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Dr Peter Harrowing LLM
Area Coroner – Area of Avon
Old Weston Road
Bristol
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26/11/2025

Dear Dr Harrowing

Re: Regulation 28 Report to Prevent Future Deaths – Amy Jo Cross who died on 10 June 2023 at HMP Eastwood Park whilst on remand

Thank you for your Report to Prevent Future Deaths (hereafter 'Report') dated 20 October 2025 concerning the death of Amy Jo Cross on 10 June 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Amy's family and loved ones. NHS England is keen to assure the family, and the Coroner, that concerns raised about Amy's care have been listened to and reflected upon.

Your Report raises the concerns outlined below, which I will endeavour to provide a response to:

1) There is no system to ensure that important healthcare information including recent administration of medicines and the results of physical observations is passed between separate providers of healthcare in the criminal justice system at the time a person is conveyed between the police, the court and the prison.

(2) There is no standard medical records system which can be accessed by each healthcare organisation to ensure the efficient and effective transfer of medical information.

The Digital Person Escort Record (DPER) is a system in place designed to share information regarding an individual's journey along the criminal justice system pathway. The DPER system is owned by the Ministry of Justice. The DPER makes provision for information to be shared from police custody onwards to the Prison Escort and Custody Services (PECS) provider, through to PECS services operating within court custody settings and then for transmission to a prison or Youth Offenders Institute (YOI).

NHS England is not responsible for commissioning police custody healthcare services; this function sits with Police & Crime Commissioners. The Police & Crime Commissioner for Devon & Cornwall Constabulary is responsible for commissioning police custody healthcare services at the Torquay and Exeter police stations. The police are responsible for detailing relevant health information on the individual's DPER within police custody suite settings, usually having taken advice from the police custody healthcare provider.

NHS England does commission Liaison & Diversion services, which also operate with police custody suites, addressing mental health and wider vulnerabilities. There is no indication that a referral was made in this case to Liaison & Diversion services at either Torquay or Exeter police custody suites. Liaison & Diversion services do not currently have access to enter information directly onto the DPER, but with an individual's consent, they will share relevant health information with the police and the police will be responsible for updating the DPER. NHS England is in discussion with PECS to commence pilot schemes in London and West Yorkshire, whereby PECS will issue licences to Liaison & Diversion Services, to enable them to directly access the DPER and enter health information. The pilots are expected to commence in 2026 at the following sites:

- London – Charing Cross Police Station and Westminster Magistrates' Court
- West Yorkshire – Kirklees, Leeds and Wakefield Police Stations and Leeds Magistrates' Court

The start date is anticipated to be around February / March 2026, as stringent monitoring of licences issued to the L&D service providers (thereby avoiding the need to access Policy and Probation systems) will need to take place as a prerequisite to access the DPER, and the pilots are anticipated to take place over the 12 month period following this.

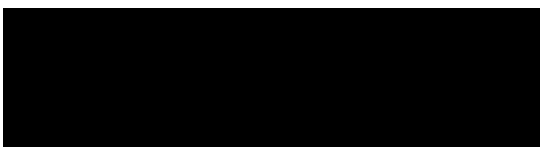
The findings, information and any learning from this case will be tabled at a future NHS England Health and Justice Delivery Oversight Group (HJDOG). The HJDOG is the senior leadership forum, which holds responsibility for the oversight of delivery and continuous improvement in Health and Justice commissioned 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.

NHS England's national health and justice team has also engaged with colleagues from the South West region on the concerns raised in your report.

I would also like to provide assurance about 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 learning and insight around events, such as the sad death of Amy, are shared across the NHS at both a national and regional level. This helps NHS England pay close attention to any emerging trends that may require further review and action.

I would like to thank you for bringing these important issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely



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