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NHS Foundation Trust

11 June 2026

Private & Confidential

Mr Ian Potter
HM Senior Coroner Mid Kent and Medway
Mid Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent ME16 8AE



Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG

Dear Mr Potter

Case No: [REDACTED] - Regulation 28 Report to Prevent Future Deaths - Inquest touching the death of Mr Thomas Daniel Ruggiero

Thank you for your regulation 28 report to prevent future deaths dated 24th March 2026 following the inquest into the death of Mr Thomas Daniel Ruggiero which concluded on 20th March 2026.

In advance of responding to the specific concerns raised in your report, I would like to express my deep condolences to Mr Thomas Daniel Ruggiero's family and loved ones. Oxleas NHS Trust is keen to assure the family and the coroner that the concerns raised about Mr Thomas Daniel Ruggiero's care have been listened to and acted upon. I appreciate that responses to Coroner Reports may constitute an important part of process through which family and friends come to terms with the passing of their loved one, and that this will have been an incredibly difficult time for them.

In your letter you raised concerns that there is a policy requirement / expectation that a member of the healthcare team should attend all ACCT reviews. In this case, there were numerous instances where this was not met. Whilst some improvement has been noted, there remains insufficient assurance that this issue has been fully addressed.

Oxleas NHS Foundation Trust acknowledges the importance of healthcare representation within the ACCT process, particularly for individuals with complex mental health needs and known risk of self-harm. We recognise that consistent attendance is a critical component of multi-disciplinary risk management and safeguarding.

Following the inquest and internal review processes, the Trust has undertaken a number of actions to strengthen compliance, improve assurance, and reduce the risk of recurrence.

In December 2024, a review of the mental health staffing model at HMP Swaleside was undertaken to strengthen the service's capacity to consistently attend and contribute to ACCT reviews. This review identified gaps in aligning staff availability with periods of higher ACCT demand. In response, revised rota arrangements were introduced, ensuring that appropriately skilled mental health practitioners are available during peak activity times, particularly during core ACCT review periods. This adjustment has improved responsiveness, reduced delays in attendance, and supported more consistent multidisciplinary input into risk management planning.

In January 2025, a structured daily safety huddle was introduced at HMP Swaleside, providing a formal mechanism for real-time oversight and coordination of high-risk patients. The huddle is held each morning and is attended by key members of the multidisciplinary team, including mental health, primary care, substance misuse, and operational leads where required. During the huddle, the team reviews all patients subject to ACCT, as well as any other individuals identified as presenting an elevated or emerging risk.

The daily huddle includes:

- A review of all open ACCTs, including current risk levels, frequency of observations, and any recent changes in presentation or behaviour
- Identification of patients due for ACCT reviews that day, ensuring mental health representation is prioritised and allocated in advance
- Escalation of any patients with deteriorating mental health, recent self-harm incidents, or concerns raised by staff
- Allocation of actions, including clinical reviews, or escalation to senior clinicians
- Cross-team information sharing to ensure all services are aware of key risks and planned interventions

This approach has strengthened governance and accountability by ensuring clear visibility of high-risk cases on a daily basis, improving communication between teams, and enabling proactive management of risk. It has also supported more timely attendance at ACCT reviews and ensures that the most vulnerable patients are consistently prioritised within service delivery.

In June 2025 the Kent ACCT Standard Operating Procedure was circulated and sets out clear guidance to all healthcare staff to reinforce expectations regarding attendance at ACCT reviews. This includes clarification of when mental health team involvement is required and the actions that must be taken if attendance cannot be achieved. The Standard Operating Procedure reiterates that a telephone or written contribution must be provided in exceptional circumstances when healthcare staff cannot attend. This updated guidance has been embedded within local induction processes and incorporated into mandatory training to support consistent understanding and application.

A formalised escalation and contingency process has been introduced to address occasions where healthcare attendance cannot be secured. This requires immediate notification to senior clinical leads, consideration of alternative appropriately qualified staff where feasible, and clear documentation of the rationale for non-attendance, alongside any mitigating actions taken to manage risk.

Multi-disciplinary working between healthcare and prison staff has been further strengthened through improved communication arrangements, particularly in relation to the scheduling of ACCT reviews. A daily tracker is circulated each evening by the prison safety team, clearly identifying individuals due for ACCT review the following day, which is then reinforced and actioned through the daily huddles. Any discrepancies are promptly identified and escalated to ensure timely resolution. Enhanced forward planning is now in place for high-risk individuals, and mental health representation at case reviews is actively monitored and supported through daily operational meetings.

Healthcare attendance at ACCT reviews is now subject to routine audit, with results reviewed through local clinical governance forums and within the Trusts Patient Safety Incident Response Framework (PSIRF) oversight structures. This is overseen by the head of healthcare and compliance is actively monitored, with any identified gaps followed up through targeted action plans. This area has also been incorporated into the Trusts risk register, with appropriate executive oversight in place.


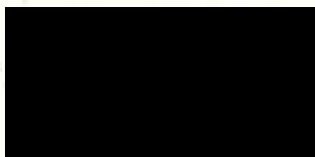
Finally, learning from this case has been disseminated across the Offender healthcare directorate. Reflective practice sessions have been undertaken with clinical teams to reinforce the importance of healthcare input within ACCT processes. Ongoing monitoring arrangements are in place to ensure that these improvements are embedded and sustained overtime.

Whilst improvements have been made, the Trust recognises that sustaining consistent healthcare attendance at ACCT reviews in a complex custodial environment requires continued focus. Assurance mechanisms are now in place to provide greater oversight, early identification of gaps, and timely intervention.

I hope that this letter reassures you that Oxleas has been highly attentive to the findings of your investigation, and that concerted remedial action has been taken on all the areas you identified to prevent any similar future deaths.

Please do not hesitate to contact me if any clarification or further assurance is required.

Yours sincerely,



Acting Chief Executive Officer
Chief Medical Officer/Responsible Officer