Oxleas
NHS Foundation Trust

Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG

8th June 2026

[redacted]

Private & Confidential

Senior Coroner Rachael Griffin
The Coroner's Office for the County of Dorset,
Civic Centre,
Bourne Avenue,
Bournemouth
BH2 6DY

Dear Ms Griffin

Regulation 28 Report to Prevent Future Deaths - Inquest touching the death of Mr George Edward James Haldenby.

Thank you for your regulation 28 report to prevent future deaths dated 2l5t May 2026 following the inquest into the death of Mr George Edward James Haldenby, which concluded on 13th May 2026.

In advance of responding to the specific concerns raised in your report, I would like to express my deep condolences to Mr George Edward James Haldenby's family and loved ones. Oxleas NHS Trust is keen to assure the family and the coroner that the concerns raised about Mr George Edward James Haldenby's care have been listened to and acted upon. I appreciate that responses to Coroner Reports may constitute an important part of process through which family and friends come to terms with the passing of their loved one, and that this will have been an incredibly difficult time for them.

In your letter you raised matters of National Concern:

1. The lack of regular refresher first aid and CPR training that Prison Staff receive after their induction training.

2. The lack of process in place in prisons without 24 hour healthcare provision to ensure hospital prescribed medication is available when prescribed out of working hours especially over weekends and bank holiday periods.

And matters of local concern for HMP The Verne

(3) The lack of local policy or process so that the prison and healthcare staff understand how to deal with the situation arising at 2 above to ensure a prisoner receives necessary medications without delay.

Following a review of these concerns, we can confirm that a formal process has been in place across the Southwest region since September 2024 through the implementation of the Southwest Out of Hours Standard Operating Procedure (SOP)- (Appendices 1). This SOP was circulated to all relevant healthcare teams upon implementation and remains accessible through the organisational document management systems, including the Ox and the SystmOne Pharmacy Document Library.

The SOP provides clear guidance to healthcare teams regarding the management of medicines required outside normal operating hours, including arrangements for sourcing and obtaining prescribed medications during evenings, weekends, and bank holidays. The issues identified within the Prevention of Future Deaths report are therefore addressed within the existing governance framework and operational guidance.

Upon reflection of the coroner's investigation, it is recognised that the Southwest Out of Hours SOP was not requested or submitted as part of the evidence considered during the investigation process. Had this documentation been provided, it may have assisted in demonstrating the existence of established governance arrangements and operational procedures relevant to the concerns raised.

In response to the learning identified through this process, we will strengthen governance arrangements by ensuring that, following any Death in Custody (DIC) investigation where additional evidence is requested, or where medicines management issues are identified, Regional Pharmacists or the Head of Medicines Management are consulted directly. This will help ensure that all relevant SOPs, policies, and supporting governance documentation are identified and submitted as part of future investigations.

In addition, this incident has provided an opportunity to further reinforce awareness of existing medicines management policies and SOPs. The Southwest Out of Hours SOP and associated guidance will be recirculated to all healthcare teams, and ongoing training sessions will continue to reinforce staff understanding and compliance. The Medicines Management SOP Log will also be redistributed to all Heads of Healthcare to improve visibility of current medicines-related procedures, alongside signposting staff to the centrally maintained document repository where the most up-to-date versions are held.

Whilst these SOPs and policies are developed and maintained centrally, responsibility for local implementation rests with Heads of Healthcare, supported by local Medicines Management teams. They are responsible for ensuring that all relevant staff are familiar with, acknowledge, and adhere to the requirements set out within the SOPs and associated policies. Compliance is monitored through established governance processes, and where individuals are identified as persistently deviating from approved procedures, they will be supported and managed in accordance with the Trust's capability and performance management policies. This may

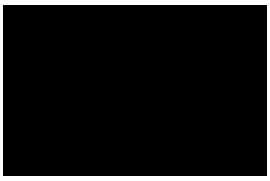
include additional training, supervision, monitoring, and, where necessary, formal capability procedures.

We are therefore satisfied that appropriate policies and procedures are in place to support the timely provision of clinically necessary medication outside normal working hours and have taken further steps to strengthen awareness, oversight, and assurance regarding their implementation across all sites.

I hope that this letter reassures you that Oxleas has been highly attentive to the findings of your investigation, and that concerted action has been taken on all the areas you identified to prevent any similar future deaths.

Please do not hesitate to contact me if any clarification or further assurance is required.

Yours sincerely,



Chief Executive