Grahame Antony Short
Senior Coroner for Central Hampshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Governor, HM Prison Winchester**
1	**CORONER** I am Grahame Antony Short, Senior Coroner for Central Hampshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19 September 2016 I commenced an investigation into the death of Sean Patrick Plumstead, aged 27. The investigation is due to be concluded at the end of the inquest listed to commence on 09 October 2017.
4	**CIRCUMSTANCES OF THE DEATH** The deceased Sean PLUMSTEAD was a prisoner in HMP Winchester serving a 16 month prison sentence. He was due for release in less than a month. On 15 September 2016 Mr Plumstead was in a shared cell. His fellow prisoner, [redacted] was watching television whilst Mr Plumstead went into the toilet area, pulling the privacy curtain around himself. He later found Mr Plumstead hanging by his neck from a ligature consisting of some material that was attached to one of the bars of the cell window. [redacted] called for prison staff who arrived and immediately called a 'Code Blue' at 18:48 and cut Mr Plumstead down prior to commencing CPR. He had no pulse initially but one returned and he was taken to Royal Hampshire County Hospital Winchester where he was treated but then died on 18 September 2016. I ordered a forensic autopsy which was performed by [redacted] on 20 September 2016 as a result of which he has reported the cause of death to be: 1a) Hypoxic-ischaemic brain injury, bronchopneumonia and myocardial infarction 1b) Prolonged cardiorespiratory arrest 1c) Compression of the neck due to ligature suspension. I have held Pre-inquest review hearings on 18 April 2017 and 11 July 2017 as a result of which I ordered inter alia disclosure by the Prison Service of recordings of telephone conversations involving Mr Plumstead and the recording of a post incident investigation by an assistant governor which I consider to be potentially relevant to the investigation.
5	**CORONER'S CONCERNS** During the course of the investigation issues have arisen, giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) Winchester Prison has been unable to produce the telephone recordings and the transcripts provided are in summary form only and so may omit potential evidence. The systems in place for proper storage of such material appear to be inadequate or non-existent.

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	(2) Winchester Prison has been unable to produce recordings of the interviews of staff and it has been stated that due to resourcing constraints written transcripts of some of the interviews were not prepared. It is uncertain whether the relevant assistant governor will be able to give live evidence of the results of her investigation and one of the officers involved is on long term absence. The systems in place for proper storage of such electronic material appear to be inadequate and the administrative processes for transcription are insufficiently resourced. (3) This is not the first death in custody at Winchester Prison where potentially important documents or electronic material has been mislaid or not found because they have not been retained with specific prisoner records. There is therefore a risk that future deaths at the prison occur when such omissions are repeated.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you the Prison Governor have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report in a timely manner, namely by 01 September 2017 so as to avoid the need to further adjourn this inquest. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] and Central & North West London NHS Foundation Trust (CNWL). I have also sent it to Government Legal Department acting for the Ministry of Justice, Hodge Jones & Allen LLP acting for [redacted] Radcliffes LeBrasseur acting for CNWL and the Prison & Probation Ombudsman who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 09 August 2017 Signature_____ Senior Coroner for Central Hampshire

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