Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nicholas Halling, a prisoner at HMP Gartree, on 29 July 2025

A report by the Prisons and Probation Ombudsman

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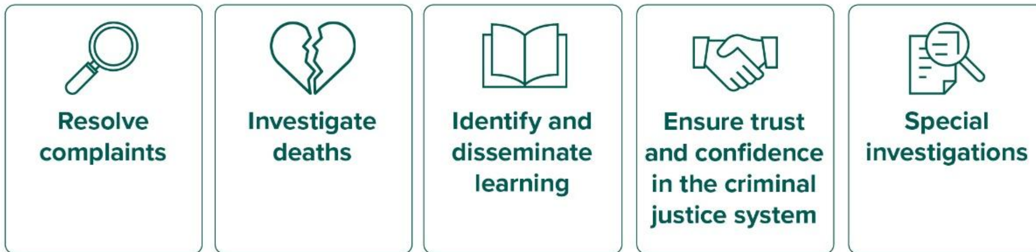
OUR VISION

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

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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. On 20 April 2006, Mr Nicholas Halling was convicted of murder and sentenced to life imprisonment. He was sent to HMP Bedford, and later to HMP Wakefield.

4. On 6 September 2022, Mr Halling was transferred to HMP Gartree.

5. Mr Halling died of myocardial infarction (heart attack) caused by ischaemic heart disease (reduced blood supply to heart) on 29 July 2025, at Gartree. He was 55 years old. We offer our condolences to Mr Halling's family and friends.

6. The Ombudsman's office wrote to Mr Halling's family to explain the investigation and to ask if they had any matters they wanted us to consider. They had no issues but asked for a copy of our report.

7. We also shared the initial report with Mr Halling's family. They did not make any comments.

8. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. NHSE (Midlands) pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

9. NHS England commissioned an independent clinical reviewer to review Mr Halling's clinical care at Gartree. The clinical reviewer's report was attached as Annex 1.

10. The clinical reviewer concluded that the clinical care Mr Halling received at Gartree was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She made seven recommendations, not related to Mr Halling's death, that the Head of Healthcare will wish to address.

11. The PPO investigator investigated the non-clinical issues relating to Mr Halling's care.

12. We did not find any non-clinical issues of concern. We make no recommendations.

Inquest

13. The inquest into Mr Halling's death concluded on the 29 December 2025. The coroner confirmed that Mr Halling died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

April 2026

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