C as a result of the incident the day before. The nurse noted Child C had a small friction burn on his hand, was withdrawn and displayed little emotion. Child C said that he had been feeling low since his seizure. Dr F also assessed Child C. The doctor noted no concerns and contacted the hospital about Child C's First Fit appointment. Hospital staff told him that the referral was currently being processed.

52. On the same day, Dr B met Child C and completed a trauma symptom checklist. This is a clinical checklist designed to measure any issues with anxiety, depression,

anger, post-traumatic stress, dissociation and sexual concerns. Dr B noted that Child C did not have a significant score on the scale and therefore he had no concerns in these areas.

53. On 8 February, Mr G telephoned the youth offending service and Child C's social worker to see if they could expedite Child C's appointment at the First Fit clinic. On the same day, Nurse C assessed Child C. She noted that his facial swelling had improved. She recorded the small burn on Child C's hand, which he said he had done himself. She encouraged him not to self-harm and had no further concerns about Child C. During a session with Ms E that day, Child C told her that he had self-harmed as he was bored. On 9 February, Nurse H saw Child C. He noted that Child C "seemed brighter" and, although they had had an emotional session, he had left in a positive mood.

54. During the MDT on 13 February, those present noted there was a 12-week waiting list for the First Fit clinic. They indicated that staff should monitor Child C's moods as he had been feeling low and had self-harmed. Nurse H met Child C later that day. The nurse noted that Child C was more negative in mood, was resistant to staff direction and was not attending education. The nurse assessed him again the next day and noted that Child C seemed more relaxed and settled. The same day, Mr G telephoned the hospital a number of times to expedite Child C's First Fit appointment.

55. On 17 February, Child C asked to use a remote-control car in the unit. When an assistant unit leader, refused he became obstructive and staff escorted him to his room by linking arms with him. They left Child C in his room to calm down and returned a short while later. The assistant unit leader said that Child C seemed sad and anxious, as he could not play computer games so, after further consultation, he agreed that he could use his remote-control car in the sports hall. A doctor assessed Child C the next day and noted he had no concerns.

56. Most Hillside staff the investigator spoke to said that they had either witnessed first-hand, or been told about, Child C having short blank episodes after his seizure. Staff said that these could last for a few minutes and it was difficult to establish whether Child C was deliberately ignoring staff or if he was genuinely unaware of his surroundings. He sometimes told staff that he could not remember what had happened after an incident like this. No one informed the GP or nurse about these episodes.

57. Overnight on 24 to 25 February, staff documented that they had completed checks on Child C, detailed in the following table:

2100	2200	2300	0000	0100	0200	0300	0400	0500	0600	0700
21.03	2203	2303	0003	0100	0200	0300	0400	0500	0600	0700
21.06	2206	2306	0006	0115	0215	0315	0415	0515	0615	0715
21.09	2209	2309	0009	0130	0230	0330	0430	0530	0630	
21.12	2212	2312	0012	0145	0245	0345	0445	0545	0645	
21.15	2215	2315	0015							
21.18	2218	2318	0030							
21.21	2221	2321	0045							
21.24	2224	2324								
21.27	2227	2327								
21.30	2230	2330								
21.33	2233	2333								
21.36	2236	2336								
21.39	2239	2339								
21.42	2242	2342								
21.45	2245	2345								
21.48	2248	2348								
21.51	2251	2351								
21.54	2254	2354								
21.57	2257	2357								

58. The checks which actually took place as seen on the CCTV are detailed in the table below:

2110	2206	2304	0010	0116	0209	0314	0501	0603	0718	0806	0903	1023
2112	2208	2326	0026			0351		0637	0749	0822	0912	
2126	2235	2341	0051							0843	0922	
2151		2353								0846	0950	
		2356								0852		
										0856		

59. Two RCOs were responsible for Child C's checks from 9.00pm until 10.00pm, at which point Mr J, a night care supervisor, took over responsibility for the checks.

60. At 12.28am on 25 February, Child C rang his bedroom buzzer and asked for his en suite toilet door to be unlocked. Mr J and a colleague did this and locked it again two minutes later. Mr J said there was nothing out of the ordinary at this point. He could not remember if Child C's night light was on but said he used a torch to do the checks. Mr J recalled that around an hour later, Child C had put his mattress on the floor (possibly therefore at the 1.16am check) and was asleep there. He said this was not unusual for young people as it was warmer due to the under-floor heating at Hillside. Mr J estimated that Child C had moved his mattress back onto his bed around an hour later and gone to sleep there on his side, facing the observation panel. Around an hour later, he had turned to face the other way.

61. Mr J said that Child C remained in the same position for a number of hours at the end of his shift but this was not unusual as Child C was a deep sleeper. Mr J said he could see the back of Child C's head and neck and his leg hanging outside the bed. He was satisfied that Child C was healthy due to his colour. He could not see if Child C was breathing as he was facing away from him. Mr J's last check was at 7.18am. The CCTV shows him looking into the room quickly using a torch and then returning immediately to look more carefully a second time before leaving.

62. Mr K checked Child C at 7.49am He recalled that Child C was lying in the same position as Mr J described. He had no concerns but said it was difficult to tell if a young person was breathing when completing such observations. Mr K said it was quite light in the room at the time and he did not need a torch.

63. Ms M completed most of the checks on Child C from 8.06am. Mr N checked Child C at 9.50am. Child C remained in the same position as previously described. Mr N said it was normal for Child C to sleep until late in the morning so he had no concerns. At 10.23am, Ms M again checked Child C. As he had not moved during the last checks she had completed she decided to go into his room to check him. She put her hand on Child C's shoulder, called his name and asked if he was all right. She said she could feel that his shoulder was cold and had a "bad feeling". She therefore left Child C's room (34 seconds after she had gone in), went to the unit office and asked Mr K to go with her, as Child C was not responding.

64. Mr K went straight to Child C's room along with Ms M, arriving 36 seconds after she had previously left. Mr K noticed Child C was in the same position as when he had

checked him earlier. He touched Child C's arm and asked if he was all right. He then realised Child C's arm was cold and shouted his name. He lifted Child C, noticed Child C's arm was stiff and heard a gurgling noise as he did so. Mr K said he hoped that this noise was Child C breathing and that, by holding him up, he was assisting him. Mr K had not received any first aid training. Mr K asked Ms M to pull the emergency alarm on her radio, which she did.

65. Meanwhile, Mr N, who had also been in the unit office when Ms M came to get assistance, had gone to the next unit to get the shift leader, who was first aid trained. He told her he thought that Child C had had another fit (this was an assumption he had made when he heard that Child C was not responding). The shift leader went straight to Child C's room, arriving 52 seconds after Mr K. She saw that Child C's face was blue, moved Child C onto the floor and started cardiopulmonary resuscitation (CPR). Mr K went to get the defibrillator from the next unit. The duty manager arrived and asked Mr N to call an ambulance. It was 10.26am. More staff arrived, they attached the defibrillator, which advised not to shock Child C, and they continued CPR.

66. The paramedics went into Child C's room at 10.34am. They noted that rigor mortis was present in Child C's arms and jaw and there was hypostasis (pooling of blood) present. Within a few minutes of their arrival, they pronounced Child C had died. (Ambulance records note this was 10.33am but all their timings are slightly earlier than those at Hillside.)

Contact with Child C's family

67. Police visited Child C's father that morning and informed him of his son's death. Child C's father telephoned Hillside and spoke to Ms L. The police also informed Child C's mother that evening. Ms L thought this delay was due to the police having difficulty obtaining his mother's contact details. On 9 March, Ms L contacted Child C's youth offending service officer about the collection of Child C's belongings. Child C's father collected these from Hillside on 13 March and staff from Hillside subsequently attended Child C's funeral.

68. Both Child C's parents said that they would have welcomed contact from Hillside staff after this. The investigator informed Hillside managers of this in mid-May. By 20 June, Hillside staff had not contacted his parents. Following further discussions with the investigator, the newly appointed Centre Manager at Hillside, sent a letter to each of Child C's parents on 28 June apologising for the delay in contacting them, expressing her condolences and offering them an opportunity to contact her, visit Hillside or meet elsewhere. Child C's parents responded and, at the time of writing, they were planning to visit Hillside on 1 December for a celebration of Child C's life.

Support for young people and staff

69. After Child C's death, Ms L debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues, and to offer support. Several further debriefs were held over the following days and Dr B and Nurse H offered staff their support. They also visited staff at home and offered occupational health referrals where appropriate.

70. Dr B and Nurse H told the young people on Nedd unit individually about Child C's death. Young people on the other units were told as a group and all were also offered the support of Dr B and Nurse H.

Post-mortem report

71. The post-mortem results were inconclusive. There was evidence of an inflammatory process present within Child C's heart but the exact role that this played in Child C's death is unclear. The clinical reviewer comments that, in the absence of any other cause of death this must be regarded as significant. The post-mortem noted that Child C's death should perhaps be regarded as due to sudden arrhythmic death syndrome (SADS), when a disturbance to the heartbeat causes the person to die.

Findings

Welfare checks

72. Following Child C's seizure on 27 January, staff agreed that he would be subject to physical checks every 15 minutes and checks through the observation panel every three minutes. On 31 January, the physical checks were stopped due to concerns they were disturbing Child C's sleep. The three-minute checks should have continued when Child C was in his room, regardless of whether he was awake or asleep. These checks were not completed as they should have been. The clinical reviewer has concluded that there is no evidence that Child C's death could have been prevented if all the checks had been conducted in accordance with policy. Nevertheless, we remain seriously concerned about a number of aspects of these checks.

Frequency of checks

73. Child C should have been checked 268 times overnight on 24 February to 25 February between 9.00pm and 10.23am. CCTV shows that Child C was checked only 35 times. During some one-hour periods, staff checked him only once or not at all. The most he was checked during an hour was six times (between 8.00am and 9.00am).

74. Mr J was responsible for the checks between 10.00pm and 7.15am. He told the investigator that he thought that the three-minute checks were until Child C was asleep and then he needed to be checked every 15 minutes. Despite this, Mr J did not complete the checks he believed were necessary. For example, Child C was awake between 10.00pm and 12.15pm and should have been checked 45 times when, in fact, Mr J checked him nine times.

75. CCSIW also looked at the CCTV for other nights and found large gaps in Child C's checks. For example, on 18 February, between 11.37pm and 6.38am, staff did not check Child C at all.

Understanding of checks needed

76. Aside from the two assistant managers, no other staff that the investigator spoke to were aware that Child C should have been checked every three minutes throughout the night. Some staff, like Mr J, believed that Child C was subject to three-minute checks until he was asleep and then every 15 minutes while asleep. Other staff believed he was subject to checks every 10 or 15 minutes when in his room. It is particularly concerning that when the investigator spoke to staff months after Child C's death, they were still not clear about the checks that they should have been completing.

77. The level of checks a young person is subject to is typically decided at the MDT meeting. The most recent reference to Child C's checks was on 6 February when the MDT minutes had a handwritten note on them saying, "3 minute checks". The checks were also specified on his summary of needs and risk (SONAR) documentation on 3 February where it was noted, "vigilant three-minute checks to continue".

78. Hillside's *night staff* policy instructs that at the start of a night shift details of the checks required on each young person will be established and recorded on the night observation record. Both the shift leader and night officer then sign this. Mr J did sign this sheet, indicating that checks were to be every three minutes. The shift leader did not sign the document. Ms L said that all staff also have access to the MDT minutes and SONAR documentation.

79. There needs to be greater clarity in documentation about the expected checks, better communication of these expectations by managers, and more vigilance by staff to ensure they understand the required level of checks for each young person.

Documenting checks

80. Ms D told the investigator that once staff had completed a check, they should document it immediately. There is a clear disparity between the number of checks documented by staff on the night Child C died and those that actually took place. Staff documented that 90 checks took place between 9.00pm and 10.23am when they had in fact completed only 35 checks. CSSIW also found significant discrepancies on other nights between the recorded checks and those shown on CCTV.

81. Mr J could not explain why there was a difference between the checks he completed and those he recorded. He believed that Child C was subject to 15-minute checks when he was asleep. He documented that he had completed all of these even though he had not. Mr J told the investigator it was possible he signed them all off at the start of his shift. Staff did not document any checks after 7.15am.

82. Mr J told the investigator that no one had spoken to him about the discrepancy between the checks he had completed and how he had documented these checks. Ms L disputed this and told the investigator that following Child C's death she had spoken to all staff about the importance of accurately recording checks. She said she had also spoken to Mr J twice individually.

83. We are particularly concerned that, despite this, Mr J has not accepted responsibility for apparently falsifying records. We are aware that Mr J no longer works at Hillside. We are also concerned that these failings were part of wider systemic issues, as evidenced by other staff failing to check Child C as required and CSSIW's concerns about welfare checks not being completed on other nights. We make the following recommendation:

The Director of Social Services should review the policies, procedures and actions of managers and staff at Hillside. They should determine whether they were sufficient to ensure that young people at Hillside were kept safe, and should report their findings and any actions they intend to take in response to the Prisons and Probation Ombudsman, the Welsh Government and the Department for Education within three months of receipt of the final version of this report.

Purpose and reasonableness of checks

84. Staff told the investigator that the purpose of checks was to ensure that a young person was safe, well and not self-harming. While some staff said they should ensure the young person was breathing, Ms L acknowledged that this would be difficult if a young person was sleeping and under their bedding. However, she said in this instance, she would expect staff to use a torch where necessary and be vigilant for other potential issues such as if the young person had not moved over several checks. Hillside's *night staff* policy explains that checks are to ensure a young person is safe. It instructs that if staff cannot see a young person they must go into the room with another member of staff.

85. Staff told the investigator that Child C had remained in the same position for several hours. When staff went into Child C's room, he had signs of rigor mortis indicating that he had been dead for some time. We are concerned that staff did not complete checks with sufficient vigilance and took too long to go into Child C's room to check on his welfare.

86. The current policy at Hillside is that all young people should be checked at least every 15 minutes. We consider that it is impractical to expect one member of staff to vigilantly check one young person every three minutes and up to seven other young people every 15 minutes. We also note the absence of a formal risk assessment process to inform the nature and frequency of checks.

Changes made since Child C's death

87. After Child C's death, Hillside stopped all three-minute checks while young people are awake. Young people are now either subject to constant checks, checks every five minutes or checks every ten minutes. When a young person is asleep, they are now either constantly observed or checked every fifteen minutes. If constant observations are needed then an extra member of staff would be on duty with the sole task of completing these checks.

88. Hillside has also introduced weekly random spot checks, comparing the checks documented against the CCTV for four different members of staff. Ms L said that all those checked so far have been completed and documented correctly. Ms L has indicated that if staff are found not to be complying then they may face disciplinary action.

89. Management at Hillside have also amended the sheet where night staff document the 15-minute checks so that these are filled in by the member of staff individually for each young person (rather than being amalgamated as they were before). Ms L has told staff that they need to refer to a young person's SONAR document regarding the level of checks that are necessary and has included this on team meeting agendas.

90. Ms L said that she has instructed staff to document checks as they are completed and to record the reasons if a check is missed. Hillside is also in the process of installing an electronic buzzer and checking system so that when a young person rings their bell or staff check them, it is automatically recorded. Ms L has instructed staff that they need to vigilantly check young people, using a torch if it is dark and to be aware of whether they have moved. Hillside management also considered installing mattresses in some young people's rooms that detect their heart rate. However, they are not considered safe for those at risk of suicide or self-harm.

91. It is evident that at the time of Child C's death there were significant issues with the way in which staff understood, conducted and documented checks on young people. We are alarmed that even after Child C had died, staff were still not clear about the checks they should have been completing and had accepted no responsibility for falsifying records. When CSSIW returned to Hillside they found that further improvements were needed to ensure compliance with scheduled checks and that young people were receiving the necessary support. We recognise that Hillside has now improved compliance in this area to ensure that young people are adequately safeguarded.

92. However, given our similar findings in investigating another death in a Secure Children's Home, we make the following recommendation:

The Welsh Government and the Department for Education should review current practice and introduce a clear framework about delivering welfare checks on young people, to include:

- **clear instruction about the nature and purpose of checks**
- **details of how to record checks accurately**
- **details of who decides what checks are necessary and how these are communicated to staff**
- **consideration of the frequency of checks required on young people including whether it is necessary to check all young people throughout the night regardless of their risk**
- **consideration of the number of staff needed to undertake checks**
- **instruction about when staff should go into a young person's room**
- **management oversight of checks.**

Clinical Care

93. The clinical reviewer concluded that Child C's clinical care was equivalent to that which he could have expected to receive in the community. After his first fit, staff made repeated attempts to expedite his appointment at the First Fit clinic. The clinical reviewer noted that the deterioration in Child C's behaviour following his fit presented staff with some challenges which they managed satisfactorily, including his risk of self-harm. We agree with this view.

94. The clinical reviewer also concluded that since the abnormalities in Child C's heart were only detected microscopically, it is unlikely that he was displaying any overt symptoms which staff could have been expected to notice.

Emergency response

95. Ms M went into Child C's room for around 30 seconds before leaving to get another member of staff as she could not get a response from Child C. Ms M said she would always get another member of staff if she was concerned about a young person. She returned around 30 seconds later with Mr K. While Ms M should have used her emergency alarm (which all staff carry), we are satisfied that her actions did not cause a significant delay.

96. Mr K said that when he moved Child C, he made a noise and he therefore hoped that by lifting Child C up, he was assisting him. A first aid trained member of staff

arrived less than a minute after Mr K and immediately started CPR. Child C was cold and had a stiff arm, indicating that rigor mortis had begun to set in. However, without medical professionals present, the clinical reviewer concluded that starting CPR was appropriate. We are satisfied that those present reacted calmly and competently to what was clearly an unexpected and distressing situation.

97. However, the clinical reviewer also comments that there is no CPR policy at Hillside. He recommends that Hillside staff have further training about the signs of obvious death and annual CPR training, and that a policy on when to start CPR should be introduced. We make the following recommendation:

The Principal Manager should ensure there is an emergency response policy at Hillside, which includes details of when it is inappropriate to start CPR.

98. Once the duty manager got to Child C's room, she asked Mr N to telephone an ambulance. He did so immediately. This was three minutes after Child C had first been found unresponsive. Hillside's *Managing a Crisis* policy indicates that those first on scene should contact the emergency services. The first two staff who went into Child C's room were not first aid trained and did not realise the gravity of the situation at first. It is understandable that they did not telephone an ambulance at this point. Shortly afterwards, a first aid trained member of staff arrived, along with the duty manager. We are satisfied that any delay in calling an ambulance was likely to be less than a minute and that staff acted appropriately.

Recording and sharing information

99. CSSIW found that there was ineffective communication at Hillside and there needed to be improved management oversight of staff compliance with procedures and the quality of record keeping. We share this view. In addition to the issue already highlighted about the communication of Child C's check level, we also found that information about Child C was often documented in the MDT minutes but not noted anywhere else.

100. Most staff the investigator spoke to had either witnessed first-hand, or been told about, Child C having short blank episodes after he had his seizure. It is impossible to know the significance of these episodes but the GP and the nurse were unaware of them. This information should have been communicated to them and may have been relevant to the hospital for Child C's appointment at the First Fit clinic. It is concerning that there was no reference to these blank episodes in any of the documentation provided to the investigator. Better systems are needed to ensure young people are appropriately supported and cared for. We make the following recommendation:

The Principal Manager should ensure that relevant information about a young person's welfare is recorded and disseminated appropriately.

Family Liaison

101. Police officers informed Hillside staff that they would inform Child C's next of kin of his death. This is in line with Hillside's *Managing a Crisis* policy. Child C's father collected Child C's belongings from Hillside but had no further contact with staff after this. No one from Hillside contacted Child C's mother. Hillside's *Managing a*

crisis policy indicates that following a death, the management team should contact a young person's next of kin to express their sympathy and provide support.

102. Both Child C's parents said that they would have welcomed contact from Hillside staff. Even after the investigator had told Hillside managers this, they did not contact Child C's parents. It was only after a further conversation with the investigator that the centre manager wrote to Child C's parents. While we recognise that this was an unprecedented event for all the staff concerned, more careful consideration should have been given in the immediate aftermath of Child C's death about how to support and maintain contact with his parents. The appointment of a family liaison officer in such a situation would facilitate this. We make the following recommendation:

The Principal Manager should ensure that whenever a young person dies, or is taken seriously ill, a family liaison officer is appointed to ensure the young person's next of kin are informed as soon as possible and to provide them with support and a point of contact.

Inquest

103. The inquest into Child C's death concluded that he died of natural causes.

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