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25 April 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Marta Elena Vento who died on 9 December 2020.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 11 March 2025 concerning the death of Marta Elena Vento on 9 December 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Marta's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised relevant to the perpetrator of Marta's death and this incredibly sad incident have been listened to and reflected upon.

Your Report raises the concern that there is a lack of national guidance to assist healthcare providers in ensuring continuity of care for a prisoner with physical or mental health needs upon release from prison, and lack of practical guidance around delivery of care to ensure such continuity. Your Report also raises a concern that there is no national guidance about the continuity of care for prisoners upon release from prison when homeless, as some Mental Health Trusts will not accept a referral where a person is homeless.

My response to the Coroner has been aided by engagement with NHS England's national Health and Justice, Mental Health and South West regional teams.

As part of the 2024/25 NHS Priorities and Operational Planning Guidance, NHS England required all Integrated Care Boards (ICBs), the organisations with responsibility for commissioning (paying for) local mental health services, to complete a review of their community mental health services by the end of September (Quarter 2) 2024/25.

The aim of this was to ensure that Systems have robust policies and practices in place to support individuals with serious mental illness who require intensive community treatment and follow-up, particularly where engagement may be challenging.

NHS guidance emphasises a 'no wrong door' approach, to ensure individuals can access holistic mental health care regardless of where they first seek support, and any people experiencing psychosis receive evidence-based treatment that enables them

to recover from a psychotic episode and/or live a meaningful life while managing ongoing symptoms.

Some individuals, however, can face challenges in accessing appropriate care and barriers to this may include services struggling to meet their needs, the impact of symptoms such as paranoia, or a lack of insight into their condition. For such individuals, it is crucial that mental health services provide tailored support through flexible engagement strategies, continuity of care, and a range of treatment options suited to varying symptom severity.

A significant change in circumstances, such as discharge from hospital or release from prison, can be associated with heightened risk, especially when individuals return to unstructured or unsafe environments. Therefore, individuals with serious mental illness and co-occurring needs, which might include homelessness, a history of violence or offending behaviour, and who also have difficulty engaging with services, should receive intensive and assertive community treatment, in line with national guidance.

Local ICB reviews can ensure appropriate intensive and assertive mental healthcare and treatment in the community is available to meet the needs, and to support the wellbeing of a particular group, of people with severe mental health illness: NHS England » Guidance to integrated care boards on intensive and assertive community mental health care

To support this approach when individuals are leaving prison, there are services in place such as RECONNECT, a non-clinical 'care after custody' service that seeks to improve the continuity of care of individuals with identified health needs, by working with them before they leave the secure estate. RECONNECT supports transition to community-based services, enabling the safeguarding of health gains made whilst in the secure estate, with the aim of helping to reduce inequalities and address health-related drivers of offending behaviours.

RECONNECT offers support and release planning to individuals for up to twelve weeks prior to release, or as soon as they are referred, and works with them up to six months post-release, or when all health care needs are met, whichever is soonest. Referrals can be taken from anyone, including His Majesty's Prison and Probation Service (HMPPS), prison healthcare, family members and self-referrals. At the time of Marta's perpetrator's release, RECONNECT services were not in place. However, I hope that this provides some assurance to the Coroner and Marta's loved ones that processes are now in place to provide more support to people leaving prison in similar circumstances.

From a prison mental health perspective, continuity of care is included in the current Integrated Mental Health Service Specification for Prisons in England, which was published in 2018, as one of three key measurable objectives which are:

1. Improved mental health and emotional wellbeing.
2. The rehabilitation of prisoners and a reduction in reoffending through the improvement of mental health and contribution to sentence planning where appropriate.

3. Improved continuity of care through the gate and within the prison system.

This service specification highlights essential and expected standards for delivery of different elements of the service, which include:

- Onward referrals to community services.
- Inviting community teams to discharge/release planning and Care Programme Approach (CPA) meetings.
- A follow-up interview with the patient/new care co-ordinator or service provider within fourteen days of release.

At present, there is no specific national pathway guidance setting out what an individual on release can expect from their local Community Mental Health Team (CMHT). The guidance relating to the Adult Mental Health Team is generic rather than focused on the prison population.

While there are no plans currently to develop national pathway guidance, NHS England will be considering this in the longer-term, working with the Adult Mental Health Team to ensure services are able to fully support those leaving prison.

There is also, at present, a review and refresh of the service specification mentioned above underway, and learning from this case will be taken into consideration as part of this refresh. Attention will be given to strengthening the service specification to ensure continuity of care is robust, to ensure successful transfer of care arrangements from prison healthcare to community healthcare teams.

I understand from my regional South West colleagues that a full investigation was undertaken into Marta's death. A multi-agency investigation stakeholder group was convened with the following organisations contributing to the investigation process:

- Dorset Council
- Orchid House Surgery/Dr Grana
- HMP Winchester
- NHSE Health & Justice team (South East)
- NHS Dorset (ICB)
- Practice Plus Group (PPG)
- Dorset & Hampshire Police
- Dorset Healthcare University NHS Foundation Trust

The perpetrator did not contribute to the process, and the perpetrator's family did not wish to contribute to the process or receive the report, although this was offered. I understand that Marta's family have been provided with a copy of the investigation report.

There has also been a learning event held to help understand how different parts of the system work together to meet the needs of an individual who presents with mental health needs, in addition to their offending behaviours. This was well attended with engagement throughout the session from various agencies, including but not limited to; NHS England (regional health and justice and independent investigation teams),

police, healthcare within prisons, NHS healthcare services, Local Authority, housing, and HM Prison & Probation Service.

During the learning event, consideration was given to how an individual is assessed for their mental health needs when entering and leaving prison, how ongoing mental health and social care needs are shared with colleagues in health and local authority services, alongside the public protection responsibilities under the Multi-Agency Public Protection Arrangements (MAPPA), in assessing and managing the risks posed by the most serious offenders. Common themes identified were:

- Data and information sharing (including application of consent)
- Impact of the courts on the pathway(s), such as early release and notification of release
- Clearer communication channels between all agencies

The NHS England South West Independent Investigations Team will support next steps from the learning event to be shared, and then taken forward within the Serious Case Review Subgroup, led by the Chief Inspector of Dorset Police.

Nationally, the findings, information and any learning from this Report will be tabled at a future NHS England Health and Justice Delivery Oversight Group (HJDOG). The HJDOG is the senior leadership forum, which holds responsibility for the oversight of delivery and continuous improvement in Health and Justice commissioned services, through both national and regional teams. All health and justice related Reports to Prevent Future Deaths are shared and discussed at the HJDOG, and assurance is sought from regions where learning and action is identified. This case will also be tabled and discussed at the NHS England Health and Justice and Sexual Assault Referral Centres (HJ&SARCs) meeting scheduled for 13 May 2025, where the learning and any improvements will be shared. These meetings are attended by Health and Justice Quality leads and representatives.

Your report also raises a concern that, in the South West region, all Integrated Care Boards (ICBs), apart from NHS Dorset, are at some stage of implementing the use of the National Record Locator (NRL) system so that South West Ambulance Service NHS Foundation Trust (SWASFT) can access this information to assist in the provision of care to those they treat. You raised that the lack of implementation by NHS Dorset would limit the information SWAST has access to about a patient in Dorset.

NHS Dorset and the Dorset Care Record (DCR) Partnership are involved in the regional and national work to adopt sharing information via the National Record Locator and were founding members of the One South West Programme. The current focus of the work across the One South West programme is supporting ambulance crews to access care plans supporting patients with frailty and palliative care. In order to also support the sharing of mental health care plans, the One South West programme would need to expand their activity. NHS England understands that NHS Dorset would actively support the expansion of this work.

In the absence of this capability, the DCR Partnership is looking to have the capability to share information with others using the NRL from March 2026 onwards, which will meet the national deadline set by NHS England. The DCR Partnership will then start

sharing records to others using the NRL, meaning that SWASFT can access the data through this method.

NHS Dorset remain keen to work with SWASFT to enable access to the Dorset Care Record directly. However, SWASFT have prioritised the NRL approach to sharing data. The DCR Partnership is hoping to work with Dorset Healthcare to share their information to the DCR in 2025, which will be another critical part of the solution.

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 Marta, 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,

[redacted]
National Medical Director