



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

REGULATION 28 REPORT TO PREVENT DEATHS	
THIS REPORT IS BEING SENT TO:	
1	██████████, Chief Executive Officer His Majesty's Prison and Probation Service
2	██████████, Minister of State for Prisons
3	██████████, HM Chief Inspector of Prisons
4	██████████, Prisons and Probation Ombudsman
5	Governor, HMP Woodhill
6	Central & North West London NHS Foundation Trust
1	CORONER I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 03 May 2024 I commenced an investigation into the death of Ronald William MEIKLE aged 47 who died on 30 April 2024. The investigation concluded at the end of the inquest on 17 February 2026. The conclusion of the inquest was that: Narrative conclusion Narrative conclusion - see attached
4	CIRCUMSTANCES OF THE DEATH Ronald (Ronnie) lived in House Unit B Cell 201 HMP Woodhill, a single occupancy cell. He had a history with drugs, particularly ██████████ and had had past instances of 'debt' within the unit. He had no known PMH or diagnosed MH history aside from repeated and long duration substance misuse, however a letter for a referral to the psychiatrist had been found in his cell. He was not on an ACCT, no wing restrictions and was employed by the prison in the garden and education services. He had reported to an officer on 29/04 that he had been self-isolating in his cell since 28/04, this was believed to be due to debt issues on the unit. He had work from 14:00 - 16:30 and then lock up was at 5pm. At the morning roll check at 7:15 nothing of note was recorded. A BT technician had attended the cell due to reported issues with his phone. When they didn't get a response, they asked an officer to gain entry. Ronald was found on his back, 'cold and stiff' with secretions coming from his mouth when CPR was commenced. SCAS and HMP GP attended and his death was declared at 09:43. Ronnie had minimal PMH, PNC briefly mentions asthma, an inhaler was found in his room but had no prescription details. The only medication prescribed by the prison was the antihistamine Cetirizine.
5	CORONER'S CONCERNS During the course of the investigation my inquiries 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:
(brief summary of matters of concern)

Concern 1: Availability of illicit substances in custody

The evidence indicated that illicit drugs, [REDACTED] were readily available within HMP Woodhill. Material before the court showed this was not an isolated issue but part of a wider and continuing prison safety problem at HMP Woodhill and likely other prisons. The availability of synthetic cannabinoids in custody creates a foreseeable risk of sudden collapse, respiratory compromise, cardiac arrest, psychosis, violence, self-harm and death.

Concern 2: Failure consistently to identify, record and respond to prisoners under the influence

The evidence showed concerns about the consistency with which prisoners suspected or found to be under the influence of illicit substances were identified, clinically assessed, monitored, referred to substance misuse services, and managed under prison and healthcare processes. There was evidence that episodes of apparent intoxication were not always met with a consistent healthcare response or documented follow-up. The head of service had an understanding of the drug under the influence policy that was starkly different to the written document. There had been multiple updates of the drug policy which were difficult to identify as to when the policy was updated / revised. I am concerned that prisoners at acute risk of overdose or deterioration may therefore not receive timely intervention.

Concern 3: Fragmented information-sharing and record keeping

The evidence demonstrated that relevant risk information was spread across multiple recording systems and was not always shared effectively between operational staff and clinical teams. This included information relevant to substance misuse, mental health, debt, bullying or coercion, self-isolation, intelligence about threats, and recent presentation under the influence. Where critical safety information is held in separate systems and not reliably brought together, there is a foreseeable risk that warning signs will be missed and protective action delayed with obvious risk of harm or death.

Concern 4: Blocked observation panels and inadequate visual welfare checks

The evidence raised serious concern that blocked observation panels were not consistently challenged or cleared, and that visual welfare checks were therefore not always effective. The jury heard evidence that officers deliberately avoided opening blocked hatches to escape abuse from the prisoners then or later. In a prison environment where prisoners may be intoxicated, unconscious, self-harming, assaulted, or otherwise incapacitated behind a locked door, failure to maintain an unobstructed observation panel creates an obvious risk of late discovery and preventable death.

Concern 5: Management of self-isolation, debt, fear and vulnerability

The evidence suggested that Mr Meikle had vulnerabilities connected to self-isolation, debt, fear of other prisoners, possible coercion or bullying, mental ill-health, and substance misuse. I am concerned that the systems for identifying and managing prisoners who remain behind their door because of debt, fear, vulnerability or drug-related pressures were not sufficiently robust, coordinated or escalated.

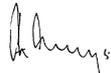
Concern 6: Absence of ACCT despite identifiable indicators of vulnerability

The concern is not that ACCT documentation disclosed a missed risk factor, but that the available materials show Mr Meikle was not subject to ACCT proceedings, despite evidence shortly before death of self-isolation, debt-related vulnerability, known substance misuse and reduced engagement. This occurred in an establishment where HM Inspectorate of Prisons had already identified weaknesses in ACCT management and welfare checking during an unannounced inspection in 2023 and had issued an Urgent Notification which included reference to "frailties in ACCT case management". I later became aware of a



	<p>second Urgent Notification issued in March 2026, shortly after completion of Mr Meikle's inquest that once again identified "frailties in ACCT case management". I am concerned that prisoners presenting with cumulative indicators of vulnerability may not be escalated into safer custody procedures when required, thereby increasing the risk that deteriorating welfare is not recognised or managed.</p> <p>Concern 7: Particular vulnerability of prisoners serving IPP (Imprisonment for Public Protection) sentences The evidence showed that prisoners serving IPP sentences may experience hopelessness, chronic frustration, deterioration in mental health and increased vulnerability to substance misuse and self-neglect. I am concerned that Mr Meikle's IPP status was not sufficiently recognised as a material risk factor requiring structured support, regular review and coordinated care.</p> <p>Concern 8: Delay or insufficiency in mental health and psychiatric input The evidence raised concern that prisoners with known vulnerabilities, substance misuse history and symptoms of deteriorating mental health may not always receive timely psychiatric assessment or sufficiently proactive mental health review. Delays in specialist assessment can increase the risk of unmanaged distress, relapse to substance use and death.</p> <p>Concern 9: Emergency response to suspected synthetic cannabinoid collapse The evidence raised concern about whether staff responding to collapse were adequately trained and equipped to consider synthetic cannabinoid intoxication promptly as a possible cause. Synthetic cannabinoid use can cause rapid deterioration and death. If staff do not recognise that possibility, there is a risk of delay in appropriate emergency action, clinical escalation and treatment.</p> <p>Concern 10: Staffing, supervision and regime limitations The evidence before the court, including wider inspection material, raised concern that staffing pressures, weak supervision, poor staff-prisoner engagement, restricted regimes, and inadequate welfare observations may materially increase the risk of undetected drug use, delayed discovery of collapsed prisoners and failure to identify vulnerable men in need of intervention.</p> <p>Concern 11: Repeated systemic concerns at HMP Woodhill Material before the court from oversight and inspection bodies demonstrated that concerns about drugs, safety, violence, self-isolation, observation panel compliance, ACCT weaknesses and welfare monitoring at HMP Woodhill had been identified over time. I am concerned that repeated identification of these issues has not resulted in sufficient or sustained remedial action, creating an ongoing risk of further deaths.</p> <p>Concern 12: Failure of state agencies to supply all information in a timely fashion.</p> <p>In this Inquest I was presented with material information at the eleventh hour. Aside from being discourteous to the family and the Court such tardy provision has potential to frustrate a full investigation into the death and allow elements of care which may impact on future deaths to pass unnoticed.</p>
<p>6</p>	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
<p>7</p>	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by May 19, 2026. I, the coroner, may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the</p>



	timetable for action. Otherwise you must explain why no action is proposed.
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>[REDACTED]</p> <p>I have also sent it to</p> <p>[REDACTED] - Preventable Death Tracker, Kings College London</p> <p>who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
9	<p>Dated: 24/03/2026</p> <p> Sean CUMMINGS Assistant Coroner for Milton Keynes</p>