

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Beal a prisoner at HMP Lowdham Grange on 14 June 2018

A report by the Prisons and Probation Ombudsman

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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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Robert Beal died on 14 June 2018 of a heart attack, caused by heart disease and drug toxicity, at HMP Lowdham Grange. He was 60 years old. I offer my condolences to Mr Beal's family and friends.

Mr Beal had bipolar affective disorder and had spent long periods in secure mental hospitals. He was maintained on high levels of antipsychotic medication and his mental health remained stable at Lowdham Grange. He also suffered with lower back and leg pain and was prescribed high levels of painkilling medication for this.

Mr Beal had potentially lethal levels of two of his prescribed medications in his system when he died. We cannot say whether this was due to a slow build up of these medications (which would raise serious questions about the safety of prescribing practices at Lowdham Grange) or whether he took an overdose, either deliberately or accidentally.

In either event, I am concerned that Mr Beal was prescribed increasing amounts of painkilling medication for back pain even though he had a history of poly-substance misuse, and there was no clinical evidence of any abnormality and no evidence that the prescribed medications were beneficial. I am also concerned that there is no evidence that anyone considered the potential risks of the combination of the painkillers with his unusually high dose of antipsychotic medication.

As far as a possible overdose is concerned, I am satisfied that Mr Beal gave no indication that he intended to take his own life or that he was stockpiling medication, and that prison staff could not have foreseen or prevented his death.

I am, however, concerned that when Mr Beal was found unresponsive during the night, the officers on duty were not aware of the prison's own procedures for dealing with an emergency.

I am also concerned that Mr Beal's next of kin details were not up to date and that his family were not informed of his death in person.

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

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Summary

Events

1. On 16 October 2001, Mr Robert Beal was given a life sentence for robbery. He was not eligible for parole until he had served seven and half years' imprisonment.
2. Mr Beal had bipolar affective disorder and spent two separate five-year periods in a secure mental hospital after sentencing. On 18 December 2013, he was transferred to HMP Lowdham Grange, where he remained until his death.
3. At Mr Beal's reception health screen it was noted that he was diagnosed with bipolar affective disorder and had a long history of mental illness. He was prescribed anti-psychotic medication but was not permitted to hold these drugs in his possession. The mental health team and a consultant psychiatrist regularly reviewed Mr Beal and he remained mentally stable throughout his time at Lowdham Grange.
4. In January 2014, shortly after his arrival at Lowdham Grange, Mr Beal complained of lower back pain and was prescribed painkilling medication to treat it. He continued to complain of severe pain and healthcare staff regularly saw him about this during his time at Lowdham Grange. His medication was varied and his dosage steadily increased. He was referred for an external scan on at least two occasions but this was never performed.
5. Mr Beal had a history of poly-substance misuse. In 2015, he was found under the influence of illicit drugs on a number of occasions; in 2016, he tested positive for buprenorphine, an opiate-like painkiller that he had not been prescribed; and in 2017, he was found under the influence of 'hooch' (illicit home-made alcohol).
6. In 2016, Mr Beal applied to the Parole Board to try to secure his release on parole. This process was delayed by the need to secure suitable post-release accommodation for him in the community due to his mental health issues. Although Mr Beal became increasingly frustrated with these delays, the mental health team had no concerns about him.
7. On 14 June 2018, an officer discovered Mr Beal unresponsive in his cell at 1.48am and an emergency response was triggered. An ambulance crew arrived but at 2.48am Mr Beal was pronounced dead.
8. Following Mr Beal's death, nine partially-digested tablets were found in his cell. These were tested and found to be painkilling medication he had been prescribed.
9. The post-mortem report concluded that Mr Beal died of a heart attack caused by heart disease and drug toxicity. The toxicology tests found that he had potentially lethal levels of two of his prescription drugs in his system.

Findings

The circumstances of Mr Beal's death

10. The clinical reviewer told us that he could not say whether Mr Beal died as a result of a slow build up of the prescribed drugs in his system or as a result of taking an overdose.
11. If he died as a result of the build-up of drugs, this would raise serious questions about the safety of prescribing practices at Lowdham Grange.
12. If he died as a result of taking an overdose, we have been unable to establish whether this was done with the deliberate intention of killing himself or whether he took an excess of his medication for some other reason (perhaps to get 'high') and died accidentally.
13. However, we are satisfied that Mr Beal gave no indication that he intended to take his own life or that he was stockpiling medication, and that prison staff could not have foreseen or prevented his death.

Clinical care

14. The clinical reviewer found that Mr Beal was appropriately managed for his mental health issues and regularly reviewed for his back pain.
15. However, we share the clinical reviewer's concerns that Mr Beal was prescribed increasing amounts of painkilling medication for back pain even though he had a history of poly-substance misuse, and there was no clinical evidence of any abnormality and no evidence that the prescribed medications were beneficial.
16. We are concerned that there is no evidence that anyone considered the potential risks of the combination of the painkillers with his unusually high dose of anti-psychotic medication.
17. We are also concerned that there was no mechanism in place to ensure that external referrals were followed up.

Emergency response

18. We are concerned that officers did not trigger an emergency response as soon as they discovered Mr Beal unresponsive. We are also concerned that they were not aware that they could unlock his cell during an emergency without the authority of a senior officer.

Contact with Mr Beal's family

19. We are concerned that the prison did not hold accurate next of kin details for Mr Beal. We are also concerned that the news of his death was communicated to his family by telephone.

Recommendations

- The Head of Healthcare should ensure that:
 - prescribing clinicians use a risk-benefit analysis before continuing to prescribe potentially inappropriate poly-pharmacy; and
 - a multi-disciplinary approach involving doctors, nurses, recovery workers and pharmacy staff is employed to aid safe prescribing in the case of patients with complex needs.
- The Head of Healthcare should ensure that there is an adequate system in place for following up referrals to external specialists.
- The Director should ensure that staff are aware of their responsibilities when dealing with emergency situations.
- The Director should ensure that:
 - a prisoner's next of kin details are up to date; and
 - the prisoner's family are informed of his death in person, in line with national guidance.

The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
21. The investigator visited Lowdham Grange on 9 August 2018. He obtained copies of relevant extracts from Mr Beal's prison and medical records.
22. The investigator interviewed four members of staff and two prisoners at Lowdham Grange on 9 August. He interviewed a consultant psychiatrist by telephone on 31 August.
23. NHS England commissioned a clinical reviewer to review Mr Beal's clinical care at the prison.
24. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
25. The investigator contacted Mr Beal's aunt to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Her son (Mr Beal's cousin) wrote back on behalf of his mother to say that they had nothing in particular to add to the investigation, but would like to be kept informed.
26. Mr Beal's family received a copy of the initial report. They pointed out some factual inaccuracies. This report has been amended accordingly.
27. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out A factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Lowdham Grange

28. HMP Lowdham Grange is a medium security prison, managed by Serco, which holds a maximum of 920 men. There are five houseblocks, typically holding 120-130 men. It holds long-term prisoners, many of whom are serving life sentences or indeterminate sentences. Nottinghamshire Healthcare NHS Foundation Trust provides general healthcare, which includes 24-hour nursing cover.

HM Inspectorate of Prisons

29. The most recent inspection of HMP Lowdham Grange was conducted in June 2015. Inspectors reported that some security procedures were disproportionate to the risks posed and, although the prison was sighted on its security issues, actions from its intelligence reports were not always prompt enough. Mandatory drug testing was below target but security finds and intelligence reports indicated a growing use of undetectable psychoactive substances. Inspectors noted that more prisoners said that it was easy to obtain illegal drugs and alcohol than had done so at the last inspection.

Independent Monitoring Board

30. 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 2018, the IMB were concerned about low staffing levels and the proportion of inexperienced staff, which contributed to a challenging atmosphere on some wings. The Board noted that the prison was running frequent recruitment drives to increase staffing levels. The IMB welcomed the changes made to healthcare provision since the new Head of Healthcare was appointed at the start of 2017. These included the provision of an agency nurse through the night.

Previous deaths at HMP Lowdham Grange

31. Mr Beal was the fifth prisoner to die at Lowdham Grange since January 2016. We have previously made a recommendation about the emergency response.

Dihydrocodeine

32. Dihydrocodeine is a semi-synthetic opioid painkiller which can be used to treat severe pain. It is available on prescription but is classed as a Class B drug when in unauthorised possession. This drug can be addictive and has been known to be used recreationally as it can provide a euphoric high when used in higher than therapeutic doses.

Amisulpride

33. Amisulpride is an anti-psychotic medication used to treat schizophrenia and mild depression. It is not ordinarily used recreationally, but can have mood brightening qualities.

Key Events

Background

34. On 16 October 2001, Mr Robert Beal was sentenced to life imprisonment for robbery. The sentencing judge stated that he would not be eligible for parole until he had served seven and half years in prison.
35. As Mr Beal was diagnosed with a mental disorder, he was initially sent to a medium secure mental health hospital where he remained for five years. On 22 September 2006, he was transferred to HMP Swaleside, where his son was also in custody. On 4 April 2008, Mr Beal's son died from an accidental drug overdose in Swaleside. Mr Beal's mental health deteriorated after this and he was transferred back to a secure hospital.
36. In November 2013, Mr Beal was transferred back into prison custody at HMP Wormwood Scrubs. On 18 December, he was transferred to HMP Lowdham Grange, where he remained until his death.
37. A nurse reviewed Mr Beal at his reception health screen. She noted that he was diagnosed with bipolar affective disorder and had a history of mental illness. She recorded that Mr Beal could not read or write, and that he had misused drugs in the past. His daily dose of medication was 600mg of amisulpride (an antipsychotic used to treat schizophrenia), 200mg of olanzapine (an antipsychotic used to treat schizophrenia and bipolar disorder), and 40mg of simvastatin (to mitigate the negative side effects of the antipsychotics on his cholesterol). Mr Beal was not allowed to hold these drugs in possession and had to take them under the supervision of a nurse to ensure that he did not hide or retain his medication.
38. On 31 December, a mental health nurse assessed Mr Beal. She referred Mr Beal to the Mental Health Team at Lowdham Grange. In April 2014, a consultant psychiatrist assessed Mr Beal. He noted that Mr Beal had recently been remitted to prison after a five-year spell in a secure mental hospital, seemingly in response his son's death. He recorded that he was satisfied with Mr Beal's medication regime but would keep him under review. In June, the psychiatrist noted that Mr Beal's mental illness appeared to be in remission. He noted that Mr Beal did not think he needed mental health reviews. The psychiatrist and the mental health team continued to monitor Mr Beal.
39. In January 2014, Mr Beal complained of lower back pain after lifting some heavy bags a month earlier. In February, a nurse reviewed him and gave him co-codamol (a painkiller) and naproxen (an anti-inflammatory). In March, a prison GP examined Mr Beal and noted that he had chronic lower back pain. She prescribed him nefopam (a painkilling medication for moderate to severe pain). In June, Mr Beal complained of pain in his left leg resulting from the same incident. He self-rated it as '10/10' (defined as 'the worst pain ever'). A nurse prescriber gave him naproxen. In July, a nurse noted that Mr Beal suffered with sciatica (pain originating in the lower back and down the back of the leg).
40. In October, a prison GP reviewed Mr Beal and diagnosed sciatica. She switched his medication to a daily dose of 120mg of dihydrocodeine (an opioid based

painkiller for severe pain), and planned for Mr Beal to have a Magnetic Resonance Imaging scan. (MRI scans use magnetic fields to generate internal images of the body.) There is no record of this scan taking place. On 1 May 2015, a prison GP increased Mr Beal's daily dihydrocodeine dose to 150mg. By autumn 2016, this was increased to 210mg.

41. In early 2015, staff observed Mr Beal to be unsteady on his feet and slurring his words on a number of occasions. Some prisoners told staff that he was under the influence of 'spice' (a synthetic psychoactive substance). Officers told a nurse that this was about the third time they thought other prisoners had given Mr Beal cigarettes 'spiked' with drugs. Over the next few months, staff reported that Mr Beal appeared under the influence on several occasions. Mr Beal consistently denied taking illicit substances and declined repeatedly to engage with the substance misuse team.
42. In October, a nurse saw Mr Beal after officers became concerned about his behaviour. Mr Beal told her that he had taken roll-ups that might have been spiked from other prisoners but denied willingly taking illicit substances. In May 2016, Mr Beal tested positive for buprenorphine during a mandatory drug test. This is an opiate-like painkiller which he had not been prescribed. He strongly denied using buprenorphine and said he did not want to engage with the substance misuse team.

Mr Beal's parole application

43. Mr Beal was eligible for parole from April 2008, and engaged a solicitor to assist him. When his son died around this time, Mr Beal's mental health deteriorated and he was transferred to a secure hospital where he stayed for the next five years. In 2013, when Mr Beal returned to prison custody at Lowdham Grange, he did not initially engage with the parole process.
44. Mr Beal's solicitor told us that Mr Beal was eligible to apply for release from April 2008 but needed to engage with the Parole Board. He also said that Mr Beal was entitled to fully-funded community health care under the provisions of Section 117 of the Mental Health Act 1983.
45. In January 2016, a multidisciplinary Parole Board meeting concluded that Mr Beal required an independent psychiatric assessment before they could discuss his case any further. In October, the Parole Board met but adjourned for three months while they awaited a psychiatric report. On 12 December, a mental health nurse at Lowdham Grange noted that Mr Beal was frustrated at being almost nine years over his sentence tariff but that his parole might realistically be granted in January 2017. The nurse recorded that Mr Beal might struggle to cope in the community because he had been in prison for 17 years. In February 2017, an independent psychiatrist assessed Mr Beal, and advised that he would benefit from a 24-hour staffed hostel for patients with mental illness.

Events from 2017

46. On 17 February 2017, a prison GP reviewed Mr Beal for his leg and back pain. He noted that Mr Beal's medications were insufficient to manage his pain but that his gait was normal and he had no spine tenderness. He prescribed a 500mg

daily dose of naproxen. On 4 May, a prison GP reviewed Mr Beal. He noted his ongoing sciatica pain issues and prescribed a 75mg daily dose of pregabalin (a drug to treat nerve pain and which can be abused because it can produce euphoric effects and enhance the euphoric effects of other drugs).

47. On 4 May, the psychiatrist reviewed Mr Beal. A prison staff member recorded the entry in Mr Beal's medical notes on the psychiatrist's behalf. The psychiatrist said that a consultant forensic psychiatrist had prepared a report for the Parole Board which supported Mr Beal's release. He noted that Mr Beal did not appear to have abnormal mood swings or acute psychosis. He discussed reducing his anti-psychotic medication but noted that Mr Beal did not want to do this. The psychiatrist documented all of Mr Beal's current medication.
48. On 6 June, a prison GP noted that pregabalin was proving ineffective for Mr Beal's back pain. He switched him to amitriptyline (for chronic nerve pain).
49. On 21 June, at 7.42pm, a nurse responded to a code blue emergency radio call after Mr Beal was found unresponsive on the floor of his cell. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) He noted that Mr Beal was breathing and responding but that his oxygen saturations were low. Mr Beal's neighbour said he had been drinking hooch (homemade alcohol). The nurse gave Mr Beal oxygen and the ambulance was stood down. Two days later, a worker from the substance misuse team spoke to Mr Beal. Mr Beal admitted to being intoxicated on hooch, but said he had no plans to drink this again. The substance misuse worker advised Mr Beal about the physical risks of drinking hooch or taking drugs.
50. In August, a Parole Board hearing into Mr Beal's release was adjourned to allow assessments to be provided. Mr Beal's solicitor told us that the Parole Board set a deadline of 22 December for probation to produce a proposal for accommodation in the community, with Mr Beal having until 31 January 2018 to reply. The Parole Board had the option of then making a decision on paper or to direct a further oral hearing.
51. On 5 August, a nurse noted that Mr Beal had not taken his olanzapine antipsychotic medication for a month. On 25 October, the psychiatrist noted that this had been stopped without explanation. He restarted Mr Beal's olanzapine, initially at a lower dose than previously.
52. On 18 August, a prison GP reviewed Mr Beal for his sciatica. She noted that amitriptyline was not helping at all and that there was no rationale for taking this as well as pregabalin. The GP stopped Mr Beal's amitriptyline and increased his daily pregabalin dose to 150mg. Mr Beal had still not had an MRI scan so the GP requested one.
53. On 13 September, a prison GP saw Mr Beal and increased his pregabalin dose to 400mg a day. He noted that Mr Beal was waiting for an MRI scan and that, if this showed no nerve damage, they would reduce his pregabalin. The GP referred Mr Beal to a physiotherapist.

54. On 5 October, the psychiatrist reviewed Mr Beal. On 27 October, a prison staff member entered notes on to Mr Beal's medical record on his behalf. The psychiatrist discussed Mr Beal's level of antipsychotic medication (which was high) but Mr Beal said that he did not want to change his medication because he did not want to risk destabilising his mental health with his parole decision pending. The psychiatrist recorded that Mr Beal had the mental capacity to make this decision and left his medications as they were.
55. On 17 November, a physiotherapist reviewed Mr Beal. He noted that Mr Beal had sustained an injury to his back four years earlier but had never had an X-ray or MRI scan or seen a physiotherapist. He recorded that Mr Beal self-rated his current health status as '0' – which equates to 'the worst health you can imagine' - and scheduled a further appointment in December. Mr Beal did not attend this appointment.
56. On 19 December, a mental health nurse reviewed Mr Beal. He noted that Mr Beal was anxious about his parole situation but otherwise appeared to be in good mental health.
57. On 11 January 2018, it was recorded that Mr Beal had not attended a scheduled psychiatric review with the psychiatrist. On 17 January, a nurse saw Mr Beal. He noted that Mr Beal continued to voice his distress at the lack of movement in his parole case. The nurse noted that although Mr Beal was clearly stressed, he detected no objective evidence of acute mental illness. He recorded that Mr Beal's probation officer was on long-term sick leave, and that a new officer had taken up his case but did not know much about it. On 6 March, a nurse noted that he had chased up Mr Beal's parole release and was told that probation should be doing this.
58. On 10 May, the psychiatrist reviewed Mr Beal. A prison staff member recorded this consultation in Mr Beal's medical notes on the psychiatrist's behalf. The psychiatrist said that he had not seen Mr Beal since October 2017. He noted that Mr Beal had been granted release on parole subject to an appropriate mental health hostel place being secured. He said that Mr Beal was "understandably rather frustrated if not annoyed with the amount of time it had taken to effect his release". He observed that Mr Beal demonstrated no signs of a relapse or psychotic illness, and that he was pleased with how robust his mental health was. He added that there was nothing clinically urgent for Mr Beal, other than the situation with his release. He scheduled a further review for four months later.

Events of 13/14 June 2018

59. In 13 June, Mr Beal was given his prescribed medication at the medication hatch as normal at 8.00am and 5.27pm, and was locked into his cell for the night at about 7.45pm. Staff did not note any concerns.
60. Officers A and B were on duty on Mr Beal's wing overnight. They conducted a roll check at 10.00pm and did not record any concerns about Mr Beal.

61. Officer A told the investigator that they were required to conduct welfare checks on every cell at about 2.00am. This involved looking through a prisoner's observation panel to ensure he was well and did not need assistance.
62. At approximately 1.48am, Officer A performed a welfare check on Mr Beal's cell. He told the investigator that he observed Mr Beal kneeling on the floor with the top half of his body face down on his bed. Officer A banged on Mr Beal's door but he did not respond so he called down to Officer B on a lower landing. Officer B joined Officer A and also tried to get a response from Mr Beal. Officer A said he then radioed through to the control room to say he had an unresponsive prisoner. He told the investigator that he thought that the senior officer in charge had to give permission before he could open a night pouch and enter a cell. (A night pouch is a sealed pouch containing cell keys for use in an emergency.) Officer A said that he had been working at the prison for two to three weeks.
63. Officer B told the investigator that some colleagues appeared after a couple of minutes and that someone asked him to turn on the lights in the office. When he got back, more officers had arrived, including a nurse. He said that someone opened the cell and that he then assisted with cardiopulmonary resuscitation (CPR). Officer B said that this was his first night shift at the prison and that although he was aware of the night pouch he did not open it.
64. A nurse recorded that at 1.48am, healthcare assistance was requested to cell G49. He noted that "Mr Beal was reported to be unconscious, unresponsive and also not breathing". He recorded that when he arrived, he had to wait for the cell to be opened 'due to night state protocols'. He arranged for Mr Beal to be placed flat on the floor and assessed him. The nurse recorded that at 1.50am "cardiac arrest confirmed, CPR commenced and ambulance was ordered". A defibrillator was connected but did not advise a shock at any time. The nurse administered glucagen (in case of diabetic shock) and naloxone (to reverse the effects of a possible opioid overdose).
65. The control room log recorded that at 1.48am, Officer A informed them that Mr Beal was face down in his cell and not breathing. It recorded that at 1.52am, Officer C had broken his night pouch and opened the cell, and that staff were performing CPR. The log recorded that at 2.15am, the ambulance arrived at the prison. At 2.48am, paramedics declared Mr Beal dead.

Events after Mr Beal's death

66. Following Mr Beal's death, the police searched his cell. They did not find a note or anything else to indicate that Mr Beal had intentionally taken his own life. They discovered nine partially-digested tablets in the cell. These were tested and shown to amount to a total of 1.86g of dihydrocodeine.
67. A prisoner, who was a friend of Mr Beal's, told the investigator that he had known Mr Beal for over 40 years, dating back to his time outside prison. He said that they became closer friends while they were in prison together. He said that Mr Beal used to use drugs in prison but had stopped doing this some time before his death because he wanted to be released on parole. He said Mr Beal had been unhappy for the past 10 or 12 days but had not said anything to him about taking

his own life. He also said that you do not always know everything about even your closest friends.

68. Mr Beal's solicitor told the investigator that Mr Beal had thought he was due to be released on 31 January 2018. He explained that this was the date set by the Parole Board for Mr Beal to say if the release location proposed by the Probation Service was acceptable to him. However, a release location and date had still not been finalised by the time of Mr Beal's death. The solicitor said that probation had done very little to further Mr Beal's release, despite him following this up with them.

Contact with Beal's family

69. Following Mr Beal's death, the prison appointed a family liaison officer (FLO), with a prison chaplain as her deputy.
70. Mr Beal's dead son was listed as his next of kin. The FLO noted that Mr Beal had a step-daughter although there was no record of any contact between them. The prison tried to contact her but was unable to do so, so officers spoke to his friend in the prison to see whether he knew anyone who could be contacted. The prisoner suggested that they try Mr Beal's former wife.
71. On 14 June, at 11.45am, the FLO and her deputy arrived at the home of Mr Beal's former wife. She said that Lowdham Grange's Deputy Director had already informed her of Mr Beal's death by phone. The FLO and her deputy offered their support and explained what would happen next. Shortly afterwards, Mr Beal's step-daughter arrived. They explained everything to her and also offered support.
72. Mr Beal's former wife later telephoned the FLO and said that Mr Beal's aunt wanted to speak to her. The following day, the FLO spoke to Mr Beal's aunt, and they agreed that she would take over next of kin duties. Her son, Mr Beal's cousin, also liaised with the prison.
73. Mr Beal's funeral was held on 18 July. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

74. After Mr Beal's death, the Deputy Director and a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
75. The prison posted notices informing other prisoners of Mr Beal'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 Beal's death.

Post-mortem report

76. The post-mortem concluded that Mr Beal died from arrhythmia (an irregular heart beat), which was caused by heart disease and drug toxicity.

77. The toxicology report said that Mr Beal had potentially lethal levels of both dihydrocodeine (a painkiller) and amisulpride (anti-psychotic medication) in his system. Both had been prescribed to him. There was no evidence of any psychoactive drug use, although there was evidence of cannabis use.

Findings

Clinical care

78. Mr Beal had a chronic and enduring mental health problem, bipolar affective disorder, and was maintained on two antipsychotic drugs during his time at Lowdham Grange. He remained mentally stable throughout his time there. We agree with the clinical reviewer that Mr Beal was appropriately reviewed by mental health staff and a consultant psychiatrist.
79. Mr Beal was on a high dose of antipsychotic medication for a sustained period which put him at increased risk of cardiovascular disease and diabetes, but the clinical reviewer is satisfied that the psychiatrist kept this under regular review. He expressed his concerns to Mr Beal and explained the additional risks of taking high doses of two antipsychotics (which is not normally recommended), but he respected Mr Beal's mental capacity to make decisions about his medication. Mr Beal said he did not want to risk a relapse in his mental health with his ongoing parole proceedings. There is no evidence of Mr Beal having delusions or psychosis while at Lowdham Grange and his bipolar disorder remained in remission.
80. Mr Beal complained of severe back pain shortly after he arrived at Lowdham Grange. Healthcare staff and GPs regularly reviewed Mr Beal for this. However, we share the clinical reviewer's concerns that Mr Beal was prescribed increasing amounts of painkilling medication even though he had a history of poly-substance misuse; multiple examinations by different clinicians did not identify any abnormal mobility or any neurological deficit, and only identified stiffness and subjective complaints of pain; and there was no evidence that the prescribed medications were beneficial.
81. Although Mr Beal self-rated his quality of life to be 'the worst health you can imagine' when he saw the physiotherapist in November 2017, we note that he worked as a wing-cleaner throughout his time at Lowdham Grange. The clinical reviewer also noted that Mr Beal frequently focused on his complaints of back pain and sciatica whenever he was engaged with healthcare staff, including mental health staff. He would avoid discussing his history of substance misuse and mental health problems, and steer the consultation to prescribed medication for back pain. It is possible that this was drug-seeking behaviour.
82. We are also concerned that, although Mr Beal was taking both unusually high levels of antipsychotics and high levels of painkillers, there is no evidence that any one reviewed his prescribed medication as a whole and the potential risks involved in the combination of drugs.
83. We, therefore, recommend:

The Head of Healthcare should ensure that:

- **prescribing clinicians use a risk-benefit analysis before continuing to prescribe potentially inappropriate poly-pharmacy; and**

- **a multi-disciplinary approach involving doctors, nurses, recovery workers and pharmacy staff is employed to aid safe prescribing in the case of patients with complex needs.**
84. We also share the clinical reviewer's concern that, although Mr Beal was referred for an MRI scan on at least two occasions, this was never performed and was not followed up. Although this would have not provided definitive answers about Mr Beal's back pain, if adequate recall systems are not in place, important investigations can be ordered and then not arranged, or the results can go un-actioned. We recommend:

The Head of Healthcare should ensure that there is an adequate system in place for following up referrals to external specialists

85. We also share the clinical reviewer's concern that visiting consultants should make their entries on a prisoner's medical records directly, rather than through an administrator. We note that the clinical reviewer has made a separate recommendation to the Head of Healthcare about this and we do not repeat this here.

Emergency response

86. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.
87. HMP Lowdham Grange had a local instruction in place at the time of Mr Beal's death: *8.006, Nights – opening cells and dealing with emergencies in cells*, which set out the procedures which staff should follow in medical emergencies at night. The instruction said:
- “Where there is, or appears to be, immediate danger to life, a cell may be unlocked without the authority of the Duty Manager and with only one officer present.
- “In the event of an emergency where a prisoner is unresponsive or there is a clear threat to life then the staff member is to request immediate assistance of the Ambulance Emergency Service through the radio net, the life-threatening incident may be either a Code Blue or Red.”
88. We are concerned that when Officer A discovered Mr Beal unresponsive he did not call a code blue emergency, and did not unlock his cell. We are also concerned that Officer B also did not call a code blue emergency or unlock Mr Beal's cell when he arrived. Both officers accepted in interview that they did not understand what to do at the time, but said they were now aware.
89. We recognise that both officers had only recently started work at Lowdham Grange, and had not previously worked a night shift. We also appreciate their honesty. However, we are very concerned that the prison scheduled two officers

to work on a night shift without being satisfied that they knew what to do in the event of an emergency. We recommend that:

The Director should ensure that staff are aware of their responsibilities when dealing with emergency situations

90. We accept that the delay in this case was unlikely to have made any difference to Mr Beal. We are satisfied that once the emergency response was triggered, staff acted promptly and efficiently.

Mr Beal's parole application and process

91. It is clear that Mr Beal became increasingly anxious about the delays in agreeing his release on parole. Decisions by the Parole Board are outside our remit and we cannot say why the process took so long or whether matters should have been resolved more quickly. We are, however, satisfied that the prison acted appropriately and did all it reasonably could to facilitate Mr Beal's release. Despite Mr Beal's continuing anxiety, the clinical reviewer has concluded that there is no evidence that this delay was objectively detrimental to his mental health.

The circumstances of Mr Beal's death

92. The post-mortem found that the arrhythmia that caused Mr Beal's death was itself caused by potentially lethal levels of dihydrocodeine and amisulpride, two drugs he was prescribed. The clinical reviewer told us that he could not tell from the toxicology report if these lethal levels were caused by a slow build up in Mr Beal's system or by an acute excess (that is, that Mr Beal took more than the prescribed doses of his medication shortly before his death).
93. If Mr Beal's death was caused by a slow build up of his medication to toxic levels, this would raise serious questions about the safety of prescribing practices at Lowdham Grange. We have made a recommendation above to address this.
94. If Mr Beal's death was due to an overdose, we have been unable to establish whether this might have been accidental or a deliberate attempt to end his life.
95. Mr Beal did not leave a suicide note. Although he was very frustrated by the delays to his release on parole, we are satisfied that Mr Beal never gave any indication that he considered taking his own life, even to his closest friend. His mental health had been consistently stable during his time at Lowdham Grange and, a month before Mr Beal's death, the psychiatrist noted how robust his mental health appeared to be despite the setbacks with his parole.
96. Nine partially-digested dihydrocodeine tablets were found in Mr Beal's cell after his death, but we cannot say where these came from. Although Mr Beal had to take his medication under the supervision of a nurse to ensure that he swallowed it, it is possible that he either 'pouched' it (hid it in his mouth) or that he swallowed it and later regurgitated it. It is also possible that he obtained the tablets illicitly from another prisoner.
97. Nor can we say why Mr Beal had the tablets in his cell. He may have intended to trade them with other prisoners; he may have used them to get 'high', given his

history of substance abuse; or he may have been stockpiling them with the intention of killing himself.

98. We are satisfied that prison staff had no reason to suspect that Mr Beal was hiding his prescribed medication and could not have foreseen that he would die of an overdose.

Contact with Mr Beal's family

99. Prison Rule 22(1) states: "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."
100. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, says, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death ... If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable."
101. We are concerned that the next of kin details listed for Mr Beal were incorrect. It is even more troubling that they were for his son who had died ten years earlier. The prison should have ensured that these details were correct and up to date.
102. We recognise that the prison managed to locate details for Mr Beal's former wife. However, we are concerned that although the FLO and her deputy travelled to see her in person, she had already been informed of Mr Beal's death by the Deputy Director by telephone before they arrived. Although we do not doubt that this was done with the best of motives, it indicates a worrying lack of organisation and of clarity about the role of the FLO. Once a FLO has been appointed, they are responsible for co-ordinating the prison's contact with the next of kin.

The Director should ensure that:

- a prisoner's next of kin details are up to date; and
- the prisoner's family are informed of his death in person, in line with national guidance.

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