Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Stephen Baddeley, a prisoner at HMP Lindholme, on 4 August

## A report by the Prisons and Probation Ombudsman

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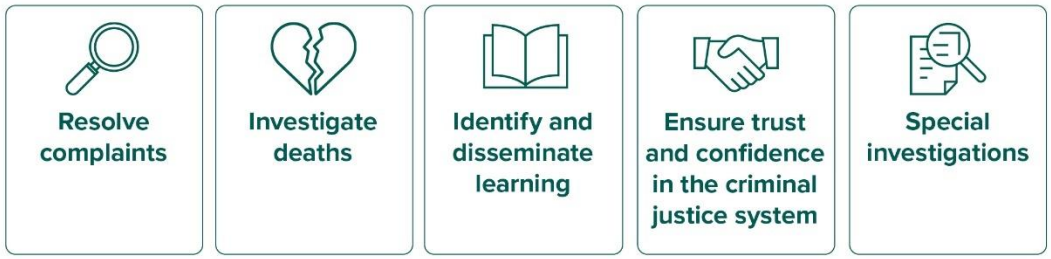
## OUR VISION

**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

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.

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.

Mr Stephen Baddeley died from a heart attack on 4 August 2024, in his cell at HMP Lindholme. This was triggered by the large amount of cocaine he had taken. He was 35 years old. I offer my condolences to Mr Baddeley's family and friends.

We did not find any evidence that Mr Baddeley intended to take his life. He had a history of substance misuse for which staff offered him appropriate support. Although it is a concern that he obtained drugs while at Lindholme, the prison is taking active steps to try to reduce drug supply and demand.

The night before Mr Baddeley died, staff falsified the record to indicate that they had completed the evening routine check when they had not. Furthermore, staff failed to check Mr Baddeley when they unlocked him the next morning, leaving a prisoner to find him unresponsive a short time later. The Governor has already taken action to address these issues.

The clinical reviewer concluded that the healthcare Mr Baddeley received was equivalent to that he would have received in the community.

This version of my report

, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Adrian Usher**
**Prisons and Probation Ombudsman** **April 2025**

# Contents

# Summary

## Events

1. In April 2022, Mr Stephen Baddeley was remanded to HMP Leeds, charged with assault, damage to property and driving offences. This was not his first time in prison. He had a history of attempted suicide and self-harm, substance misuse and had attention deficit hyperactivity disorder (ADHD).

2. At Leeds, Mr Baddeley was under the care of the mental health team and was diagnosed with psychosis with emotionally unstable personality disorder. He was prescribed antidepressant and antipsychotic medication.

3. Mr Baddeley transferred to HMP Lindholme on 23 November 2022. He settled into prison and remained under the care of the mental healthcare team.

4. From February 2023 onwards, Mr Baddeley struggled to attend work, citing his mental health as the reason. He had a history of anxiety that affected his ability to associate in groups and he often felt that people were talking about him. A psychiatrist saw Mr Baddeley and made a change to his antipsychotic medication.

5. Mr Baddeley tested negative following random drug tests completed on 2 January, 15 May and 10 July. In December, staff suspected that Mr Baddeley was under the influence of drugs. Mr Baddeley denied this and attributed his behaviour to not taking his antipsychotic medication. He subsequently restarted his medication.

6. During 2024, Mr Baddeley's attendance at work was sporadic and he also failed to engage with the mental health team. In May, he referred himself to the substance misuse team stating that he used cannabis daily. However, he subsequently said this was not true and failed to attend substance misuse appointments.

7. On 3 August, staff did not do the evening routine check but falsified the record to indicate they had. On 4 August, staff noted that they saw Mr Baddeley moving when they checked him at about 5.30am. At 9.08am, an officer unlocked prisoners including Mr Baddeley. She did not check Mr Baddeley when she did so.

8. At 9.24am, a prisoner went to visit Mr Baddeley in his cell. He found Mr Baddeley unconscious lying behind his cell door. Another prisoner alerted staff immediately. Staff responded and called an emergency code at 9.28am. Prison and healthcare staff provided emergency care. Staff removed a wrap of cling film, tied with a knot, from Mr Baddeley's mouth. Paramedics arrived and pronounced life extinct at 10.07am.

9. The post-mortem found that Mr Baddeley had taken a large amount of cocaine and the cling film in his mouth tested positive for a metabolite of cocaine. The pathologist concluded that taking cocaine had triggered Mr Baddeley to have a heart attack. He also had ketamine in his system.

## Findings

10. Mr Baddeley had a history of substance misuse. However, there was little evidence of him using drugs in 2024. We found that he was offered appropriate substance misuse support. Lindholme are taking appropriate steps to try to tackle drugs coming into the prison.

11. In the days before he died, Mr Baddeley did not collect his meals or medication. Staff should have recorded this and spoken to Mr Baddeley about it. More generally, healthcare staff also did not plan how to address Mr Baddeley's non-compliance with his medication. However, despite this, the clinical reviewer found that Mr Baddeley's clinical care was of a good standard and equivalent to what he would have received in the community.

12. Staff did not check Mr Baddeley in the evening of 3 August but falsified the record to indicate that they had. Staff also failed to check Mr Baddeley when they unlocked him the next morning or remove the obstruction from his observation panel.

## Recommendations

- The Head of Healthcare should ensure that when prisoners do not attend for their medications on a number of occasions, a plan is documented within their SystmOne medical records to ensure a multi-disciplinary approach is taken when reviewing their care.

# The Investigation Process

13. HMPPS informed us of Mr Baddeley's death on 5 August 2024. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Baddeley's prison and medical records, CCTV footage, phone records and body worn video camera (BWVC) footage. He also obtained the Northwest Ambulance Service records.

15. The investigator interviewed three prisoners and ten members of staff at Lindholme in September 2024.

16. NHS England commissioned a clinical reviewer to review Mr Baddeley's clinical care at the prison. She and the investigator jointly interviewed staff.

17. We informed HM Coroner for South Yorkshire East District of our investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Baddeley's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Baddeley's stepfather asked the investigation to provide further details about the emergency response when Mr Baddeley was found unconscious in his cell, including details of the plastic bag (cling film) that was in his mouth. His family wanted to know why Mr Baddeley had cuts on both his hands, elbows and his forehead. These questions are answered in our report.

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

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

# Background Information

## HMP Lindholme

21. HMP Lindholme is a medium security prison near Doncaster. Practice Plus Group provides healthcare services, with healthcare staff on duty between 7.30am and 7.30pm every day.

## HM Inspectorate of Prisons

22. The most recent inspection of Lindholme was in July 2023. Inspectors noted that during the previous three years, the frequency of deaths had reduced. A consolidated action plan addressed PPO recommendations and key messages on emergency response were reinforced to all staff twice a year. They noted that night staff did not make sure that prisoners kept cell observation panels unblocked at night and were not adequately supported to do so by managers. The key working scheme was not well established. Only about a third of scheduled appointments were delivered and records showed that they rarely focused on progression goals.

23. Inspectors noted that illicit drugs were far too easily available in the prison, with cannabis and psychoactive substances identified as the drugs most commonly detected. It noted that Lindholme's site consisted of buildings spread over a large area with a very long fence line which was vulnerable to drones. Inspectors found that the increasing sophistication of drone technology was outstripping the prison's vigorous attempts to stop them.

## Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2024, the IMB reported that illegal drugs were problematic within the prison. It noted that most mental health referrals were dealt with on time, or within five days, and missed appointments were usually due to the prisoner not attending.

## Previous deaths at HMP Lindholme

25. Mr Baddeley was the fourth prisoner to die at Lindholme since August 2021. Of the previous deaths, one was self-inflicted and the remaining two were from natural causes. There are no significant similarities between our findings in the investigation into Mr Baddeley's death and our investigation findings about the previous deaths. To the end of January 2025, there have been no deaths at Lindholme since Mr Baddeley's.

## Incentives Scheme

26. Each prison has an incentives scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and

safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

# Key Events

27. Mr Stephen Baddeley was arrested and remanded to HMP Leeds on 13 April 2022, charged with assault (against his partner), damage to property and driving offences. This was not his first time in prison. Mr Baddeley had a history of attempted suicide and self-harm (he had used ligatures, cut himself and taken overdoses in the past) and substance misuse (including cannabis, cocaine and alcohol). He also had attention deficit hyperactivity disorder (ADHD – can involve restlessness, trouble concentrating or acting on impulse).

28. During his prison and healthcare reception screening, Mr Baddeley said he experienced poor mental health when he was unable to access his medication. Staff recorded that he had attempted suicide in 2021. Mr Baddeley said he had ADHD and schizophrenia (a condition often associated with hallucinations and delusions). He said that he had been prescribed antipsychotic medication in the community because he heard voices. A GP prescribed him omeprazole (for reflux), amitriptyline (a painkiller and to help him sleep), olanzapine (an antipsychotic) and atomoxetine (used to treat ADHD). Mr Baddeley said that he had not recently taken his ADHD medication. He had a history of drug misuse and admitted that he had used cocaine recently. However, Mr Baddeley refused the support of the prison's substance misuse team.

29. In May, staff found Mr Baddeley in possession of hooch (illicitly brewed alcohol). He was given a prison warning and downgraded from the standard to basic level of the incentive scheme for a set period. In July, staff found drug paraphernalia in Mr Baddeley's cell. He was given a prison warning, and again downgraded to the basic level of the incentive scheme.

30. In June, at Mr Baddeley's request, healthcare staff changed his antipsychotic medication from olanzapine to aripiprazole.

31. In August, staff monitored Mr Baddeley under suicide and self-harm procedures, known as ACCT, for a week, after he took an overdose of his prescribed medication that he had been stockpiling. Mr Baddeley said he had taken the overdose following a meeting with his solicitor, who had informed him that he might be given a lengthy prison sentence. He was no longer allowed to keep his medication in his possession. Healthcare staff changed his antipsychotic medication to quetiapine.

32. In October, Mr Baddeley was sentenced to four years in prison. Mr Baddeley remained under the care of the mental health team throughout his time at Leeds and was regularly reviewed by a psychiatrist. He was not always compliant with taking his medication and regularly reported having sleeping problems and hearing voices. In November, a psychiatrist diagnosed Mr Baddeley with psychosis with emotionally unstable personality disorder (EUPD – can cause extreme mood swings and make it difficult to maintain relationships) and confirmed his ADHD.

## HMP Lindholme

33. Mr Baddeley transferred to HMP Lindholme on the 23 November 2022. During his reception healthcare screening, Mr Baddeley told the nurse that he had a history of attempted suicide but gave no details about this. He said he had no current

thoughts of suicide or self-harm. Mr Baddeley declined to provide any details about his substance misuse history. Staff noted that Mr Baddeley was prescribed quetiapine and amitriptyline which they continued, he was no longer prescribed medication for ADHD. He had to attend the medication hatch to collect them, twice daily, in the morning and evening. The nurse referred Mr Baddeley to the mental health team.

34. Mr Baddeley settled into life at Lindholme. He was allocated a job and attended education classes. Staff who conducted key work sessions with Mr Baddeley reported no concerns, although he was known to not be at his best in the mornings, where his mood was described as “snappy”. He continued to take his medication.

## 2023

35. Mr Baddeley tested negative in a random drug test completed on 2 January 2023. On 30 January, Mr Baddeley attended a healthcare appointment. He told the nurse that he was coping well with his ADHD and did not need to be medicated for it. He requested that his amitriptyline dose was increased. Staff put Mr Baddeley on the waiting list to see the psychiatrist to discuss this.

36. From February onwards, staff noted that Mr Baddeley struggled to attend work, citing a bad hand and his mental health as the reason. He said he had anxiety and felt paranoid. He was issued with a sick note from healthcare staff several times (so that he had a legitimate reason not to attend work or education).

37. In April, a psychiatrist assessed Mr Baddeley. Mr Baddeley said that he was not sleeping well and was paranoid that others were talking about him. The psychiatrist changed his antipsychotic medication from quetiapine to olanzapine. He diagnosed Mr Baddeley with low grade psychosis and traits of EUPD. Mr Baddeley denied that he had any thoughts to harm himself or that he had used illicit substances. Mr Baddeley remained under the care of the mental health team.

38. Mr Baddeley tested negative in a random drug test completed on 15 May. Three days later, during a search of Mr Baddeley’s (and his cellmate’s) cell, staff found a small amount of white powder in a wrap of paper. This was tested and found to be 70% tramadol (a pain relief medication). No further information was recorded, or action taken.

39. In June, Mr Baddeley failed to attend work several times due to health issues, and while he said that he wanted to work, he struggled to put this into practice. His key worker noted that Mr Baddeley struggled to get up in the mornings. Mr Baddeley tested negative in a random drug test completed on 10 July 2023.

40. In August, staff referred Mr Baddeley to see the psychiatrist after he complained that he was not sleeping well, was struggling with his mental health and required a sick note. Staff later issued him a sick note and noted that he seemed more settled after this. At his key work session, Mr Baddeley said that he just wanted to keep his head down. In September, Mr Baddeley told his key worker that he struggled to get out of bed in the morning and had problems sleeping.

41. On 12 September, a psychiatrist reviewed Mr Baddeley. Mr Baddeley asked him what was wrong with him, and the psychiatrist told him that he had a combination of

long-standing personality difficulties that were contributing to his paranoia. The psychiatrist continued his olanzapine once daily and planned for Mr Baddeley to continue to work with the mental health team on his anxiety.

42. A week later, a member of the mental health team saw Mr Baddeley. They recorded that he would be allowed to keep his olanzapine medication in possession, something he was happy about. They planned to see Mr Baddeley again in three weeks' time.

43. By the end of September, wing staff noted that Mr Baddeley's mood had improved, and his mental health was a lot better. He had started a cleaning job in the laundry, which had a positive effect on him. In November, Mr Baddeley started a job as a wing painter. He told staff that he enjoyed this work as it made time pass quickly. By December, Mr Baddeley had moved up to the enhanced level of the incentives scheme because he had consistently demonstrated positive behaviour.

44. On 22 December, staff found Mr Baddeley on the wing landing unsteady on his feet. His speech was slurred, and he was shouting and gesturing as if he was attempting to provoke a fight. Staff believed he was under the influence of an illicit substance. Staff relocated Mr Baddeley to the segregation unit (prisoners are transferred there for significant behavioural issues, or if there are concerns for their or others safety).

45. While in the segregation unit, a nurse examined Mr Baddeley. Mr Baddeley denied that he had used illicit substances. He attributed his behaviour to not taking his antipsychotic medication. The nurse said that she would arrange for him to be reviewed by a psychiatrist. Due to his non-compliance with his medication, Mr Baddeley was no longer permitted to keep his olanzapine in his possession.

46. A substance misuse practitioner also saw Mr Baddeley. He again denied that he had used any illicit substances and said that he had not taken his olanzapine for some time. He said the medication was working its way out of his system and that this had brought on his feelings of psychosis. He refused the support of the substance misuse service.

47. Later that day, staff attempted to move Mr Baddeley to G Wing, a standard wing. However, he refused to move because he did not want to share a cell with another prisoner. He made threats to kill an officer and had to be restrained. Staff returned him to the segregation unit and reduced him to the basic level of incentives. Mr Baddeley restarted taking his medication by attending the medication hatch.

48. On 25 December, Mr Baddeley moved to a single cell on J Wing, a standard residential wing. On 29 December, a mental health nurse phoned Mr Baddeley on his in-cell phone, but he did not answer. She placed him on the ledger to be followed up.

**2024**

49. During the first six months of 2024, Mr Baddeley often asked not to attend work or missed work without permission. Sometimes he said he was waiting for a sick note from the mental health team so that he had permission not to work, sometimes he had a sick note and on other occasions he had been refused one. His incentives level therefore fluctuated between basic, standard and enhanced.

50. On 23 January, Mr Baddeley told a nurse that his mental health had declined because he had not taken his olanzapine. There is no record as to why he had stopped taking it. Mr Baddeley wanted to be reviewed by a psychiatrist and be provided with a month's sick note due to his mental health issues. The nurse noted that Mr Baddeley had become increasingly anxious and paranoid over the last week. Mr Baddeley agreed to restart taking his medication that day and was issued a sick note for one month (expiring 20 February).

51. On 8 February, a nurse called Mr Baddeley, but he did not answer. She contacted wing staff, who stated that they had had no concerns about him.

52. On 10 March, a nurse called Mr Baddeley to discuss his application for another a sick note. Mr Baddeley did not answer his phone. She put him on the ledger for this to be followed up. On 29 March, Mr Baddeley moved to K wing, a standard residential wing.

53. During his time at Lindholme, Mr Baddeley had complained of having lower back pain on several occasions and had pain medication. The healthcare team had referred him to hospital for an MRI (a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body). The MRI was completed on 4 April and the result was normal. He was advised to ask to see a physiotherapist.

54. On 2 May, a mental health nurse attempted to see Mr Baddeley, but this was not possible. On 13 May, Mr Baddeley submitted an electronic application to the mental healthcare team. He said that he was hearing voices and had sent a number of requests to be seen by the mental health team for an appointment and no one had come to see him. A member of the mental health team responded and told Mr Baddeley that they would see him soon. (We saw no evidence that Mr Baddeley had asked the mental health team to see him but note that healthcare staff logged that they had tried to see him on 17 April, when he was noted as not available, and 18 April when he failed to attend an appointment.)

55. On 17 May, Mr Baddeley referred himself to the substance misuse team. He noted in his referral that he wanted to be moved to a wing away from cannabis. The substance misuse team made an appointment for Mr Baddeley. Also on this day, Mr Baddeley failed to attend his physiotherapist appointment.

56. On 20 May, an officer saw Mr Baddeley for a key work session. He noted that Mr Baddeley engaged well. Mr Baddeley said that he was looking forward to an upcoming visit from his parents. He raised no concerns.

57. On 21 May, Mr Baddeley failed to attend his appointment with the substance misuse team. The next day, a substance misuse recovery worker saw Mr Baddeley. Mr Baddeley said that he wanted to move to L Wing, the drug recovery wing, and be substance free. He admitted that he used cannabis daily and wanted to stop. She advised Mr Baddeley that he would need to complete psychosocial work before they would consider this. She told us that she thought that Mr Baddeley had not been honest about his cannabis use and was trying to obtain a move to L wing because he claimed that he had a brother on this wing. (The prison had no knowledge of Mr Baddeley having a brother in the prison.)

58. On 5 June, a physiotherapist examined Mr Baddeley. He diagnosed him with mechanical back pain and provided him exercises to help this. The physiotherapist advised Mr Baddeley that if his symptoms did not improve, he would see him again.

59. On 6 June and 7 June, a registered nurse learning disability (RNLD) visited Mr Baddeley on the wing for a mental health appointment. Mr Baddeley was at work on both occasions. She rebooked his appointment.

60. On 10 June, the RNLD visited the wing and attempted to see Mr Baddeley. Mr Baddeley was in bed and said he was not feeling well, had an upset stomach and was not in the mood to speak to the nurse. She agreed to see Mr Baddeley at the end of the week. She again attempted to see Mr Baddeley on 12 June. Mr Baddeley told the nurse that he was not feeling well and was not fit to talk about his mental health. She agreed to see him in two days' time.

61. On 13 June, Mr Baddeley told a prison GP that he had been using illicitly obtained pregabalin (for neuropathic pain and epilepsy) for his pain. The GP told Mr Baddeley that he should not use this medication and prescribed him naproxen for his back pain. No other information was recorded, and staff did not submit an intelligence report.

62. On 14 June, Mr Baddeley told the RNLD that he felt his schizophrenia was not being managed well. He said he was hearing voices and seeing things through his television. He felt stressed and had received a number of behaviour warnings. She noted that these were transient episodes, whereby, one day Mr Baddeley felt okay, and the next, his mood was low, and he was unable to get out of bed for work. She referred Mr Baddeley to the psychiatrist to review his medication and his ADHD. She added Mr Baddeley to the mental health team's multi-disciplinary team (MDT) meeting for discussion.

63. On 21 June, Mr Baddeley did not attend his appointment with the substance misuse recovery worker because he was at work. She rescheduled his appointment for 27 June and sent the details of this to Mr Baddeley's prison issue laptop.

64. On 21 and 22 June, the pharmacy technician noted in Mr Baddeley's medical record that despite him being called several times to collect his morning medication, he did not attend the medication hatch. On 25 June, staff noted that Mr Baddeley did not attend work.

65. On 26 June, a prison GP reviewed Mr Baddeley. Mr Baddeley told the consultant that his paranoia had got worse, his mood was changeable (for no reason) and he felt that others were talking about him. He said he preferred to stay in his cell and not be around people and spent his time sleeping and watching television. He said he had no suicidal thoughts. Mr Baddeley said that he was concerned that he had received warnings for not attending work. The GP challenged Mr Baddeley about his use of cannabis. Mr Baddeley denied that he used cannabis regularly and said he had lied about this, to instigate a move to L wing. The GP reminded Mr Baddeley about the risks of taking illicit substances alongside his antipsychotic medication. He increased Mr Baddeley's olanzapine medication and referred him for a routine repeat electrocardiogram (ECG).

66. On the same day, at the MDT meeting, staff agreed that the RNLD would continue to assess Mr Baddeley's needs to address his ADHD, with a view to potentially recommencing his ADHD medication.

67. On 27 June, Mr Baddeley failed to attend his appointment with the substance misuse recovery worker. The appointment was rebooked for 16 July. Mr Baddeley did not attend work this day and the next day.

68. On 2 July, healthcare staff noted in Mr Baddeley's medical record that he had informed them that he no longer needed a sick note, as he now had a job on the wing. However, from 2 July – 8 July, an officer noted that Mr Baddeley had not attended work in the workshop, as he was not required.

69. On 10 July, prison records noted that Mr Baddeley was allocated a job in the servery on K Wing. On 16 July, Mr Baddeley again failed to attend his appointment with the substance misuse recovery worker. She sent a letter to Mr Baddeley regarding his non-attendance at his appointments and did not offer any further appointments at that time.

70. On 17 July, Mr Baddeley failed to attend a healthcare appointment that had been made for him, after he had complained of sickness, acid reflux, heartburn and stomach pains. Mr Baddeley's medical record showed that he had not attended the medication hatch to collect his medications, despite being called by the pharmacy team eight times at the end of June and in July. From 20 July onwards, Mr Baddeley collected his medication.

71. On 31 July, Mr Baddeley failed to attend his mental health appointment and his appointment for the ECG. Staff noted that his mental health medication annual review was due on 20 October, and his ECG would be conducted then.

72. On 1 August, the substance misuse recovery worker saw Mr Baddeley on the wing and asked him why he had missed his appointments. Mr Baddeley apologised and said that he had not seen the appointment messages on his laptop. He said that nothing had changed since his initial triage in May. She scheduled a further appointment to see Ms Baddeley on 6 August.

73. During the day on 2 August, staff raised no concerns about Mr Baddeley. That evening, around 5.03pm, an officer visited Mr Baddeley in his cell to check on his wellbeing, as he was aware that he had not collected his evening meal or medication. Mr Baddeley was sat watching television and said he was okay. He raised no concerns. That evening, the wing diary was left blank and there was no confirmation that the roll check had been completed.

74. A prisoner who lived in the cell next door to Mr Baddeley told us that he heard loud noises coming from Mr Baddeley's cell. He said it sounded like someone crying and smashing up the cell.

75. The following morning, 3 August, an officer unlocked the prisoners on the right side of K Wing. Immediately after this, the prisoner in the cell next door visited Mr Baddeley to check on his wellbeing. Mr Baddeley was laid on his bed, his cell appeared normal, it was clean and tidy with no apparent evidence of any destruction, as the prisoner had expected. Mr Baddeley said he was okay and

blamed the late-night noise on him repeatedly falling over. The prisoner said that Mr Baddeley had marks on his wrists, elbow, knees and feet.

76. Around 9.30am, Mr Baddeley collected his items purchased from the prison shop from his weekly canteen order. An officer gave the items to Mr Baddeley and had no concerns about him. Mr Baddeley returned to his cell.

77. When an officer completed the afternoon routine check of all prisoners at 12.16pm, he had no concerns about Mr Baddeley. While he was aware that Mr Baddeley had not collected his breakfast or lunch, he said it was not uncommon for many of the prisoners to make alternative meals in their cells.

78. Another prisoner told the investigator that he visited Mr Baddeley in his cell in the afternoon. They chatted and had a coffee together. He had no concerns about Mr Baddeley. At 2.03pm, Mr Baddeley phoned a female friend. Their conversation was general.

79. At 4.28pm, CCTV shows that Mr Baddeley left his cell, walked onto the wing landing and adjusted a towel that was hanging over the railing. He left his shoes outside his cell before going back into his cell and shutting the door. An officer completed the evening routine check of all prisoners. At 5.12pm, he checked Mr Baddeley and had no concerns.

80. In the evening, between 5.15pm and 5.25pm, Mr Baddeley made three phone calls to his partner and his sister. Their conversations were general and contained nothing of significance to the investigation.

81. At 7.30pm, an officer phoned the prison communication room to confirm that he had completed the evening routine check. However, he did not record this in the wing diary (which was left blank) and CCTV shows that he did not do the check.

82. At 9.04pm, an Operational Support Grade (OSG), checked that all prisoner cell doors were locked. He was not required to do a visual check of prisoners at that time.

83. At 11.40pm, Mr Baddeley phoned his sister. While their conversation was general, Mr Baddeley told his sister that he had taken an illicit substance that evening. His sister reiterated that taking “it” was not good for him and that he should get some help.

84. That night, a prisoner said he heard similar banging noises to the previous night, coming from Mr Baddeley’s cell.

## Events on 4 August

85. The investigator watched CCTV and body worn video camera (BWVC) footage. He also obtained information from the Yorkshire Ambulance Service. The following account has been taken from all sources.

86. Between 12.53am and 1.08am, the OSG responded to Mr Baddeley’s cell bell on four separate occasions. The first occasion occurred at 12.53am. Mr Baddeley said to the OSG, “I can see you”, after which he turned his back on the OSG and did not

speak. The OSG walked away from the cell. On the second occasion, at 12.57am, Mr Baddeley pressed his cell bell and asked for a toilet roll. The OSG gave this to him within a minute. Mr Baddeley was polite and raised no concerns. At 1.01am, Mr Baddeley pressed his cell bell and asked what time it was. The OSG responded and walked away. He returned to Mr Baddeley's cell at 1.03am, for less than a minute, although he could not recall the reason. The last time that Mr Baddeley pressed his cell bell was at 1.08am. He told the OSG that he had pressed the bell by mistake.

87. Around 5.30am, the OSG started the morning routine check. CCTV shows that he got to Mr Baddeley's cell at 5.34am. He spent over two minutes knocking on his door, and with the aid of his torch, looked through the gaps around the frame of cell door. He told us that it was difficult to see Mr Baddeley through the cell door observation panel because he had used a towel as a privacy screen which was hanging from the ceiling, covering the front of his bed, and therefore obscuring the view. He said that Mr Baddeley had not covered his observation panel at this point. By looking through the sides of the door, he was able to get a wider view and angle of Mr Baddeley's bed. He said that he saw movement from Mr Baddeley's leg and head.

88. The OSG finished his duty around 7.15am and handed over to Officer A. The officer conducted several checks on the wing but was not required to conduct a routine check of all prisoners. He did not check Mr Baddeley.

89. At 9.08am, an officer unlocked Mr Baddeley for exercise and to allow him to mix with other prisoners. Like other cells that she had unlocked before she arrived at Mr Baddeley's cell, she did not look through his observation panel or try to engage with him. She did not push the door open.

90. At 9.18am, a prisoner went to see Mr Baddeley in his cell. However, when he arrived, Mr Baddeley's cell door appeared as if it was locked. He pushed the door, but it did not open, and the observation panel was covered. He presumed that Mr Baddeley had already left his cell that morning after being unlocked. He went to have a shower. On his return to his cell, at 9.24am, he again checked to see whether Mr Baddeley was in his cell. On this occasion, he pushed Mr Baddeley's cell door harder to see if it would open. He noticed that it felt as if something was obstructing the door from fully opening. However, the door opened enough for him to see Mr Baddeley's foot and leg behind it and obstructing it from opening. He shouted to another prisoner, to alert staff.

91. The other prisoner alerted Officer A, who was on the exercise yard. He responded and arrived at Mr Baddeley's cell at 9.27am. He saw that Mr Baddeley's door was ajar and was being obstructed by what appeared to be Mr Baddeley's body, laid behind it. Mr Baddeley failed to respond when he called his name. The officer squeezed through the door opening. Mr Baddeley was unconscious. He immediately radioed a code blue emergency (used when a prisoner has stopped breathing or is having breathing difficulties). Control room staff immediately called an ambulance at 9.28am. Further prison staff responded, including a Senior Officer (SO), who arrived first, in approximately 30 seconds.

92. Officer A, assisted by the SO, moved Mr Baddeley from behind the cell door. He was cold to touch, and his arms were quite rigid. Mr Baddeley showed no signs of

life and so the officer started cardiopulmonary resuscitation (CPR), and alternated this with the SO.

93. At 9.29am, nursing staff arrived. They examined Mr Baddeley and found his jaw was stiff and there was some form of liquid secretion, possibly blood, coming from his mouth. On checking his airway, they found that he had a wrap of cling film, tied with a knot, in his mouth. They removed this and the nurses used medical equipment to manage Mr Baddeley's care while prison staff continued CPR. Further healthcare and prison staff arrived and assisted.

94. The paramedics arrived at 9.43am and took over Mr Baddeley's care. At 10.07am, they pronounced life extinct.

## Contact with Mr Baddeley's family

95. The prison appointed a family liaison officer. At around 1.45pm, the Governor and a prison manager visited Mr Baddeley's sister's house in Leeds, as she was recorded as his next of kin. Mr Baddeley's sister was not in, and they rang her and left a message asking her to contact the prison. Soon after, Mr Baddeley's sister returned the phone call. At her request, she was informed of the news of Mr Baddeley's death over the phone and asked that the prison visit her the following day. Mr Baddeley's stepfather later contacted the prison and staff provided him with further details surrounding Mr Baddeley's death. Lindholme contributed to funeral costs in line with national instructions.

## Support for prisoners and staff

96. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. This included a hot debrief, chaired by a prison manager, for staff involved in the emergency response and Listeners (prisoners trained by the Samaritans to provide confidential peer-support) were engaged to identify prisoners most affected by Mr Baddeley's death.

97. The prison posted notices informing other prisoners of Mr Baddeley's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Baddeley's death.

## Post-mortem report

98. The post-mortem report gave the cause of Mr Baddeley's death as hemopericardium (when blood fills the layers within the heart putting pressure on its ability to work effectively) caused by acute myocardial infarction (heart attack – when the supply of blood to the heart is blocked) which was caused by ischaemic heart disease (reduced blood flow to the heart).

99. Toxicology tests noted that Mr Baddeley had a very high level of cocaine in his system, at a concentration that was well within the fatal range. The pathologist noted that the cocaine overdose had contributed to Mr Baddeley's death, by either triggering or aggravating his heart attack. The cling film found in Mr Baddeley's

mouth tested positive for ecgonine methyl ester (a metabolite of cocaine which can be used to make it).

100. Toxicology tests also confirmed that Mr Baddeley had used ketamine, amitriptyline, olanzapine and fexofenadine (an antihistamine) at some point prior to his death. Mr Baddeley was prescribed all these medications apart from ketamine. The tests indicated that Mr Baddeley had not taken ketamine in the hours before his death.

## Information received after Mr Baddeley's death

101. A prisoner contacted Lindholme's Governor and the PPO. He said that an officer had brought illicit items in parcels into the prison and that Mr Baddeley had recently received one of these parcels. The prison could not substantiate this.

102. On 19 December 2024, a prison manager submitted a security intelligence report. They noted that a prisoner had said that Mr Baddeley was being bullied and forced to keep in his possession cocaine that belonged to another prisoner. The prisoner said that Mr Baddeley did not use drugs and was not in debt to anyone.

## Inquest

103. The Coroner's inquest held on 18 May 2026 determined the medical cause of death to be haemopericardium, acute myocardial infarction and, cocaine toxicity, with ischaemic heart disease listed as a contributory factor.

104. The jury returned a narrative conclusion, stating that Mr Baddeley's death was caused by an unreversible acute cardiac event triggered by cocaine use.

# Findings

## Substance misuse

105. The pathologist concluded that the high level of cocaine in Mr Baddeley's system either triggered or aggravated his heart attack. He had also taken ketamine, which is not prescribed to prisoners at Lindholme.

106. Mr Baddeley had a history of illicit substance misuse. In 2023, he provided negative random drug tests but was suspected to be under the influence once and on another occasion staff found a white powder, later found to be mainly tramadol, in his cell. He refused any substance misuse support. In May 2024, he referred himself for substance misuse support. He told his substance misuse worker that he used cannabis daily. However, he later said that he had only said this to try to get a wing move. He subsequently failed to attend appointments with substance misuse services. Aside from this, there was no intelligence about Mr Baddeley's involvement with the use and/or supply of illicit drugs, or that he was being bullied to hold drugs (as a prisoner had asserted after he died).

107. We cannot say whether Mr Baddeley's use of illicit drugs was regular, but it is clear that he used drugs in the period (and during the night) before his death. Mr Baddeley often preferred to spend most of his time in his cell which would have given him more opportunity to have taken drugs undetected. There is nothing to suggest that Mr Baddeley wanted to take his life or harm himself and it appears that his death was the result of the impact of an unintentional cocaine overdose on his heart pre-existing disease. We are satisfied that Mr Baddeley was aware of the potentially fatal risks of misusing drugs, and he was offered appropriate access to substance misuse services.

108. Lindholme has a Drug Strategy dated January 2024, which sets out the actions that the prison has taken and plans to take to eliminate the supply of drugs, reduce demand and promote user recovery. The Head of Drug Strategy told us that this strategy is renewed annually, and the prison are continually striving to disrupt and stop illicit substances coming into the prison. Lindholme had introduced several important measures to try to address this and the illicit drug economy problem, including introducing amnesties for prisoners (allowing prisoners to voluntary handover illicit drugs), property searches and full rub down searches when prisoners enter and leave wings. While Lindholme do not benefit from having enhanced gate security, they have increased the searching of staff and visitors. It had been identified that drones were the main ingress route for drugs such as cocaine, and supported by the regional Drug Strategy Team, a new drone policy had been introduced, with the assistance of the police also, to combat this issue.

109. Given the measures that Lindholme are already taking and that this is the first drug-related death there in four years, we make no recommendation.

### Routine checks and unlock procedures

110. An officer confirmed to the prison control room that he had completed the roll check on the evening of 3 August. However, CCTV footage shows that he had not done so. Failure to carry out his official prison duty, as well as falsifying documents is a

serious disciplinary matter. However, the officer resigned from the Prison Service before disciplinary investigations had concluded. We informed the police of the officer's actions, and they were considering whether to take the issue any further. It did not impact on the outcome for Mr Baddeley since he was later seen by the OSG when he answered his cell bell and did the morning routine check.

111. When an officer unlocked prisoners cells on 3 August and 4 August, she did not look through their observation panel or get responses from them, including Mr Baddeley. While it was unlikely to have changed the outcome for Mr Baddeley, had she completed her unlock duties correctly on 4 August, she would have found Mr Baddeley unresponsive, rather than there being a short delay before a prisoner found him.

112. Following Mr Baddeley's death, senior managers spoke to the officer about her actions and sent a notice to all staff outlining expectations when conducting routine checks, welfare checks or unlocking prisoners. The notice also included clear instructions to remind staff about what to do when they encounter blocked cell observation panels. We therefore make no recommendation.

### Staff contact with prisoners

113. While Mr Baddeley had been allocated a job in the servery from 10 July, there was no evidence that he attended. From 1 August, Mr Baddeley spent most of his time in his cell. We note that he did not collect his meals or medication for two days before he died but this was not documented in his prison records. These issues were highlighted in the HMPPS' Early Learning Review, which noted that the prison had since taken steps to address them. Staff now kept a record if prisoners did not attend activities (such as work or education), which was shared with the wing cleaning officer and activity hub, noting what actions had been taken. After the serving of every meal, staff were now required to inform the cleaning officer of any prisoner that had failed to attend the kitchen servery to collect their meal. Staff would then speak to the prisoner to ascertain the reason why he did not collect his meal, and this would be recorded on their prison records and a food refusal log opened if required. Given this, we make no recommendation.

## Clinical care

114. The clinical reviewer noted that the clinical care extended to Mr Baddeley was of a good standard and equivalent to that which he would have received in the community.

115. It was clear from records and interviews that Mr Baddeley was difficult to engage with at times and regularly failed to attend medical appointments. Despite his non-attendance, the mental health and substance misuse teams continued to offer him appointments and tried to engage with him.

### Medication, mental healthcare and wellbeing

116. Mr Baddeley failed to collect his medication several times. It was not clear why and this was sporadic at times. Healthcare staff told us that if a prisoner had prolonged periods of poor medication compliance, this was discussed with the psychiatrist and

at the MDT meeting. However, we found no evidence that this happened in Mr Baddeley's case, nor that staff had spoken to or planned to speak to him about his non-compliance. Had this been done, it could have better informed the MDT meetings about his mental health. We make the following recommendation:

**The Head of Healthcare should ensure that when prisoners do not attend for their medications on a number of occasions, a plan is documented within their SystmOne medical records to ensure a multi-disciplinary approach is taken when reviewing their care.**

117. At the time of his death, Mr Baddeley was under the care of the mental health team. While he had not taken his ADHD medication for some time, the RNLD was in the process of assessing and exploring his ADHD in order to provide a holistic support plan for him to address this and his potential need to restart his medication. However, Mr Baddeley failed to attend a number of appointments with her, and so this was not completed before he died.

## Governor to note

### Key work

118. In 2023/24, due to exceptional staffing and capacity pressures, some prisons were delivering adapted versions of the key work scheme while they worked towards full implementation. Any adaptations, and steps taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability. Lindholme told us that, at the time of Mr Baddeley's death, their agreed model for the delivery of key work was one key worker session to be completed every two weeks. However, this was not happening. HMIP highlighted that Lindholme's key working scheme was not well established and only about a third of scheduled appointments were delivered.

119. During 2024, Mr Baddeley had one key work session, on 20 May. His only key work session also took place over ten weeks before he died, during a period when he reported that he was struggling with his mental health and was not regularly attending work. It is difficult to measure the impact on Mr Baddeley during this time, however regular key work sessions with a consistent officer can help to improve wellbeing and safety.

120. Lindholme told us that they aimed to provide a key work session to every prisoner every 28 days, with some ability to focus on prisoners considered most vulnerable, including new arrivals and those who are self-isolating. They said this had led to an incremental improvement in the delivery of key work sessions.

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