NHS
Central and
North West London
NHS Foundation Trust

Executive Office

18 May 2026

Sean Cummings
HM Assistant Coroner for Milton Keynes
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
MK9 3EJ

Dear Mr Cummings,

Re: Regulation 28: Report to prevent future deaths

Thank you for your Regulation 28 report dated 24 March 2026 following the inquest into the death of Mr Ronald Meikle at HMP Woodhill. I write to provide the Trust's response to the concerns you have raised.

Central and North West London NHS Foundation Trust (CNWL) deeply regrets the sad death of Mr Meikle, and we extend our sincere condolences to his family.

We have reviewed the issues identified in your report and have examined our governance and clinical practice, working closely with HMPPS colleagues at HMP Woodhill. I have sought and received assurance that learning from this case is embedded. We have implemented improvements, and our executive team continues to oversee this work.

Concern 1: Availability of illicit substances in custody
We have worked with our staff to ensure that they recognise their key role in mitigating harm and responding to associated clinical risks of illicit substances. We have increased addictions support and staff are contributing to prison safety arrangements, including weekly Safety Intervention Meetings (SIM) and monthly drug strategy/priority meetings.

Concern 2: Identification, recording and response to prisoners under the influence.
We have clarified clinical roles and expectations, strengthened governance, and introduced additional audit measures within the addictions team to monitor referral timeliness and escalation. We have jointly developed a 'SPICE' policy and local operating procedure (LOP) that provides clear clinical guidance for assessing and managing intoxication. We have introduced a new risk-based triage model that

identifies and prioritises individuals at highest risk. Intoxicated prisoners are being immediately referred to the addictions team for review within 48 hours.

Concern 3: Information sharing and record keeping.
Handover documentation has been revised. This has improved identification and escalation of concerns to prison colleagues. We are ensuring that healthcare attend multidisciplinary forums, weekly Safety Intervention Meetings, and daily wing briefings. We have added a prompt to our handover to ensure that staff consider what information needs to be share with prison colleagues.

Concern 4: Blocked observation panels and inadequate visual welfare checks
We are supporting prison colleagues by escalating concerns about vulnerable patients including making recommendations for enhanced observation where necessary.

Concern 5: Management of self-isolation, debt, fear and vulnerability
We are working with staff to ensure that individuals identified as experiencing prolonged isolation are subject to structured review processes, including mental health assessment and ongoing welfare monitoring, where required. Concerns relating to isolation, debt and vulnerability are raised by staff within regular multidisciplinary forums and more complex cases are reviewed regularly.

Concern 6: Absence of ACCT despite identifiable indicators of vulnerability
Healthcare are aligned with the prison's Suicide and Self-Harm Prevention policy, We have added an ACCT prompt to our handover sheet. All staff complete SASH and ACCT training and we monitor this.

Concern 7: Vulnerability of IPP prisoners
We are explicitly considering IPP status within clinical risk assessment and referral processes. Because this is an explicit vulnerability, we can structure our clinical support packages and ensure regular reviews by the MDT.

Concern 8: Delay or insufficiency of mental health and psychiatric input
We have worked on our waiting list management, setting clearer escalation thresholds, and increasing the use of remote clinics. The mental health and clinical leads review waiting lists every week and prioritise patients based on clinical risk and time waiting to ensure timely assessment and follow-up. We have also expanded clinical capacity by introducing advanced clinical practitioner roles to support routine reviews, while escalating more complex cases directly to consultant psychiatrists. Recruiting to substantive consultant posts remains a key priority for the service.

Concern 9: Emergency response to suspected synthetic cannabinoid collapse
We have improved staff capability to recognise deterioration linked to synthetic cannabinoid use by providing structured assessment tools, clear escalation expectations, and more visible clinical leadership. All CNWL clinical staff receive training in recognising deterioration using the NEWS2 protocol, and we have reinforced clear escalation pathways across our services, ensuring every clinician understands how and when to escalate concerns. We actively participate in joint simulation exercises and contribute to prison-led first aid and emergency response

training to improve recognition of medical emergencies and ensure prompt, appropriate escalation.

Concern 10: Staffing, supervision and regime limitations
Escalation of healthcare concerns related to reduced engagement, restricted regimes or health deterioration is conducted through established governance and safer custody processes such as SIM meetings, ACCT reviews, clinical handovers, and mental health zoning meetings.

Concern 11: Repeated systemic concerns at HMP Woodhill
Governance oversight of Health and Justice services at HMP Woodhill has been improved. We are undertaking a focused review of incident themes. We have looked at ensuring escalation is effective and how we implement learning to ensure that it is consistent.

Concern 12: Failure of state agencies to supply all information in a timely fashion.
CNWL takes its role in any inquest very seriously and will continue to endeavour to supply all information requested in a timely fashion.

Thank you for bringing your concerns to our attention. While healthcare services alone cannot mitigate all risks within custody, the Trust is committed to learning from Mr Meikle's death and to strengthening how vulnerability is identified and responded to across Health and Justice services. Should you have any questions or comments, please do not hesitate to contact me.

Yours sincerely,

Chief Executive