REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 Minister of State for Prisons, Probation and Reducing Reoffending**
1	**CORONER** I am Peter TAHERI, HM Assistant 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** On 04 December 2023 I commenced an investigation into the death of **Martin COLLINS** aged **66.** The investigation concluded at the end of the inquest on 12 September 2025. The conclusion of the inquest was: **Narrative Conclusion - Martin Collins, a 66 year old male, was serving a 10 year sentence residing at HMP Highpoint from June 2023. Approximately two years into his sentence, on 25/11/2023 Martin Collins was found suspended [redacted] in his cell at HMP Highpoint. Martin Collins was found by a prison officer at precisely 6am. Martin Collins' estimated time of death is noted as between about 10:01pm on 24 November 2023 and about 6am on 25 November 2023. Martin Collins died by way of suicide.** **Martin Collins arrived at HMP Highpoint with an inadequate OASys which may have contributed to a lack of understanding from staff who worked at HMP Highpoint. This resulted in a missed opportunity to triage Martin Collins effectively and share information so that all colleagues working with Martin Collins could undertake a thorough assessment of his needs during his time in prison.** **Furthermore evident inadequate application of processes possibly left many staff reliant on professional curiosity of the individual, rather than clear systematic procedures that were understood by staff and communicated effectively, leading to a lack of information sharing and understanding amongst key staff, who were responsible for Martin Collins' care. For example, the magnitude of Martin Collins' previous mental health history.** **A misunderstanding by Martin Collins in regards to his sentence plan or progression may have contributed to his death.** **A failure by healthcare to triage or follow up on Martin Collins' need to be seen by the Mental Health team in prison, following 3 October 2023. This may have contributed to Martin Collins' death due to a missed opportunity to identify his needs.**

	Finally, Martin Collins' reaction to his visit on 24 November 2023 and his inability to get through to his partner on the telephone that day, possibly contributed to a decline in his state of mind. The medical cause of death was confirmed as: **1a Hanging** **1b** **1c** **1d** **2**
4	**CIRCUMSTANCES OF THE DEATH** **The relevant circumstances for the purposes of this report are as follows:** **i) The deceased's partner gave evidence that "a clear sign that he was becoming less stable in mental health was when he would become very demanding and compulsively telephone me from his in-cell phone even at times when he knew I was unavailable or at antisocial hours. He could be very demanding and regularly repeat dialled me over 100 times non-stop... I was surprised that the prison service had not identified the volume of unanswered calls being made".** **ii) On 24 March 2023, 8 months before the death of the deceased, a multi-disciplinary team meeting, arranged, in his previous prison, to discuss the deceased's self-harm attempts and how he could be supported, identified that: "the trigger for Mr Collins to self-harm generally tends to be around his relationship with his partner. ... Further concerns raised by the chaplaincy around the amount of phone calls Mr Collins makes to his partner... If a negative phone call takes place, Mr Collins attempts to harm himself."** **iii) According to the Prisons & Probation Ombusdman's report, on the evening of the deceased's death: "Between 5.05pm and 11.18pm, Mr Collins attempted to telephone his partner 61 times."** **iv) The Jury did not find that "omission to monitor the volume of Martin's telephone calls" was a possible contributory factor to the death (this having been a potential contributor to the death that I had invited the Jury to consider, in part to assist me in considering this report). However, the Jury did conclude that one of the possible contributory factors to the deceased's death included "his inability to get through to his partner on the telephone that day". This indicates that the Jury accepted the evidence of at least a possible link between telephone calls made by the deceased to his partner and self-harm or suicide by him.** **v) Governor [redacted] of HMP Highpoint gave evidence that: There is nothing on the prison's telephone system that would flag up if an individual is making a high number of phone calls or an unusual number of phone calls. If a member of staff accesses the computer system and searches a particular prisoner, then they could run the report of the prisoner's call log, which would list each telephone call and the time and date it was made. Essentially, the data is available if searched for, but there is no automated way of recognising a pattern of high or unusual calls being placed by a prisoner.** **vi) Governor [redacted] did not believe that it is within the technical capabilities of the system, even with reasonable and proportionate change, for the electronic system to notify prison staff about the frequency and timing of groups of calls. The reason she gave for not thinking it is presently possible was that provision of the PIN phone is a contracted service and it is not within the Ministry of Justice's capability to develop the technology in the way that would be required.**

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: **The available telephone system for prisoners does not presently have the capability, in an automated manner, to recognise high or unusual volumes of calls by prisoners - and then to notify prison staff or healthcare in the event of such a pattern. This is despite the fact that the data on telephone calls made by a particular prisoner is available and is readily capable of being obtained, such that patterns of calls could be monitored manually by staff.** **The lack of system for monitoring of volumes of prisoners' telephone calls may lead to missed opportunities to identify risk triggers and so missed opportunities to intervene and prevent suicide.** **Even though the Ministry of Justice or HM Prison Service may not themselves be able directly to make changes to the software or computer system and although the electronic system is provided under contract with the Ministry, it remains for the Ministry to obtain and implement the technology in question. Changes could therefore be sought of a technology provider by the Ministry.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 November 12, 2025. 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] **Practice Plus - Inquests** I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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	**Dated: 17/09/2025** [redacted] **Peter TAHERI** **HM Assistant Coroner for Suffolk**