Miss K J Gomersal LLB | Senior Coroner | Cumbria

HM Coroner's Courts, Allerdale House, Workington, Cumbria CA14 3YJ

[redacted]

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13 May 2026

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: NHS England

1) CORONER

I am Mr Robert Cohen, HM Assistant Coroner for Cumbria

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 21 March 2025 an investigation commenced into the death of Nigel John KEENAN. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Suicide

1a Hanging

1b

1c

II

4) CIRCUMSTANCES OF THE DEATH

The jury's findings in respect of Mr Keenan's death were as follows:

Death by hanging [redacted]
at HMP Haverigg. At a time between 8 pm on 12th March 2025 and the time of being found: 3:15 am 13th of March 2025. Time of death officially recorded by North West ambulance service: 4:20 am 13th of March 2025

As John's release date approached issues arose regarding his life after prison and how restrictions imposed due to the nature of his offence could impact this. Finding suitable housing was proving problematic. Only eight days prior to release John was finally notified that he would be able to reside with a family member. However it is probable that the heightened stress and worry of this matter contributed more than minimally to his death. Other possible contributing factors to the stress and anxiety John was facing at this time was a recent relationship breakdown and financial worries.

The week before John's death intelligence suggested John was planning to do something that would shock the prison.

Prison staff interpreted this as John being a risk of absconding. John had mentioned, a month earlier, that he was experiencing suicidal thoughts. However after following this up with healthcare providers he was not deemed a risk.

When questioned John denied making the comment. Given the prior mention of suicidal thoughts and then the threat of doing something to shock the prison, a simple questioning of whether he said this with no further exploration could have been a missed opportunity. However HMP Haverigg have demonstrated they have multiple avenues of support available some of which John chose not to engage with.

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. –

In the course of hearing evidence in this inquest I was told that: 1) Mental health provision is only commissioned within HMP Haverigg during the week and is not available at the weekends. I was told that in the event that a prisoner experienced crisis during the weekend they would be cared for by prison staff using the ACCT procedure, but that mental health input would not be available until Monday morning. 2) Because HMP Haverigg is a Category D 'open' prison it has far fewer staff available to monitor prisoners. As such it is not able to place prisoners on 'constant watch'. As a result if a prisoner requires very regular or constant observation (as a result of being in crisis) they would have to be transferred to a closed prison. 3) This means that prisoners who are in crisis have something of an incentive to deny their intent to self harm because to admit to it would result in their being transferred to a closed prison.

I am concerned that the decision not to commission 7 day a week mental health support at HMP Haverigg is therefore counterproductive. Because of the limited number of prison officers at the establishment it gives rise to a higher risk than wiould be the case at a closed prison. In particular, it risks providing an incentive for prisoners in crisis to play down the true extent of their situation.

6) ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that, as healthcare in prisons is directly commissioned, NHS England 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 8th July 2026. 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.

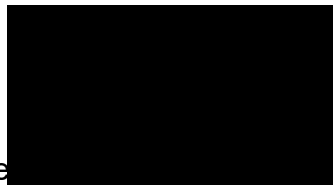
8) COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the Interested Parties.

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.

13 May 2026

Signature 

Robert Cohen HM Assistant Coroner for