



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

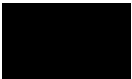
NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 Central North West London NHS Foundation Trust 2 Governing Governor HMP Woodhill 3 Minister of State for Prisons 4 Director General of Prison Service 5 H.M. Inspector of Prisons
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 05 December 2023 I commenced an investigation into the death of Roy Richard SINCLAIR aged 45. The investigation concluded at the end of the inquest on 19 March 2026. The conclusion of the inquest was that: Misadventure
4	CIRCUMSTANCES OF THE DEATH Roy Richard Sinclair, aged 45, was a serving prisoner at HMP Woodhill. He had a history of mental health difficulties, self-harm, substance misuse, and vulnerability, including debt to other prisoners. In October 2023, he reported taking a substantial paracetamol overdose. The jury found that after this first overdose there were failures in his care, including no contact with Toxbase, no effective follow-up when blood tests were refused, a lack of professional curiosity, and a miscommunication about whether his ACCT document remained open or had been closed. Two days later, he seriously self-harmed [REDACTED] and was taken to hospital, where he was treated for paracetamol poisoning and later discharged back to prison. After his return to prison, he remained subject to ACCT monitoring for a period. On 15 November 2023 the ACCT entered post-closure review, although his vape-related debt remained unresolved. On 22 November 2023, Mr Sinclair reported that he had taken a further overdose of [REDACTED] paracetamol tablets and said that he wanted to die. His ACCT was reopened, he was assessed in prison, and he was taken to Bedford Hospital, where he received treatment for paracetamol poisoning. His condition deteriorated, he was transferred to intensive care, and he died on 25 November 2023.



	The medical cause of death was multi-organ failure, liver necrosis, and paracetamol toxicity.
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) In the course of this inquest, I heard evidence giving rise to concern that there is a risk of future deaths unless action is taken. This inquest concerned the death of Roy Richard Sinclair, aged 45, who died on 25 November 2023 at Bedford Hospital following paracetamol toxicity. 1.ACCT documentation and operation The evidence disclosed serious difficulty in the recording, communication, and use of ACCT documentation. After the first overdose, there was a handover miscommunication as to whether the ACCT remained open or had been closed. Relevant mental health and welfare information was recorded on System 1 but not entered on the ACCT. Risk factors, including debt and vulnerability, were not consistently reflected in the care plan. There was accepted evidence that post-closure monitoring did not occur. The evidence also suggested wider and recurring difficulty in ensuring ACCT documentation accurately recorded risk, care planning, review, closure, and post-closure actions. I am concerned that the ACCT process may not reliably communicate relevant risk information between prison and healthcare staff, creating a risk that vulnerable prisoners will not be managed safely. I have presided over many death in custody Inquests and a universal feature is the ACCT process is not sufficiently taught, understood or completed. 2. Management of suspected paracetamol overdose The evidence disclosed deficiencies in the management of the first reported overdose in October 2023. There was no formal policy then in place governing paracetamol overdose. Blood samples were not obtained after refusal and no effective further attempt was made overnight. Toxbase / Poisons Information advice was not sought. The jury found this represented a lack of professional curiosity. A handover failure contributed to delayed medical follow-up on 14 October 2023. Although evidence was given of later changes, including a Toxbase flowchart, training, and revised practice, I am concerned that the systems in place at the material time did not provide a sufficiently clear and robust framework for the management of suspected overdose in custody. 3.Failure to raise intelligence reporting and investigate source No prison intelligence report was raised after the first reported overdose. The evidence established that such a report should have been submitted and that, had it been, a search of the cell would likely have followed within 24 hours. The failure reduced the opportunity to investigate how Mr Sinclair had obtained the paracetamol. 4.Debt, vulnerability, and safeguarding The evidence showed that Mr Sinclair had debt to other prisoners connected with vapes and that this formed part of his vulnerability. Although attempts were made to support him, the debt remained outstanding when the ACCT entered post-closure review on 15 November 2023, was not consistently incorporated into the ACCT care plan, and there was uncertainty as to whether managing it outside the ACCT process provided sufficient safeguarding. I am concerned that where prisoner debt is linked to vulnerability, distress, self-harm risk, or exploitation, it may not be identified, recorded, and managed in a sufficiently integrated way. 5.Wider operational context



	The evidence referred to serious staffing shortages, recruitment and retention difficulties, and heavy operational pressures at HMP Woodhill during 2023. I am concerned that wider operational pressures may increase the risk of failures in information-sharing, safeguarding, incident response, and the management of vulnerable prisoners. The court learned only at the conclusion of the inquest of a concurrent HMIP inspection and urgent notification concerning the prison while the Inquest was proceeding, appearing to contradict evidence given by prison staff. Where such information is not provided to the court in a timely manner there is a realistic prospect of the court being misled.
6	ACTION SHOULD BE TAKEN 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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by June 24, 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 following Interested Persons Family of the deceased. Prison and Probation Ombudsman I have also sent it to who may find it useful or of interest. 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. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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.
9	Dated: 13/05/2026  Sean CUMMINGS Assistant Coroner for Milton Keynes