

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Douglas Stack-Pash a prisoner at HMP Lewes on 28 May 2018

**A report by the Prisons and Probation Ombudsman**

## 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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Clifford Stack-Pash died of heart and lung disease in hospital on 28 May 2018, while a prisoner at HMP Lewes. He was 75 years old. I offer my condolences to Mr Stack-Pash's family and friends.

Mr Stack-Pash received a high standard of care at Lewes. Healthcare staff were responsive to his symptoms and took immediate steps to refer him for investigative tests when his health deteriorated. I am satisfied that his clinical care was at least the equivalent of that he could have expected to receive in the community.

The prison did not contact Mr Stack-Pash's next of kin until ten days after his admission to hospital. The failure to notify families promptly that a prisoner is seriously ill is an issue that this office has raised with Lewes several times. It is disappointing to have to do so again and I draw this to the attention of the Governor's manager.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**December 2018**

## **Contents**

|                                 |   |
|---------------------------------|---|
| Summary .....                   | 1 |
| The Investigation Process ..... | 2 |
| Background Information .....    | 3 |
| Key Events .....                | 4 |
| Findings.....                   | 7 |

# Summary

## Events

1. On 3 October 2016, Mr Douglas Stack-Pash was convicted of sexual offences and remanded to HMP Lewes. He was subsequently sentenced to 15 years in prison. Mr Stack-Pash had many chronic health conditions, including heart disease, high blood pressure, diabetes and chronic obstructive pulmonary disease (the name for a group of lung conditions that cause breathing difficulties).
2. Three days after he arrived at Lewes, Mr Stack-Pash was admitted to hospital to have a toe and part of his left foot amputated. When he returned to Lewes, he was an inpatient in the healthcare unit for 15 months until February 2018. Healthcare staff created care plans and reviewed him daily. He also attended nurse-led clinics and hospital outpatient appointments. Mr Stack-Pash was admitted to hospital on three further occasions, for amputation of his lower left leg, chest pain and an infection of his right foot.
3. On 15 May, Mr Stack-Pash seemed unwell and confused. He was admitted to hospital and doctors planned to amputate his right leg. However, the surgery did not take place as he developed an infection and a blood clot. Mr Stack-Pash did not respond to treatment and died at 10.22pm on 28 May.

## Findings

4. The investigation found that healthcare staff at Lewes provided a high standard of care to Mr Stack-Pash. They were responsive to changes in his condition and quickly referred him to secondary care when he required specialist treatment. We agree with the clinical reviewer that Mr Stack-Pash received a high standard of care at Lewes, at least equivalent to that which he could have expected to receive in the community.
5. Prison staff did not follow Prison Rules and the national policy on contacting and supporting the families of seriously ill prisoners. Ten days elapsed before the prison notified Mr Stack-Pash's family that he was in hospital. Subsequent attempts to alert them to his deterioration in the last three days of his life were unsuccessful, but we believe more could have been done to make contact during that time.

## Recommendations

- The Governor should ensure that the next of kin are informed promptly when seriously ill prisoners are admitted to hospital and that staff consider alternative methods of communication when they are unable to contact them by telephone.
- The Prison Group Director, Kent, Surrey and Sussex Group should assure himself that effective steps are taken to implement this recommendation.

## The Investigation Process

6. 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/her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Stack-Pash's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Stack-Pash's clinical care at the prison.
9. We informed HM Coroner for East Sussex of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. The investigator wrote to Mr Stack-Pash's son, his next of kin, to explain the investigation and to ask if he had any matters for the investigation to consider. He did not respond to our letter.
11. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

# Background Information

## HMP Lewes

12. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. The prison's healthcare centre provides 24-hour cover and has a 12-bed inpatient unit. It makes use of specialist NHS facilities when needed. There is a full-time senior medical officer and healthcare staff run a range of clinics.

## HM Inspectorate of Prisons

13. The most recent inspection of HMP Lewes was in January 2016. Inspectors found that primary care services and the management of long-term conditions were good, with an appropriate range of clinics and services, including wound care. They also reported that a senior nurse had been assigned to care for older prisoners. A specific clinic and age-appropriate screening was in place and prisoners had access to mobility and health aids.

## Independent Monitoring Board

14. 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 January 2018, the IMB reported that the number and needs of older prisoners had increased and their conditions had become more complex. The Board considered it was difficult to provide a good inpatient service in Lewes' Victorian buildings.

## Previous deaths at HMP Lewes

15. Mr Stack-Pash's death was the tenth from natural causes at HMP Lewes since the beginning of 2016. There has since been a further death apparently from natural causes. We have raised the issue of contacting prisoners' families several times with Lewes.

## Key Events

16. On 3 October 2016, Mr Douglas Stack-Pash was convicted of sexual offences and remanded to HMP Lewes. It was his first time in prison. He was subsequently sentenced to 15 years imprisonment.
17. At an initial health screen, a nurse recorded that Mr Stack-Pash had a history of ischaemic heart disease, insulin dependent type 2 diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and pains in his legs. The nurse referred him to the prison GP.
18. On 5 and 6 October, a prison GP noted that Mr Stack-Pash's large right toe had been amputated and his feet had several necrotic areas (the death of cells due to disease). The GP diagnosed diabetic peripheral vascular disease. He thought that Mr Stack-Pash might require further surgery and referred him to hospital. During the afternoon of 6 October, he was taken urgently to the Royal Sussex County Hospital, where he had surgery to remove a toe and part of his left foot.
19. After his discharge from hospital on 24 October, Mr Stack-Pash was immediately admitted to the prison's inpatient unit (where he remained for 15 months). Healthcare staff monitored him closely and created care plans to manage his wounds and other clinical needs. They referred him for social care and prison disability carers assisted him. Mr Stack-Pash attended various prison clinics, including those for diabetes, podiatry, heart and vascular disease, as well as outpatient appointments with hospital specialists.
20. In spite of the close monitoring by clinical staff, Mr Stack-Pash's diabetes was poorly controlled and his vascular disease and diabetic foot disease persisted. This led to the amputation of his lower left leg at the Royal Sussex County Hospital on 15 March 2017, followed by rehabilitation appointments a few months later at Brighton General Hospital. Mr Stack-Pash had further admissions to hospital from 24 - 26 April (acute chest pain) and 22 - 28 March 2018 (infection of his right foot).
21. On 2 February, Mr Stack-Pash moved to a residential wing. Healthcare staff reviewed him daily. They changed his dressings as necessary; monitored his blood sugar levels; helped to administer insulin; and referred him for specialist assessment. Prison carers continued to assist him on the wing.
22. On 9 May, Mr Stack-Pash fell from his wheelchair. A GP examined him and concluded that there was no major injury, but increased his painkillers.
23. In the early hours of 15 May, a wing officer asked a nurse to examine Mr Stack-Pash, as he had caught his toes in the spokes of his wheelchair and was bleeding profusely. The nurse stemmed the flow and applied a protective dressing. He also arranged for an urgent review of Mr Stack-Pash's foot and this was carried out just after 9.00am.
24. Later that day, Mr Stack-Pash appeared confused and unwell, with intense pain and inflamed infection in his leg. Healthcare staff sent him in a taxi to the Royal Sussex County Hospital, escorted by two prison officers without restraints.

25. Hospital doctors had planned to amputate Mr Stack-Pash's leg, but postponed the surgery as he developed a chest infection and a blood clot in his heart. He did not respond to treatment and, given his state of health, they decided not to resuscitate him if his heart or breathing stopped. Throughout Mr Stack-Pash's stay as an inpatient, healthcare staff contacted the hospital for updates.
26. On 28 May, the hospital withdrew treatment and Mr Stack-Pash died at 10.22pm.

### **Contact with Mr Stack-Pash's family**

26. The escort log showed that during the evening of 21 May, a hospital nurse asked the prison escort officers about the next of kin protocol. The officers advised that this should be raised with the prison manager who performed the daily management check the following day. On 23 May, an escort officer noted that a doctor would update Mr Stack-Pash's son about the deterioration in his father's condition.
27. On 25 May, a member of the prison's safer custody team informed Mr Stack-Pash's daughter-in-law that he was in hospital. His daughter-in-law said they might visit later and the prison's safer custody team member said she would try to arrange for a family liaison officer to meet and support them. There is no evidence that this visit took place.
28. The same day, a nurse asked the officers if Mr Stack-Pash's family were due to visit as they should come "sooner rather than later". One of the officers passed this information to a custodial manager who said that they would be visiting the following week. The hospital said they would telephone his son and were given his details, but it was later recorded that staff had been unable to make contact. On 27 and 28 May, hospital doctors repeated that Mr Stack-Pash's son should be contacted.
29. A custodial manager was assigned as the prison's family liaison officer. He noted in the family liaison log that he attempted, unsuccessfully, to contact Mr Stack-Pash's son between 26 and 28 May. Calls were logged twice on 26 May, once on 27 May (during the daytime on both days) and three times (late afternoon/early evening) on 28 May. There is no note of whether voicemail messages were left.
30. The morning after Mr Stack-Pash's death, the family liaison officer went to his son's home, with a prison chaplain and a supervising officer. They informed his son's wife that Mr Stack-Pash had died and she replied that the police had visited in the early hours of the morning to break the news. The prison staff outlined the processes to be followed and offered practical and pastoral support.
31. Mr Stack-Pash's funeral has yet to take place. However, in line with national guidance, the prison has arranged to contribute to the funeral costs.

### **Support for prisoners and staff**

32. The prison posted notices informing staff and other prisoners of Mr Stack-Pash's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Stack-Pash's death.

## Post-mortem report

33. A post-mortem examination revealed that Mr Stack-Pash's cause of death was 1a cardiorespiratory failure, due to 1b ischaemic hypertensive heart disease and chronic obstructive pulmonary disease.

# Findings

## Mr Stack-Pash's clinical care

34. Mr Stack-Pash arrived at Lewes with several longstanding and complex medical problems. Prison healthcare staff immediately assessed his needs and managed his conditions, with timely referrals to secondary care specialists. For much of his time at Lewes, he lived in the healthcare inpatient unit, which enabled close daily monitoring of his health and this continued after he moved to a residential wing in early February 2018.
35. When Mr Stack-Pash seemed unwell on 15 May, staff quickly arranged for him to be transferred to hospital for further assessment and sought updates on his condition. The security risk assessment took full account of his age, medical condition and reduced mobility.
36. We are satisfied that healthcare staff at Lewes managed Mr Stack-Pash appropriately and we agree with the clinical reviewer's conclusion that his care was at least equivalent to that which he could have expected to receive in the community.

## Contact with Mr Stack-Pash's family

37. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, sets out the expectation that if a prisoner suffers an unpredicted or rapid deterioration in their physical health an appropriate member of prison staff should engage with their next of kin to provide information and support.
38. There was no evidence of any attempts to contact Mr Stack-Pash's family until 25 May, ten days after his admission to hospital. Although prison staff did not initially expect him to die, he had been admitted to hospital with a serious condition that became progressively worse over the following days. When doctors indicated that Mr Stack-Pash might not survive and that his family should be told, the prison's family liaison officer tried to telephone them again, without success. The police notified his family of his death.
39. We consider that Mr Stack-Pash's serious condition and admission to hospital merited notification to his family at the outset. Also, given the urgency to tell them about his poor condition in the last few days of his life, the prison should have considered early morning and late evening calls, as well as alternative ways to update them. We are concerned that despite several previous recommendations on the issue of contact with families, the prison has again failed to follow national guidance. We make the following recommendations:

**The Governor should ensure that the next of kin are informed promptly when seriously ill prisoners are admitted to hospital and that staff consider alternative methods of communication when they are unable to contact them by telephone.**

**The Prison Group Director, Kent, Surrey and Sussex Group should assure himself that effective steps are taken to implement this recommendation.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations