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HM Senior Coroner for Surrey
HM Coroner's Court
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National Medical Director
NHS England
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11th February 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Diana Ocean Grant who died on 20th November 2021

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24th November 2025 concerning the death of Diana Ocean Grant on 20th November 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Diana's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Diana's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused Diana's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

NHS England was not a party to the inquest, and we have therefore not had sight of or heard the full extent of the witness evidence relating to the issues raised within Sections 3 and 4 of your Report, which fall outside of NHS England's role and remit. However, we note you have stated at Section 5 that, as a result of the extensive evidence received during the inquest, all of these issues were addressed by reason of changes made since Diana's death, save for one remaining concern.

The outstanding concern raised within Section 5 of your Report is that many people are being detained in prison who require immediate admission to a secure mental health unit. Their detention means that their needs are not fully met due to differences in the physical environment, the nursing and therapeutic regimes and access to psychological treatment between prisons and mental health units. You have raised that this is principally due to the restricted capacity of the secure mental health unit estate.

For completeness, NHS England's London Region team have liaised with Central and North West London NHS Foundation Trust's Community Mental Health Team (CMHT) in respect of some of the clinical issues raised throughout your Report. They have also

had sight of the witness evidence provided by the CMHT at inquest. The London Region is satisfied that actions have been taken since Diana's death, and ongoing work is taking place, in order to avoid such issues arising again.

At the time of Diana's death, the healthcare provision at HMP Bronzefield was commissioned by Sodexo, with Mental Health services being commissioned by NHS England. Since April 2023, NHS England's South East Health and Justice team have commissioned the whole healthcare prime provider model at HMP Bronzefield. This includes all primary care services, substance misuse and mental health.

An independent review of the healthcare provision at HMP Bronzefield was commissioned and submitted to the Prisons and Probation Ombudsman (PPO) in February 2023. The PPO's final report was published in January 2025. Alongside Sodexo, the Clinical Lead for Central and North West London NHS Foundation Trust was involved with developing an action plan in May 2023 and this was submitted to the PPO.

Locally, NHS England's South East Health and Justice Commissioning team and Direct and Specialised Commissioning Quality team have engaged with the national programme of mental health improvements, along with working with local providers, to review areas that can cause delays to achieve the 28 day transfer target referred to within your Report, including looking at the Who Pays guidance, escalation pathways, referral forms and contact lists. There are also working groups with a focus on alternatives to custody.

Single Point of Contact process

In addition, in May 2024, the Single Point of Contact (SPoC), otherwise known as the Single Point of Access (SPA), was set up for HMP Bronzefield. This was implemented to ensure that information from the community reaches the prison healthcare reception team and is acted upon.

The SPoC process ensures that complex medical in confidence information and social care needs can be received by prison healthcare in a timely manner and acted upon ahead of a patient's arrival in prison. It is recognised that, across the South East Region, the current risk and complex medical information sharing arrangements between prison healthcare and external stakeholders vary considerably. This poses a risk to patient safety on a person's first night in prison.

The SPoC process involves a generic NHS mailbox address for each South East prison reception, for the purpose of information sharing, together with a read receipt function and a prison healthcare phone number for more urgent cases. This inbox is regularly monitored during the prison's reception times. A Standard Operating Procedure has also been communicated to all reception staff and wider healthcare staff to outline this new process.

NHS England's South East Region are assuring this new process via a data return process in their Liaison & Diversion (L&D) contract review meetings. The L&D providers submit information onto a tracker. One part of this tracker will identify how

prisons have responded to information shared via the SPoC. Trends will be picked up if there are non-responses and those prisons will be approached.

National Forensic Services Work

NHS England's Adult Forensic Services Team are currently mapping arrangements across all 15 Adult Secure Provider Collaboratives for emergency admissions to an adult forensic bed, including out of hours, to understand variation across England.

Using this information, and in collaboration with relevant stakeholders, we are developing a new national service specification for Access Assessment Services (for adult forensic services), that will include a requirement that arrangements are in place for emergency admissions to an adult forensic bed, including out of hours.

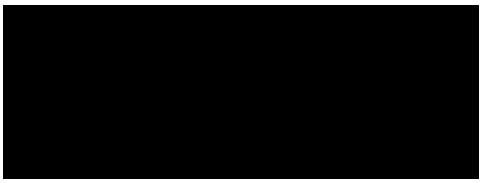
We have also created a database of Access Assessment Services (for adult forensic services) across England, that includes the direct contact information for referrals and urgent referrals, and out of hours contact information. This has now been launched and is accessible via the NHS Futures Collaboration Platform.

There is also an ongoing significant national programme of work to address delays in transfers from prison to mental health hospitals.

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 Diana, 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
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