

**Prisons &
Probation**

Ombudsman
Independent Investigations

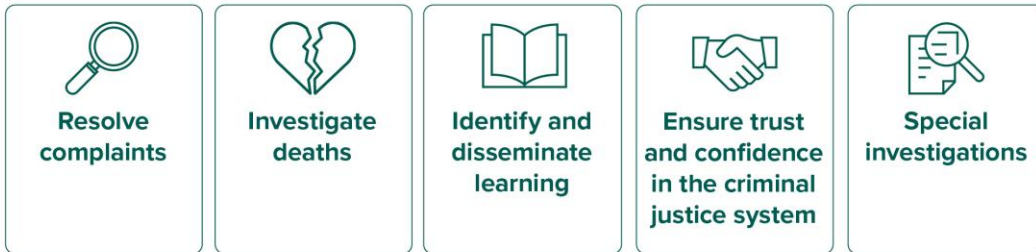
Independent investigation into the death of Mr Stephen Coster, a prisoner at HMP Lewes, on 5 May 2022

A report by the Prisons and Probation Ombudsman

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



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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.

Mr Stephen Coster died of meningitis in hospital on 5 May 2022 while a prisoner at HMP Lewes. He was 43 years old. I offer my condolences to Mr Coster's family and friends.

Prison staff found Mr Coster lying naked on the floor of his cell in the early morning of 3 May. He was agitated and refused to let a prison nurse examine him. Staff thought he might be under the influence of alcohol or drugs. The nurse told officers to check him every 30 minutes and report any concerns. She also recorded that the day nurses should carry out an urgent review.

Around three hours later, an officer found Mr Coster curled up in a ball on the floor of his cell, struggling to breathe. A nurse arranged for an emergency ambulance to be called and Mr Coster was taken to hospital, where he died two days later.

My investigation found that the handovers between night and day staff were poor. The day nurses were unaware that they should have carried out an urgent review of Mr Coster and the wing officer was unaware that Mr Coster should be checked every 30 minutes. He checked on Mr Coster at 7.00am, shortly after starting his day shift but did not check on him again until 8.30am.

I am also concerned that when the officer found Mr Coster struggling to breathe, he did not immediately call a medical emergency code. It was another 25 minutes before an ambulance was called.

Mr Coster was in the ambulance for over 40 minutes before it was permitted to leave the prison, even though paramedics stressed to prison staff that Mr Coster was very unwell and needed to go to hospital. The delay was caused by staff preparing the escort paperwork. I consider this completely unacceptable and urge the Governor to ensure that ambulances are despatched as quickly as possible in medical emergencies.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

January 2023

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Summary

Events

1. On 26 April 2022, Mr Stephen Coster was remanded in prison custody, charged with sexual assault and domestic violence-related offences, and sent to HMP Lewes.
2. During a roll check at approximately 5.30am on 3 May, staff found Mr Coster lying naked on the floor of his cell. He was conscious and breathing but appeared agitated. A nurse tried to assess him, but he refused to let her examine him. She thought that he might be under the influence of alcohol or drugs. She asked staff to check on him every 30 minutes and report any concerns to healthcare staff. She also recorded that the day nurses should urgently review him.
3. At approximately 7.00am, after receiving a handover from the night staff, an officer went to check on Mr Coster. He saw Mr Coster on the edge of his bed. He asked him if he was okay, and Mr Coster raised his arm and mumbled some words. The officer thought Mr Coster's condition had improved, compared to how night staff had described him.
4. At approximately 8.30am, the officer checked on Mr Coster again. He opened the observation panel and saw Mr Coster lying naked on the floor of his cell, curled up in a ball with his knees against his chest. He was struggling to breathe, and the officer thought he may be having a seizure. The officer went to get another officer and they entered the cell. They both agreed that a nurse should attend.
5. One of the officers went to get a nurse and brought her back to the cell. She asked for a more senior nurse to assess Mr Coster. A senior nurse attended approximately five minutes later and assessed that Mr Coster needed an emergency ambulance which was called at 8.55am.
6. At approximately 9.10am, paramedics arrived. They assessed that Mr Coster needed to be taken to hospital. The paramedics took Mr Coster to the ambulance, but it did not leave Lewes until 10.29am due to delays with the escort paperwork.
7. Mr Coster died in hospital at 6.01am on 5 May.
8. The post-mortem report concluded that Mr Coster died of meningitis caused by a bacterial infection.

Findings

9. The clinical reviewer found that the care Mr Coster received was not equivalent to that which he could have expected to receive in the community. She noted that the majority view of prison and healthcare staff that Mr Coster's condition was possibly due to drugs or alcohol meant that they did not properly assess whether he had an acute medical condition. She was concerned that healthcare staff did not use several clinical tools to aid their assessments and a nurse did not complete a mental capacity assessment after Mr Coster refused to allow her to complete observations. She also found that handovers given by night healthcare staff to day

healthcare staff were of poor quality and did not convey the importance of reassessing Mr Coster's condition.

10. We found that prison staff handovers were of poor quality. The officer who checked on Mr Coster after starting his day shift told the investigator that he was unaware that Mr Coster should have been checked every 30 minutes. He checked him at 7.00am but then did not check him again until 90 minutes later.
11. We are concerned that the officer did not call a medical emergency code when he found Mr Coster struggling to breathe and possibly having a seizure. This delayed the calling of an ambulance by 25 minutes.
12. We consider that the 40-minute delay in permitting the ambulance to leave the prison while escort paperwork was completed was totally unacceptable. The Governor should review what happened and ensure that emergency ambulances are despatched promptly in future.

Recommendations

- The Head of Healthcare should ensure that healthcare staff consider completing a mental capacity assessment when a prisoner refuses medical examinations and that this is clearly documented.
- The Head of Healthcare should ensure that healthcare staff use Glasgow Coma Scale (GCS) or Alert, Voice, Pain, Unresponsive (AVPU) tools when assessing prisoners with altered states of consciousness.
- The Head of Healthcare should ensure that healthcare staff understand the circumstances when they should complete a National Early Warning Score (NEWS2) assessment to detect clinical deterioration.
- The Head of Healthcare should ensure that all prisoners are offered a secondary health screen within seven days of arrival.
- The Head of Healthcare should ensure that when healthcare staff ask prison staff to complete observations on prisoners, they explain what prison staff should look out for in the prisoner's presentation.
- The Governor and Head of Healthcare should ensure that handovers provided to staff starting their shifts are thorough and contain all relevant information about a prisoner's current condition and any reviews or checks required.
- The Governor should ensure that prison staff understand when to use medical emergency codes, in line with PSI 03/2013.
- The Governor should review the actions of staff involved in dispatching Mr Coster to hospital to identify learning and prevent a recurrence.
- The Governor should resolve the issue with the downloading of cell bell records as soon as possible and ensure that cell bell records are provided promptly to the PPO investigator when requested.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. NHS England commissioned an independent clinical reviewer to review Mr Coster's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews of prison and healthcare staff at HMP Lewes on 14 July.
15. The investigator completed one additional interview of prison staff on 19 July. All interviews were completed by video conference.
16. We informed HM Coroner for East Sussex of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr Coster's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She wanted a better understanding of the events on the morning of 3 May and asked us to review the qualifications and actions of staff involved. Most of this information has been covered in this report and/or the clinical review. Additional queries have been covered in separate correspondence.
18. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.
19. We sent a copy of our initial report to Mr Coster's mother, and to his father, who contacted us after we had issued our initial report. They did not notify us of any factual inaccuracies.

Background Information

HMP Lewes

20. HMP Lewes is a Category B prison in the southeast of England. It holds approximately 600 prisoners in a mixture of single and double cells. Practice Plus Group provides healthcare services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Lewes was in May 2022. The inspection raised concerns about the quality of healthcare services at Lewes. They reported that the prison relied too heavily on agency healthcare staff which led to gaps in prisoner care. They found that the prison struggled to enable health services to run, and ineffective communication had led to considerable prisoner frustration.
22. Inspectors reported that reception and screening processes had been strengthened to make sure that clinical risk was prioritised. Advanced nurse practitioners saw all new arrivals to ensure continuity of their prescribed medications before a GP review. Immediate needs were identified, with appropriate onward referrals. Secondary health screenings were generally completed within seven days.

Independent Monitoring Board

23. 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 31 January 2022, the IMB reported that they found both physical and mental healthcare services had deteriorated since their visit the previous year.

Previous deaths at HMP Lewes

24. Mr Coster was the eleventh prisoner to die at Lewes since May 2020. Of the previous deaths, seven were from natural causes and three were self-inflicted. We have previously raised concerns about delays in officers calling medical emergency codes.

Key Events

25. On 26 April 2022, Mr Stephen Coster was remanded in prison custody, charged with sexual assault and domestic violence-related offences, and sent to HMP Lewes.
26. During a roll check (a count of prisoners) at approximately 5.30am on 3 May, an Operational Support Grade (OSG) looked through the cell door observation panel into Mr Coster's cell but could not see him. He fetched the Night Orderly Officer (the most senior officer in charge during the night) who looked through the observation panel and saw Mr Coster lying on the floor naked. He asked further officers and healthcare staff to attend.
27. Approximately five minutes later, further prison staff and Nurse A arrived, and they entered the cell. Mr Coster was conscious and breathing but would not allow Nurse A to complete observations on him. Nurse A thought Mr Coster might be under the influence of alcohol or drugs. She asked prison staff to check on Mr Coster every 30 minutes and to let healthcare staff know if they had any concerns. She also recorded that day nurses should complete an urgent review of Mr Coster.
28. At approximately 6.40am, an OSG gave Officer A a handover at the start of his shift. She told him that Mr Coster had been found shaking on the floor of his cell earlier that morning and that he should check on him.
29. At approximately 7.00am, Officer A went to see Mr Coster. He opened the observation panel and saw Mr Coster sitting on the edge of his bed. When Officer A spoke to him, Mr Coster mumbled some words and raised his hand. Officer A considered his condition had improved based on the information he had been provided about his condition earlier that morning. He reported this to a Custodial Manager (CM) (who was Oscar One, the most senior officer in charge during the day).
30. At approximately 8.30am, Officer A went to check on Mr Coster. He opened the observation panel and saw Mr Coster on the floor of his cell. He was naked, with a blanket around him, and was curled up in a ball, with his knees against his chest. He was shaking and appeared to be struggling to breathe. The officer went to get his colleague, Officer B, for a second opinion.
31. A few minutes later, both officers arrived back at Mr Coster's cell. They agreed that a nurse needed to assess Mr Coster. Officer B went to get a prison nurse. When the nurse attended the cell, she considered that a more senior nurse needed to assess Mr Coster.
32. Approximately five minutes later, Nurse B arrived and completed observations on Mr Coster. Nurse B assessed that Mr Coster needed to be taken to hospital. At 8.55am, the prison called for an emergency ambulance.
33. At 9.10am, paramedics arrived at Lewes and assessed that Mr Coster needed to be taken to hospital. He was taken to the ambulance, which was parked in the forecourt of the prison. It is not known what time paramedics put Mr Coster onto the ambulance, but records show that he was in the ambulance from at least 9.50am.

34. Paramedics did not leave the prison until 10.29am due to delays with Mr Coster's escort risk assessment documentation and decisions about the level of restraints. Paramedics had stressed to staff that they needed to leave the prison due to Mr Coster's condition. The CM told the paramedics that they could not leave until the documentation had been completed.
35. Mr Coster died in hospital at 6.01am on 5 May.

Contact with Mr Coster's family

36. At 11.45am on 3 May, the Head of Safety contacted Mr Coster's next of kin, his mother, to tell her that Mr Coster had been taken to hospital. He kept in contact with her while Mr Coster was in hospital.
37. Following Mr Coster's death, the Head of Safety handed over to the allocated family liaison officer.
38. The prison contributed financially to Mr Coster's funeral in line with national guidance.

Support for prisoners and staff

39. After Mr Coster's death, the Head of Complex Units offered bedwatch officers a debrief, to give them the opportunity to discuss any issues and offer support. The officers declined as there was nothing they wanted to raise, and they were aware of support available to them.
40. The prison posted notices informing other prisoners of Mr Coster's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they felt impacted by Mr Coster's death.

Post-mortem report

41. The post-mortem report concluded that Mr Coster died of meningoencephalitis (a form of meningitis causing inflammation in the brain and tissue protecting the brain and spinal cord), caused by streptococcus pneumoniae (a bacterial infection).

Findings

Clinical care

42. The clinical reviewer concluded that the care that Mr Coster received at Lewes was not equivalent to that which he could have expected to receive in the community. She was concerned that there was a majority view from both healthcare and prison staff that Mr Coster was under the influence of alcohol or drugs and that this overshadowed the fact that Mr Coster had an acute medical condition.

43. When Mr Coster refused to allow Nurse A to complete observations on him, she did not complete a mental capacity assessment. In line with the Mental Capacity Act (2005), a mental capacity assessment would have been appropriate to assess Mr Coster's decision-making ability to refuse healthcare examinations. We recommend:

The Head of Healthcare should ensure that healthcare staff consider completing a mental capacity assessment when a prisoner refuses medical examinations, and this is clearly documented.

44. Nurse A did not use clinical tools such as the Glasgow Coma Scale (GCS) or Alert, Voice, Pain, Unresponsive (AVPU) to assess Mr Coster. Given Mr Coster's condition, it would have been appropriate to use these tools which might have indicated that Mr Coster needed medical treatment.

45. When Nurse B completed observations on Mr Coster, he did not complete a National Early Warning Score (NEWS2) assessment. (NEWS2 is a clinical tool to assess a patient's clinical deterioration.) We recommend:

The Head of Healthcare should ensure that healthcare staff use Glasgow Coma Scale (GCS) or Alert, Voice, Pain, Unresponsive (AVPU) tools when assessing prisoners with altered states of consciousness.

The Head of Healthcare should ensure that healthcare staff understand the circumstances when they should complete a NEWS2 assessment to detect clinical deterioration.

46. The clinical reviewer found that Mr Coster did not receive a secondary health screen. This should occur within seven days of arrival, in line with NICE guidance on the physical health of people in prison. In Mr Coster's case, this would have acted as an additional stage to complete observations and review his healthcare. We recommend:

The Head of Healthcare should ensure that all prisoners are offered a secondary health screen within seven days of arrival.

Staff handovers

47. After Nurse A saw Mr Coster, she asked prison staff to check on him every 30 minutes. She also recorded that day nurses should complete an urgent review of Mr Coster. There is no evidence that she told prison staff what they should look for

when carrying out the checks. Also, Nurse B told the investigator that while he was aware of Mr Coster from the morning handover, he was unaware that prison staff had been told to check on him every 30 minutes and that day nurses were supposed to review him urgently. We were unable to interview Nurse A as she was an agency nurse and no longer works at the prison.

48. The OSG gave Officer A a morning handover and told him to check on Mr Coster. However, Officer A told the investigator that he was not aware that he should have checked on Mr Coster every 30 minutes.
49. We are concerned that Nurse A did not clearly state what prison staff should be looking for when checking on Mr Coster. In addition, healthcare and prison staff handovers were of a poor quality. This resulted in nobody checking on Mr Coster for 90 minutes, during which time his condition had deteriorated. We recommend:

The Head of Healthcare should ensure that when healthcare staff ask prison staff to complete observations on prisoners, they explain what prison staff should look out for in the prisoner's presentation.

The Governor and Head of Healthcare should ensure that handovers provided to staff starting their shifts are thorough and contain all relevant information about a prisoner's current condition and any reviews or checks required.

Use of emergency codes

50. PSI 03/2013 on medical emergency response codes states that if a prisoner is having difficulty breathing or believed to be having seizures, officers should immediately radio a medical emergency code blue. This will alert both prison and healthcare staff to attend the incident and alert the control room to call an emergency ambulance immediately.
51. In his statement, Officer A said that when he saw Mr Coster at around 8.30am, he appeared to be struggling to breathe. He subsequently recorded in NOMIS (the electronic prison record) that Mr Coster was possibly having a seizure. We consider that he should have called a medical emergency code blue at that point. Had he done so, an ambulance would have been called immediately. Instead, it took another 25 minutes before an ambulance was called. We recommend:

The Governor should ensure that prison staff understand when to use of medical emergency codes, in line with PSI 03/2013.

Delay in ambulance departure

52. After paramedics put Mr Coster into the ambulance, they spent at least 40 minutes waiting to leave Lewes, which we consider unacceptable. This was due to delays in completing escort risk assessment documentation. The investigator was also told during interview that there were several changes to which officers would accompany Mr Coster, and that this may have added to the delays.
53. During interview, the CM said that the security team were not aware that Mr Coster's escort was an emergency and assessed that he should go to hospital,

double cuffed. The CM then asked for this to be reduced to single cuffs, which meant that it had to be reauthorised by a governor. Eventually, paramedics told prison staff that Mr Coster should not be restrained and recorded in escort paperwork that this was because he was “profoundly unwell”.

54. PSI 33/2015 on taking prisoners outside the prison (escorts) says that if an emergency escort is required, escorts can be authorised to leave the prison and any outstanding paperwork should be completed within 24 hours.
55. The CM said that paramedics provided conflicting information to her on whether Mr Coster’s condition was being treated as an emergency. However, we consider that as a nurse requested an emergency ambulance, and paramedics then arrived within 15 minutes and assessed that Mr Coster needed treatment at hospital, it was apparent that Mr Coster was being treated as an emergency. We consider as Oscar One, the CM should have authorised Mr Coster to leave Lewes with any outstanding paperwork to follow.
56. The CM also said during interview that as Mr Coster was conscious and responsive while in the ambulance, this supported her understanding that Mr Coster’s escort was not an emergency. Staff should be reminded not to assume that because a prisoner is conscious and responsive that their condition is stable. We recommend:

The Governor should review the actions of staff involved in dispatching Mr Coster to hospital, to identify learning and prevent a recurrence.

Cell bell records

57. The investigator requested Mr Coster’s cell bell records on several occasions, but the prison was unable to provide them. The prison told us that they had been unable to download the records due to a problem with the back-up disc for the cell bell system. They had been trying to obtain a new back-up disc but had so far been unsuccessful.
58. While we acknowledge the prison’s efforts in trying to resolve this issue, reviewing cell bell information is an important part of an investigation. In this case, the investigator has not been able to confirm if Mr Coster used his cell bell to ask for help and if so, how many times and how quickly prison staff responded. We recommend:

The Governor should resolve the issue with the downloading of cell bell records as soon as possible and ensure that cell bell records are provided promptly to the PPO investigator when requested.

Inquest

59. At the inquest, held on 4 December 2023, the jury recorded a narrative conclusion. While they recorded that Mr Coster died of natural causes, they noted:
- Healthcare staff who attended failed to carry out adequate observations and examinations to reach conclusions about the extent of Mr Coster's conditions and failed to escalate to a more thorough assessment.
 - Healthcare staff and prison staff assumed that Mr Coster was under the influence of illicit substances, failing to consider alternative causes of his symptoms.
 - Healthcare staff failed to provide prison staff with an appropriate care plan to effectively monitor his conditions.
 - Inadequate written and verbal communication between prison and healthcare staff resulted in a lack of recorded checks of Mr Coster's condition.
 - Healthcare staff failed to include adequate information on paperwork of Mr Coster's medical condition, resulting in lack of urgency in releasing him to hospital.
 - Lack of knowledge of processes and procedures led to a catalogue of errors affecting Mr Coster's care.
 - Inadequate leadership leading to a breakdown in communication amongst prison staff resulting in a delay to Mr Coster's medical care.
60. The jury recorded that there was a realistic possibility that the above points more than minimally, negligibly and trivially contributed to his death.

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