

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr Stephen Coates, a prisoner at HMP Preston, on 9 April 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.

This is the investigation report into the death from peritonitis, of Mr Stephen Coates at HMP Preston on 9 April 2015. He was 39 years old. I offer my condolences to Mr Coates' family and friends.

The investigation found that the standard of healthcare Mr Coates received in prison was equivalent to that he could have expected to receive in the community and I am satisfied that staff at the prison could not have foreseen or prevented Mr Coates' sudden death. However, I am concerned that, after his death, there was insufficient contact with Mr Coates' partner, who he had named as his next of kin.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

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Summary

Events

1. On 6 April 2015, Mr Stephen Coates was remanded to HMP Preston for alleged offences of burglary and theft. He was due to appear in court again on 1 May.
2. Mr Coates was dependent on opiates and benzodiazepines. A prison GP referred Mr Coates to the substance misuse team and lived on the specialist wing for prisoners withdrawing from drugs. Mr Coates had no other significant health issues when he arrived and did not report any health problems over the next two days.
3. In the early hours of 9 April, Mr Coates complained of abdominal pain. A nurse gave him indigestion tablets and paracetamol, which alleviated the pain. Just after 8.10am, an officer unlocked Mr Coates' cell and found him collapsed on the floor. He was not breathing and his skin looked grey. The officer alerted another officer who radioed an emergency medical code. Healthcare staff arrived quickly and began cardiopulmonary resuscitation. Paramedics arrived and continued the resuscitation attempt until, at 9.30am, a paramedic pronounced that Mr Coates had died.
4. A post-mortem examination found that Mr Coates had died from peritonitis and a perforated chronic duodenal ulcer.
5. Mr Coates had named his partner as his next of kin but was still married and his wife asked his mother to act as the principal family contact. His family arranged his funeral, which his partner did not attend.

Findings

6. The investigation found that staff at the prison could not have foreseen or prevented Mr Coates' death. He received appropriate treatment for his substance misuse problems and the standard of healthcare he received was equivalent to that he could have expected in the community. There was some difficulty with family liaison, which the prison generally handled sensitively. However, the prison had no further contact with Mr Coates' partner after 14 April. As Mr Coates had named her as his next of kin, we consider the prison should have continued to offer his partner support, at least until the time of his funeral on 28 April.

Recommendations

- The Governor should ensure that, after the death of a prisoner, family liaison officers maintain contact with the prisoner's nominated next of kin and keep them up to date with information and developments.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Coates' prison and medical records. He interviewed six members of staff at the prison in May 2015.
9. NHS England commissioned a clinical reviewer to review Mr Coates' clinical care at the prison. The clinical reviewer interviewed two nurses with the investigator.
10. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Coates' partner, who he had named as his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The family liaison officer also wrote to Mr Coates' mother but received no response. Mr Coates' partner was concerned that the prison had not supported her and had not kept her informed after Mr Coates had died.
12. Mr Coates' family received a copy of the draft report. Mr Coates' partner raised a number of issues that do not impact on the factual accuracy of this report. The prison also received a copy of the draft.

Background Information

HMP Preston

13. HMP Preston is a local prison holding up to 842 adult men. Lancashire Care Foundation Trust provides healthcare services at the prison. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Preston was in April 2014. Inspectors reported that healthcare, overall, was safe and decent. The inpatient unit provided patients with complex needs good support. However, some aspects of the environment and regime needed improvement.

Independent Monitoring Board

15. 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 March 2014, the IMB reported that healthcare staff offered a caring and committed service, which was effectively managed. There was a flexible and cooperative interface between the prison and healthcare.

Previous deaths at HMP Preston

16. Mr Coates was the thirteenth prisoner to die of natural causes at Preston since the beginning of 2011. There were no significant similarities with the circumstances of the other deaths.

Key Events

17. On 6 April 2015, Mr Stephen Coates was remanded to HMP Preston charged with burglary and theft. He was due to attend court again on 1 May.
18. At an initial health screen, a nurse recorded that Mr Coates had been diagnosed with hepatitis C in 1999 and took medication for depression. Mr Coates told the nurse that he had no concerns about his physical health. A prison GP, examined Mr Coates and noted he used opiates and benzodiazepines and referred him to the substance misuse team. Mr Coates had been on a methadone maintenance programme in the community and the doctor continued to prescribe him methadone. Mr Coates had a shared cell on a wing supporting prisoners withdrawing from drugs and alcohol.
19. On 7 April, a nurse saw Mr Coates for a health and wellbeing assessment. She recorded that Mr Coates had used heroin and crack cocaine in the past (including in the days before he arrived at Preston) and had been prescribed methadone in the community for the last nine years. The nurse noted Mr Coates did not have any major health issues and did not report any physical problems. He smoked 10 to 15 cigarettes a day and declined help to stop. The nurse recorded that Mr Coates had experienced drug-induced psychosis in the past and was taking medication for depression and an antipsychotic.
20. Later that day, the GP examined Mr Coates and prescribed medication to relieve stomach cramps and for diarrhoea, which are typical opiate withdrawal symptoms. This was a routine prescription to manage expected symptoms and the GP said that Mr Coates had not reported them at the time. On 8 April, two nurses took Mr Coates' blood pressure, pulse and temperature, as part of routine monitoring, since his arrival. The observations were within the normal range.
21. At about 5.00am on 9 April, Mr Coates complained of severe abdominal pain. A nurse examined Mr Coates, who said the pain was worse in his lower abdomen and that he was sweating. Mr Coates said his stomach pain had started suddenly and had woken him. The nurse checked his vital signs and recorded that his blood pressure and oxygen levels were normal. She measured his pulse twice and although the first time it was high, the second time it was lower and she was not concerned about it. Mr Coates told her that he was taking methadone and the nurse considered he had stomach cramps as a symptom of drug withdrawal. She gave him indigestion tablets and paracetamol. She reviewed Mr Coates twice in the following two hours and he said the pain was easing and he felt much better.
22. At 8.10am, an officer started to unlock the cells on Mr Coates' wing. At approximately 8.25am, he opened Mr Coates' cell but could not get a response from Mr Coates or his cellmate. He went into the cell and found Mr Coates on his back on the floor, with his feet towards the door and his head resting on the pipes on the back wall. He did not appear to be breathing and his skin looked grey. His cellmate then woke up and ran out of the cell in shock.
23. Two officers, who was on the landing, to get medical help. At about 8.32am, an officer radioed an emergency medical code and the communications room requested an ambulance at 8.33am. Two nurses arrived quickly with emergency

equipment. A third nurse also attended. One of the nurses was unable to find any signs of life and began to attempt cardiopulmonary resuscitation. At 8.37am, paramedics arrived and took over the emergency treatment. At 9.30am, a paramedic pronounced that Mr Coates had died.

Contact with Mr Coates' family

24. A prison chaplain, acted as the family liaison officer. He and the Governor, went to see Mr Coates' partner, who he had named as his next of kin, and informed her of his death. They offered support and advice.
25. In the following days, it emerged that Mr Coates was still married and his wife asked his mother to act on her behalf. After this, the prison withdrew from contact with Mr Coates' partner and the chaplain liaised with Mr Coates' mother and helped her to arrange the funeral.
26. Mr Coates' funeral was on 28 April 2015. The prison contributed towards the costs, in line with national policy. No one informed his partner of the date of the funeral.

Support for prisoners and staff

27. The prison issued notices informing staff and prisoners of Mr Coates' death and the support available. The duty governor debriefed the staff involved in the emergency response and offered them support. The prison reviewed prisoners identified as at risk of suicide and self-harm, in case the news of Mr Coates' death had adversely affected them. Staff and the chaplains supported Mr Coates' cellmate and made sure he was able to speak to the Samaritans and Listeners if wanted to. (Listeners are prisoners trained by the Samaritans to support other prisoners in distress.)

Post-mortem report

28. A post-mortem examination established that the cause of Mr Coates death was peritonitis (an inflammation in a tissue inside the abdomen) caused by a perforated chronic duodenal ulcer.

Findings

Clinical Care

29. The clinical reviewer found that Mr Coates care was equivalent to that he could have expected to receive in the community. She did not consider his sudden death could have been foreseen or prevented. There was no delay in the emergency response when he was found collapsed and nurses acted professionally and appropriately. Mr Coates had been in prison only three days when he died. When he arrived at Preston, healthcare staff noted he was in good general health and referred him appropriately for substance misuse treatment. In the early hours of 9 April, the nurse reasonably considered his pain was due to his withdrawal from drugs and managed this appropriately. She took his clinical observations, which did not indicate any significant concerns.
30. We are satisfied that healthcare and prison staff addressed Mr Coates' long-term drug use well and in accordance with the National Offenders Management Service (NOMS) Integrated Drug treatment System (IDTS). Healthcare staff referred Mr Coates to the substance misuse team, and he was accommodated appropriately in the substance misuse unit as soon as he arrived at the prison.

Liaison with Mr Coates' nominated next of kin

31. When Mr Coates arrived at the prison, he had named his partner as his next of kin. Her details were clearly recorded in his prison records and when Mr Coates died, the chaplain and Governor visited Mr Coates' partner to break the news and offer support.
32. On 10 April, Mr Coates' stepdaughter told the chaplain that Mr Coates was still married. Although he was separated from his wife, they had never divorced and, until his remand to prison, he had kept in contact with his wife. The chaplain decided that because Mr Coates was married, his wife should be regarded as his 'legal next of kin'. The chaplain spoke to Mr Coates' wife who said that she wanted Mr Coates' mother to deal with the prison and make the funeral arrangements on her behalf.
33. After 14 April, the prison decided their main family contact should be with Mr Coates' mother and the chaplain had no further contact with Mr Coates' partner, even though he had named her as his next of kin. The chaplain told us that he had not involved Mr Coates' partner in further decisions, including about Mr Coates' funeral, as Mr Coates' mother did not want her to be involved. He told us that he understood that the 'legal next of kin' takes precedent over any nominated next of kin. Mr Coates' funeral was on 28 April. No one informed Mr Coates' partner when it had happened. The prison returned Mr Coates' property to his mother.
34. Prison Service Instruction (PSI) 64/2011, safer custody, gives national guidelines about contact between the prison and a prisoner's family after a death. The instructions note that all families are different and can include "chosen" as well as biological members. It says that any approach to the family should be in accordance with individual needs and can include providing different members of the same family with information. It is for the prisoner to nominate a next of kin,

who could be a friend of partner and does not have to be a relative. The prison is expected to keep the nominated next of kin updated regularly after a prisoner's death.

35. Strictly speaking, 'next of kin' has no legal meaning in English law (apart from for inheritance purposes when someone dies without a will). The family dynamics in this case were complex and we recognise that the chaplain tried to deal with a difficult situation sensitively. Mr Coates did not leave a will and in the absence of specific wishes to the contrary, it would be usual for his legal family and relatives to take priority for such matters as property and funeral arrangements. We do not disagree with that decision. However, we consider that the prison should also have kept in contact with Mr Coates' partner and offered her ongoing support and information, at least until the time of his funeral. We make the following recommendation:

The Governor should ensure that, after the death of a prisoner, family liaison officers maintain contact with the prisoner's nominated next of kin and keep them up to date with information and developments.

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