Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald Veale, a prisoner at HMP Littlehey, on 24 January 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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.

Mr Donald Veale died of a heart attack at HMP Littlehey on 24 January 2021. He was 87 years old. I offer my condolences to his family and friends.

The clinical reviewer found that, overall, the care Mr Veale received was of a good standard and was equivalent to that he could have expected to receive in the community.

Staff worked diligently to try to resuscitate Mr Veale. However, I have made a recommendation about ensuring that prison staff are confident using defibrillators and that the equipment is properly maintained. I am satisfied though that this had no impact on Mr Veale's death.

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 **July 2021**

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Summary

Events

1. On 26 February 2016, Mr Donald Veale was sentenced to 20 years imprisonment for sexual offences. On 3 May 2019, he was sent to HMP Littlehey.

2. On 19 January 2021, Mr Veale complained of chest pain. Staff performed an electrocardiogram (ECG – a test that checks the rhythm and electrical activity of the heart) and a prison GP assessed the results. A follow up appointment with another GP took place two days later. The GPs were satisfied that there was no cause for immediate concern and agreed with Mr Veale that he probably had indigestion. They told him to contact healthcare staff again if his condition deteriorated.

3. On 24 January, an officer found Mr Veale collapsed on the floor of his cell. Extensive attempts at resuscitation were unsuccessful and Mr Veale was pronounced dead at 5.15pm.

4. The post-mortem examination found that Mr Veale died from a heart attack.

Findings

5. The clinical reviewer was satisfied that, overall, the healthcare Mr Veale received at Littlehey was good and was equivalent to that he could have expected to receive in the community. She made no recommendations.

6. During the attempt to resuscitate Mr Veale, staff thought that the defibrillator was not working and collected another. Both were working correctly. In emergencies staff need to have confidence in their training and equipment. We are also concerned about aspects of the maintenance log for the defibrillators. We are satisfied that neither issue had any impact on Mr Veale's death.

7. A prisoner complained that staff were laughing during the resuscitation. We found that staff worked diligently to try to resuscitate Mr Veale over a prolonged period and that the prisoner's perception that staff were not treating the situation seriously was not supported by visual footage of the incident. Although there was some nervous laughter at times, we are satisfied that this was due to the tension of the situation and that staff treated Mr Veale with respect throughout.

8. A disparity in the PPE between healthcare and prison staff administering CPR was evident in this case, but it has since been addressed by the prison.

Recommendation

- The Governor and Head of Healthcare should review the training of prison staff in the use of defibrillators and the maintenance protocols, and provide assurance to the Ombudsman that they are satisfied that these are adequate.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded, and the issue they raised is discussed in this report.

10. The investigator obtained copies of the relevant extracts from Mr Veale's medical and prison records.

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

12. The investigator and clinical reviewer jointly interviewed four members of staff in March 2021. The interviews were conducted by telephone due to the restrictions in place during the COVID-19 pandemic.

13. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Veale's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Veale's son did not respond to our letter.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Background Information

HMP Littlehey

16. HMP Littlehey is a medium security prison housing approximately 1,200 men. A high proportion of the prison's population are men who have been convicted of sexual offences. There is a substantial elderly population and nearly half of the prisoners are aged over 50.

17. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons (HMIP)

18. The most recent inspection of HMP Littlehey was in August 2019. Inspectors reported that healthcare provided prompt access to a range of primary care clinics, and referrals to secondary care were well managed. They said that the patient records that they sampled were informative and demonstrated patients' involvement in their care. The records also demonstrated good care plans for long-term conditions. They said there was good health promotion at the prison.

19. Inspectors also carried out a scrutiny visit of HMP Littlehey in June 2020, focussing on key issues for prisoners during the COVID-19 pandemic. Inspectors reported that Littlehey had been declared an official COVID-19 outbreak site in March 2020 and that the prison, in conjunction with Public Health England (PHE), took swift action to control the spread of the virus. They found a strong emphasis on shielding for vulnerable men in the prison

Independent Monitoring Board

20. 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 2020, the IMB emphasised the positive and safe environment in the prison, but drew attention to the inappropriateness of the location of the healthcare centre on a first floor given the large number of elderly prisoners with mobility issues.

Previous deaths at HMP Littlehey

21. Mr Veale was the 22nd person to die at Littlehey since January 2019. Of the previous deaths, all were from natural causes, except one, which was self-inflicted. One of our recent reports, raised concerns about staff PPE during resuscitation, a matter which also arose in this investigation.

Key Events

22. On 26 February 2016, Mr Donald Veale was sentenced to 20 years in prison for sexual offences. On 3 May 2019, he was sent to HMP Littlehey.

23. Shortly after he arrived at Littlehey, Mr Veale said that he was a bit wheezy. Staff thought he had developed mild late onset asthma and gave him an inhaler. Mr Veale had steadily been increasing in weight since 2016, and by the time he arrived at Littlehey, he had just slipped into the obese category. However, Mr Veale appeared healthy for his age and he had very few healthcare issues while at the prison.

24. In September, a prison GP saw Mr Veale as he was still wheezy at times. The GP considered whether there could be any heart issues, but without any additional symptoms or history of heart disease, they considered no further tests were necessary at that time.

25. There were no further issues until 19 January 2021, when Mr Veale rang his cell bell, complaining of pains to the centre of his chest that felt like bad indigestion. Wing staff arranged for him to go to the healthcare unit where staff assessed him and performed an electrocardiogram (ECG – a test that checks the heart's rhythm and electrical activity). A GP reviewed the results and although there were some slight abnormalities in the readings, they appeared to relate to an older issue with the heart rather than a recent one. The GP gave Mr Veale indigestion medication and advised him to contact healthcare staff if he had any further problems.

26. On 21 January, a different GP reviewed Mr Veale, and both he and Mr Veale thought indigestion was the issue. The GP again advised Mr Veale to contact healthcare staff if he had further problems.

Events of 24 January

27. On 24 January, in a phone call to his son at 9.00am, Mr Veale said he felt fine apart from a bit of indigestion. Mr Veale was locked up at midday after lunch and he did not raise any concerns. At 4.10pm, just before the evening meal, an officer found Mr Veale collapsed on the floor of his cell. He immediately called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance).

28. There was a prompt response from other officers, and they took Mr Veale out onto the wing landing where there was more room, and began cardiopulmonary resuscitation (CPR).

29. At 4.19pm a nurse arrived and was followed very shortly afterwards by another nurse. Prison and healthcare staff worked together continuously giving CPR until the ambulance paramedics arrived at 16.45pm. They continued CPR for about another 20 minutes but, unfortunately, it was unsuccessful. During the whole resuscitation attempt, there was no defibrillator advice to shock Mr Veale. A paramedic declared his death at 5.15pm.

Contact with Mr Veale's next of kin

30. The prison appointed an officer as the family liaison officer. He managed to contact one of Mr Veale's sons later that day, who told him that Mr Veale's other son in Belgium would be the official next of kin. Mr Veale's son asked him to wait until the next day so he could talk to his brother first. As agreed, the officer contacted him the following day, and continued to correspond with him through telephone and email after that about arrangements following his father's death.

31. The prison made the arrangements for Mr Veale's funeral and contributed financially in line with national guidance.

Support for prisoners and staff

32. After Mr Veale's death, a Custodial Manager (CM) carried out a hot debrief for the staff who had been present and compiled a list of those involved for the Care Team to give follow up support.

33. The prison posted notices to staff and prisoners informing them of Mr Veale's death, and offering support.

Post-mortem report

34. The post-mortem report gave the cause of death as ruptured acute myocardial infarction (a heart attack with associated splitting of some of the structures of the heart), due to circumflex artery thrombosis (a blockage to one of the heart's arteries), and severe coronary artery atherosclerosis (a significant narrowing of the arteries restricting blood supply to the heart).

Findings

Clinical care

35. The clinical reviewer considered that overall, the care Mr Veale received at Littlehey was good and was equivalent to that he could have expected to receive in the community. She had no concerns about the care he received and made no recommendations.

Maintenance of the wing defibrillators

36. Each wing at Littlehey has a defibrillator for use in emergencies. When Mr Veale was found collapsed on 24 January, the I Wing defibrillator was quickly brought to the scene. In his post incident statement, a CM said that this defibrillator was not working, so he ordered one to be brought from J Wing. At interview, a Supervising Officer (SO) said that they were not sure if the original defibrillator was working as it did not sound right. In a written reply to further questions about this, Littlehey told the investigator that the SO had said that because the original defibrillator had not advised to shock, they had wanted to try another one.

37. No subsequent fault on the original defibrillator was reported, and the investigator was also told by Littlehey that the wing defibrillators are checked once a month and if there had been a fault it would have been reported. The logs of the monthly defibrillator checks do not show any faults with the defibrillator on I Wing, but the check for December 2020 records a battery expiry date of April 2019, and that the defibrillators on the other wings had a variety of battery expiry dates. The battery expiry dates were not filled in for the checks in January and February 2021, but the check for March shows that all the batteries had an expiry date of October 2021. It is surprising that the batteries would all be replaced (some in December were showing an expiry date of 2025) with such short life batteries. The manufacturer for the I Wing defibrillator says their batteries have a standby life of five years, and actual life will, of course, depend on usage. They recommend weekly checks.

38. In its guidance on automatic external defibrillators (AEDs), the Resuscitation Council UK says all current AEDs perform regular self-checks and issue warnings (one of these is reported on the Littlehey monthly wing checks for December 2020 for a different wing from Mr Veale's), and recommends that defibrillators should be checked regularly for warnings, but does not specify an interval. The Head of Healthcare said at interview that the healthcare defibrillators are checked weekly.

39. The building layout at Littlehey means that if necessary, a defibrillator can be obtained quickly from another wing. This was the case on 24 January, and video footage shows that a replacement was in position within a minute and a half of being asked for. The replacement defibrillator was from a different manufacturer. It did not advise a shock at any time.

40. There is no suggestion that the doubts about the defibrillator on I Wing played any part in the outcome for Mr Veale. However, it is important that all staff have confidence in life saving equipment and that inspection checks of that equipment are rigorously carried out. We recommend:

The Governor and Head of Healthcare should review the training of prison staff in the use of defibrillators and the maintenance protocols, and provide assurance to the Ombudsman that they are satisfied that these are adequate.

Complaint raised by a prisoner

41. A prisoner wrote to the PPO and complained that during the resuscitation attempts, staff failed to hide their amusement and that their laughter displayed contempt and lack of dignity for Mr Veale.

42. There was extensive video footage of the attempt to revive Mr Veale, which the investigator has viewed. The video showed that staff attempted diligently over a long period of time to resuscitate Mr Veale. The footage also shows that on several occasions there was an element of laughter amongst those involved in the incident. When staff were asked about this at interview, they had no recall of any laughter and were a little shocked to be told there had been any.

43. It is quite clear from the video footage that there was no amusement about Mr Veale or his situation, and that the shallow laughter emanated from the tension of the situation and over slight mis-hearings of staff. However, without the visual information, it is easy to see how the situation could be misinterpreted from behind a cell door, especially with the stress of hearing a prolonged resuscitation attempt over a period of about an hour. We are satisfied that all staff treated Mr Veale with respect during the resuscitation and we make no recommendation.

Use of PPE during resuscitation

44. It was evident from the video footage of the resuscitation attempt, that there was a significant difference in the PPE used by healthcare and wing staff. The wing staff used face masks and gloves and were well directed by a SO in their compliance in using face visors before engaging in CPR. However, when healthcare staff attended, wing staff helped them to put on more comprehensive body cover.

45. Conducting chest compressions as part of CPR is an aerosol generating event, which in the case of someone infected with COVID-19, would potentially endanger someone carrying out resuscitation if they were not adequately protected.

46. Since Mr Veale's death, the sufficiency of protection of staff during CPR has been responded to by Littlehey following a PPO investigation into an earlier death. Littlehey have assured the PPO that operating procedure version 6, which describes PPE for staff involved in CPR, is now adhered to and that the correct PPE is available. Therefore, we make no further recommendation.

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