

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Wignall, a resident at Highfield House Approved Premises, on 17 September 2015

**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*



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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 we oversee can improve their work in the future.

Mr Stephen Wignall died of heart failure on 17 September 2015, while a resident at Highfield House Approved Premises in Accrington. Mr Wignall was 65 years old. I offer my condolences to Mr Wignall's family and friends.

Mr Wignall had lived at Highfield House since 11 September after leaving HMP Preston on licence. He suffered from asthma and epilepsy, and had a history of alcohol abuse.

I am satisfied that staff at Highfield House appropriately supported Mr Wignall and could not have done anything to prevent his death. I am also satisfied that staff reacted quickly when Mr Wignall collapsed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2016

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Summary

Events

1. On 11 September 2015, Mr Stephen Wignall was released on licence from HMP Preston to live at Highfield House Approved Premises, Accrington. He suffered from asthma, epilepsy, an overactive bladder and had a history of alcohol abuse. Mr Wignall registered with a local GP who prescribed appropriate medication. Staff at Highfield House breathalysed Mr Wignall each day to monitor his alcohol consumption and to determine if and when he should be referred to an alcohol support service. The readings showed Mr Wignall was consuming alcohol.
2. On 13 September, Mr Wignall suffered an alcohol induced epileptic seizure, while out in town. He was taken to hospital, where he remained overnight. Doctors increased his epilepsy medication and Mr Wignall returned to Highfield House during the evening of 14 September.
3. On 15 September, Mr Wignall met with his offender supervisor, who advised him that his behaviour was not acceptable. She referred him to an alcohol support service and told him he had breached the conditions of his licence and would have to appear in court.
4. At 9.00pm on 17 September, a resident alerted staff that Mr Wignall had collapsed in their shared room. Two members of staff immediately went to Mr Wignall's room and found him unresponsive. They commenced cardiopulmonary resuscitation and called an emergency ambulance. Paramedics arrived at approximately 9.30pm but, despite all efforts, Mr Wignall died at approximately 10.00pm.

Findings

5. We are satisfied that staff at Highfield House could not have done anything to prevent Mr Wignall's death and responded appropriately when he collapsed. We note that this was the first death in custody at Highfield House and consider that the family liaison officer offered good support to Mr Wignall's daughter after his death.

The Investigation Process

6. The investigator issued notices to staff and residents at Highfield House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Wignall's records. She spoke to two members of staff and one resident on the telephone.
8. We informed HM Coroner for Blackburn of the investigation who gave us a copy of the post-mortem examination. We have sent the coroner a copy of this report.
9. One of the Ombudsman's family liaison officers contacted Mr Wignall's daughter to explain the investigation process and to ask if she had any matters they wanted the investigation to consider. She did not have any concerns.
10. Mr Wignall's daughter was informed the initial report was available, but did not wish to receive a copy or make any comment.
11. The initial report was shared with the National Probation Service. They identified no factual inaccuracies.

Background Information

Highfield House Approved Premises

12. 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 health and are expected to register with a GP.
13. The National Probation Service manages Highfield House in Accrington. It has 19 rooms, 16 single rooms and three double rooms. The Approved Premise provides evening meals and there is a communal area for dining and socialising, and areas for group work. Each resident is allocated a key worker/offender supervisor to oversee their progress, well-being and adherence to licence conditions and the premises' rules. Probation service employees are on duty at Highfield House 24 hours a day.

Previous deaths at Highfield House

14. There had been no previous deaths at Highfield House. Since Mr Wignall's death, there has been one other death.

Key Events

15. On 30 March 2015, Mr Stephen Wignall was sentenced to six months in prison for breaching a sexual offences prevention order and sent to HMP Preston. On 11 September 2015, he was released on licence. His licence conditions required him to live at Highfield House Approved Premises with a curfew between 8.00pm to 8.00am. He was also required to report to Highfield House at 1.00pm each day. Mr Wignall agreed to be of good behaviour and accept treatment for his alcohol addiction if required. Mr Wignall understood that if he breached his licence conditions he could be recalled to prison. Mr Wignall shared a room with another resident.
16. Mr Wignall had asthma, epilepsy, an overactive bladder and a history of alcohol abuse. On 12 September, he registered with a community GP at Peel House medical surgery and a GP prescribed his medication.
17. The local pharmacy delivered Mr Wignall's medication to Highfield House and staff arranged a repeat prescription on his behalf. Staff gave him his medication as prescribed and breathalysed him daily to monitor his alcohol consumption.
18. At 1.00pm on 13 September, Mr Wignall did not report to Highfield House as required by his licence conditions. Staff asked other residents if they had seen Mr Wignall and searched the grounds of the premises. Mr Wignall did not have a mobile telephone so staff were unable to contact him. At 3.45pm, staff told the police that Mr Wignall had breached the conditions of his licence.
19. At 2.15am on 14 September, a police officer telephoned Highfield House and said Mr Wignall was in hospital. At 2.35am, a hospital nurse told staff Mr Wignall had suffered an alcohol induced, epileptic seizure in town and would return to Highfield House later that day.
20. At 8.30pm on 14 September, Mr Wignall returned to Highfield House by ambulance. Hospital doctors had increased his dose of epilepsy medication and advised staff that Mr Wignall should take this medication regardless of his alcohol consumption.
21. On 15 September, Mr Wignall met with his offender manager and the manager at Highfield House. The offender manager gave Mr Wignall a breach letter because he had not complied with his licence conditions, which said he was required to attend court on 24 September. She also referred Mr Wignall to an alcohol support service.
22. On 17 September, Mr Wignall left Highfield House to visit in town. That day he returned to Highfield House and reported in at 1.00pm, in accordance with his licence conditions, then returned to Chorley. Mr Wignall returned to Highfield House at 4.25pm. Staff breathalysed him, which showed that Mr Wignall had consumed alcohol. Staff gave Mr Wignall his prescribed medication and Mr Wignall said he was going to bed. Staff did not see Mr Wignall again that evening.
23. Another resident shared a room with Mr Wignall. At approximately 6.30pm, the resident left their room. He told us that Mr Wignall's behaviour was normal and

he had no concerns about his health. He returned to the room at approximately 9.00pm and found Mr Wignall unresponsive on the floor. He left the room immediately and told the late duty staff at Highfield House.

24. Staff went to Mr Wignall's room with the first aid bag. Mr Wignall was still unresponsive and appeared not to be breathing. One member of staff used her mobile phone to call an ambulance. The ambulance service told her to turn Mr Wignall on his side and clear his airway. Her colleague attached the defibrillator, which advised to start shock treatment, and started cardiopulmonary resuscitation (CPR). The paramedics arrived at approximately 9.30pm and took over Mr Wignall's care. Mr Wignall did not respond and died at approximately 10.00pm at Highfield House.

Contact with Mr Wignall's family

25. On 18 September, the National Probation Service appointed an operations manager who covers Highfield House as the family liaison officer. Mr Wignall had nominated his offender manager as his next of kin. Mr Wignall had limited contact with his family; however, staff were aware that he had children.
26. The premises manager contacted the police victim liaison officer, who provided contact details for Mr Wignall's daughter but suggested the police should tell her. On 19 September, a police officer visited Mr Wignall's daughter and informed her of his death. The family liaison officer then telephoned Mr Wignall's daughter and offered her condolences, advice and support. She remained in regular contact with Mr Wignall's daughter until after his funeral, on 1 October. Highfield House paid for the funeral in line with national policy.

Support for residents and staff

27. On 9.15am on 18 September, the premises manager informed the residents of Highfield House in person that Mr Wignall had died. Residents were offered the opportunity to talk about Mr Wignall. Additional support services, including counselling, were offered.
28. The same day, the premises manager spoke to the staff involved in the emergency response and offered counselling. She also sent an email to all staff offering counselling and thanking them for their professional and respectful behaviour. Staff told us that they felt well supported by her.

Post-mortem report

29. The post-mortem report gave the cause of death as left ventricular hypertrophy (thickening of the lower chambers of the heart) with myocardial fibrosis (thickening of the heart valves). Toxicology results showed Mr Wignall had consumed alcohol and would have been intoxicated before his death, though the levels of alcohol were not sufficient to have caused his death.

Findings

Clinical care

30. Mr Wignall had several medical conditions and a history of alcohol abuse. Shortly after his release on licence, he registered with a GP and a local pharmacy delivered his prescribed medication to Highfield House. Staff ensured Mr Wignall received it and re-ordered his prescriptions as necessary.
31. Mr Wignall was independent and, as with anyone else in the community, was responsible for managing his own health and attending medical appointments. Nevertheless, staff at Highfield House supported Mr Wignall with managing his medical conditions and monitored his alcohol consumption level daily. When it became clear that Mr Wignall was consuming too much alcohol, staff referred him to a support service. We are satisfied that staff at Highfield House could not have done anything to prevent Mr Wignall's death.

Emergency response

32. Highfield House has a comprehensive first aid policy in line with the NOMS' Approved Premises Manual, which clearly states in what circumstances staff should call an ambulance, the location of the emergency bag, what it contains and how it should be used.
33. Staff reacted immediately when a resident told them Mr Wignall was unresponsive in their room. They took the emergency bag, called an ambulance immediately, properly used a defibrillator and started CPR. We consider this is a commendable response.

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