Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Philip Eldridge, a prisoner at HMP The Verne, on 2 August 2024

A report by the Prisons and Probation Ombudsman

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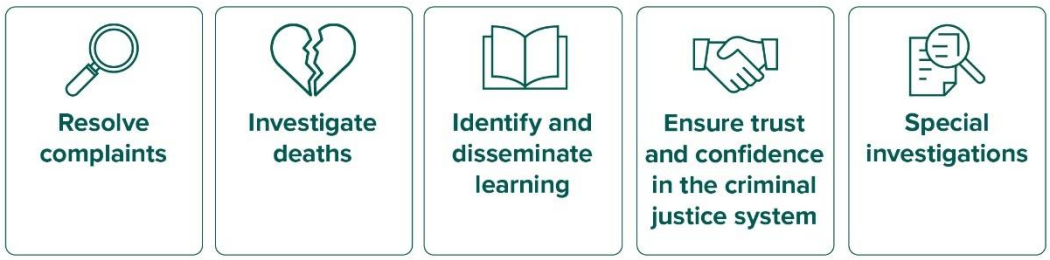
OUR VISION

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

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In 2018, Mr Philip Eldridge was sentenced to seven years imprisonment for sexual offences. He died on 2 August 2024, while a prisoner at HMP The Verne. The cause of his death was a pulmonary thromboembolism (with severe obesity and sepsis due to left leg cellulitis cited as underlying causes). He was 58 years old. We offer our condolences to Mr Eldridge's family and friends.

4. The Ombudsman's office wrote to Mr Eldridge's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Eldridge's clinical care at HMP The Verne. The clinical reviewer's report was attached as Annex 1.

6. The PPO investigator investigated the non-clinical issues relating to Mr Eldridge's care. We did not find any non-clinical issues of concern.

7. The clinical reviewer concluded that the clinical care Mr Eldridge received at The Verne was partially equivalent to that which he could have expected to receive in the community. She found that his wound care was inconsistent and not in line with national recommendations on managing leg ulcers. The wound care plan lacked detail and was not reviewed after it was implemented; and when it became evident that the wound was not healing, there should have been a full vascular assessment, as well as a timelier referral to the Tissue Viability Nurse for more specialised advice.

8. The clinical reviewer made recommendations not directly related to Mr Eldridge's death that the Head of Healthcare will wish to address. She also made the following recommendation, relevant to his clinical care, which we endorse and recast:

    - The Head of Healthcare should ensure that healthcare staff comply with the National Wound Care Strategy Programme on managing leg ulcers.

Head of Healthcare to note

9. There were delays in giving the ambulance service relevant clinical information about Mr Eldridge, as well as a miscommunication about requesting a suitable (bariatric) ambulance. The audio recording of the request makes it clear that the latter was attributable to a misunderstanding by the ambulance service. While we cannot say whether the delays impacted adversely on the outcome for Mr Eldridge

and his death the following day, the Head of Healthcare might wish to review the processes for providing clinical information in an emergency.

10. Mr Eldridge's next of kin received a copy of the initial report. She did not report any factual inaccuracies.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendation. A copy of the action plan is attached.

Inquest

12. At an inquest held on 29 October 2025, the coroner concluded that Mr Eldridge died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **January 2026**

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