

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none"> 1. GOVERNOR HMP WANDSWORTH 2. DIRECTOR OF OFFENDER HEALTHCARE OPERATIONS, OXLEAS 3. NHS ENGLAND
1	<p>CORONER</p> <p>I am BERNARD RICHMOND KC, Assistant Coroner, for the coroner area of Inner West London.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 10th July 2023, an inquest was opened into the death of Rajwinder Singh (Date of Birth 18th August 1986). The inquest was heard between 23rd July and 6th August 2025.</p> <p>The conclusion of the inquest was: Misadventure contributed to by neglect.</p> <p>Probable causes:</p> <ol style="list-style-type: none"> a) The reduction of pregabalin dose and the failure to communicate this to Mr Singh; b) Inconsistent provision of medication and the consequential effect on Mr Singh's physical and mental health; c) Failure to provide Mr Singh with adequate mental health support in a timely manner; d) Failure to answer the cell bell within 5 minutes on the night of 20th June between 20.36 and 21.06. <p>Possible causes:</p> <ol style="list-style-type: none"> a) Failure to conduct observations as directed by Mr Singh's ACCT on 20th June. <p>Medical cause of death: 1a Hypoxic encephalopathy 1b Ligature compression of the neck.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 9th June 2023 at the Southwark Crown Court, Rajwinder Singh was sentenced to a term of imprisonment. He was taken to Wandsworth Crown Court. He was identified in the Prison Escort Record as someone was at risk of self-harm and suicide. During his health screening an ACCT was opened. An action plan followed. An ACCT assessment was made on 13th June 2023. It was accepted in evidence that this assessment lacked detail. At the end of the assessment it was decided that Mr Singh would be the subject of hourly observations.</p> <p>During the time that Mr Singh was in Wandsworth post 9th June the evidence showed that the supervising officer on the wing regularly failed to review the ACCT document. From the evidence the following became clear:</p> <ol style="list-style-type: none"> 1. The assessment of risk to Mr Singh was inadequate. Those who were making assessments were not aware of Mr Singh's full history. 2. Those undertaking the assessments had varying degrees of understanding as to risk assessment. Nobody had any formal training in the subject.

	<ol style="list-style-type: none"> 3. There was also a failure to ensure that all relevant information was recorded in the ACCT. Healthcare did not record previous healthcare issues which were of relevance to the Assessments. 4. There were numerous gaps or omissions in record keeping. 5. Observations were not staggered and, on occasion, did not happen at all. 6. Agency healthcare staff had no or no adequate training in ACCT and did not understand their obligations 7. Prison staff whilst receiving some training at induction, had no update or refresher training in ACCT. As a consequence they had forgotten many of the principles and, particularly when overworked, tended to fail to maintain records and handovers were insufficient or non-existent. <p>As a consequence of the above (and other matters) the risk assessments gave inadequate weight to Mr Singh's self-harming behaviour ([REDACTED]) and his increasingly negative state of mind. His cell bells were not all answered on 20th June and, following a failure to answer his cell bell during the evening of 20th June Mr Singh [REDACTED]. He was transferred to St George's Hospital where he died on 25th June 2026</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence 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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> (1) There is no mandatory ACCT refresher training for prison officer at HMP Wandsworth; (2) 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
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>
7	<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 16th April 2026. The coroner, may extend the period.</p> <p>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.</p>
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>The Family of Rajwinder Singh Director of Offender Healthcare Operations, OXLEAS Ministry of Justice</p> <p>I have also sent a copy to the Governor of Wandsworth Prison.</p>

	<p>I am also under a duty to send the Chief Coroner a copy of your response.</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. 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	19th February 2026 <i>Bernard Richmond KC</i>