Sarah Laurie Whitby
Assistant Coroner for Central Hampshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] HMP Winchester**
1	**CORONER** I am Sarah Laurie Whitby, Assistant 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 11/05/2015 I commenced an investigation into the death of Sheldon Woodford, aged 24 . The investigation concluded at the end of the inquest on 23 February 2016. The conclusion of the inquest was Sheldon Woodford deliberately chose to suspend himself by a ligature but the evidence does not fully explain whether or not he intended that the outcome be fatal or that on balance he intended the outcome be fatal, to which a failure to respond to an evident risk of self harm contributed. The deceased was detained at HMP Winchester on the 16th January 2015. He was found in his cell on the 9th March 2015 with a ligature made of bedding deliberately placed around his neck suspended from the door. He subsequently died in the Royal Hampshire County Hospital on the 12th March 2015. There was a failure to adequately identify the escalating level of risk of self harm as a result of the following: 1. Insufficient levels of staffing of both prison and healthcare.2. Inadequate appropriate ACCT training especially for temporarily promoted officers.3. Unstructured application of the ACCT process resulting in an inadequate integrated approach between prison staff and healthcare.4. On the balance of probabilities Sheldon Woodford's mental health issues are likely to have contributed to his death. Cause of Death: Delayed Effects of Ligature Suspension
4	**CIRCUMSTANCES OF THE DEATH** Sheldon Woodford had a history of mental health issues, and was on regular observation in prison. He was found in his prison cell hanging on the 9th March 2015. After being admitted to Royal Hampshire County Hospital intensive care unit, he remained unconscious and had suffered significant hypoxic brain injury. He was deemed brain stem dead. Treatment was withdraw and the death occurred on the 12/03/2016
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters 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)That in the reception process the SASH document is not identifiable to all relevant staff. (2)Training of Officers in the ACCT processes.

6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you [redacted] Head of Safer Custody HMP Winchester have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th July 2016. 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. A. [redacted] B. Central and North West London NHS Foundation Trust 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 16 May 2016 Signature Sarah Whitley Assistant Coroner for Central Hampshire