

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eric Heald, a prisoner at HMP/YOI Doncaster, on 28 June 2025

A report by the Prisons and Probation Ombudsman

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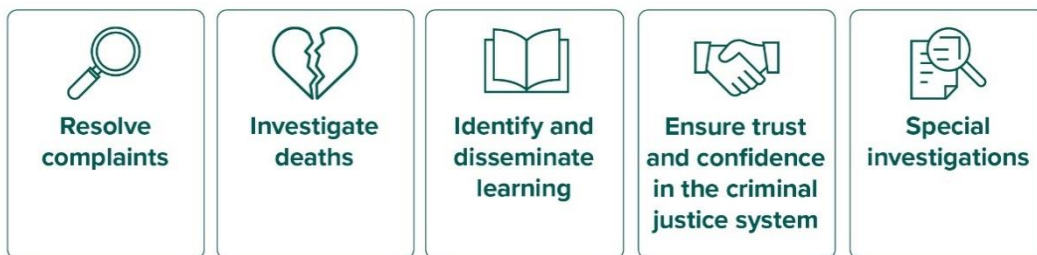
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OUR VISION

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



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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 June 2023, Mr Eric Heald was sentenced to 13 years in prison for sexual offences. He died of acute myocardial ischaemia (reduced blood flow to the heart) on 28 June 2025, at HMP Doncaster. He was 90 years old. We offer our condolences to Mr Heald's family and friends.
4. The Ombudsman's office wrote to Mr Heald's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had concerns about why they could not visit Mr Heald in the last few days prior to his death and asked for a copy of our report. We have addressed the next of kin's concerns in separate correspondence.
5. NHS England commissioned an independent clinical reviewer, to review Mr Heald's clinical care at HMP Doncaster.
6. The clinical reviewer concluded that the clinical care Mr Heald received at Doncaster was of a standard equivalent to what he could have expected to receive in the community. She found appropriate care planning was in place for Mr Heald's health conditions. Healthcare and social care staff reviewed him regularly, which resulted in continuity of care and effective relationships being formed. The clinical reviewer made one recommendation not related to Mr Heald's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Heald's care. We did not find any non-clinical issues of sufficient concern to require a recommendation.

Governor to note

8. Due to Mr Heald's health issues, he received informal support with everyday tasks from another prisoner on the same wing.
9. Mr Heald's next of kin raised concerns with the allocated Family Liaison Officer (FLO), that they had received updates on Mr Heald's condition from the other prisoner and not from prison staff. The FLO raised her concerns with the Head of Safety, however she assured us that in her 15 years' experience as the FLO, this had never happened before. We are satisfied that this is not a systemic issue, but the Governor will want to reflect on the learning.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

11. Mr Heald's family received a copy of the initial report. They did not make any comments.

Adrian Usher
Prisons and Probation Ombudsman

January 2026

Inquest

At the inquest held on 19 March 2026, the coroner concluded Mr Heald died of natural causes.



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