Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Haldenby, a prisoner at HMP The Verne, on 29 January 2022

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. On 28 September 2017, Mr George Haldenby was convicted of arson and sentenced to eight years in prison. He died from congestive cardiac failure and hypertensive and ischaemic heart disease on 22 January 2022, while a prisoner at HMP The Verne. He was 56 years old. We offer our condolences to Mr Haldenby's family and friends.

4. The Ombudsman's office contacted Mr Haldenby's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked us about his prison and clinical care. We have answered her questions in the clinical review and in separate correspondence.

5. NHS England commissioned an independent clinical reviewer to review Mr Haldenby's clinical care at The Verne.

6. The clinical reviewer concluded that the clinical care Mr Haldenby received at The Verne was not equivalent to what he could have expected to receive in the community. Mr Haldenby had a diagnosis of ischaemic heart disease, heart disease and atrial fibrillation. There was a delay in referring him to a cardiologist and creating a long-term condition care plan. Mr Haldenby did not see a cardiologist before he died. Mr Haldenby had poor compliance with his prescribed medication, which contributed to the deterioration of his cardiac conditions. We make the following recommendations:

   - **The Head of Healthcare should ensure that prisoners with life limiting conditions have an advanced care plan in accordance with guidelines. This should be regularly reviewed and specific to the prisoner's needs.**

   - **The Head of Healthcare should ensure the process for referrals to secondary care is robust and regularly monitored.**

   - **The Head of Healthcare should ensure that the missed medication policy provides clear guidance to staff about action that must be taken when critical medication is missed.**

7. The clinical reviewer also made recommendations relating to other aspects of Mr Haldenby's care, which the Head of Healthcare will need to address.

   The investigator investigated the non-clinical issues relating to Mr Haldenby's care. We found no non-clinical issues of concern.

8. We shared the initial report with Mr Haldenby's family. The solicitor representing his daughter wrote to us and asked a question that does not impact on the factual

accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

9. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Inquest

10. At the inquest, which took place between 20 April and 13 May 2026, the Coroner concluded that Mr Haldenby died of natural causes. The Coroner commented that the effects of an act of self-harm in May 2020, in circumstances where Mr Haldenby did not adequate medication for his heart disease and exertion on the day of his death hastened Mr Haldenby's death.

Adrian Usher
Prisons and Probation Ombudsman **April 2025**

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