Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Beamish, a prisoner at HMP Chelmsford, on 3 October 2023

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 I 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. Mr Ronald Beamish died in hospital of ischaemic heart disease on 3 October 2023, while a prisoner at HMP Chelmsford. He was 86 years old. We offer our condolences to Mr Beamish's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Beamish received at Chelmsford was variable. Some aspects were equivalent to that which he could have expected to receive in the community, but others were not. The clinical reviewer made recommendations on wound management, adherence to the national guidance on assessing and preventing falls in older people and safeguarding. As the recommendations were not directly related to Mr Beamish's cause of death, we do not repeat them in this report, but the Head of Healthcare will wish to consider them.

5. We found that the decision to restrain Mr Beamish for his journey to hospital and while he was an inpatient was not justified given his advanced age, poor mobility and intravenous treatment.

Recommendation

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff accurately complete the medical information section of the escort risk assessment to reflect how the prisoner's health, medical condition and mobility affects their risk of escape;**
- **authorising managers show that they have taken this information into account and their decision is based on the risk the prisoner presents at the time; and**
- **restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.**

The Investigation Process

6. HMPPS notified us of Mr Beamish's death on 3 October 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Beamish's clinical care at HMP Chelmsford.

8. PPO investigators investigated the non-clinical issues relating to Mr Beamish's care.

9. The Ombudsman's office wrote to Mr Beamish's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Beamish's daughter asked several questions about her father's care. The issues within our remit have been addressed in this report, the clinical review and in separate correspondence.

10. We sent a copy of our report to Mr Beamish's next of kin. She made several observations and highlighted some personal concerns. Two factual errors she identified have been amended.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted the recommendation.

Previous deaths at HMP Chelmsford

12. Mr Beamish was the eighth prisoner to die at Chelmsford since October 2020. Of the previous deaths, two were from natural causes and five were self-inflicted. There have since been three further deaths. There are no significant similarities between the findings in our investigation into Mr Beamish's death and those from our investigations into the previous deaths.

Key Events

13. Mr Ronald Beamish was convicted of sexual offences on 26 October 2022. He was sentenced to three years imprisonment on 17 July 2023 and sent to HMP Chelmsford. It was his first time in prison.

14. At his initial health screen, a nurse recorded that Mr Beamish had several existing long-term health conditions, including type 2 diabetes, high cholesterol, stage 4 chronic kidney disease, diabetic retinopathy and a previous deep vein thrombosis. His right leg had been amputated above his knee and he used a wheelchair. The nurse noted that Mr Beamish's blood pressure was raised.

15. On 31 July, an audit showed that Mr Beamish's second-stage health screen was overdue and it was held that day. Healthcare staff placed him on the long-term conditions pathway and relevant care plans were created. He was also added to the complex care register and monitored weekly at the Multi-Professional Complex Care Caseload (MPCCC) meeting. Staff gave Mr Beamish an adapted cell in the Enhanced Care Unit, a small unit for men with complex needs.

Deterioration in Mr Beamish's health and admission to hospital

16. Mr Beamish's daughter contacted the prison on 14 August to raise concerns about her father's health. Over the next few days, healthcare staff conducted additional welfare checks to monitor his condition.

17. Mr Beamish was admitted to Broomfield Hospital on 17 August due to abdominal pain, dehydration and vomiting. He was escorted by two prison officers, using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). During the afternoon, Mr Beamish complained of wrist pain and bruising and a prison manager authorised removal of the restraints. The escort staff on duty that evening were told to reapply the escort chain.

18. Mr Beamish was diagnosed with a mild upper gastrointestinal bleed and treated with intravenous medication and fluids. After he returned to the prison on 19 August, healthcare staff generally conducted welfare checks twice a day.

19. On 27 August, Mr Beamish felt unwell. He vomited, his respiratory rate was raised and he appeared confused. He was admitted to hospital, with a urinary tract infection and was later diagnosed with a deep vein thrombosis. He was treated intravenously Mr Beamish was again restrained with an escort chain. A risk assessment dated 29 August, instructed escort staff to use double handcuffs for travel and an escort chain during treatment and consultations. The restraints were removed on 31 August, as a nurse had difficulty finding a vein. They were reapplied for a scan on 7 September.

20. On 31 August, a hospital consultant decided that Mr Beamish should not be resuscitated if his heart or breathing stopped. A 'do not attempt cardiopulmonary resuscitation' (DNACPR) order was completed and the prison was informed.

21. On 22 September, Mr Beamish was discharged from hospital and sent to a community rehabilitation centre. However, his condition worsened and he was admitted to Basildon University Hospital on 28 September. He was treated for a urinary tract infection and pneumonia.

22. On 1 October, a hospital doctor discussed end of life decisions with Mr Beamish. The escort officers noted that it was unclear whether he understood what was said.

23. Mr Beamish died on 3 October.

Post-mortem report

24. The post-mortem report concluded that Mr Beamish died of ischaemic heart disease. Pneumonia and hypertensive heart disease also contributed to his death.

Non-Clinical Findings

Restraints, security and escorts

25. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

26. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

27. These requirements are reflected in the HMPPS policy framework, *Prevention of Escapes – External Escorts*, which states that restraints will not normally be necessary when mobility is severely limited due to advanced age or disability, unless there is intelligence to suggest that there will be an attempt to escape.

28. The judgements about how Mr Beamish's health and mobility affected his risk were inconsistent. The clinical section of the risk assessment on 17 August indicated that he was incapacitated, with a life-threatening condition and the one completed for 27 August noted that he was an amputee and wheelchair user. In spite of this, both clinical assessments considered that he could escape unaided and operational staff authorised the use of an escort chain each time.

29. The clinical opinion on the risk assessment for 29 August, was that Mr Beamish was unable to escape unaided, yet the level of restraints was raised to double handcuffs for travel and an escort chain during treatment and medical consultations.

30. Mr Beamish was a category C prisoner on the enhanced level of the prisoners' incentives scheme. He was described as compliant with no adverse behaviour or disciplinary problems. The security risk assessments identified no potential to escape and no reasons why restraints were necessary.

31. The security risk assessment process appears to be poorly understood by some healthcare and operational staff. It is difficult to see how any objective assessment of Mr Beamish's risk could have concluded that an 86-year-old, amputee and wheelchair user, weakened by multiple chronic health conditions and undergoing invasive treatment, had the ability to escape unaided from two prison officers. It is particularly inexplicable that double handcuffing, which is usually required for moving category A or B prisoners in good health was necessary at any point. We have repeatedly criticised HMPPS culture on this issue as being unduly risk averse. We believe that, in this instance, the use of restraints was unjustified, inhumane and showed a lack of decency by those involved in the assessments. We recommend:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff accurately complete the medical information section of the escort risk assessment to reflect how the prisoner's health, medical condition and mobility affects their risk of escape;**
- **authorising managers show that they have taken this information into account and their decision is based on the risk the prisoner presents at the time; and**
- **restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.**

Governor to note

Liaison with Mr Beamish's family

32. Prison Service Instruction (PSI) 64/2011, about safer custody, states that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill. In addition, the PSI and Prison Rule 22 says that a prisoner's next of kin should be informed immediately if they become seriously ill, or if there is an unpredicted or rapid deterioration in their physical health.

33. Prison staff did not inform Mr Beamish's daughter that he had been admitted to hospital. We consider it unacceptable that she found out by ringing local hospitals to locate him, 11 days after his admission. Given that we have not identified similar issues in other cases at Chelmsford, we have not made a recommendation. However, the Governor will want to reflect on the circumstances that allowed this to hdxmkl-00pp juhik.,appen to Mr Beamish's family and ensure learning is identified.

Inquest

34. At an inquest held on 16 December 2025, the coroner concluded that Mr Beamish died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100