Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Palfreyman a prisoner at HMP Featherstone on 31 August 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Mark Palfreyman died on 31 August 2017 of 'Sudden Unexpected Death in Epilepsy' (SUDEP) at HMP Featherstone. Mr Palfreyman was 44 years old. We offer our condolences to Mr Palfreyman's family and friends.

I am satisfied that the clinical care Mr Palfreyman received at Featherstone was equivalent to that which he could have expected to receive in the community, and that when Mr Palfreyman collapsed the emergency response was prompt and well co-ordinated.

I note that Mr Palfreyman's family were initially notified of his death by phone, which is not in line with Prison Service policy. I recognise, however, that the Governor visited the family in person shortly after the phone call and I am, therefore, satisfied that the family were treated with appropriate consideration.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **March 2018**

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Summary

Events

1. On 7 April 2017, Mr Mark Palfreyman was remanded to HMP Hewell. A health screen on his reception at Hewell revealed he had diabetes, which he managed himself, and a 23-year history of epilepsy. Mr Palfreyman was taking three anti-epileptic drugs to control his epilepsy, and a prison GP renewed this prescription.

2. On 15 April, Mr Palfreyman declined to take one of his anti-epileptic drugs due to the side effects. On 26 April, Mr Palfreyman signed a disclaimer to show he was aware of the potential consequences of not taking this drug.

3. On 4 May, Mr Palfreyman was convicted and sentenced to two years and four months imprisonment for robbery. On 22 May, he was transferred to HMP Featherstone. A health screen on his reception at Featherstone recorded his history of epilepsy and diabetes. He continued to manage his diabetes himself, and received a prescription for his two remaining anti-epileptic drugs.

4. At the end of May, Mr Palfreyman's son was killed by a hit-and-run driver. During the summer, Mr Palfreyman started working in the textiles workshop. He missed a few shifts due to his son's death, but otherwise had no relevant health issues.

5. On 31 August, just before 9am, Mr Palfreyman attended work as usual. Shortly after his arrival, he collapsed. His friend placed him on the floor, in the recovery position, before calling for help. The instructor on duty called an emergency immediately and, within a minute, a nurse and healthcare assistant arrived.

6. The nurse observed that Mr Palfreyman was unresponsive and was not breathing properly. She placed him on his back and started cardiopulmonary resuscitation (CPR). After one cycle of CPR she attached a defibrillator and administered a shock, as advised. More healthcare staff arrived shortly afterwards and CPR was continued. Mr Palfreyman's blood glucose level was tested and appeared unremarkable, so healthcare staff suspected a cardiac arrest. They delivered oxygen-rich air to Mr Palfreyman in between chest compressions, and administered adrenaline to improve his chances of survival.

7. Paramedics arrived at 9.16am. At 9.51am, they took Mr Palfreyman to hospital where, at 10.35am, he was pronounced dead.

8. At 10.22am, the Duty Governor telephoned Mr Palfreyman's father to inform him that his son was being taken to hospital. At 10.54am, a prison family liaison officer telephoned Mr Palfreyman's father to inform him of his son's death. Shortly afterwards, the Governor and Deputy Governor visited Mr Palfreyman's father in person to offer their condolences.

Findings

Clinical care

9. We agree with the clinical reviewer that the clinical care Mr Palfreyman received at Featherstone was equivalent to that which he could have expected to receive

in the community. Staff managed Mr Palfreyman's epilepsy and diabetes well, despite this being complicated by his reluctance to take certain medication.

Emergency response and CPR

10. When Mr Palfreyman collapsed, the emergency response was prompt and healthcare staff attended the scene quickly. Following their arrival, CPR was started without delay, and his life-support was coordinated well. We consider that the emergency response was conducted appropriately.

Family contact

11. Prison Service policy is clear that the news of a prisoner's death should be delivered in person. In this case Mr Palfreyman's father was first told of his son's death by telephone. We recognise that the Governor visited Mr Palfreyman's father in person shortly after the phone call and we are satisfied that the family were treated with appropriate consideration.

12. We are concerned, however, that the Family Liaison Officer's record of contact with Mr Palfreyman's next of kin was not properly updated and documentary evidence was not provided to the Investigator promptly, despite repeated requests.

Escorts and restraints

13. Mr Palfreyman was not restrained when he was taken to hospital. We consider that the prison took the appropriate decision not to restrain him.

Recommendations

- The Governor of Featherstone should ensure that a member of Prison Service staff informs a prisoner's family or next of kin of their death in person, in line with national guidance.
- The Governor of Featherstone should ensure that the appointed family liaison officer keeps comprehensive records, which detail all interactions with the next of kin, from the date he or she is appointed.
- The Governor of Featherstone should ensure that relevant documents are provided to the PPO promptly.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator visited HMP Featherstone on 4 September 2017. He obtained copies of relevant extracts from Mr Palfreyman's prison and medical records.

16. The investigator interviewed three members of staff and one prisoner at HMP Featherstone on 4 September 2017.

17. NHS England commissioned a clinical reviewer to review Mr Palfreyman's clinical care at the prison.

18. We informed HM Coroner for Staffordshire South of the investigation, and he gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Palfreyman's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They mentioned that Mr Palfreyman had expressed his concern to them about the management of his diabetes.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

21. Mr Palfreyman's family 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

HMP Featherstone

22. HMP Featherstone is a medium security, Category C prison, holding around 650 convicted men. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

23. The most recent inspection of Featherstone was conducted in November 2016. Inspectors reported that there was “a shocking worsening of standards” since the previous inspection in 2013, and that, staff and prisoners spoke openly about what they perceived to be a lack of leadership and direction in the prison.

24. Inspectors judged that primary healthcare services were reasonably good, despite staff shortages, but the range of services offered had reduced. They also observed that too many prisoners experienced long delays accessing external hospital appointments.

Independent Monitoring Board

25. 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 October 2017, the IMB said that the prison’s new health management team had employed a business manager, leading to a more efficient running of the healthcare department. There were no vacancies in the department; an improvement on the previous year.

26. The board recognised the improvement in staffing levels at the prison and noted that relationships between staff and prisoners were much improved as a result.

Previous deaths at HMP Featherstone

27. Mr Palfreyman’s death was the fourth to occur from natural causes at Featherstone since the start of 2016. On each previous occasion, we have made recommendations about family contact following a prisoner’s death. Since Mr Palfreyman’s death, there has been another death and an investigation into that is ongoing.

Sudden Unexpected Death in Epilepsy

28. ‘Sudden Unexpected Death in Epilepsy’ (SUDEP) is extremely rare and affects around 500 people in Britain every year. Although little is known about SUDEP, research has shown that it is usually associated with a seizure. It is believed that the part of the brain controlling respiration may be affected, causing breathing to stop.

29. The Epilepsy Society have defined SUDEP as:

    “the sudden, unexpected, witnessed or unwitnessed, non-traumatic, and non-drowning death in patients with epilepsy with or without evidence for a seizure,

and excluding documented status epilepticus, in which post-mortem examination does not reveal a structural or toxicological cause for death”.

Key Events

30. On 7 April 2017, Mr Mark Palfreyman was remanded to HMP Hewell. A nurse reviewed Mr Palfreyman at a health screen on his reception. She noted that he had a history of diabetes dating to 2003, which Mr Palfreyman had difficulty in controlling, experiencing both hypo- and hyperglycaemic attacks. He had responsibility for managing his diabetes, and was given a blood glucose testing and treatment kit, including an insulin pen.

31. The nurse also recorded that, following a head injury, Mr Palfreyman had been epileptic for 23 years. He informed her that his seizures were severe and came on without warning, mainly at night, and that he had had 18 seizures in the week prior to his detention. Mr Palfreyman was prescribed medication in the community to manage his epilepsy. Later that day, a prison GP reviewed him and renewed his prescription for three anti-epileptic drugs (epilim chrono, lamotrigine and vigabatrin).

32. On 15 April, a prison GP recorded that Mr Palfreyman was refusing to take the vigabatrin because he said it gave him heartburn. He was prescribed Rennie antacid tablets to address this. On 26 April, pharmacist noted that Mr Palfreyman was still not taking the vigabatrin. He informed her that he was no longer having fits during the day but was having seizures at night instead. He signed a disclaimer which stated that he was aware of the potential consequences of not taking his vigabatrin. She noted that a GP review was required to discuss alternative treatment. There is no record of any further review at Hewell.

33. On 4 May, Mr Palfreyman was convicted and sentenced to two years and four months imprisonment for robbery. He was initially returned to Hewell but, on 22 May, was transferred to HMP Featherstone.

34. A healthcare assistant reviewed Mr Palfreyman at a health screen on his reception at Featherstone. He recorded that Mr Palfreyman was epileptic, and noted that he should be given a lower bunk and that staff should be mindful of his condition when assigning work duties. Mr Palfreyman's existing epilepsy prescription was renewed. He also noted that Mr Palfreyman had diabetes, and that he was responsible for his own management of this.

35. On 23 May, a prison GP issued a prescription for Mr Palfreyman which included vigabatrin. The following day another prison GP recorded that this medication had been stopped because Mr Palfreyman was not complying due to the side effects.

36. On 29 May, a chaplain informed Mr Palfreyman that his son had been killed by a hit-and-run driver. Mr Palfreyman's cellmate provided him with support, but he declined the offer of a Listener (a prisoner trained to offer support). On 1 June, a prison GP reviewed Mr Palfreyman, who told him that his son had been "murdered on Sunday" and that he was "not in a good place". The GP prescribed diazepam (used to treat anxiety disorders). In interview, a nurse stated that Mr Palfreyman stopped taking the diazepam after four days "because it was making him feel funny".

37. At the same consultation, a prison GP noted that Mr Palfreyman complained that he was in a top bunk, rather than a bottom one, contrary to the arrangements agreed given his epilepsy. Later that day, Mr Palfreyman informed an officer that he had been experiencing some problems on his wing from other prisoners due to his son's death. Shortly afterwards, he accepted a move to another wing, and there were no further concerns about his location.

38. On 28 June, a prison GP performed a routine assessment of Mr Palfreyman's risk of cardiovascular disease, due to his diabetes and family history of heart attack. He was deemed to be at a 10% risk of a heart attack within the next ten years so the GP prescribed atorvastatin (used to block the production of cholesterol).

39. Mr Palfreyman worked in the textiles workshop throughout the summer. During June he missed a few shifts due to the death of his son, but otherwise had no significant health concerns.

31 August 2017

40. On 31 August, just before 9am, Mr Palfreyman attended work as usual. He was working with his friend, sitting near his workstation before starting work. The instructing officer on duty in the workshop was fixing a machine nearby. He saw Mr Palfreyman come in and stated in interview that everything appeared normal at this stage. He was aware that Mr Palfreyman had diabetes and that he managed this himself with insulin.

41. In interview, the friend recalled that Mr Palfreyman had told him that "his head was not right. I asked if it was to do with the sugar – he said no, the second time he snapped there is something not right with my head". The friend said that he then sat him down but, a few seconds later, Mr Palfreyman collapsed. He grabbed him to stop him falling and put him on another chair. He added, "He was like a dead weight. Another lad then helped me to put him in the recovery position". He then went to get help.

42. The instructing officer stated in interview that he heard the friend shout "man down", and that when he saw it was Mr Palfreyman, he thought it was to do with his diabetes, because he was not known to use drugs. He said, "I saw how serious it was, so called a code blue immediately". (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) The code blue call was made at approximately 9am.

43. Within a minute, a nurse arrived, along with a healthcare assistant. She was not delegated as the emergency responder that day, but was close by when she heard the call. In interview, she recalled that Mr Palfreyman was in the recovery position when she arrived, so she assessed him to determine any immediate concerns. She observed that he was non-responsive, his pupils were fixed and dilated, and that he was cyanose (a bluish or purplish discolouration of the skin caused by having low oxygen saturation). She recalled that he also had agonal breathing. (This is an inadequate pattern of breathing associated with extreme physiological distress, often indicative of cardiac arrest.) Mr Palfreyman was moved onto his back, and she started cardiopulmonary resuscitation (CPR).

Shortly afterwards, an officer returned with a defibrillator, and she attached the pads to Mr Palfreyman. After one cycle of CPR, the defibrillator advised a shock, which was administered.

44. At approximately 9.05am, a charge nurse arrived, along with two nurses and the Deputy Head of Healthcare. A nurse inserted an airway to keep Mr Palfreyman's airway clear, and attached a breathing bag to assist his breathing. The charge nurse inserted a cannula into Mr Palfreyman's arm to enable them to administer medication or drain off fluid. They tested Mr Palfreyman's blood glucose level, which showed that he was not in a hypoglycaemic coma (induced by dangerously low glucose levels). The charge nurse recalled in interview that they delivered 40% oxygen to Mr Palfreyman between chest compressions, doubling the normal dose to his brain to maximise his chances of a full recovery. He added that after the first two shocks from the defibrillator, they administered intramuscular adrenaline into Mr Palfreyman's thigh (to concentrate blood around the vital organs and improve his chances of surviving a cardiac arrest). They also gave Mr Palfreyman naloxone (to block or reverse any ill effects from opiates) in case he had overdosed, before giving him a further shock.

45. At 9.16am, paramedics arrived. They transferred Mr Palfreyman to the ambulance and at 9.51am, Mr Palfreyman was taken to hospital, accompanied by two officers, but not restrained.

46. At 10.35am, Mr Palfreyman was pronounced dead.

Contact with Mr Palfreyman's family

47. Mr Palfreyman's son was recorded in his prison notes as next of kin. Mr Palfreyman's son had died at the end of May 2017, but nevertheless remained as the designated next of kin in Mr Palfreyman's records.

48. On 31 August, the prison appointed a family liaison officer. Mr Palfreyman's father was his nearest blood relative, and lived approximately 30 miles from Featherstone. Mr Palfreyman's partner's details were also on record, and she lived approximately 14 miles away.

49. At 10.22am, the Duty Governor telephoned Mr Palfreyman's father to inform him that his son was being taken to hospital.

50. At 10.54am, the family liaison officer telephoned Mr Palfreyman's father and informed him of his son's death. She offered support and asked whether there was anyone he wanted her to call. At 10.56am, she called Mr Palfreyman's partner on her mobile to inform her of his death. Mr Palfreyman's partner said she would make her way to the hospital.

51. At 11.25am, the family liaison officer called Mr Palfreyman's father again, but his sister took the call. She informed Mr Palfreyman's sister that the Governor would be coming out in person to see the family that day. At 12.10pm, the Governor and Deputy Governor left to visit Mr Palfreyman's father. They offered their condolences and support to him and to other members of Mr Palfreyman's family who were present. They returned to the prison at 5.20pm.

52. Mr Palfreyman's funeral was held on 20 September. The prison contributed to the costs in line with national guidance.

Support for prisoners and staff

53. After Mr Palfreyman's death, a Duty Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

54. The prison posted notices informing other prisoners of Mr Palfreyman'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 Palfreyman's death.

Post-mortem report

55. The pathologist concluded that Mr Palfreyman died due to a sudden unexpected death in epilepsy (SUDEP).

56. A Consultant Pathologist noted that there was "no indication of any injuries and no visible cause of death either with the naked eye or microscopic examination. Toxicology was essentially negative". He also stated that "a diabetic related catastrophe was unlikely".

57. The Consultant Pathologist concluded that with no indication of any cardiac injury, brain injury or injury to other essential organs, SUDEP was the most likely cause of death, probably mediated by an arrhythmic disturbance within Mr Palfreyman's heart.

Findings

Clinical care

58. The clinical reviewer considered that the clinical care Mr Palfreyman received at Featherstone was equivalent to that which he could have expected to receive in the community. Staff managed Mr Palfreyman's epilepsy and diabetes to the best of their ability, which was challenging given he did not always cooperate with his regime and medical requirements.

Emergency response and CPR

59. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

60. We find that the emergency response was prompt, and that CPR was performed appropriately. On discovering that Mr Palfreyman had collapsed, the instructing officer called a code blue almost immediately, and healthcare staff arrived on the scene within a minute. An initial assessment was appropriate, and CPR was started without delay. Additional healthcare staff arrived within a few minutes, and CPR was rotated appropriately. Healthcare staff assessed Mr Palfreyman throughout, and drugs and adrenaline were administered effectively to give him the best chance of surviving a suspected cardiac arrest.

Family contact

61. Prison Rule 22(1) states: "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

62. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* states that "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death …If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable".

63. Mr Palfreyman's father was first informed of his son's death over the telephone, despite living very close to the prison. The PSI allows for notification by telephone if it is not possible to visit in person, but there is no suggestion that this was the case here. We appreciate that Mr Palfreyman's father had only been told about half an hour earlier that his son had been taken to hospital and that it may, therefore, have been thought necessary to inform him as soon as possible that his son had died. We also commend the fact that the Governor visited Mr Palfreyman's family in person as soon as he possibly could, after the phone call.

Nevertheless, it is clear that Prison Service policy expects the news of a prisoner's death to be delivered in person. If the prison took the view that there were strong reasons for not doing so in this case, this should have been recorded and justified in the FLO's log. We, therefore, make the following recommendation:

The Governor of Featherstone should ensure that a member of Prison Service staff informs a prisoner's family or next of kin of their death in person, in line with national guidance

64. PSI 64/2011 further states that "A log book recording contact with the next of kin must be opened when the FLO is first deployed to the family. Every contact with the family and their representatives should be recorded wherever possible. Log entries need to be an accurate and transparent record and should be written up as soon as possible after a meeting".

65. We are concerned that there appears to have been some confusion between the family liaison officer and the Governor about the family being notified. There was no entry in the FLO log about the telephone call made by the Duty Governor to Mr Palfreyman's father when he was taken to hospital. The visit made by the Governor to Mr Palfreyman's father was only documented at the end of the log, which must have been at least 18 days after the visit took place.

66. We are also disappointed that at the time of writing this report, the complete FLO log had not been received by the investigator, despite numerous requests. (A full copy of the FLO log was subsequently received, and this report has been edited accordingly.)

The Governor of Featherstone should ensure that the appointed family liaison officer keeps comprehensive records, which detail all interactions with the next of kin, from the date he or she is appointed.

The Governor of Featherstone should ensure that relevant documents are provided to the PPO promptly.

Escorts and restraints

67. Mr Palfreyman was not restrained at all when he was taken to hospital. We consider that the prison took the appropriate decision not to restrain him.

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London, SE1P 4XY
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