REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. HMYOI Cookham Wood**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent and Medway
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 5th July 2019 I commenced an investigation into the death of Caden Stewart, age 16. The investigation concluded at the end of the inquest on 10th August 2021. The jury found that Caden Stewart died on 27th June 2019 from an internal brain haemorrhage at King's College Hospital where he had been taken for specialist care having been found unconscious in his cell on the evening of 26th June 2019. The conclusion of the jury was that Caden Stewart died from natural causes, the death occurring at a time when there were inadequate reporting and recording procedures in place coupled with insufficient communication between prison officers and healthcare staff combined which led to healthcare failing to attend Caden Stewart's requests to see him. It could not be concluded that all of these factors contributed to the death having occurred
4	**CIRCUMSTANCES OF THE DEATH** Caden Stewart was remanded to HMYOI Cookham Wood on 7th June 2019. He presented as a fit, healthy youth with no medical history. On the afternoon of 26th June 2019 he had supervised exercise with other young persons, playing football in goal and then lifting weights in the gym. CCTV showed Caden to perform two sets of weightlifting repetitions before sitting down and rubbing the back of his head. He remained seated and was clearly in discomfort. Although the gym was supervised by two officers, some time passed before they noticed Caden and when questioned, Caden stated he had a headache. Caden was told he would be returned to the houseblock so that he could obtain painkillers from healthcare and an escort was summoned by radio. Caden was escorted back to his wing and put in his cell. Healthcare was not informed that Caden was feeling unwell. Approximately 40 minutes later Caden rang his emergency bell and asked to see healthcare. He reported a headache to the wing officer who was shown on CCTV to walk towards the healthcare area and on his return a short while later return to Caden's cell; he stated in evidence to tell him that healthcare would come to see him. .

	The healthcare area was manned at the relevant time but the nurse on duty denied having been told that Caden had requested to be seen. Caden was seen by four different officers on five occasions over the next four hours through the cell observation panel or whilst delivering his dinner. Whilst he did not make a further request to see healthcare, he did tell one officer that he wasn't feeling too well and was uncommunicative or terse with others. At 20.50, five and a half hours after first reporting feeling unwell Caden Stewart was found collapsed and unresponsive in his cell. He had not seen anyone from healthcare during this time. Caden was taken by ambulance to Medway Maritime Hospital where a CT scan revealed a brain haemorrhage. He was conveyed to King's College Hospital and underwent surgery but sadly died. A post mortem examination revealed that the haemorrhage resulted from a ruptured intracerebral arteriovenous malformation, a congenital defect. The inquest established that the rupture likely occurred as a result of weightlifting
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. Physical Education Instructors were unaware of the existence of PSI 58/2011 and the requirements within 2. There was a lack of communication between officers such that the physical education instructors did not inform the escort that Caden needed to see healthcare, the escort did not inform the wing officer in charge that Caden felt unwell and needed to see healthcare, none of the officers responsible for checking Caden's welfare during patrol state were aware that he had reported feeling unwell and was waiting to see healthcare 3. The wing officer in charge did not check whether Caden had been seen by healthcare at any stage over the following hours nor did he inform his successor on handover that Caden was waiting to see healthcare and had not been seen
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report,

	namely by 30th November 2021. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Government Legal Department, Simpson Millar solicitors representing the family, Oxleas NHS Foundation Trust, Hackney Social Services, Prison and Probation Ombudsman and to the Local Safeguarding Board. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**[DATE]4th October 2021 [SIGNED BY CORONER] Patricia Harding**