Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roy Sinclair, a prisoner at HMP Woodhill, on 25 November 2023

A report by the Prisons and Probation Ombudsman

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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 Roy Sinclair died in hospital of multi-organ failure, liver necrosis and paracetamol toxicity on 25 November 2023 after taking an overdose of paracetamol at HMP Woodhill on 22 November. He was 45 years old. I offer my condolences to Mr Sinclair's family and friends.

Mr Sinclair was the fifth prisoner to take his own life at Woodhill in three years.

Mr Sinclair had several risk factors for suicide and self-harm. He had no family support and found himself in debt to other prisoners. Mr Sinclair chose to isolate in his cell for the majority of his time at Woodhill. Although some of the support offered to Mr Sinclair was good and aimed at resolving his issues, my investigation found that prison staff stopped suicide and self-harm monitoring (known as ACCT) prematurely and before staff had implemented a plan to manage his debt. Prison staff did not monitor how Mr Sinclair was coping once the monitoring had ended.

The clinical reviewer concluded that the mental health care Mr Sinclair received at Woodhill was not equivalent to what he could have expected to receive in the community. Mental health nurses did not attend case reviews or complete an assessment after Mr Sinclair seriously self-harmed.

Since Mr Sinclair's death, and in response to an Urgent Notification issued by HM Inspectorate of Prisons in August 2023, Woodhill has introduced measures to improve the quality of ACCT management. The prison will need time to demonstrate the effectiveness of these changes in preventing future self-inflicted deaths.

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 **April 2025**

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Summary

Events

1. On 7 February 2022, Mr Roy Sinclair was remanded to HMP Elmley, charged with robbery and possession of an offensive weapon. He was sentenced to five years and four months in prison on 25 April and moved to HMP Woodhill on 9 June.

2. Mr Sinclair had a history of self-harm, mental illness and substance misuse. He completed a methadone detoxification programme in March 2023. Mr Sinclair was prescribed anti-psychotic and antidepressant medication which he was not allowed to keep in his cell.

3. Mr Sinclair was managed under the prison's isolating individuals policy for the majority of his time at Woodhill after he told prison staff that he was in debt, felt anxious and wanted to remain in his cell. Prison staff created a debt support plan and Mr Sinclair started paid in-cell education. In May, Mr Sinclair told staff he was no longer in debt.

4. From 13 October 2023, prison staff managed Mr Sinclair under Prison Service suicide and self-harm prevention measures (known as ACCT) after he told them that he had taken an overdose of paracetamol because he felt anxious. On 15 October, Mr Sinclair made cuts to his wrists and was taken to hospital. He returned to Woodhill on 23 October.

5. On 7 November, Mr Sinclair told the case review team that he was in debt again. Safer custody staff agreed to give Mr Sinclair an advance to repay his debt and support his application for employment. Prison staff decided to continue ACCT monitoring because of Mr Sinclair's outstanding issue with debt.

6. At a case review on 15 November, staff stopped ACCT monitoring because Mr Sinclair did not have any current thoughts of suicide and self-harm. Mr Sinclair told the case review team that he still had an outstanding issue with debt. Prison staff did not complete the seven day post-closure monitoring form.

7. At around 1.57pm on 22 November, a prison officer went to Mr Sinclair's cell after he rang his cell bell. He told the officer that he had taken an overdose of paracetamol. Prison staff started ACCT monitoring. A nurse assessed Mr Sinclair and as staff were concerned about damage to his liver, Mr Sinclair went to hospital for further assessment.

8. Mr Sinclair's condition deteriorated in hospital, and he died at 9.00am on 25 November.

Findings

9. Mr Sinclair had several risk factors for suicide and self-harm. We found that ACCT procedures provided him with some support. Mr Sinclair's care plan did not refer to his poor mental health or substance misuse, despite him taking an overdose of non-prescribed medication.

10. We found that in some respects, the support offered to Mr Sinclair through the ACCT process was good and clearly aimed at resolving his issues, staff were too quick to conclude that Mr Sinclair was not at risk and ended support procedures prematurely. This was despite Mr Sinclair making the case review team aware that his issues with debt were not resolved. Prison staff did not complete the seven day monitoring form or make any entries in his prison record related to his welfare or risk.

11. We are satisfied that since Mr Sinclair's death, the prison has taken necessary steps to improve the management of ACCT procedures.

12. The clinical reviewer concluded that Mr Sinclair's mental health care was not equivalent to what he could have expected to receive in the community. As Mr Sinclair was unwilling to engage, he was not on the mental health team caseload which meant that a mental health nurse did not attend case reviews. When Mr Sinclair returned from hospital after a serious incident of self-harm, he was not assessed by a mental health nurse.

13. Since Mr Sinclair's death, the prison has issued an instruction which sets out the immediate steps that staff must take if a prisoner is under the influence of illicit substances or if they inform staff that they have taken an overdose. The prison has also amended the local security strategy to ensure that staff are aware when a cell search must take place and the procedure for sharing intelligence with security.

14. In June 2024, the prison implemented a debt management strategy to identify, manage and support prisoners that are in debt. This includes a designated custodial manager in the safer custody team with responsibility for monitoring the effectiveness of the policy in reducing and managing custodial debt.

Recommendations

- The Head of Healthcare should review the contribution to the ACCT process from mental health nurses for prisoners who have seriously self-harmed, including those not on the mental health team's caseload.

- The Head of Healthcare should investigate why a mental health nurse did not assess Mr Sinclair when he returned from hospital after a serious incident of self-harm.

The Investigation Process

15. HMPPS notified us of Mr Sinclair's death on 27 November 2023.

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

17. The investigator visited Woodhill on 15 December. She obtained copies of relevant extracts from Mr Sinclair's prison and medical records and viewed CCTV footage and body worn camera footage. She also obtained the HMPPS Early Learning Review.

18. NHS England commissioned a clinical reviewer to review Mr Sinclair's clinical care at the prison.

19. The investigator interviewed 11 members of staff at Woodhill between February and April 2024. She and the clinical reviewer jointly interviewed healthcare staff.

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

21. The Ombudsman's office wrote to Mr Sinclair's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not ask any questions but asked for a copy of the report.

22. We shared the initial report with Mr Sinclair's family. They did not make any comments.

23. We also shared the initial report with HM Prison and Probation Service (HMPPS). Central and Northwest London NHS Foundation Trust pointed out some factual inaccuracies, and we have amended the clinical review accordingly.

Background Information

HMP Woodhill

24. HMP Woodhill is a relatively modern prison in Milton Keynes. In addition to its role as a category B training prison, it holds several category A prisoners on remand and operates several specialist units, making it a complex and high-risk institution. Central and North-West London NHS Foundation Trust provides physical and mental health services.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Woodhill was in August 2023. Following the inspection, the Chief Inspector of Prisons invoked the Urgent Notification (UN) process because he was so concerned about conditions there. (The Urgent Notification process allows His Majesty's Chief Inspector of Prisons to directly alert the Lord Chancellor and Secretary of State for Justice if he has an urgent and significant concern about the performance of a prison.) He noted that none of the recommendations from the 2021 inspection had been achieved and many poor outcomes previously identified had worsened in some important areas, particularly with regard to safety. Despite this, there were many excellent, dedicated staff in the prison who were doing their best to support the prisoners in their care. The issues highlighted included:

- Prisoners were self-isolating in their cells in fear for their safety and the prison had the highest rate of serious assaults against staff.
- Reported incidents of violence had risen sharply and use of force against prisoners was amongst the highest in the adult male estate.
- The rate of reported self-harm was the highest in the adult male estate, there had been 829 incidents of self-harm involving 124 prisoners.
- Illicit drug use was a serious problem.
- Staff were relatively inexperienced and lacked the confidence to challenge poor behaviour. A chronic shortage of prison officers remained at the crux of the prison’s difficulties.

26. Despite efforts by the safer custody team to upskill staff, there were frailties in the ACCT process and quality assurance was absent or ineffective. Inconsistent case management was a source of frustration for those in crisis and, if completed at all, individual care plans often lacked proper focus. Observations were not always conducted at the required frequency and interactions were often transactional.

Independent Monitoring Board

27. 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 November 2023, the IMB

reported that the quality of the comments and interactions with men managed under the ACCT process varied widely. Some comments showed a clear understanding and concern for the men in their care, whilst others could best be described as satisfying the requirements to fill in the paperwork. The Board was concerned that there was no consistency of staff attending ACCT reviews.

Previous deaths at HMP Woodhill

28. Mr Sinclair was the eighth prisoner to die at Woodhill since November 2020, and the fifth self-inflicted death. Up to the end of June 2024, there has been one death at Woodhill since Mr Sinclair's death, the cause of which has not yet been established.

29. As a result of these self-inflicted deaths and the Urgent Notification issued by HMIP, Woodhill is receiving additional support and monitoring from HMPPS regional and national safety teams.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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 multidisciplinary review meetings involving the prisoner.

31. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan 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

32. On 7 February 2022, Mr Roy Sinclair was remanded to HMP Elmley. On 25 April, he was sentenced to five years and four months in prison for robbery and possession of an offensive weapon. Mr Sinclair transferred to HMP Woodhill on 9 June.

33. Mr Sinclair had a long history of offending and had spent most of his adult life in prison. He had no family contact and did not make any telephone calls or have any visitors during his time at Woodhill.

34. Before he moved to Woodhill, Mr Sinclair was managed under Prison Service suicide and self-harm prevention measures (known as ACCT) on 20 occasions after making cuts (recorded as superficial) and expressing suicidal thoughts.

HMP Woodhill

35. When he arrived at Woodhill, a prison officer completed Mr Sinclair's first night induction interview. He noted that Mr Sinclair engaged well and was aware of the support available to him. Mr Sinclair told staff he was not in debt. He had last self-harmed over a year ago and said he did not have any current thoughts of suicide and self-harm. Prison staff completed a cell sharing risk assessment (CSRA, assesses a prisoner's suitability to share a cell). This recorded that Mr Sinclair was not suitable to share a cell due to previous incidents of violence against other prisoners.

36. A reception nurse noted Mr Sinclair's previous history of substance misuse and poor mental health. He was diagnosed with paranoid schizophrenia (a mental health condition where people experience things that are not real and may hear or see things that others cannot see or hear) in October 2017. Mr Sinclair was prescribed anti-psychotic and antidepressant medication which he was not allowed to keep in his cell. The nurse referred him to the substance misuse service (SMS) and mental health team.

37. A SMS recovery worker saw Mr Sinclair on 10 June. He agreed to start a methadone detoxification programme, which he completed in March 2023. Mr Sinclair was discharged from the SMS on 3 May.

38. On 12 June, a mental health nurse completed a mental health assessment and did not record any concerns. He created a mental health care plan on 19 June. This noted Mr Sinclair's substance misuse, mental health and self-harm history. Mr Sinclair did not express any concerns about his prescribed medication. A GP at the prison completed monthly medication reviews.

39. Between July 2022 and March 2023, prison staff monitored Mr Sinclair under the prison's self-isolation strategy (designed to monitor and support prisoners who withdraw from other prisoners and the prison regime). Mr Sinclair told staff he had borrowed vapes from other prisoners and was in debt but would not provide any information about the amount of money he owed. Safer custody staff created an isolating individuals plan which included a debt support plan. The plan said that Mr Sinclair should start paid in-cell education to enable him to make payments towards

his debt and to complete the money management workbook. Staff also gave him workbooks to manage his anxiety. Safer custody staff completed regular welfare checks and houseblock staff completed a residential monitoring plan. Mr Sinclair said he did not have any current thoughts of suicide and self-harm and he did not need extra support. Staff discussed Mr Sinclair at the monthly self-isolators multi-disciplinary team (MDT) meeting and safety intervention meeting (SIM - a meeting to discuss prisoners with complex needs). The MDT noted that Mr Sinclair experienced anxiety and paranoia and had received support from the SMS and mental health team. There was no security intelligence to suggest that Mr Sinclair was under threat from other prisoners.

40. On 18 April 2023, a GP at the prison saw Mr Sinclair because his anxiety had increased. Mr Sinclair said that he coped with his anxiety by isolating in his cell and asked for medication to manage it. The GP decided that Mr Sinclair did not need medication and could benefit from anxiety management therapy. The mental health MDT discussed Mr Sinclair on 20 April and referred him for a psychology assessment. This did not take place before Mr Sinclair died.

41. On 3 May, prison staff created Mr Sinclair's personal learning plan. This said that he had no formal education and limited employment experience. Staff decided that he should continue with education and find suitable employment once his English and maths had improved.

42. On 11 May, Mr Sinclair started isolating in his cell again. Prison staff provided a money management workbook and in-cell education. During a welfare check, Mr Sinclair told the mental health team that he did not have any current thoughts of suicide and self-harm and he did not need any support. He told the safer custody team that he was not in debt and preferred to remain in his cell because it made him feel less anxious.

43. Staff continued to discuss Mr Sinclair at the monthly self-isolators MDT and noted that he had agreed to continue with in-cell education. He declined a move to another house block and said he wanted a transfer to another prison. Records show that the Offender, Categorisation and Assessment (OCA) unit contacted several prisons about a transfer for Mr Sinclair, but they were unable to accept him because he did not meet their allocation criteria.

44. On 8 and 17 September, healthcare staff gave Mr Sinclair two paracetamol after he complained of toothache. He was prescribed two paracetamol again on 18 September and 1 October for back pain. On each occasion he received the medication from the medications hatch dispensary. The medication is dispensed in a clear cup and prisoners are required to drink 200mls of water (also from a clear cup) after. A prison officer is always in attendance at the medication hatch to ensure no medication is passed to other prisoners. Prisoners who are allowed to keep their medication in their cells are prescribed a maximum of 16 tablets. Paracetamol is not available to purchase on the prison's canteen (shop) list.

45. Mr Sinclair did not attend a GP appointment to discuss his back pain on 11 October.

46. On 12 October, Mr Sinclair agreed to move to houseblock 2. Prison staff noted that he did not have any concerns and knew how to seek support. That day, he declined

support from the mental health team. Mr Sinclair packed his own possessions before he moved cells.

47. At around 10.45pm on 13 October, prison staff started ACCT monitoring after Mr Sinclair said he had taken an overdose of 80 paracetamol tablets. A nurse examined Mr Sinclair and recorded that his observations were normal, he looked well and did not have abdominal pain. She told Mr Sinclair he would need a blood test after 2.00am, to determine the level of paracetamol in his body. Mr Sinclair said that he had concealed paracetamol in his cell, and he felt depressed. Staff decided that they should monitor him five times during the night. When the nurse returned to Mr Sinclair's cell, he refused to have a blood test. Staff did not submit a security information report (SIR) or search Mr Sinclair's cell after he reported taking an overdose and there was no investigation into how he obtained the paracetamol.

48. On 14 October, Mr Sinclair told a case review that he felt stressed about life. He agreed to be referred to the mental health team. Mr Sinclair denied any thoughts of suicide and self-harm. A Custodial Manager (CM) was allocated the role as case manager. He added one action to Mr Sinclair's caremap (designed to identify the main areas of concern and the actions required to reduce risk), which said that he should engage with prison staff to enable him to stop isolating. The CM assessed Mr Sinclair's risk of suicide and self-harm as raised and decided he should be monitored twice an hour during the day and five times during the night. That day, a nurse saw Mr Sinclair after he complained of abdominal pains. His observations were normal. and he was advised to drink plenty of fluids. Mr Sinclair refused to have a blood test. Healthcare staff observed Mr Sinclair during the night and did not record any concerns.

49. At around 5.13am on 15 October, prison staff completing an ACCT check saw that Mr Sinclair had made cuts to both wrists. An officer radioed an emergency code red (which indicated that Mr Sinclair was bleeding) and the control room called an ambulance. A nurse immediately responded and noted that he was pale, clammy and cold to touch. Mr Sinclair had lost around 500mls of blood. Paramedics arrived and took Mr Sinclair to hospital. He remained in hospital until 23 October.

50. A nurse saw Mr Sinclair when he returned to Woodhill and noted that hospital doctors had prescribed him diazepam for three days when he was discharged. The same day, Mr Sinclair told a case review that he had no current thoughts of suicide and self-harm. Staff decided that they should monitor him once an hour and five times during the night.

51. On 24 October, the case manager held a case review. Mr Sinclair said that he felt stressed about life and had taken the paracetamol because he wanted to feel sedated. He refused to provide any information about how he had obtained the paracetamol. Mr Sinclair did not want to complete in-cell education and enjoyed listening to his radio and watching television. He denied any current thoughts of suicide and self-harm. The case manager decided to keep his observations unchanged to ensure support remained in place. Mr Sinclair told staff that he was no longer isolating.

52. On 25 October, a mental health practitioner completed a welfare check. Mr Sinclair said that he felt better now he was taking diazepam and did not want mental health

support. The mental health practitioner did not record her interaction with Mr Sinclair on the ACCT document.

53. On 27 October, Mr Sinclair told a nurse that he felt anxious and was not in the right state of mind. The nurse gave Mr Sinclair diazepam for a further three days. There is no record that he referred Mr Sinclair to the mental health team.

54. The case manager held a case review on 30 October. Mr Sinclair said that he felt better, and the diazepam had calmed him down. He said he had no current thoughts of suicide and self-harm. Mr Sinclair said he was sleeping well. The case manager reduced Mr Sinclair's observations to one conversation during the morning and afternoon and three observations during the night.

55. On 7 November, Mr Sinclair told a case review that he was feeling much better and had no current thoughts of suicide and self-harm. He was associating with other prisoners on the houseblock, taking his medication and staff did not have any concerns. The case manager noted that prisoners had given Mr Sinclair three boxes of vapes and he was now unable to pay for them. Safer custody staff agreed to provide Mr Sinclair with an advance to repay his debt and, as he was no longer isolating, staff would support his application for employment. This would enable Mr Sinclair to earn money to repay his debt. The case manager added one action to Mr Sinclair's caremap, which said that the safer custody team were creating a debt management plan. He also gave Mr Sinclair a journal to record how he was feeling and said he would be paid if he completed it. He noted that staff should continue with ACCT monitoring because of Mr Sinclair's outstanding issue with debt and to ensure that his mood did not deteriorate.

56. On 8 November, a healthcare MDT meeting discussed Mr Sinclair and noted that staff should continue to offer him support on the wing.

57. On 13 November, Mr Sinclair told a prison GP that he had difficulty sleeping and complained of general aches and pains. As the GP was cautious not to prescribe painkillers due to Mr Sinclair's history of overdose, he prescribed promethazine (a sedative).

58. On 15 November, a Supervising Officer (SO) held a case review with a nurse. Mr Sinclair presented well and did not have any current thoughts of suicide and self-harm. He told the SO that he still had an outstanding issue with debt for vape boxes and the safer custody team were creating a debt management plan. The SO said he would look into this. He and the nurse agreed to stop ACCT monitoring. They assessed Mr Sinclair's risk as low and considered that the actions on his caremap were complete. The post-closure phase would end on 22 November. Prison staff did not complete the seven day post-closure monitoring form or make any entries in Mr Sinclair's prison record about his welfare or risk of suicide and self-harm over the next week.

59. On 17 November, Mr Sinclair made an application for employment in the prison laundry, supported by his case manager.

Events of 22 November

60. On 22 November, the employment board approved Mr Sinclair's application for employment and noted that he would start work in the prison laundry on 27 November.

61. At around 1.57pm, Mr Sinclair pressed his cell bell, and an officer went to his cell. Mr Sinclair said that he had taken an overdose of 75 paracetamol. The officer asked a SO to come to Mr Sinclair's cell. Mr Sinclair said that he wanted to die because his family were all dead. In a written statement, the officer said that Mr Sinclair appeared emotionless and did not show any signs of being in pain. She looked around the cell and did not see any medication or illicit substances. As a nurse was dispensing medication on the houseblock, the SO asked her to examine Mr Sinclair in his cell. Prison staff started ACCT monitoring again and decided that staff should monitor Mr Sinclair twice an hour. Staff did not submit an SIR or search Mr Sinclair's cell after he reported the overdose.

62. The nurse noted that Mr Sinclair was alert and sitting on his bed. He appeared well but complained of feeling dizzy. She recorded Mr Sinclair's national warning score (NEWS - a tool used to assess illness severity and the risk of deterioration) as 1 (low risk). She sought advice from TOXBASE (the clinical toxicology database, providing advice on the management of poisoned patients), who said that staff should continue to monitor Mr Sinclair for signs of deterioration. At around 3.12pm, another nurse and a CM decided that due to the level of concern about liver damage, Mr Sinclair needed further examination at hospital. Two prison officers went with Mr Sinclair and used an escort chain (a long chain with a handcuff at each end, one end is attached to the prisoner and the other to an officer).

63. Mr Sinclair deteriorated in hospital, and he died at 9.00am on 25 November.

Contact with Mr Sinclair's family

64. When Mr Sinclair went to hospital on 22 November, the prison appointed a family liaison officer (FLO). As Mr Sinclair did not have any contact with his family, the FLO asked the police for assistance. After Mr Sinclair died, police enquiries found contact details for Mr Sinclair's half-sister. The police visited her on 27 November and broke the news of Mr Sinclair's death. That day, the FLO spoke to Mr Sinclair's half-sister on the telephone and offered support.

65. The prison arranged and paid for Mr Sinclair's funeral 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 prisoners 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 Sinclair's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

68. The prison posted notices informing other prisoners of Mr Sinclair's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Sinclair's death.

69. Safer custody staff gave prison listeners and the wing manager postvention leaflets to share with prisoners and staff.

Post-mortem report

70. The post-mortem report concluded that Mr Sinclair died from multi-organ failure, liver necrosis and paracetamol toxicity. The pathologist said that a previous paracetamol overdose in October 2023, had damaged Mr Sinclair's liver and led to multi-organ failure.

Findings

Assessment of Mr Sinclair's risk

71. Mr Sinclair had a number of risk factors that increased his risk of suicide and self-harm. He had a previous history of self-harm, mental illness and substance misuse. Mr Sinclair chose to withdraw from the prison regime for the majority of his time at Woodhill, he had no support from friends or family, made no phone calls and received no visits.

72. Mr Sinclair was supported by ACCT procedures after he told staff he had taken an overdose of paracetamol on 13 October. We consider that the ACCT procedures provided some support to Mr Sinclair. His ACCT case manager held regular case reviews which appropriately assessed his risk. Prison staff added actions to Mr Sinclair's caremap which reflected that he was isolating and was struggling with debt. However, Mr Sinclair's caremap did not refer to his poor mental health or substance misuse issues, despite him taking an overdose and obtaining medication that he was not prescribed.

73. We consider that the ACCT was closed prematurely and before a significant action on the caremap was complete, despite Mr Sinclair telling the case review team that the issue related to debt was still outstanding. The ACCT was closed by a member of prison staff who was not Mr Sinclair's case manager and who had limited knowledge of his support needs. Safer custody staff had not implemented the debt management plan and Mr Sinclair had not started work, both issues that were causing Mr Sinclair anxiety.

74. Mr Sinclair was in the post-closure phase of ACCT monitoring when he took a second overdose. Staff did not complete the post-closure monitoring form and there were no entries on his prison record during the post-closure phase. This meant that staff did not assess how Mr Sinclair was coping without support or monitor if his risk was increasing.

75. Since Mr Sinclair's death, Woodhill has introduced various measures to improve the quality of ACCT management, including additional staff in the safer custody team, quality assurance and additional case management training for operational staff. HMPPS has provided more extensive guidance and resources to support the safer custody team. Keywork (which provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address) has also been reintroduced, initially targeted at the most vulnerable prisoners, including those in the induction unit and prisoners subject to ACCT monitoring. We appreciate that the prison will need time to demonstrate the effectiveness of these supportive measures, we therefore make no recommendation.

Mental health

76. The clinical reviewer concluded that Mr Sinclair's mental health care was not equivalent to what he could have expected to receive in the community. Mr Sinclair had a diagnosis of paranoid schizophrenia and was prescribed an antipsychotic medication. A mental health nurse created a mental health care plan shortly after he

arrived at Woodhill, but this was not implemented or reviewed. As Mr Sinclair regularly told mental health nurses that he did not need their support he was discharged from their care. A mental health nurse did not attend case reviews and there was no discussion about how his poor mental health may have contributed to his decision to self-harm. In addition, the lack of input from the mental health team into the ACCT process meant that Mr Sinclair was not offered mental health support after serious incidents of self-harm. We recommend:

The Head of Healthcare should review the contribution to the ACCT process from mental health nurses for prisoners who have seriously self-harmed, including those not on the mental health team's caseload.

77. When Mr Sinclair returned from hospital on 22 October after a serious incident of self-harm, he was not assessed by a mental health nurse. The assistant practitioner who saw Mr Sinclair did not record her assessment on Mr Sinclair's ACCT management plan to ensure that the case review team had the necessary information to appropriately assess his risk. We recommend:

The Head of Healthcare should investigate why a mental health nurse did not assess Mr Sinclair when he returned from hospital after a serious incident of self-harm.

Under the influence policy

78. Mr Sinclair was able to take an overdose of a significant amount of paracetamol on two occasions despite being assessed as unsuitable to have medication in his cell. He told staff he had hidden the medication in his cell but did not provide any information about how he managed to obtain it. The investigation found that staff did not submit a SIR after he told staff he had taken the first overdose shortly after he moved cells and they did not investigate how he had obtained such a large quantity of paracetamol. This meant that the security team did not search his cell or investigate how he had obtained the medication. The Head of Security told the investigator that at the time of Mr Sinclair's death, Woodhill did not have a specific 'under the influence' instruction to staff. We have not uncovered any evidence to indicate where Mr Sinclair obtained the paracetamol.

79. On 8 May 2024, the Governor issued a notice to staff to ensure they were aware of the immediate steps that they must take if a prisoner is suspected of being under the influence of illicit substances or if they inform staff that they have taken an overdose. This includes completing welfare checks every 15 minutes in addition to ACCT checks, recording the incident in the unit observation book, prison record and submitting a SIR. Staff should also ensure that healthcare staff make appropriate referrals to the SMS and mental health team.

80. On 21 May, Woodhill amended their local security strategy on searching techniques and cell searches. This states that on discovery of a prisoner who is under the influence, staff must conduct a cell search immediately or as soon as it is safe to do so. Staff must make the security team aware of the outcome of the search. Prisoners who staff suspect are under the influence or who are obtaining medication illicitly will also be subject to intelligence led searches.

81. We are satisfied that since Mr Sinclair's death, Woodhill has put in place an appropriate under the influence instruction and cell searching strategy.

Self-isolation strategy

82. Woodhill's Isolating Individuals Strategy (updated in July 2023) says that prisoners identified as self-isolating for longer than 72 hours should be referred to the safer custody team and entered on the challenge, support and intervention plan database (a process used to manage difficult prisoners and victims of violence or threat). Prisoners who are confirmed as self-isolating should be allocated a liaison from safer custody to understand why they are isolating, to seek a solution and signpost to other support.

83. Mr Sinclair was first identified as self-isolating in July 2022, when he told prison staff that he wanted to remain locked in his cell because he was in debt to other prisoners. A prison officer completed an isolating individuals referral form. Safer custody allocated a prison officer as Mr Sinclair's safer custody liaison officer to ensure that Mr Sinclair was appropriately monitored while he was self-isolating. Staff discussed Mr Sinclair at the monthly self-isolators meeting and safety intervention meeting.

84. Safer custody staff spoke to Mr Sinclair to investigate why he did not want to participate in the normal wing regime and to ensure Mr Sinclair understood the self-isolator regime. Mr Sinclair was reminded of the support available from Listeners and the Samaritans. Mr Sinclair continued to receive support from the safer custody team and staff explored a transfer to another prison. Mr Sinclair agreed to move to another houseblock and was not isolating when he died.

85. We are satisfied that prison staff took appropriate action when Mr Sinclair was identified as self-isolating.

Management of Mr Sinclair's debt

86. When Mr Sinclair told prison staff he was in debt they created a debt management plan and provided money management workbooks. Mr Sinclair's debt management plan identified that he was unable to pay for vapes because he had had no family support and needed to earn money. Staff created an individual learning plan to support Mr Sinclair with completing paid in-cell education while he was isolating and to improve his employment prospects.

87. At the time of Mr Sinclair's death, Woodhill did not have a specific debt management policy. Prisoners in debt were managed under the prison's Isolating Individuals Strategy.

88. In June 2024, the prison implemented a debt management strategy which includes a designated CM in the safer custody team with responsibility for overseeing the actions that safer custody staff must take when a prisoner is in debt. The strategy enables prison staff to understand why prisoners get into debt, to prevent it happening and to respond appropriately to prisoners who are in debt. It provides specific guidance to ensure staff effectively manage prisoners who are in debt and to support collaborative working with prisoners to prevent future debt.

89. We are satisfied that Woodhill has an appropriate strategy to manage and support prisoners who are in debt.

Inquest

90. At the Inquest held between 16 and 19 March 2026, a jury returned a verdict of misadventure.

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