

6 July 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 13 May 2026 following the inquest into the death of Mr Roy Richard Sinclair, which concluded on 19 March 2026.

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

We write to address your concerns detailed below having reviewed our governance and clinical practice and working closely with HMPPS colleagues at HMP Woodhill. Oversight of the actions arising from this case is maintained through Trust governance processes.

Concern 1: ACCT documentation and operation

We have made changes to our handover process with a revised clinical handover template requiring explicit discussion of all open ACCTs, confirmation of whether reviews have been completed and documentation of outcomes and agreed actions with named clinician responsible for follow-up.

We ensure that there is a healthcare contribution to the ACCT process. Clinical staff provide risk assessment and relevant clinical information to inform ACCT care planning and review. This is supported by multidisciplinary oversight.

All patients returning from hospital following a serious self-harm incident, are receiving a full mental health assessment by a registered clinician. Findings are shared in the ACCT and risk management processes.

Trust Headquarters, 350 Euston Road, London NW1 3AX
Telephone: 020 3214 5700
www.cnwl.nhs.uk

We are regularly reinforcing the importance of accurate and complete documentation through staff communication and staff are aware of the need to record consistently on both Systmone and in ACCT documentation. We undertake spot-check audits to ensure this is occurring. We have also audited documentation of clinical contact in the prison ACCT document and on SystmOne.

We have held a staff session on ACCT processes, documentation standards, care planning and the recording of key risk factors, including debt, vulnerability and medication-related risk and provided bespoke training for the mental health team with prison colleagues, on risk formulation and vulnerability factors in ACCT care planning.

Concern 2: Management of suspected paracetamol overdose

We have introduced an overdose clinical pathway. This provides guidance on Toxbase, assessment, monitoring, escalation and transfer and is supported by visual flowcharts displayed in all clinical areas. We have trained staff on the pathway and undertaken scenario-based learning and have seen this implemented in practice in a recent event.

We have reinforced the pathway through team meetings and supervision, and it is incorporated into staff induction materials. We have reviewed incident data and undertaken an audit and are assured that the pathway is being complied with.

Concern 3: Failure to raise intelligence reporting and investigate source

The healthcare handover process now includes a prompt to consider whether any clinically relevant concerns need to be escalated to prison colleagues including issues around medication access and potential hoarding of medication. This has been reinforced through team discussions focussing on the key role staff play in identifying and communicating relevant information arising from clinical contact and is included within staff induction processes reinforcing the role staff play in supporting wider risk management within the prison.

Concern 4: Debt, vulnerability and safeguarding

Staff have been reminded to consider these risk factors, document and incorporate into both clinical assessment and ACCT care planning. A recent debt awareness session delivered jointly with prison safer custody and security teams is being incorporated into healthcare training. We have also completed targeted mental health training and reinforced across the wider clinical team.

Concern 5: Wider operational context

HMP Woodhill has been operating within a challenging operational environment, including high levels of self-harm and wider safety pressures.

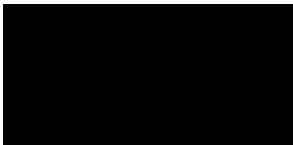
The Trust continues to escalate risks through established governance routes and to work collaboratively with prison colleagues and commissioners to improve patient

safety. We will continue to take all reasonable steps within our control to reduce harm and improve outcomes.

We recognise that improvement in this area requires sustained focus and effective joint working with our prison partners. We are monitoring the impact of the actions described and will take further steps where required.

Thank you for bringing these matters to our attention and again I would like to reiterate our condolences for the loss of Mr Sinclair. Should you require any further information, please do not hesitate to contact me.

Yours sincerely,



Chief Executive