NHS England

Ms. Rachael Clare Griffin
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NHS England
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[redacted]

13th July 2026

Dear Ms. Griffin,

Re: Regulation 28 Report to Prevent Future Deaths - George Edward James Haldenby who died on 29th January 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21st May 2026 concerning the death of George Edward James Haldenby on 29th January 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to George's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about George's care have been listened to and reflected upon.

Your Report raises concerns the following concerns:

1. There is a lack of regular refresher first aid and CPR training for Prison Staff after their induction training.
2. There is a lack of a process in place for patients to receive hospital prescribed medications in prisons out of hours, particularly over weekends and bank holiday periods.

1. Lack of refresher training

The issue of training for prison officers is the responsibility of HM Prison and Probation Service, so NHS England is unable to answer this concern. We note that the Coroner has also addressed the Report to the Minister for Prisons, Probation and Reducing Reoffending, who will be best placed to answer this.

2. Out of hours healthcare in prisons

The national health and justice service specification details core service delivery and standards that providers are expected to prioritise which, in the primary care specification, includes out of hours (OOH) action in establishments without 24-hour healthcare. Not all prisons provide 24-hour healthcare. Delivery against this specification is usually managed locally under contract management.

HMP The Verne is a category C establishment which is defined as a training and resettlement prison. As such the healthcare services available should mirror those provided in the wider community, but delivered within a secure custodial environment In the event of there being serious concerns about an individual's health, it is expected that a 999 call is made to request an ambulance in the same way an ambulance would be called for a person in their own home; this is described as 'urgent referrals'.

Under the pharmacy and medicines optimisation section of the specification, it sets out that the provider is required to arrange and use a process for the dispensing of urgent medication from local pharmacies, or other urgent care or OOH primary care services, outside of core hours (including public holidays). This should be available on request although pick up/delivery of the medicines must be arranged by the prison teams.

All national health and justice service specifications are under review at present and it is expected this review will be completed by Autumn 2026.

Of note, the healthcare provider has changed at HMP The Verne since George's death.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of George, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director
NHS England