	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Governor, HMP Highpoint, cc HM Prison and Probation Service.** **2. The Head of Healthcare, HMP Highpoint, cc NHS England**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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.
3	**INVESTIGATION and INQUEST** At the conclusion of the inquest into the very sad death of LEVI CRONIN, the jury recorded a conclusion of 'Suicide' but also found that 'there was a series of interconnected system inadequacies and failures which contributed to the death', these being: 'Insufficient recording of information. For example, inadequate recording of information in NOMIS and the Wing Observation Log such as recording of phone calls indicating welfare and other concerns.'; 'Insufficient communication. For example, lack of information sharing between departments on Levi's welfare.'; 'Inadequate staffing levels, at the time, within mental health department and prison officer staff. For example, failure of offender supervisor to see Levi in a timely manner, failure to follow up within a timely manner after referral to mental health department and subsequent appointments.'; and 'Inadequate support and supervision to the mental health department.'
4	**CIRCUMSTANCES OF THE DEATH** Levi Cronin died in very tragic circumstances and was confirmed deceased at the West Suffolk Hospital having been taken there from HMP Highpoint where he was a serving prisoner and had been found hanging in the shower on his wing. Levi had a history of depression and self harm and had a number of current concerns in that he was worried about losing his flat, which was subject to a repossession order, had worries about his relationship and had received a letter from his girlfriend during the last week, and was anxious to obtain release on Home Detention Curfew so that he could continue a plumbing course he was very motivated to carry on with. Levi was not able to meet his offender supervisor to discuss this, due to apparent staff shortages, and it was also clear that there had been considerable staffing problems in respect of mental health staff as well as prison staff. On the day of his very sad death, as he had run out of credit, Levi was allowed to use an office telephone to speak to his girlfriend by an officer who remained present for what was clearly a difficult and emotional phone call. Sadly, Levi hung himself in the shower later that day.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows. – During the inquest, concerns and questions arose about: - The sharing of information between healthcare staff and prison staff, while accepting the importance of medical confidentiality and consent. - The recording of 'Static' or 'historical' risk information (on a need to know basis) in a form that would make it more readily accessible to those at a later stage who might have to assess a changing situation and make a new dynamic risk assessment following a recent 'trigger' event - The importance of ensuring that there is adequate and appropriate recording on prison wings of potentially significant event or observed changes in a person's mood or behaviour that could, if all were taken together, assist staff in their very difficult task of making risk assessments in the complex and challenging environment of a busy prison.
6	**ACTION SHOULD BE TAKEN** While it is accepted that much has already been done by staff and management at the prison to try and reduce the risk of similar fatalities and that, in this particular tragedy, even those closest to Levi did not foresee what was about to occur, I would respectfully ask that attention and consideration is given by both prison and healthcare staff to the matters found and outlined above to try to reduce the risk of further fatalities.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 1st of December 2017. 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: The family and their legal representatives. Similarly, you are 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.
9	**Dr Peter Dean** **6-10-17** P Dean