

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Bird a resident at Manor Lodge Approved Premises on 8 June 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Bird died from multiple organ failure at hospital on 8 June 2016 while a resident at Manor Lodge Approved Premises, Windsor. He was 73 years old. I offer my condolences to Mr Bird's family and friends.

Mr Bird had lived at Manor Lodge since March 2016, after his release from HMP Winchester. He suffered from a number of chronic conditions and had poor mobility. I am satisfied that staff at Manor Lodge appropriately supported Mr Bird and there was nothing they could have done to predict or prevent his death.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

October 2016

Contents

Summary 1
The Investigation Process 2
Background Information 3
Key Events 4
Findings..... 6

Summary

Events

1. In November 2009, Mr Michael Bird was sentenced to 10 years in prison for sexual offences. In March 2016, he was released from HMP Winchester on licence and required to live at Manor Lodge Approved Premises, Windsor. Mr Bird had a number of chronic health conditions including leg ulcers and prostate cancer. He had poor mobility and used a wheelchair.
2. When Mr Bird arrived at Manor Lodge staff went through the induction process, assigned him a disabled room on the ground floor and made arrangements for him to register with a local GP. The approved premises manager organised a social care assessment and this took place the same day.
3. Staff at Manor Lodge monitored and reviewed Mr Bird frequently. They issued his medication daily and helped facilitate his hospital and doctors appointments by providing taxis while he waited for an electric mobility scooter. District nurses visited Mr Bird at Manor Lodge to change his ulcer dressings regularly and staff supported their visits.
4. At about 10.00am on 6 June, a residential assistant spoke to Mr Bird through his bedroom door and he reported difficulty getting out of bed. The residential assistant informed the approved premises manager, who subsequently entered Mr Bird's room with another member of staff. Mr Bird told the manager that his back had jarred and that it was causing him significant pain. She immediately requested an ambulance and Mr Bird was taken to hospital as an emergency.
5. On 8 June, at 5.50pm, a member of staff from the hospital informed an offender supervisor at Manor Lodge that, sadly, Mr Bird had died at 4.50pm.

Findings

6. We are satisfied that the level of care and support Mr Bird received at Manor Lodge was of a very high standard. The staff could not have done anything to prevent Mr Bird's death and responded appropriately when he told them that his back had jarred.

The Investigation Process

7. The investigator issued notices to staff and prisoners at Manor Lodge Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Bird's prison, probation and medical record.
9. The investigator interviewed three members of staff at Manor Lodge on 12 July 2016.
10. We informed HM Coroner for Berkshire of the investigation who provided the cause of death. We have given the coroner a copy of this report.
11. There was no family involvement in this investigation.
12. The initial report was shared with the Probation Service. The Probation Service did not find any factual inaccuracies.

Background Information

Manor Lodge Approved Premises

13. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.
14. Manor Lodge Approved Premises in Windsor, Berkshire, is managed by the National Probation Service. It has 24 single rooms, including a ground floor room with disabled facilities. The accommodation is self catered and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and well-being and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Manor Lodge 24 hours a day.

Previous deaths

15. Mr Bird was the second person to die from natural causes at Manor Lodge. The first was in July 2013. There were no similarities with the circumstances of the previous death.

Key Events

16. On 20 November 2009, Mr Michael Bird was sentenced to 10 years imprisonment for sexual offences and was sent to HMP Winchester. He had a number of chronic health conditions including leg ulcers and prostate cancer which had spread to his spine. Prison GPs monitored Mr Bird's conditions and a specialist urologist at the hospital reviewed him every six months. Mr Bird had poor mobility and used a wheelchair to get around.
17. On 18 March 2016, a prison GP reviewed Mr Bird and asked a nurse to swab an ulcer on his left leg. The GP noted that Mr Bird was due to be released from prison and gave him a letter to pass on to his community GP. On 20 March, a nurse changed Mr Bird's ulcer dressing and swabbed the wound for analysis.
18. On 29 March 2016, Mr Bird was released on licence and was required to live at Manor Lodge Approved Premises, Windsor. An offender manager from the Plymouth probation office escorted him.
19. When Mr Bird arrived at Manor Lodge, an offender supervisor went through the induction process. He obtained Mr Bird's permission to release information from his medical record and arranged for him to register with a local GP. Mr Bird was assigned a ground floor room with disabled access and the approved premises manager arranged for a social care assessment to take place the same day. The staff kept Mr Bird's medication in the office and he had to collect it daily.
20. On 30 March, Mr Bird went to a GP registration appointment by taxi. When he returned he told staff that district nurses would be visiting him every day to change his ulcer dressing. There was some initial confusion about the district nurse appointments and Mr Bird had to have his dressing changed at the local walk-in centre on 2 April. However, on 6 April, the district nurses visited Mr Bird at Manor Lodge for an assessment and agreed to see him every Monday, Wednesday and Friday. The staff from Manor Lodge facilitated their appointments.
21. On 26 April, Mr Bird reported ongoing constipation and a dull ache in his spine to the offender supervisor during a weekly key worker session. He advised Mr Bird to notify a member of staff should he need any medical assistance or feel unable to cope with his health problems. The staff at Manor Lodge continued to give Mr Bird his medication daily and conduct regular welfare checks.
22. On 5 May, during a key worker session, the offender supervisor noted that Mr Bird was waiting for the outcome of an assessment by the SSAFA (Soldiers, Sailors, Airmen and Families Association) for an electric mobility scooter. Mr Bird did not report any significant changes to his physical health, although he did say he was waiting for the result of a blood test. Mr Bird received his mobility scooter before he died, but the exact date remains unclear.
23. On 20 May, Mr Bird reported that a recent blood test and spinal X-ray identified a vitamin B12 deficiency and a cracked vertebra. The offender supervisor noted that he would need to attend the GP surgery three times a week to have blood tests and injections for a period of three weeks and once a month thereafter. Mr Bird reported that he was pleased that his cancer had not spread beyond his

spine as suspected. The staff at Manor Lodge continued to monitor Mr Bird frequently and the district nurses changed his ulcer dressing as required.

24. On 6 June at approximately 9.30am a residential assistant went to Mr Bird's room to remind him to collect his medication. He spoke to Mr Bird through his door and he said that he was getting dressed. Around 15 minutes later, he returned to Mr Bird's room to remind him that he had a GP appointment and he said that he would be out soon. When he went back to Mr Bird's room for a third time, at approximately 10.00am, Mr Bird said that his back had locked and that he could not get out of bed. He offered him reassurance and went to the office to get help.
25. The residential assistant alerted the approved premises manager and the offender supervisor to the situation and they entered Mr Bird's room immediately. They found him lying on his side and he said that his back had jarred and that he could not move. The manager pressed her panic button and asked the residential assistant to call an ambulance. Mr Bird told her he had significant back pain, so she stayed and reassured him until the first response paramedic arrived. The paramedic examined Mr Bird and arranged for an emergency ambulance to take him to hospital. The staff at Manor Lodge telephoned the hospital twice a day to obtain updates on Mr Bird's condition.
26. On 8 June at approximately 5.50pm, an offender supervisor received a call from the hospital notifying her that, sadly, Mr Bird had died at 4.50pm.

Contact with Bird's family

27. Mr Bird did not wish to provide his next of kin details to the staff at Manor Lodge.
28. Mr Bird's funeral was on 28 July and the approved premises manager attended with another Manor Lodge resident. The Probation Service contributed to the cost, in line with national policy.

Support for residents and staff

29. Following the news of Mr Bird's death, an offender supervisor telephoned the out of hours manager, who offered immediate support to those members of staff on duty and told them that she was available during the night if needed. The next day, the manager offered support to all staff who knew and had worked with Mr Bird.
30. On 9 June, during a morning meeting, an offender supervisor told all the residents that Mr Bird had died and offered support. Notices were posted to inform all staff and residents of Mr Bird's death and offering support.

Cause of death

31. The coroner confirmed that Mr Bird died of multi organ failure with underlying sepsis (a generalised infection) and pneumococcal pneumonia.

Findings

Clinical care

32. Mr Bird was 73 years old and had a number of chronic health conditions including leg ulcers and prostate cancer. Following his release on licence, the staff at Manor Lodge conducted a full induction and arranged for him to register with a local GP. Mr Bird did not have his prescribed medication in his possession but collected it from staff daily. The approved premises manager told the investigator that they decided to personally dispense his medication so that staff could ensure he took it and it also enabled them to conduct additional welfare checks. We consider that this arrangement was appropriate.
33. A social care assessment took place on the day that Mr Bird arrived at Manor Lodge. The approved premises manager told the investigator that she had concerns about the extent of Mr Bird's mobility difficulties and wanted to make sure the disabled room was suitable for his needs. We consider this action to be appropriate and are satisfied that Manor Lodge's wheelchair accessible room was suitable.
34. Although Mr Bird had mobility difficulties he was relatively independent and, as with anyone else in the community, was responsible for managing his own health and attending medical appointments. Nevertheless, the staff at Manor Lodge supported Mr Bird with managing his conditions and helped him to get to his medical appointments by providing taxis until he got his mobility scooter. They facilitated district nurse appointments and reviewed him frequently throughout the day and during key worker sessions. Staff made additional welfare checks at set times during the night.
35. We are satisfied that staff at Manor Lodge could not have done anything to prevent Mr Bird's death. They ensured that he received emergency treatment by calling an ambulance immediately they realised he was in significant pain and required medical assistance.

**Prisons &
Probation**

Ombudsman
Independent Investigations