



Grahame Antony Short
Senior Coroner for Central Hampshire

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: HM Prison and Probation Service & Carillion (AMBS) Limited</p>
1	<p>CORONER</p> <p>I am Grahame Antony Short, Senior Coroner for Central Hampshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 19 September 2016 an investigation was opened into the death of Sean Patrick Plumstead aged 27. The investigation concluded at the end of the inquest on 18 October 2017</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Sean Plumstead was a convicted prisoner serving a 16 month prison sentence in HM Prison Winchester. He was due for release on 8 October 2016. He had no recorded history of mental illness, nor previous incidents of self harm. In the days leading to his death there were indications that he was distracted and thinking about suicide, but he did not disclose his plans and no ACCT had been opened. On 15 September 2016 Mr Plumstead was sharing a cell with a fellow prisoner, ██████████ who had that day moved into the cell with him. ██████████ was watching TV whilst Mr Plumstead went into the toilet area, pulling the privacy curtain around himself. ██████████ activated the emergency cell bell at 17.39 and at an unknown later time he found Mr Plumstead hanging by his neck from a ligature consisting of clothing material that was attached to one of the bars of the cell window. Members of the prison staff arrived and immediately called for assistance at 18:50 and they 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. A razor blade was found in the sink near the toilet and he presented with a laceration on the right side of his neck and a ligature wound along the front of the neck. His pulse and a heartbeat resumed but he had little brain activity. On 18 September 2016, medical staff took the decision to withdraw treatment and he died at 23:44 that day. His cause of death has been given as: 1a Hypoxic-ischaemic brain injury, bronchopneumonia and myocardial infarction 1b Prolonged cardiorespiratory arrest 1c Compression of the neck due to ligature suspension</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>1. ACCT Training</p> <p>I issued a Regulation 28 Report on 4 October 2016 in relation to a death of another prisoner at HMP Winchester ██████████ concerning inter alia Assessment Care and Custody and Teamwork (ACCT) training plans and received a response from the</p>

Ministry of Justice dated 12 December 2016 in which it was stated that refresher training was taking place for 48 members of staff that month and at least monthly thereafter and that 12 new prison officers were expected to complete the Prison Officer Entry Level Training course that includes training on suicide and self-harm awareness (SASH) and ACTT process before starting work at Winchester by March 2017.

In an inquest starting on 13 March 2017 in relation to a death of another prisoner at HMP Winchester [REDACTED] evidence was given by the prison governor that at August 2016 41% of staff had received ACTT training; at the date the evidence was given 61% of staff had received ACTT training; and that the aim was for 80% of staff to receive ACTT training by Autumn 2017. The Assistant Coroner issued a Regulation 28 Report on 11 April 2017 concerning inter alia ACCT training plans and received a response from the Ministry of Justice dated 21 June 2017 which stated that at the date of the letter 120 out of 162 prison officers at HMP Winchester (74%) had received ACCT training.

Evidence adduced in the inquest into the death of Mr Plumstead disclosed statistics for the provision of SASH training had been completed as follows:

- As at September 2016 77.29% of forward-facing prison service staff
- As at September 2016 64.27% of all prison service staff
- As at September 2017 72% of forward-facing prison service staff
- As at September 2017 57% of prison service staff were "in date" with such training.

The evidence was that the current aim is to achieve the 80% target by mid 2018.

It was apparent from the evidence that due to staff turnover, a lack of trainers qualified and available to provide such training and other priorities, targets for SASH training are failing to be met and if anything the ratio of prison staff with the appropriate skills is reducing rather than increasing. This means that the risk of prisoners at risk of self harm and suicide may not be recognised by staff who have had no such training with whom they come into contact.

2. Training of All Prisoner-facing Staff

The investigation into the death of Sean Plumstead, including evidence heard during the inquest, has highlighted matters of concern relating to Carillion's past and present operations at HMP Winchester and possibly at other establishments nationally. The evidence showed that in the 18 months before Mr Plumstead's death in September 2016, at least two Carillion staff were employed in prisoner-facing roles at the prison (in the Clothing Exchange Store) without any training in self-harm/suicide prevention (in apparent contradiction to the national policy - the Prison Service Instruction 64/2011 in its latest version). Further, one of those staff members was expected to make entries in an (ACCT) support document without having had relevant training. As of October 2017, one of those staff members has still to be trained in self-harm/suicide prevention.

It remains unclear whether the (Carillion) Works Manager and other Carillion supervisors (at a local and national level) are aware of the issue. The prison have since assumed the responsibility for the training of all staff in prisoner-facing roles but there is, as yet, no clarity on the obligations and assumptions which Ministry of Justice and Carillion were operating at the material time (2015-2016) nor indeed what arrangements will pertain in the future. Indeed, I have also heard evidence that the prison do not hold training records for Carillion staff. There is therefore some division of responsibility between the

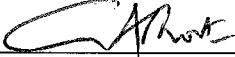
prison and Carillion and a risk that training of staff is missed because of the absence of such records.

I consider there is a risk arising from my investigation that there was and continues to be a gap in training which Carillion is either unaware of or unconcerned with - a gap that may continue here and elsewhere. I understand that Carillion has a contractual obligation to ensure that staff provided to the prison will be appropriately trained, but I cannot identify any requirement for self-harm/suicide management training, nor any commitment by Carillion to make staff available for such training by the prison as necessary. The apparent ambiguities in the arrangement could compromise the safety of prisoners that Carillion personnel are dealing with.

I am also concerned of a risk in other prisons, where Carillion staff are directly engaging with prisoners without adequate or appropriate training in suicide and self-harm management. I invited Carillion to be an Interested Party to the inquest, a request which they declined to take up. Nevertheless, following the evidence in the inquest, the prima facie concerns have hardened. I consider Carillion has the power to take action to remedy these shortcomings and that in collaboration with the Ministry of Justice both can address these concerns and clarify responsibilities.

3. Emergency Cell Bells

The emergency cell bell (ECB) in Mr Plumstead's cell had been activated by his cellmate but the response to this took 10.5 minutes whereas the expected response time is 5 minutes. The evidence showed that there was and continues to be widespread misuse of ECB's by prisoners particularly those on general wings, which leads to prison officers responding on occasions over an hour after the ECB has been activated. There are only limited sanctions available for enforcement of the proper use of the system by prisoners. The system allows no means of prioritising calls or identifying the time when the ECB has been pressed. Prisoners who have a genuine emergency have no alternative means of requesting assistance and therefore the risk is that there medical emergencies will not have a timely response and further deaths in such circumstances will occur. The current system is not fit for purpose and notices to prisoners are ineffective.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you HM Prison and Probation Service and (in relation to (2) only) Carillion (AMBS) Limited have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 December 2017. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> • [REDACTED] and • Central & North West London NHS Trust <p>I have also sent a copy of my report to the Governor of HM Prison Winchester who may find it of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 19 October 2017</p> <p>Signature </p> <p>Senior Coroner for Central Hampshire</p>