

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Paul Waddingham, a prisoner at HMP Moorland, on 28 June 2022**

**A report by the Prisons and Probation Ombudsman**

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## Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



## Our values

We are:

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity



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## Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Paul Waddingham died in hospital of idiopathic pulmonary fibrosis (a condition in which the lungs become scarred causing difficulty in breathing) on 28 June 2022, while a prisoner at HMP Moorland. He was 66 years old. We offer our condolences to Mr Waddingham's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Waddingham received at Moorland was equivalent to that which he could have expected to receive in the community. She found that the reception nurse did not refer Mr Waddingham to several Long-Term Condition (LTC) clinics when he arrived at Moorland. However, she was satisfied that Mr Waddingham's conditions were regularly reviewed and the lack of referrals to the LTC clinics did not impact his care.
5. We found no non-clinical issues of concern.

## Recommendations

- The Head of Healthcare should ensure that the reception nurse refers prisoners to the relevant Long-Term Condition (LTC) clinics when they arrive at the prison.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Waddingham's clinical care at Moorland.
7. The PPO investigator investigated the non-clinical issues relating to Mr Waddingham's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Waddingham's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked questions about Mr Waddingham's lung condition, which have been covered in the clinical review.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
10. Mr Waddingham's family received a copy of the draft report. They pointed out some factual inaccuracies within the clinical review, which has been amended accordingly. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## Previous deaths at HMP Moorland

11. Mr Waddingham was the eleventh prisoner to die at Moorland since June 2020. Of the previous deaths, nine were from natural causes and one was drug-related. There are no similarities between our findings in the investigation into Mr Waddingham's death and our investigation findings from the previous deaths.

## Key Events

12. On 12 October 2018, Mr Paul Waddingham was convicted of sexual offences and sentenced to 27 years imprisonment. He was sent to HMP Leeds.
13. Before he was sent to prison, Mr Waddingham had already been diagnosed with several long-term health conditions including asthma, diabetes and hypertension (high blood pressure).
14. On 14 October 2019, Mr Waddingham was diagnosed with idiopathic pulmonary fibrosis (where the lungs become scarred causing difficulty in breathing).
15. On 17 February 2021, Mr Waddingham was moved to HMP Moorland. A nurse completed a reception health screen. There is no record that the nurse referred Mr Waddingham to Long-Term Condition (LTC) clinics to support him with his asthma, diabetes and hypertension management. However, healthcare staff regularly reviewed Mr Waddingham's conditions. Mr Waddingham was located in a cell on the low-mobility unit.
16. On 16 May 2022, a nurse saw Mr Waddingham after he had fallen earlier that morning. Mr Waddingham complained of pain in his hip and ribs. The nurse assessed Mr Waddingham should be taken to hospital. Prison staff requested an ambulance and he was taken to hospital later that day.
17. The hospital could not find any fractures and discharged Mr Waddingham the following day. Prison healthcare staff reviewed Mr Waddingham on his return and completed an occupational therapy assessment.
18. On 13 June, a nurse saw Mr Waddingham after he had fallen in his cell during the night. He told the nurse he had pain in the right side of his chest since falling. The nurse completed observations which did not raise any concerns. She agreed to monitor Mr Waddingham's condition.
19. On 15 June, a prison GP reviewed Mr Waddingham as he continued to complain of right-sided chest pain following his fall. He also felt short of breath and had a loss of appetite. The GP completed observations and was concerned about poor air entry to his right lung. She requested an emergency ambulance to take Mr Waddingham to hospital, where he was admitted.
20. On 17 June, a prison nurse rang the hospital for an update on Mr Waddingham's condition. A hospital nurse told her that Mr Waddingham had fractured his ribs and had a haemothorax (where blood collects between the chest wall and the lungs). Mr Waddingham had a chest drain in place to treat this.
21. Mr Waddingham's condition continued to deteriorate while in hospital. On 28 June, a hospital consultant told Mr Waddingham there was not much more they could do for his condition. At approximately 5.45pm, Mr Waddingham asked for all treatment to be withdrawn. He died at 6.15pm.

## **Post-mortem report**

22. The post-mortem report concluded that Mr Waddingham died of idiopathic pulmonary fibrosis. Diabetes, fatty liver and ischaemic heart disease are also listed as contributory factors.

**Louise Richards**  
**Assistant Ombudsman**

**October 2022**

## **Inquest**

23. At the inquest, which concluded on 19 July 2023, the jury concluded that Mr Waddingham's death was accidental.

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