

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Daniel Adewole, at HMYOI Cookham Wood, on 4 July 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

Daniel Adewole died suddenly from epilepsy on 4 July 2015 at HM Young Offender Institution Cookham Wood. He was 16 years old. I offer my condolences to Daniel's family and friends.

I am satisfied that Daniel received appropriate treatment for his epilepsy at Cookham Wood and I consider it would have been difficult for staff to have predicted or prevented his death.

However, I am concerned, as I have found in other cases involving deaths of children in young offender institutions, that too many of the procedures and staff responses replicated those in adult prisons. For example, a paediatric neurology appointment in June, to review Daniel's epilepsy, was cancelled simply on the grounds that Daniel and his parents were aware of the date. There was also a reluctance to go into Daniel's cell when staff could not get a response from him on the morning of his death, a delay compounded by staff appearing to be unaware of Daniel's condition or how to respond to a child in these circumstances. It is unlikely that an earlier intervention could have altered the tragic outcome for Daniel, but in other cases it could be crucial.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2016

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Summary

Events

1. On 2 June 2015, Daniel Adewole was sentenced to a six month detention and training order and went to HMYOI Cookham Wood. Daniel was 16 and had been diagnosed with epilepsy when he was five years old. He took medication to help prevent seizures. Nurses saw Daniel twice each day to give him his medication. Daniel had an outstanding paediatric neurology hospital appointment on 16 June but the prison cancelled the appointment the day after he arrived, citing security reasons, because he and his family knew the date and time of the appointment.
2. On the early morning of Saturday 4 July, there were two night patrol officers (operational support grade) on duty on Daniel's houseblock. Just before 6.00am, one of the officers began a security check to establish that all the boys were in their cells by looking through the observation panels in the cell doors. He looked into a cell and saw what he thought were bedclothes on the floor. There was no cell card identifying an occupant, so he thought the cell was empty and was not concerned. After checking the records, he realised that Daniel occupied the cell.
3. The officer did not go back to check the cell immediately, but went for a short break with the other officer. At 6.14am, he went back to Daniel's cell but could get no response from him. He went to get the other patrol officer but neither of them could get a response. They did not go into the cell but telephoned for help. At 6.31am, two prison officers arrived and opened the cell. Daniel was on the floor and not breathing so they started cardiopulmonary resuscitation. One of the officers radioed an emergency code. At 6.35am, the prison called an ambulance. Paramedics attended and administered emergency treatment. At 7.44am, the paramedics recorded that Daniel had died.

Findings

4. The clinical reviewer concluded that the standard of healthcare Daniel received at Cookham Wood was equivalent to that he could have expected to receive in the community. The emergency response from officers, once they went into Daniel's cell, was good. However, we are concerned that Cookham Wood automatically cancels children's hospital appointments when they or their parents know the date. This meant that Daniel missed a scheduled epilepsy review with a paediatric neurologist.
5. We are also concerned that staff did not have sufficient understanding of Daniel's condition or what to do when there was an emergency or any concerns about him. We consider that there was an unacceptable delay in the night patrol officers seeking help when they could not get a response from Daniel. They should have gone into the cell quickly or sought urgent help much earlier.
6. As in other investigations into deaths of children in young offender institutions, we are concerned that too many of the systems and security procedures simply replicated those in adult prisons, without a recognition of the special duty of care owed to children.

Recommendations

- The Governor and Head of Healthcare should ensure that there is a presumption that hospital appointments for children are not cancelled. When an appointment is cancelled there should be overriding fully justified and documented security reasons and healthcare staff should be satisfied that there is no detriment to the child's health.
- The Governor should ensure that all staff understand, subject to an appropriate individual risk assessment, their responsibility to enter a cell without delay if there is a risk to the life of a child.
- The Governor and Head of Healthcare should ensure there is an effective system to inform prison staff of young people's relevant medical conditions and what to do in an emergency or if there are any other concerns.

The Investigation Process

7. The investigator issued notices to staff and young people at HMYOI Cookham Wood informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator and a colleague visited Cookham Wood on 7 July. They obtained copies of relevant extracts from Daniel's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Daniel's clinical care at the prison.
10. On 14 July, the investigator and a colleague met members of the Local Safeguarding Children's Board (LSCB) for Thurrock local authority, Daniel's home authority, and representatives of the Youth Justice Board and Thurrock Youth Offending Team, to discuss the remit of the investigation.
11. The investigator and a colleague interviewed three young people at Cookham Wood on 15 July and five members of staff on 12 August. The investigators and the clinical reviewer interviewed six members of healthcare and prison staff on 26 August.
12. We informed HM Coroner for Mid-Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Daniel's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Daniel's father was concerned about the standard of his healthcare at Cookham Wood, including his compliance with his medication and that Daniel had missed an important medical appointment. He said that he had asked the prison to put a bed guard up as Daniel tended to have fits first thing in the morning. Daniel's father was also concerned that another boy at Cookham Wood had assaulted Daniel.
14. The initial report was shared with the Prison Service. They did not identify any factual inaccuracies.
15. Daniel's parents received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMYOI Cookham Wood

16. HMYOI Cookham Wood is a young offender institution in Kent, for up to 178 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. Out-of-hours cover is provided by a local GP practice.

HM Inspectorate of Prisons

17. The most recent inspection of HMYOI Cookham Wood was in May 2015. Inspectors reported that levels of healthcare staff had improved. Healthcare staff were up to date with mandatory training but clinical supervision was not consistently used or documented. There were sufficient GP clinics.
18. Inspectors noted all new arrivals received information about health services and any boy reported as being involved in a physical incident was seen promptly and followed up the next day, which offered good support. Most medicines were given as supervised doses but some medicine queues were not well supervised.
19. Inspectors noted that child protection procedures required further improvement. Behaviour management was not sufficiently effective in response to significant challenges. Procedural security was mostly appropriate but dynamic security required greater emphasis. Levels of violence remained high and measures to reduce violent behaviour were poorly applied. A high proportion of boys the Inspectorate surveyed said they felt unsafe and Inspectors had serious concerns about safety.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that those in custody are treated fairly and decently. In its latest annual report, for the year to July 2014, the IMB reported that the range and quality of healthcare, education and enrichment services had improved. However, there had been an increase in violence linked to an increase in the population and an ongoing shortage of staff. The IMB regarded healthcare at Cookham Wood as good but noted that shortage of staff had created delays and missed appointments.

Previous deaths at HMYOI Cookham Wood

21. Daniel was the second boy to die at Cookham Wood since 2012. In our investigation into the previous death we were concerned that staff delayed going into the boy's cell during night state. We repeat our recommendation from that report.

Key Events

22. On 2 June 2015, Daniel Adewole was sentenced to a six month detention and training order and was sent to HMYOI Cookham Wood.
23. When he arrived at Cookham Wood a nurse, who had considered Daniel's relevant pre-sentence reports, carried out a full health screen. Daniel told her that he had suffered from epilepsy since the age of five. The nurse created an epilepsy care plan and referred him to a prison GP, who prescribed Daniel's anticonvulsant medication (oxcarbazepine 300mg and zonisamide 300mg to be dispensed twice each day, morning and evening).
24. The Placement Information Form, a mandatory document from the Local Authority's Young Offending Team, recorded that Daniel had a paediatric neurology appointment on 16 June 2015. On 3 June, the healthcare appointment coordinator at Cookham Wood contacted Daniel's mother to verify this. His mother confirmed the appointment. The appointment co-ordinator asked for a copy of the appointment letter and subsequently wrote to the hospital asking them to re-arrange Daniel's appointment for security reasons (as Daniel and his parents knew the date of the appointment). The hospital moved the appointment to 12 October.
25. On 3 June, Daniel told a nurse that his last seizure had been in January 2015 and that he had experienced no aura (a warning or sensation some people get just before they have a seizure). He had no memory of the seizure after the event. A prison GP examined Daniel and discussed with him the importance of taking his anticonvulsant medication. The GP recorded that Daniel was taking his medication as prescribed, and recorded no concerns. He noted that Daniel did not present with any significant side effects.
26. On 5 June, a nurse asked for a blood test to check Daniel's levels of oxcarbazepine and his previous compliance with taking it. Another nurse took a blood sample later that day and sent it to hospital. The laboratory subsequently rejected the sample. A GP filed the letter without ordering another test.
27. On 16 June, a Supervising Officer (SO) recorded that other boys had assaulted Daniel. Daniel's Caseworker at Cookham Wood recorded that three boys had assaulted Daniel. (Two were referred to the police and one to the independent adjudicator, a district judge who hears serious prison disciplinary cases, but it appears that after Daniel's death no further action was taken.) After the assault, a nurse examined Daniel in the prison's healthcare centre. He took Daniel's clinical observations, which were normal, and did not record any concerns. Daniel had no evident injuries. The next day a nurse reviewed Daniel, who said he was fit and well.
28. On 25 June, a nurse recorded that Daniel had been involved in a fight and examined him in his cell. He noted that there was a swelling on the top of Daniel's right eye socket. Daniel complained of pain in his left arm and wrist but had full range of movement in his arm. The nurse offered Daniel pain relief medication (paracetamol and ibuprofen) but Daniel did not want any.

29. On 26 June, a nurse examined Daniel and recorded that he appeared to have full range of movement and no swelling or dislocation. Healthcare staff did not record any further concerns over the next days.
30. On Friday 3 July, Daniel was reported to have been behaving and socialising normally. He did not complain of any pain or health problems. His friends told us he was a funny and popular person. He played cards and ping-pong with them during the recreation period. Prescription records show that nurse supervised Daniel taking his oxcarbazepine at 8.13am and zonisamide at 7.00pm, as usual. Boys were locked in their cells for the night between 7.45pm and 8.00pm.

Saturday 4 July 2015

31. The night patrol officers on Daniel's houseblock on the night of 3/4 July were both operational support grade (OSG) staff who have limited contact with prisoners. OSG 1 was responsible for A Wing, where Daniel was, and OSG 2 for B Wing. During their night patrols of the landings, neither heard anything unusual and Daniel did not ring his cell bell to call them.
32. At 5.56am on 4 July, CCTV (closed circuit television) shows that OSG 1 started a roll count to check that all the boys were present in their cells, by looking through the cell observation panels. When he arrived at Daniel's cell, he noticed there was no cell-card to indicate an occupant and there were bedclothes on the floor. He therefore believed there was no one in the cell and continued the count. He then went back to the houseblock office where OSG 2 was.
33. OSG 1 checked the roll board in the office and noted that Daniel was in the cell he thought had been unoccupied. In front of Daniel's name on the board were the letters 'MED-E' (an abbreviation for 'Medical' and 'Epilepsy'). Both OSGs then went for a cigarette break.
34. At 6.14am, OSG 1 went back to the cell and tried to get a response from Daniel by kicking the door. All he could see was a pile of bedclothes on the floor. He said that at this point he realised that something was not right and went back to the office and told his colleague that Daniel was not responding.
35. At 6.19am, both OSGs went to Daniel's cell and tried to get him to respond for about two minutes. Both members of staff had a cell key in a sealed pouch for use in an emergency, but did not use it. OSG 1 said they did not consider this at any time. He said that, when they noticed that the mattress was over the edge of the bed, they considered that Daniel might have fallen out of the bed. He then went back to the office and telephoned a custodial manager, the night manager in charge of the prison. The custodial manager asked two officers to go to the houseblock.
36. Approximately ten minutes later, at 6.31am, two officers arrived and opened Daniel's cell. Daniel was lying on the floor with a duvet wrapped around him. Officer A could not rouse him. Officer B noted Daniel was very wet and she thought he was breathing. The custodial manager arrived shortly afterwards.
37. The officers put Daniel in the recovery position and the custodial manager checked for a pulse but could not find one. Officer B radioed a code blue (a medical emergency code, indicating a prisoner is unconscious, not breathing or

is having breathing difficulties). The officers began cardiopulmonary resuscitation. At 6.35am, the control room officer called an ambulance, in response to the code blue.

38. Paramedics arrived at about 6.54am and moved Daniel to the landing where there was more room. Paramedics and officers continued emergency treatment until, at 7.44am, paramedics recorded that Daniel had died.

Liaison with Daniel's family

39. A prison manager acted as the family liaison officer. At 11.40am, she and a prison chaplain visited Daniel's mother, informed her of his death and offered condolences and support. His father telephoned while they were there and they spoke to him. The family liaison officer remained in contact with Daniel's parents to offer support and guidance.
40. Daniel's funeral was held on 23 September 2015. The prison contributed towards the costs in line with national policy.

Support for young people and staff

41. A senior manager debriefed the staff involved in the emergency response and offered her support and that of the care team.
42. Staff informed the boys in Daniel's houseblock of his death. The prison posted notices informing staff and other boys and offered support. Staff reviewed all boys who had been assessed as at risk of suicide and self-harm, in case they had been adversely affected by Daniel's death. The prison held a memorial service on 23 July 2015.

Post-mortem report

43. After a post-mortem examination, the coroner gave the cause of death as sudden unexpected death in epilepsy. The toxicology report did not detect any unexpected drugs or alcohol. The toxicologist explained that they did not monitor therapeutic drugs and it was not possible to say with confidence the level of zonisamide present. Oxcarbazepine is not able to be detected. An examination of Daniel's brain found no evidence of focal lesion or haemorrhage.

Findings

Clinical Care

44. The clinical reviewer concluded that the clinical care Daniel received at Cookham Wood was equivalent to that he could have expected to receive in the community. Healthcare staff properly identified Daniel's epilepsy, created an appropriate care plan and saw him twice a day to give him his medication.
45. On 3 June, a GP prescribed Daniel's anticonvulsant medication to be dispensed by nurses twice a day (each morning and evening). On 5 June, a nurse requested a routine blood test to check Daniel's levels of oxcarbazepine. The test was rejected by the hospital but not re-ordered. The clinical reviewer said that this was not critical to Daniel's ongoing care because he did not present with any side effects and his epileptic control was excellent. This did not affect the outcome for Daniel. The clinical reviewer has made a recommendation in his review about managing test results, which the Head of Healthcare will need to address.
46. On 3 July, (the day before his death), nurses gave Daniel his anticonvulsant medication as usual, in the morning and in the evening and supervised him taking it. The clinical reviewer said that as Daniel's medication was supervised he would have ingested it the night before he died. He noted that Daniel was stable on his medication regime and had not had an epileptic fit since January 2015 (before he went to prison). A nurse who saw Daniel often told us that Daniel was given his medication under supervision to ensure that he was taking it regularly. He said that healthcare staff did not have any concerns about Daniel's compliance. The clinical reviewer considered that Daniel's presentation at Cookham Wood was consistent with being fully compliant with his medication.

Cancellation of hospital appointment

47. When Daniel arrived at Cookham Wood he had a scheduled paediatric neurology appointment at hospital on 16 June. We are concerned that Cookham Wood cancelled the appointment without any appropriate justification. This was apparently because he and his family knew the time and place of the appointment, yet there was no evidence of any security concerns.
48. The Head of Healthcare told us that the prison's security policy was that when a prisoner or his family knew the date of an appointment the appointment was automatically rescheduled unless considered urgent. The prison did not provide any evidence that anyone had assessed the importance of Daniel's appointment. He said that no one had asked healthcare staff to provide any information about Daniel's condition before the appointment was cancelled.
49. Thurrock Council (Youth Offending Services) told us they had written to the Governor in January 2015 with a number of concerns, including the prisons' practice of cancelling medical appointments. It does not appear that there was any change as a result; Cookham Wood continued to cancel and reschedule

medical appointments routinely, when a boy or his family knew the date, without making a proper assessment.

50. The Head of Healthcare told us that since Daniel's death, they have changed the procedures to include risk assessments of appointments on a case-by-case basis. The Governor said that there was no written policy or local instructions about this. We would expect there to be a presumption that any healthcare appointment, particularly for a child, would not be cancelled unless there were serious and overriding security concerns.
51. The Prison Service National Security Framework, which governs prisons' security arrangements, does not require hospital appointments to be cancelled automatically when those in custody become aware of the time and date, although our experience is that prisons often do this without sufficient reason. The national security guidance says that the prisoner's condition and the urgency of the treatment required should be taken into account when making such a decision and, if necessary, additional security arrangements can be put in place rather than cancelling appointments.
52. There was no evidence that Daniel was considered high risk or that there was any security intelligence to suggest he would try to escape. We found no reason why his appointment could not have gone ahead as planned. The clinical reviewer did not consider that cancelling the appointment compromised Daniel's ongoing medical care, but this should not have happened. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a presumption that hospital appointments for children are not cancelled. When an appointment is cancelled there should be overriding fully justified and documented security reasons and healthcare staff should be satisfied that there is no detriment to the child's health.

Emergency Response

53. For security reasons, Prison Service staff working in residential units at night do not carry standard keys but have a radio and a cell key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, (Management and Security of Nights), says that each establishment should have a local security strategy, which clearly states the local procedures when staff are faced with a potentially life threatening situation. It says that when there appears to be an immediate danger to life, staff can unlock cells (by using the key in the sealed pouch) without the authority of the night orderly officer (the manager in charge at night.) Otherwise the night manager should be present. This is reflected in local instructions at Cookham Wood.
54. When OSG 1 arrived at Daniel's cell shortly after 5.56am on 4 July, he said there was no cell card to identify an occupant and the bedclothes were on the floor. He told us that three boys had been released the day before and he thought the cell was one that had been vacated. When he got back to the office he checked the roll board and saw that Daniel was the occupant of the cell. As he had been unable to see Daniel when he looked into the cell, we consider he should have

gone back immediately to check him. Instead he went for a cigarette break with his colleague.

55. The roll board in the office had 'MED-E' next to Daniel's name. This was to indicate he had epilepsy. OSG 1 did not have a good understanding of the code. He said that no one had briefed him about Daniel's epilepsy, or what he should do in the case of an emergency or if there were other concerns. OSG 2 said she was not aware Daniel had epilepsy and an officer also said he was not aware of the MED E code. We are concerned that staff were not properly informed of young people's medical conditions and the implications for their care.
56. Both OSGs could not see Daniel or get a response from him but did not consider using their emergency keys to go into the cell. They waited a considerable time before summoning help. When OSG 1 eventually decided to get help, he did not use his radio but went back to the office and telephoned the night manager. It was not until 6.31am that two officers arrived, went into the cell, and called an emergency code. We are satisfied that there was an appropriate emergency response from that point. However, while we understand that the night patrol officers were unsure of the situation, we consider there was an unacceptable delay in getting help to an unresponsive child.
57. OSG 1 told us that before starting his role at the prison, a year earlier, he had shadowed another operational support grade for a week but did not have any other training. It was clear that he did not understand what he should do in a life-threatening situation. OSG 2 said she had been an operational support grade for eleven years but had not dealt with an emergency before. She knew she could use the key from sealed pouch, but was not confident about going into the cell because she could not see Daniel and there was a risk he could have been hiding.
58. In its response to one of our recommendations after the investigation into the previous death of a boy at Cookham Wood in 2012, the prison said, "We will review instructions for procedures around opening of cell doors on night state to ensure they clearly remind staff of their responsibility to ensure there is no delay if there is potential for risk to the life of a child". This investigation found little evidence that this had happened. We repeat our previous recommendation below.
59. The clinical reviewer said that, had staff entered Daniel's cell at the first possible time at 5.56am, it is likely that the window of opportunity to save his life might already have passed, as paramedics found signs of post-mortem changes and the beginnings of rigor mortis. Nevertheless, the delay was unacceptable. Whenever any child is unresponsive, this should prompt an immediate response from staff. This was particularly so in Daniel's case, because of his medical condition. In future emergencies such a delay could be critical.
60. As we have found in previous investigations into deaths of children in young offender institutions, too many of the security procedures and staff responses exactly mirror those in prisons for adult men. The best interests of the child should always be the primary consideration in all actions concerning children. We also consider there should be clear information sharing arrangements between healthcare and prison staff, to ensure young people's medical

conditions are understood and staff know what to do when there are any concerns. We make the following recommendations:

The Governor should ensure that all staff understand, subject to an appropriate individual risk assessment, their responsibility to enter a cell without delay if there is a risk to the life of a child.

The Governor and Head of Healthcare should ensure there is an effective system to inform prison staff of young people's relevant medical conditions and what to do in an emergency or if there are any other concerns.

Bed Guard

61. Daniel's father said that he had asked the prison to provide a bed guard, as Daniel had fits first thing in the morning. There is no record of this request, and no member of healthcare staff could remember anyone passing this request to them. Daniel had not had a fit since January 2015 (before going to Cookham Wood) and the clinical reviewer was satisfied that his epileptic control was good. The post-mortem showed that Daniel had not suffered any traumatic injury, consistent with falling out of bed. While it is unfortunate that there appears to have been some miscommunication about this issue, it does not appear that the provision of a bed guard would have altered the outcome for Daniel.

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