Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Keenan, a prisoner at HMP Haverigg, on 13 March 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Nigel Keenan (who was also known as John) was found hanged in his cell at HMP Haverigg 13 March 2025. He was 62 years old. I offer my condolences to Mr Keenan's family and friends.

Mr Keenan was the second prisoner to take their own life at Haverigg since March 2022.

Mr Keenan took his own life on the day he was due for release. In the weeks before he died, Mr Keenan was prescribed a new medication for nerve pain. He subsequently reported thoughts of suicide to healthcare staff, who considered them to be a side effect of the medication.

Prison staff were reassured by Mr Keenan's behaviour and no one thought he needed additional support from suicide and self-harm monitoring procedures (known as ACCT).

However, Mr Keenan had risk factors for suicide including a history of anxiety, recent relationship breakdown, and fears about risks to his safety on release. I consider there was sufficient reason to think that ACCT procedures were appropriate.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **July 2026**

Contents

Summary

Events

1. On 16 June 2022, Mr Nigel Keenan was sentenced to five and a half years in prison for sex offences. He was sent to HMP Doncaster. He had no significant recorded history of thoughts of suicide or acts of self-harm.

2. On 13 February 2024, Mr Keenan moved to HMP Haverigg. A nurse conducted an initial health screen and recorded that he reported anxiety. The mental health team offered Mr Keenan an appointment and anxiety group work, but he declined.

3. Over the next 11 months, Mr Keenan progressed through his sentence relatively well. However, he had difficult relationships with his prison offender managers (POMs).

4. On 13 January 2025, a GP reviewed Mr Keenan and prescribed him medication to treat nerve pain. However, this was stopped after he reported suicidal thoughts. Healthcare staff did not make a mental health referral or start suicide and self-harm prevention measures, known as ACCT, as they thought he was experiencing side effect of his medication. Prison staff who spoke to him were reassured that he did not intend to act on the thoughts.

5. Between 11 February and 11 March, prison staff submitted intelligence reports following prison phone monitoring indicating that Mr Keenan's risk of suicide and self-harm may have increased. However, staff concluded that his comments were indicative of his history of perceived manipulative behaviour and took no action.

6. Mr Keenan was due to be released on 13 March. Mr Keenan's prison offender managers worked closely with his community offender manager (COM) on his release planning. His COM considered several release addresses, including his partner's, but hers was assessed as inappropriate and she ended their relationship. It was agreed that Mr Keenan would live with a brother on release, despite concerns about so-called paedophile hunter groups operating in the area.

7. At approximately 3.15am on 13 March, an Operational Support Grade (OSG) conducted a routine roll check and found Mr Keenan had covered the observation panel on his cell door. The OSG opened the door and found Mr Keenan hanging from a ligature. He radioed a medical emergency.

8. At 3.18am, a custodial manager (CM) arrived at the cell with an officer. The officer cut the ligature and started cardiopulmonary resuscitation (CPR). At 3.35am, paramedics arrived at the prison. They reached Mr Keenan's cell two minutes later and took over the resuscitation. At 4.20am, a paramedic pronounced life extinct.

Findings

Assessment of risk

9. Mr Keenan had risk factors for suicide and self-harm, including some that increased in the weeks leading to his death. We consider that there was sufficient evidence to indicate that suicide and self-harm monitoring procedures (ACCT) would have been

appropriate and provided staff with an opportunity to properly explore his risk. Instead, staff placed greater emphasis on their perceptions of him as manipulative.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff understand their responsibilities to identify and assess risk information and begin ACCT procedures when required.
- The Head of Healthcare should ensure that when a prisoner reports suicidal thoughts, staff consider making a referral to the mental health team and document their decision making.

The Investigation Process

10. HMPPS notified us of Mr Keenan's death on 13 March 2025.

11. The investigator issued notices to staff and prisoners at HMP Haverigg informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator visited Haverigg on 20 March and interviewed four prisoners.

13. The investigator interviewed eight members of prison staff at Haverigg on 27 and 28 May. He also interviewed four members of healthcare staff by video conference between 14 May and 24 June

14. NHS England commissioned an independent clinical reviewer to review Mr Keenan's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed healthcare staff.

15. We informed HM Coroner for Cumbria of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's office contacted Mr Keenan's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She wanted to know about Mr Keenan's relationship with his prison and community offender managers.

17. Mr Keenan's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Haverigg

19. HMP Haverigg is an open prison for adult men, located in Cumbria. It provides a variety of living arrangements, including cellular house blocks, residential treatment units, and billet-style accommodation that are largely shared dormitory-like setups.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Haverigg was in March 2025. Inspectors found that Haverigg was one of the most impressive prisons in the country and provided a safe environment that reduced the risk of self-harm and suicide. They also found that incidents of self-harm were very low and that leaders proactively identified prisoners who may need additional support.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2024, the IMB reported that Haverigg was a safe prison, with incidents of self-harm remaining low. However, they also reported that problems arose when discharge housing could not be secured in good time.

Previous deaths at HMP Haverigg

22. Mr Keenan was the seventh prisoner to die at Haverigg since March 2022. Of the previous deaths, five were from natural causes and one was self-inflicted. There were no similarities between any of these and Mr Keenan's death.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The policy for supporting prisoners assessed as at risk of suicide and self-harm, including ACCT procedures, is set out in the Prison Safety Policy Framework, which was implemented in January 2025.

24. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

25. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

26. On 16 June 2022, Mr Nigel Keenan (who was also known as John) was sentenced to five and a half years in prison for sexual offences. He was sent to HMP Doncaster. On 22 September, Mr Keenan was moved to HMP Moorland. He had no significant recorded history of thoughts of suicide or acts of self-harm.

2024

27. On 13 February 2024, Mr Keenan was moved to HMP Haverigg. Nurse A conducted an initial health screen and recorded that he was prescribed medication for diabetes. Nurse B, a mental health nurse, saw him for a mental health review and recorded that while he did not have a history of self-harm in prison, he did report anxiety. The mental health team offered him an appointment and anxiety group work, but he declined.

28. On 5 May, Officer A saw Mr Keenan for a link session (which provide one-to-one support for prisoners). He noted that Mr Keenan had difficulty deciding who he wanted to live with on release and said that he was not sure whether he could live with his partner as she had a young daughter.

29. On 21 August, Ms A, a Prison Offender Manager (POM) saw Mr Keenan for enhanced behaviour monitoring (EBM, a collaborative approach to helping prisoners understand and manage their own risks). She recorded that they discussed his attitude towards children and that he said he continued to have a good relationship with his partner. She added that he also said he had decided to write to his wife in India, from whom he was separated.

30. On 18 December, Ms A reviewed Mr Keenan and reminded him that he would not be able to visit his partner's address due to her daughter, who was under the age of 18, living there. She noted that Mr Keenan said he understood.

31. Mr Keenan appeared to settle well into life in Haverigg and staff recorded no significant concerns about him.

2025

32. On 7 January 2025, Rethink Mental Illness, a charity that provides psychological therapy for anxiety and depression at Haverigg, sent Mr Keenan a letter offering him the opportunity to attend anxiety management groupwork before he was released on 13 March. He did not attend.

33. On 13 January, Dr A, a GP, reviewed Mr Keenan and noted that he reported ongoing pain caused by meralgia parasethetica (a condition that causes nerve pain in the outer thigh). He prescribed duloxetine (an antidepressant that can also be used to treat nerve pain) and set a review for four weeks.

34. On 27 January, B, Mr Keenan's Community Offender Manager (COM), attended a pre-release meeting by video conference with Ms A, Ms C, also Mr Keenan's POM, and Mr Keenan. Ms B noted that Mr Keenan said he wanted to live with his father

following release and that while he reported feeling anxious, he said he did not need support.

35. On 31 January, Ms B visited Mr Keenan's father's address to assess the suitability of him being released there. Ms B noted that she discussed with Mr Keenan's partner, who was present, how they would manage contact between Mr Keenan and his partner's daughter.

36. On 2 February, prison staff submitted an intelligence report (IR) stating that Mr Keenan's partner had given him a letter during a visit stating that she wanted to end their relationship.

37. On 3 February, Ms B emailed Ms A to tell her that Mr Keenan's father's address was not suitable as it backed onto a school. Later the same day, Ms A met with Mr Keenan and recorded that he said he disagreed with the assessment that he presented a risk to children. He added that he would go to his former wife's address and that he had wanted to end his relationship with his partner for months.

38. On 4 February, Mr A, an Advanced Clinical Practitioner (ACP) and acting Head of Healthcare, saw Mr Keenan for a diabetes review and recorded that Mr Keenan said he felt irritable and anxious since starting duloxetine and had been thinking about ways to kill himself. ACP A added that Mr Keenan said he would not act on his thoughts and said he had "everything to live for".

39. Later that day, Dr B, a GP, reviewed Mr Keenan and changed his medication to amitriptyline (for pain management and to reduce his thoughts of suicide and self-harm). There is no record that ACP A or Dr B considered starting suicide and self-harm monitoring procedures, known as ACCT, or making a mental health referral.

40. On 6 February, Ms A and Custodial Manager (CM) A spoke to Mr Keenan about his suicidal thoughts. Ms A recorded that he said that he had been on medication for nerve pain and that suicidal thoughts were a known side effect. He added that he had no intention of acting on his thoughts and had started a new medication. They concluded that it was not necessary to start ACCT procedures.

41. On 10 February, Ms B recorded that Mr Keenan's former wife did not want him to live with her, but one of his brothers said he could live with him. She asked the police for a housing review and noted that she had spoken to Mr Keenan's partner, who confirmed that she ended their relationship after social services told her they would need to notify her daughter's father.

42. On 11 February, prison staff submitted an intelligence report (IR). Mr Keenan's phone calls had been subject to monitoring (prison staff can listen to phone calls prisoners make either at random, or based on suspicion or intelligence) and staff reported that Mr Keenan had encouraged his former partner to tell social services they had split up and she said that as she was still supporting him, they would interpret that as a relationship. Staff also noted that Mr Keenan said, "life has gone downhill real fast". However, they concluded that; "this is indicative of his [Mr Keenan's] well-known history of manipulative behaviour. Therefore, it is highly likely that this is just malicious behaviour".

43. On 19 February, Ms B recorded that the police had concluded that as Mr Keenan's brother's address was located within a mile of several children's facilities, and that residents of the village had previously put sex offenders in danger by posting online, they did not assess the address as suitable. (The danger is taken to be from self-organised groups, often referred to as paedophile hunters, who attempt to identify, expose and sometimes confront individuals they believe to have sexually exploited children.)

44. Later that day, Ms B copied Ms A and Ms C into an email stating that although the police did not assess Mr Keenan's brother's address as suitable, she had spoken to her manager, and they decided that based on the risk assessment of his known offending behaviour, he could live there. (As the lead agency, the Probation Service can override the police's decision if they assess the risks could be appropriately managed.) There was no reference to paedophile hunter groups in the email.

45. On 4 March, Nurse C noted that she had reviewed Mr Keenan after he collapsed. He was taken to hospital, where medical staff identified raised blood sugar levels, but he was unwilling to wait and discharged himself. Prison staff submitted an IR stating that Mr Keenan said he would "do something next week that will shock the fucking prison". The assessment said, "due to the amount of intelligence regarding [Mr] Keenan's behaviour, it is likely these are empty threats made by him as a way of causing trouble for the sake of it."

46. At 10.59am on 5 March, Officer B recorded that he had spoken to Mr Keenan about the intelligence indicating that he would be doing "things" during his last few days in prison. Mr Keenan denied saying anything and said he planned on keeping his head down. There is no record that Officer B asked him about thoughts of suicide and self-harm or considered starting ACCT procedures.

47. At 11.30am, Ms C recorded that she and Ms A met with Mr Keenan for the first time since Ms B's email on 19 February and informed him that his brother's address had been approved by probation.

48. On 9 March, Mr Keenan phoned one of his brothers (not the one he planned on living with). Unfortunately, we have not been able to listen to the call due a technical issue. However, prison phone records show that this was the only time he phoned one of his brothers between 19 February (the first recorded reference to so-called paedophile hunters) and 12 March. This would suggest it was during this call that he told him about the so-called paedophile hunter groups.

49. On 10 March, prison phone records show Mr Keenan phoned his former wife (who was now in England). He told her that he was sorry for everything he had done and she said she would never forgive him. He told her that it was the last time he would hear her and she said, "it sounds like you're dying". He told her to look after herself and that he would love her forever. Mr Keenan's former wife told us that Mr Keenan was "filled with regret" and "sounded like he was going to kill himself". There is no evidence that prison staff listened to the call as part of the monitoring process or that Mr Keenan's former wife notified the prison of her concerns.

Events on 11 March

50. On Friday 11 March, ACP A saw Mr Keenan for a diabetes review and noted that Mr Keenan said he had been feeling very stressed over the past few weeks. He said that he felt his POMs had "got it in for him" and that his partner no longer wanted contact with him. There is no evidence ACP A considered a mental health referral or followed up on Mr Keenan's previous thoughts of suicide and self-harm.

51. Later that day, prison staff submitted an IR stating that during phone monitoring, staff had heard Mr Keenan tell a friend that he felt stressed, and anxiety had caused his *"levels to rise*". He said that his ex-partner had left him with nothing and not sent him any more money. Staff also noted that a male named "Mr B" had spoken to Mr Keenan's partner about money and that he [Mr Keenan] could not do "any business" (we do not know what this might have referred to).

52. At 4.00pm, Ms C recorded that she and Ms A met with Mr Keenan and told him that his brother's address had been approved. Ms C recorded that Mr Keenan remained adamant that he could travel to India on licence despite them telling him it would be unlikely.

Events of 12 March

53. At 4.00pm on 12 March, Ms B phoned Mr Keenan's brother to inform him of Mr Keenan's licence conditions. Mr Keenan's brother said that Mr Keenan had told their other brother that paedophile hunter groups were operating near his address. She noted that Mr Keenan's brother was worried about these groups finding out that Mr Keenan was living with him.

54. At 4.05pm, Ms B contacted Ms A who confirmed that she and Ms C had told Mr Keenan that so-called paedophile hunter groups operated in the area of his brother's address.

55. At 6.00pm, Ms B telephoned Mr Keenan's brother and told him that Mr Keenan's sexual offence did not appear in an internet search. She noted that having reassured his brother, he agreed that Mr Keenan could stay with him.

56. Between 7.35pm and 9.20pm, Mr Keenan made 10 phone calls to his family and friends. Again, the investigator was unable to listen to the calls. He expressed emotional distress, health concerns and anxieties about his release, particularly his living arrangements. During the calls he expressed gratitude, love and affection.

57. At 8.00pm, Officer C conducted an evening roll check and did not see anything unusual. Four prisoners, who lived on the same billet as Mr Keenan, told the investigator that he presented as his normal self and was laughing and joking throughout the night. They said that while he was giving his property away (which can be a sign of suicidal intent), handing out cards and saying things like "I won't need that were I'm going", they did not think anything of it as he was due for release the following day.

Events of 13 March

58. At around 3.15am, Operational Support Grade (OSG) A and OSG B entered Mr Keenan's billet to conduct a roll check. When OSG A arrived at Mr Keenan's cell, he found that he had covered the cell observation panel from the inside. OSG A opened the door and saw Mr Keenan stood at the back of the cell with a cord around his neck, attached to the window handle. At 3.17am, OSG A radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties). At interview, he told the investigator that he tried to lift Mr Keenan's body to reduce the pressure on his neck. He did not cut the ligature.

59. At 3.18am, the control room called an ambulance. At the same time, CM A arrived at Mr Keenan's cell, but without a prison mobile phone, which would have allowed her to speak to the ambulance service. Body worn video camera (BWVC) footage shows OSG B stood outside Mr Keenan's cell and OSG A in the middle of the cell, not holding the weight of Mr Keenan's body.

60. Around 20 seconds later, Officer D arrived at the cell. BWVC footage shows CM A and OSG A stood in the middle of the cell while Mr Keenan remained hanging. CM A and Officer D entered the cell and Officer D cut the ligature, before laying Mr Keenan on the floor. He attached a defibrillator (a machine that monitors and, in some situations restarts, the heart) with assistance from OSG A and started cardiopulmonary resuscitation (CPR).

61. At 3.35am, paramedics arrived at the prison. They got to Mr Keenan's cell around two minutes later. Paramedics took over the resuscitation effort but pronounced life extinct at 4.20am.

Contact with Mr Keenan's family

62. At 5.51am, CM A contacted HMP Wakefield to ask whether one of their family liaison officers (FLOs) could notify Mr Keenan's former partner, his named next of kin, of his death, as she lived near Leeds, around 150 miles away from Haverigg. Wakefield agreed to help.

63. At 8.00am, Haverigg appointed Officers E and Officer F as the prison FLOs. At 10.15am, FLOs from Wakefield visited Mr Keenan's ex-partner and broke the news. They left contact details for Officer E and Officer F.

64. At 11.00am, Mr Keenan's former partner phoned Officer F and told her that Mr Keenan's family thought he had 10 months left to serve. At 4.00pm, Mr Keenan's wife phoned Officer F about his death. Officer F offered support.

65. Officer E and Officer F continued to support to Mr Keenan's family until his cremation, which took place on 11 April. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

66. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in

custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

67. After Mr Keenan's death, Mr C and Mr D, prison managers, debriefed the staff involved in the emergency response, and staff and prisoners were offered ongoing support. The prison deployed Listeners (prisoners trained to offer peer-led support), and the Samaritans visited the prison to offer support to staff and prisoners. We are satisfied that the prison appropriately initiated postvention procedures.

Post-mortem report

68. A post-mortem examination found that Mr Keenan died as a result of hanging. Toxicology analysis of Mr Keenan's blood found therapeutic levels of amitriptyline.

Events after Mr Keenan's death

69. Mr Keenan left several letters addressed to various members of staff at Haverigg. In a letter addressed to Mr E, the Head of Security, he said, "my mind has been broken for the last two months" and "I've had so much stress from my OMU" (which we take to mean from his POMs). He said that social services had threatened his partner, and this led to her ending their relationship. He added that his health had also gone "downhill" in the last eight days and therefore "my head is truly screwed".

Findings

Assessment of risk

70. The Prison Safety Policy Framework (which was issued on 1 November 2024 and came into effect in January 2025) requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

71. Mr Keenan was not subject to ACCT monitoring at Haverigg. Prison records show that he had a good relationship with most staff, engaged well with other prisoners and generally abided by the rules.

72. On 4 February, Mr Keenan told ACP A that he was having thoughts of suicide. Later the same day, Mr Keenan also saw a GP. Both members of healthcare staff considered that Mr Keenan's thoughts of suicide were most likely to be a side effect of duloxetine, the antidepressant he had recently been prescribed for nerve pain. This, combined with Mr Keenan's assurances that he had no plans to act on the thoughts, was sufficient to satisfy them that he was not at raised risk of suicide or self-harm. They did not consider starting ACCT procedures or make a referral to the mental health team. The clinical reviewer considered that voicing suicidal thoughts was a change in Mr Keenan's presentation, no matter the reason for those thoughts, and that staff missed an opportunity to assess his risk and to explore any emerging suicide plans.

73. Prison staff only considered starting ACCT procedures once, on 6 February. Again, the staff were reassured by Mr Keenan's explanation and did not think ACCT procedures were necessary.

74. Staff submitted intelligence over the following weeks that indicated Mr Keenan's risk of suicide might be raised. However, staff who worked with Mr Keenan described him as manipulative and considered this was manipulative behaviour rather than concerning behaviour. We are concerned that staff allowed this perception of Mr Keenan to hold greater weight than what was known about his risks. He had expressed thoughts of suicide, which was not usual behaviour for him, his relationship had recently broken down and he was very close to release. Finding him suitable release accommodation had not been straightforward, and Mr Keenan had been told that his safety might be at risk at his brother's address. The Prison Safety Policy Framework is clear that ACCT procedures should be started where there are concerns about a prisoner's risk. The multi-disciplinary approach would have allowed staff to explore Mr Keenan's risk in a meaningful and supportive way. That neither healthcare nor prison staff thought ACCT procedures were necessary, based on assumptions and perceptions, is of concern and we make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff understand their responsibilities to identify and assess risk information and begin ACCT procedures when required.

The Head of Healthcare should ensure that when a prisoner reports suicidal thoughts, staff consider making a referral to the mental health team and document their decision making.

75. Mr Keenan had a difficult relationship with his POMs and he documented the negative emotional impact this had on him in his letter to M. We consider that they had little direct evidence to indicate Mr Keenan's risk of suicide was increasing although they were aware that he was anxious and frustrated about some aspects of his upcoming release. Mr Keenan's death serves as a sobering reminder that the time leading up to release is often a period of heightened vulnerability, during which the risk of suicide and self-harm significantly increase.

Governor to note

Emergency response

76. CM A did not collect a mobile phone prior to responding to the code blue, as she should have done according to the prison's death in custody contingency plan. While this did not impact the outcome in Mr Keenan's case, as the seriousness of his condition was promptly conveyed to the ambulance service, the prison reviewed the contingency plan and amended it. The night CM must now always carry a prison mobile phone. We are satisfied that this response was appropriate.

77. OSG A did not cut the ligature when he entered Mr Keenan's cell. He told us that he had an anti-ligature knife but could not access it as he was trying to lift Mr Keenan. However, BWVC footage shows that CM A and OSG A were stood in the middle of the cell when Officer D arrived, and Mr Keenan was still suspended by the ligature. While we recognise the distressing nature of such situations, it is vital that staff respond, cut the ligature and begin CPR without delay. The Governor will want to reflect on this finding. D

Inquest

78. At the inquest, which took place between 10 and 13 May 2026, the Coroner concluded that Mr Keenan died by hanging.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100