REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
2.	**DATE OF REPORT** 21st May 2026
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**THIS REPORT IS BEING SENT TO** 1. Minister of State for Prisons, Probation and Reducing Reoffending 2. Minister of State for Health and Social Care 3. Governor of HMP The Verne 4. Chief Executive of Oxleas NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th July 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** **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. **Matters of local concern at HMP the Verne** 3. The lack of local policy or process so that the prison and healthcare staff have an understanding of how to deal with the situation arising at 2 above to ensure a prisoner receives necessary medications without delay.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 7th February 2022, I commenced an investigation into the death of George Edward James Haldenby, aged 56 years born on 24th March 1965. The Inquest concluded before a jury on the 13th May 2026. The medical cause of death was: Ia Congestive Cardiac Failure Ib Hypertensive and Ischaemic Heart Disease How, when and where George came by his death was recorded by the jury as: George Edward James Haldenby died on 29th of January 2022 at Dorset County Hospital, Dorset, following a collapse at HMP the Verne. The impact of George's medication regime and the impact of George's move from Wing B2 to the Care and Separation Unit (CSU) on 29th January 2022, these probably caused or contributed more than minimally to his death. The following three matters cannot be said to be causal or contributory in George's death but are recorded for completeness. 1. George was located in a cell which was not in a flat location 2. George was not under secondary care for his cardiac health whilst at HMP the Verne and follow up referrals to cardiology and social care were not made

	3. Primary survey following George's collapse was not completed The conclusion recorded by the jury was a narrative conclusion as follows: George Edward James Haldenby died as a consequence of a combination of naturally occurring disease and the effects of an act of self harm in March 2020, in circumstances where George did not have adequate medication for his heart disease and he experienced exertion on the day of his death which hastened his death.
8.	**CIRCUMSTANCES OF DEATH** George was a serving prisoner at HMP The Verne having arrived there on the 18th May 2021. Following an incident of self harm in March 2020 he developed severe heart failure on an already pre existing background of ischaemic heart disease. He was prescribed various medications to manage his heart disease, however there had been a history of varied compliance. Between the 10th January and the 26th January 2022 George was not prescribed his Furosemide mediation by the prison healthcare. On Friday 21st January 2022 George was taken to Dorset County Hospital, Dorchester having presented to the prison GP with deteriorating heart failure. Following assessment at the hospital his diuretic mediation, Furosemide, was increased from 20mg a day to 80mg a day. This was prescribed by the hospital after 6pm on a FP10 form. The hospital pharmacy closes at 6pm on a Friday and so it could not be dispensed to take back to the prison as "To Take Out" (TTO) medication. The prescription was therefore taken back to the Prison. The healthcare team at the prison, at the time operated between 7.30am to 6pm daily, however on weekends and bank holidays the team was only staffed by 2 nursing staff and 2 support workers. The GP working hours at the prison were, and still are, Monday to Friday. The prescription from the hospital was not actioned until the next GP review on Wednesday 26th January 2022 and the medication was taken by George at the increased dose on Thursday 27th January and Friday 28th January 2022. On the evening of the 28th January 2022 George defecated in his cell, Cell 23 on Wing B2. On the morning of the 29th January 2022 a decision was made to move him to the Care and Separation Unit (CSU) so he could be showered and an assessment of him take place. This move was assisted by a number of prison officers. George struggled to move to the CSU and just after he arrived in the shower area he collapsed. Healthcare staff, who were at that time on the CSU, were called for and attended. They undertook a visual check of George and believed he was faking the collapse. They instructed the officers to sit him up and they left the shower room.

	Once sat up the officers were concerned and so placed George in the recovery position. They could not feel a pulse or identify George breathing and so healthcare were requested again and when they arrived a code blue emergency call was made and CPR commenced. This was approximately 9 minutes after George first collapsed. He was taken to Dorset County Hospital where he died that day. Evidence was given by the Home Office Registered Forensic Pathologist, the treating doctor who issued the prescription at the hospital and a Consultant Cardiologist that lack of medication played a part in George's death.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: After prison officers and prison staff carry out their induction training which covers basic first aid training including the delivery of cardio pulmonary resuscitation (CPR), there is no further mandatory refresher training on first aid or CPR. During the evidence, a Custodial Manager at HMP the Verne stated that the last time he had first aid or CPR training was in 1991, 35 years ago, when he started as a prison officer. Whilst there is a requirement to have a duty first aider on site 24 hours a day, without all staff being suitably and regularly trained in signs of collapse and administering CPR, there could be a delay in delivering effective CPR as it may take time for the duty first aider to get to the prisoner, and a future death could occur. In prisons without 24 hour healthcare provision, if a prisoner receives treatment at a hospital and is issued with a medication prescription on a FP10 form, this cannot be processed at the prison in the absence of a doctor or prescribing nurse, and pharmacies in hospitals are not always open 24 hours a day for it to be dispensed as TTO medication. This means there will be a delay in prisoners receiving necessary and lifesaving medication over a weekend or bank holiday period until staff are in the prison who can action the prescription. Whilst at HMP The Verne there is now a duty Doctor who can be called upon out of hours to progress such prescriptions, there is a lack of local policy or process to ensure the prison and healthcare staff have an understanding of how to deal with the situation should a FP10 be issued outside of hours when a prescribing health professional is not available in the prison to ensure a prisoner receives necessary medications without delay. Although critical medications are held at the prison in a locked cabinet, not all medication are included and Furosemide, which was critical in George's care, is one of those that is not held by the prison as a critical medicine.
10.	**COPIES AND PUBLICATION OF THIS REPORT**

	I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. George's family 2. Practice Plus Group 3. Dorset County Hospital 4. NHS England 5. Prison and Probation Ombudsman 6. Governor of HMP Guys Marsh 7. Governor of HMP Portland I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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