

**Prisons &
Probation**

Ombudsman
Independent Investigations

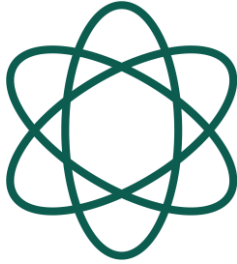
Independent investigation into the death of Mr Michael Birdie, a prisoner at HMP Peterborough, on 10 November 2022

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

OGI

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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. If my office is to best assist HM Prison and Probation Service 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 Michael Birdie died of bronchopneumonia (an inflammation of the lungs usually brought on by an infection) in hospital on 10 November 2022, while a prisoner at HMP Peterborough. This was caused by congestive cardiac failure (the heart being unable to pump blood around the body properly) and ischaemic heart disease (where the heart is starved of oxygen due to a lack of blood flow). He also had hypercholesterolaemia (an excess of cholesterol in the blood) which contributed to but did not cause his death. Mr Birdie was 76 years old. I offer my condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Birdie received at Peterborough was of a reasonable standard and equivalent to that which he could have expected to receive in the community.
5. However, a copy of the medical escort risk assessment for 10 October was not provided, and the escort risk assessment for 19 October did not include the rationale for the decision made by the nurse not to object to restraints.
6. The decision that two prison officers were not sufficient to prevent a 76 year old man dying of heart failure and bronchopneumonia from escaping or committing further offences and therefore an additional escort chain was required cannot be justified.

Recommendations

- **The Director 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 complete the medical information section of the escort risk assessment in full; and**
 - **prison staff completing escort risk assessments give adequate consideration to a prisoner's presenting health, alongside the factors associated with public protection.**
- **The Director and Head of Healthcare should ensure that documents are retained, securely stored and promptly provided to the Prisons and Probation**

Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Birdie's clinical care at HMP Peterborough.
8. The PPO investigator investigated the non-clinical issues relating to Mr Birdie's care.
9. The PPO family liaison officer wrote to Mr Birdie's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not have any specific questions.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.
11. Mr Birdie's family received a copy of the draft report. They did not make any comments.

Previous deaths at HMP Peterborough

12. Mr Birdie was the eleventh prisoner to die at Peterborough since 10 November 2020. Of the previous deaths, seven were from natural causes, one was self-inflicted and two were drug-related.
13. We have previously made recommendations about the importance of healthcare staff contributing to escort risk assessments. Following our recommendations, Peterborough agreed in April 2022 to remind and brief clinical staff to check a patient's medical notes before contributing to an escort risk assessment, including an assessment of a prisoner's clinical condition and mobility.

Key Events

14. On 24 February 2022, Mr Michael Birdie was remanded into custody for sex offences and sent to HMP Peterborough. He was 76 years old.
15. Mr Birdie had a number of medical conditions, including but not limited to left ventricular systolic dysfunction (a form of heart failure), atrial fibrillation (an irregular heartbeat) and high blood pressure. He also had reduced mobility and used a walking stick for short distances and a wheelchair for anything greater.
16. On 5 April, Mr Birdie was admitted to hospital. A hospital consultant concluded that Mr Birdie's heart failure was terminal, and he was referred for palliative care.
17. On 14 April, Mr Birdie returned to HMP Peterborough, and he was moved to the healthcare unit.
18. On 29 April, an emergency care and treatment plan was drawn up with Mr Birdie. It was recorded that in the event of an acute event, Mr Birdie would prefer to be transferred to hospital/hospice for end-of-life care and that cardiopulmonary resuscitation was not recommended.
19. On 10 October at 2:53pm, a nurse saw Mr Birdie and carried out routine observations (Mr Birdie was checked by healthcare staff every day). She calculated a National Early Warning Score (NEWS2, a tool to detect and respond to clinical deterioration) of six. Anything above five requires an urgent response and she asked for an ambulance to be called.
20. Before Mr Birdie left the prison, staff completed an escort risk assessment. They recorded that he posed a medium risk to the public due to the nature of his alleged offence. It was noted that there was no intelligence to suggest that he would try to escape, and that Mr Birdie had been escorted outside the prison before, with no concerns raised. The form indicated that medical advice had been sought but the prison could not find the medical risk assessment and so the PPO investigator was unable to view it.
21. The conclusion reached by the officer completing the assessment was that Mr Birdie should be restrained using a standard double cuff as he was on remand.
22. The duty authorising manager concluded that due to Mr Birdie's limited mobility and health issues, he should be escorted by two prison officers and restrained using an escort chain. An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.
23. At 9.50pm, the duty authorising manager advised staff that the escort chain could be removed if Mr Birdie was moved to a ward.
24. On 11 October at 7.59pm, the escort chain was removed from Mr Birdie after he was moved to a ward.
25. On 14 October, Mr Birdie was discharged from hospital and escorted back to Peterborough and was restrained using an escort chain.

26. On 19 October, Mr Birdie had to attend a hospital appointment. A nurse completed the medical escort risk assessment form and recorded that there were no medical objections to the use of restraints, but that Mr Birdie's mobility was impaired. No reasons for the decision were recorded.
27. The officer who completed the security risk assessment recommended that Mr Birdie should be escorted by two officers and restrained using a standard double cuff. The reasons cited for this decision were the nature of Mr Birdie's offences and that he was currently on remand.
28. The duty authoring manager concluded that an escort chain would be sufficient and should only be removed with authorisation from the duty authorising manager. Mr Birdie was admitted to hospital that day. The prison could not find the log completed by officers at the hospital with Mr Birdie, so it is not clear if or when the restraints were removed.
29. On 26 October, Mr Birdie returned to Peterborough, where he lived in the healthcare unit. Once back in prison, staff checked him every two hours.
30. On 9 November, a GP at Peterborough reviewed Mr Birdie. He concluded that despite being offered food and drink, he had become seriously dehydrated and needed to be admitted to hospital.
31. A medical risk assessment was completed, and it was noted that there were medical objections to the use of restraints because Mr Birdie was frail and approaching the end of his life. The security assessment also recommended that no restraints should be used.
32. On 10 November, Mr Birdie died in hospital.

Post-mortem report

33. A post-mortem examination established that Mr Birdie died from bronchopneumonia (an inflammation of the lungs usually brought on by an infection) caused by congestive cardiac failure (the heart being unable to pump blood around the body properly) and ischaemic heart disease (where the heart is starved of oxygen due to a lack of blood flow). Mr Birdie also had hypercholesterolaemia (an excess of cholesterol in the blood) which did not cause but contributed to his death.

Inquest into Mr Birdie's death

34. The inquest into Mr Birdie's death was held on 19 June 2023 and a verdict of natural causes was recorded.
35. The coroner concluded that Mr Birdie's death was due to bronchopneumonia caused by congestive cardiac failure and ischaemic heart disease.

Findings

Clinical findings

36. The clinical reviewer found that the care that Mr Birdie received at Peterborough was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.
37. She identified a few areas of good practice: requests made by the healthcare team for a GP review were timely, GP reviews were very responsive and there was a good standard of communication and coordination of care from the senior nursing and management team at Peterborough.
38. However, the clinical reviewer was concerned that the medical escort risk assessment form for the admission on 10 October could not be provided and that the rationale for the decision not to object to restraints on medical grounds on 19 October was not recorded.
39. The clinical reviewer made one recommendation to Peterborough which did not directly relate to Mr Birdie's death but which the Head of Healthcare will need to address.

Restraints, security and escorts

40. HMPPS 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. 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 he has 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.
41. Prison Service Instruction 33/2015, *External Prisoner Movement*, defines the policy and guidance for the external escort of prisoners. It says that a risk assessment must be undertaken to decide whether restraints must be used on an escort. It also says that restraints will not normally be used when a prisoner's medical condition, advanced age or physical impairment renders restraints inappropriate.
42. In the case of an admission to hospital, healthcare staff are required to complete a medical risk assessment which is then considered alongside all other relevant intelligence and information.

Hospital admission on 10 October

43. When a nurse requested an ambulance, Mr Birdie had a NEWS score of 6 and needed oxygen. Mr Birdie was 76 years old, had heart failure, was receiving palliative care and used a walking stick for short distances and a wheelchair for anything greater.
44. Mr Birdie's risk assessment form recorded that he posed a medium risk to the public due to the nature of his alleged offence. There was no intelligence to suggest a risk of escape and Mr Birdie had been escorted out of the prison previously, with no issues raised. Despite this, the officer completing the assessment recommended that Mr Birdie should be restrained using a standard double cuff due to the nature of his offences and that he was on remand.
45. The medical risk assessment form was not provided to the investigator so we could not review the recommendation made by the healthcare professional.
46. The duty authorising manager did not agree with the decision reached and instead recommended that an escort chain should be used due to Mr Birdie's limited mobility and health issues.

Hospital admission on 19 October

47. A nurse completed the medical risk assessment form and recorded that there were no medical objections to the use of restraints, but that Mr Birdie's mobility was impaired. She should have explained the reason for her decision, particularly given Mr Birdie's poor mobility.
48. The clinical nurse manager responded to our questions about why healthcare staff had no medical objections to the use of restraints and advised that Mr Birdie was able to walk a short distance unaided. (His medical records, however, advised that he needed a walking stick to walk short distances.) The clinical reviewer and investigator received conflicting information about whether healthcare staff received formal training on how to complete the medical risk assessment.
49. Mr Birdie was again restrained by an escort chain when he left the prison. As we were not provided with the bedwatch logs, we are unable to establish how long Mr Birdie remained restrained and if restraints were reapplied for the journey back to Peterborough on 25 October.
50. Given Mr Birdie's age, his health conditions, his limited mobility and that he was escorted by two prison officers, Peterborough did not justify that the use of restraints on Mr Birdie was proportionate to the risks he posed. We made a recommendation to Peterborough previously about ensuring that healthcare staff accurately reflected the prisoner's current clinical condition and mobility when making their assessment. That recommendation was accepted. The circumstances in this investigation are different and so we make the following recommendation:

The Director 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 complete the medical information section of the escort risk assessment in full**
- **prison staff completing the risk assessments give adequate consideration to a prisoner’s presenting health, alongside the factors associated with public protection**

Record keeping

51. The PPO investigator asked Peterborough to provide the escort risk assessments and bedwatch logs for October and November 2022. However, they could not find the requested documents. This adversely affected our investigation as we could not be certain what, if any, medical information was considered as part of the escort risk assessment on 10 October, and we do not know how long Mr Birdie remained restrained following his admission on 19 October and if he returned to prison restrained. We make the following recommendation:

The Director and Head of Healthcare should ensure that documents are retained, securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

**Adrian Usher
Prisons and Probation Ombudsman**

July 2023

**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 | 020 7633 4100