Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Johnson, a prisoner at HMP Bullingdon, on 28 August 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

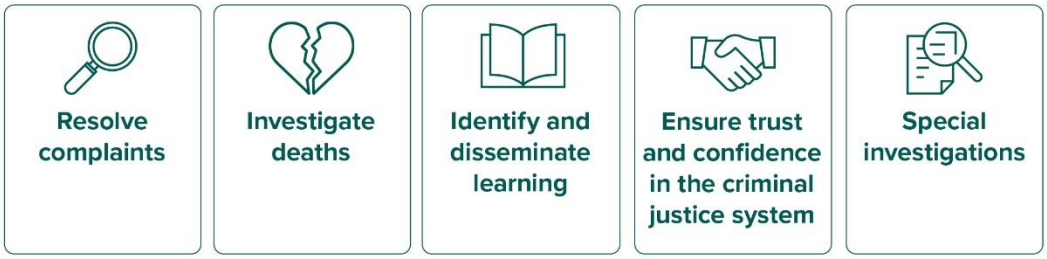
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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. 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.

3. In June 2018, Mr Arthur Johnson was sentenced to 15 years for sexual offences. He died in hospital of heart disease on 28 August 2024, while a prisoner at HMP Bullingdon. He was 87 years old. We offer our condolences to Mr Johnson's family and friends.

4. The Ombudsman's office contacted Mr Johnson's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She wanted to know how Mr Johnson broke his hip, given he was not mobile. (Mr Johnson died the day after his hip replacement operation.)

5. NHS England commissioned an independent clinical reviewer to review Mr Johnson's clinical care at HMP Bullingdon.

6. The clinical reviewer concluded that the clinical care Mr Johnson received at Bullingdon was equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations not related to Mr Johnson's death that the Head of Healthcare will wish to address.

7. In response to Mr Johnson's daughter's query, the clinical reviewer noted that despite Mr Johnson's limited mobility, he could transfer himself between his bed and wheelchair, and once in the wheelchair, he could move around the wing. On 25 August, staff found Mr Johnson in his cell on one knee in front of his wheelchair. The clinical reviewer considered this consistent with a fall from a wheelchair while leaning forward and overreaching. The clinical reviewer also noted Mr Johnson was particularly frail and suffered from several significant medical conditions which contributed to his death.

8. The PPO investigator investigated the non-clinical issues relating to Mr Johnson's care.

9. We did not find any non-clinical issues of concern. We make no recommendations.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

11. We sent a copy of our initial report to Mr Johnson's daughter. She did not notify us of any factual inaccuracies.

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

Inquest

At the inquest, held on 16 June 2025, the jury concluded that Mr Johnson died from natural causes. They found his death was due to the natural progression of pre-existing health conditions such as ischaemic heart disease, aortic valve stenosis and cardiac amyloidosis, causing cardiac arrest. This was likely exacerbated by the fall on 25 August 2024 and subsequent surgery.

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