

Mr Bernard Richmond KC.
HM Assistant Coroner
Inner West London
Inner West London Coroner's Court
33 Tachbrook Street
London
SW1V 2JR

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[REDACTED]
16 April 2026

[REDACTED]
Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Rajwinder Singh who died on 25 June 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 February 2026 concerning the death of Rajwinder Singh on 25 June 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Singh's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Singh's care have been listened to and reflected upon.

Your Report raised concerns the following:

1. The lack of mandatory [Assessment Care in Custody and Teamwork \(ACCT\)](#) refresher training for prison officers at HMP Wandsworth.
2. That there are no mandatory procedures to ensure that, before they are deployed in the prison setting, Oxleas agency staff have the same mandatory ACCT training as that provided to permanent healthcare staff.
3. When Prison officers and/or healthcare staff are given ACCT induction training at HMP Wandsworth, there is no training in the principles of risk formulation.

Assessment Care in Custody and Teamwork (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm.

Concerns 2 & 3

NHS England's London regional colleagues have advised that [Oxleas NHS Foundation Trust](#) now have a process in HMP Wandsworth to ensure that all staff, permanent and temporary (including agency), have undertaken mandatory ACCT training. At the time of Mr Singh's death, access to ACCT training was sporadic, due to a shortage of [Safer Custody](#) staff available to lead in training. This has since been resolved, with Safer Custody staff now available to deliver ACCT training for healthcare staff on two dates per month. In addition, all members of temporary staff receive an induction before working at HMP Wandsworth.

NHS England undertook a quality assurance visit to the healthcare team at HMP Wandsworth on the 19th March 2026. At that visit, the process was verified and it was confirmed that all temporary staff had undertaken ACCT training, with the exception of two. It was confirmed that the two outstanding members of temporary staff were booked onto ACCT refresher training.

In addition to the above, NHS England's central Health and Justice Team received a PFD report on 4th October 2023 relating to the sad death of Mr Z on 20 March 2021 in HMP Wormwood Scrubs. The Coroner noted as a matter of concern that training of agency staff in ACCT did not appear to be part of the commissioning process by NHS England, and that individual healthcare providers did not appear to provide training in the ACCT process to agency staff.

In response to the findings of that report and to support national learning, the National Director for Health and Justice requested that regional commissioning teams confirm that there are appropriate arrangements in place to ensure that all staff, including agency and bank staff, have timely access to all joint training, including ACCT, that is necessary for them to undertake their role effectively within the prison environment. Therefore, regional commissioners gained assurance from healthcare providers operating across London prisons, that there were arrangements in place whereby ACCT training was in place for temporary staff working in prison settings. Further assurances were gained by NHS England (London Region) from regional prison health providers in March/ April 2026 that there continue to be suitable systems and processes in place to ensure that all staff, including bank and agency staff, have accessed the required training, including ACCT training, to undertake their roles.

Concern 3

A number of actions and recommendations from the internal and external investigations that took place in response to the death of Mr Singh related to training and staff development. In response, Oxleas NHS Foundation Trust commissioned independent training, to enhance staff skills when assessing the risk of self-harm and suicide, which incorporates the recognition of risk factors and early warning signs, risk formulation, and the utilisation of collateral information and past risk history. The training was for all healthcare staff.

The two-day training, known as ACCT Plus, focusses on a deeper examination of the risk of self-harm and suicide in the prison population, beyond the ACCT process and associated interventions. The training specifically looks at models of suicide, the underlying reasons for self-harm, and their relationship to different mental disorders. The training is delivered through mixed media/methods, including a full day working with an actor, to enable staff to practise and test out new skills.

The training initially took place in January 2025 (13th and 14th, 23rd and 24th) with staff booked onto the sessions in advance. The training was also available for prison officers at HMP Wandsworth. Further sessions have taken place since the initial dates to ensure wider uptake. The training has been undertaken by staff working across all aspects of the healthcare service, including Primary Care, Mental Health, Psychology, and Substance Misuse services. This equates to 44 staff members who have

undertaken the training to date, including two prison officers. A further 17 members of healthcare staff will be undertaking the training between April and June 2026.

Additional training and development has also taken place. Since coming into post in 2024, the mental health operational manager has focussed on refreshing and developing the skills of the mental health team in effectively triaging patient referrals, given that the investigations cited above identified this is an area requiring improvement.

As well as staff support through training provision, the healthcare service at HMP Wandsworth and wider Trust have also been considering their approach to staff induction, to support staff on arrival to the service. Competency documents have been developed across areas of the service to support staff on their initial 6 weeks. The competency documents have been updated, as has the wider induction process, to ensure that principles of the NHS guidance [‘Staying Safe from Suicide’](#) can be shared on with staff upon entering working with the service. ‘Staying Safe from Suicide’ is an approach that puts safety assessment, formulation, management and planning in the context of the relational, therapeutic engagement, which is known to improve outcomes in assessing and managing suicide risk. ‘Staying Safe from Suicide’ provides a clear focus on risk formulation and the requirement to include this as part of every psychosocial assessment.

In addition to the above, London regional colleagues hold regular assurance visits to prison healthcare services to monitor service improvement initiatives and progress against learning identified from significant and/or fatal incidents. London regional colleagues have received appropriate evidence from the healthcare provider that improvements have been made against the action plans that were developed in response to the death of Mr Singh following the internal patient safety investigations by Oxleas NHS Foundation Trust and the external investigation by the [Prison and Probation Ombudsman](#).

Specific and enhanced training had been provided across the mental health services’ most critical area of patient risk, suicide and self-harm. During the most recent assurance visit to HMP Wandsworth, the service was able to demonstrate appropriate clinical governance arrangements that support their care pathways, including processes, clinical audit and oversight meetings. The healthcare leadership team could demonstrate improvements in pathways and patient safety, with a focus on supporting the workforce through service change and development.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Mr Singh, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director
NHS England