

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Baddiley, a prisoner at HMP Oakwood, on 7 December 2022

A report by the Prisons and Probation Ombudsman

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



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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 Arthur Baddiley died of old age, frailty and advanced dementia on 7 December 2022 at HMP Oakwood. He was 92 years old. We offer our condolences to Mr Baddiley's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Baddiley received at Oakwood was of a high standard and equivalent to that which he could have expected to receive in the community.
5. We did not find any non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Baddiley's clinical care at HMP Oakwood.
7. The PPO investigator investigated the non-clinical issues relating to Mr Baddiley's care, including Mr Baddiley's 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 Baddiley's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He had no questions but asked for a copy of our report.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.
10. Mr Baddiley's son received a copy of the initial report. He did not make any comments.

Previous deaths at HMP Oakwood

11. Mr Baddiley was the eighth prisoner to die at Oakwood since December 2020. Of the previous deaths, five were from natural causes and two were drug related.

Key Events

12. In March 2016, Mr Arthur Baddiley was sentenced to 15 years imprisonment for sexual offences. On 16 April 2018, Mr Baddiley was moved to HMP Oakwood.
13. Mr Baddiley was an elderly man who had several medical conditions. He was located on Ash Wing, a wing for vulnerable individuals and those who needed assisted supported living.
14. Mr Baddiley regularly attended appointments with prison healthcare staff and was escorted to hospital for external appointments promptly. The prison healthcare team also undertook routine healthcare checks, which included regular age-related assessments to check Mr Baddiley's cognitive function (the brain's ability to function). An assessment in March 2020 showed that Mr Baddiley's cognitive function was slowly declining.
15. In November 2021, a routine cognitive function assessment showed further decline, specifically with Mr Baddiley's memory and language. Prison staff also noticed that Mr Baddiley sometimes struggled to complete everyday activities. A prison nurse completed a dementia assessment, and diagnosed dementia syndrome (dementia is a term for several diseases that affect memory, thinking and the ability to perform daily activities). The nurse opened a dementia care plan.
16. Over the next year, prison staff supported Mr Baddiley and followed his dementia care plan. The healthcare team reviewed Mr Baddiley's care plan regularly and ensured that he could remain independent where possible. His care plan was overseen by several professionals including social care staff. A wing carer helped him to complete everyday activities.
17. On 13 September 2022, the healthcare team added Mr Baddiley to the palliative care register (a list of the people in prison who may be approaching the end of their life).
18. During the month of November, healthcare staff noticed a significant deterioration in Mr Baddiley's condition. He was becoming increasingly confused, agitated, and was struggling to complete activities in his cell. Prison staff arranged for him to be moved into a disabled cell, and he was given an electric hospital bed.
19. On 7 December, Mr Baddiley died in his cell.

Cause of death

20. The Coroner accepted the cause of death provided by a prison GP and no post-mortem examination was carried out. The GP gave Mr Baddiley's cause of death as old age, frailty and advanced dementia.

Louise Richards
Assistant Ombudsman

July 2023

Inquest

The inquest, held on 11 January 2024, concluded that Mr Baddiley died from natural causes.

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