Re : Diana Ocean Grant, Deceased

Regulation 28 Report to Prevent Future Deaths

	Regulation 28 Report to Prevent Future Deaths This Report is being sent to: 1. [redacted]**CEO, NHS England** 2. [redacted]**The Secretary of State for the Department of Health and Social Care.**
1	**CORONER** I am Richard Travers, HM Senior Coroner for Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Diana Ocean Grant. The inquest, which was heard with a jury, concluded on the 2nd April 2025 when the jury found that the medical cause of death was: Ia Cardio Respiratory Collapse Ib Obstruction of Upper Airway by Foreign Body and the jury's conclusion as to the death was: Diana Grant died as a result of putting a foreign object in her mouth which then became lodged in her upper airway, in circumstances which cannot be ascertained, whilst she was suffering a relapse of paranoid schizophrenia and symptoms of psychosis. Diana Grant's death was possibly contributed to more than minimally by a failure by the Community Mental Health Team to contact, assess, treat and manage her between the 12th and 17th November 2021,

	Diana Grant's death was probably contributed to more than minimally by a failure by the Psychiatric Liaison Team at St. Mary's Hospital to request a Mental Health Act Assessment or to conduct a mental health assessment by a doctor on the 17th or 18th November 2021, Diana Grant's death was possibly contributed to more than minimally by a failure by the Liaison and Diversion Psychiatric Service at Colindale Police Station to request and await a Mental Health Act Assessment on the 18th November 2021, and Diana Grant's death was probably contributed to more than minimally by a failure by HMP Bronzefield to locate her in the health care unit and to open an ACCT process following her detention in prison on the 19th November 2021. I subsequently held a hearing, on the 11th November 2025, to receive evidence relating to the prevention of future deaths.
4	**CIRCUMSTANCES OF THE DEATH** The jury found as follows: Diana Grant was diagnosed with paranoid schizophrenia in 2002. Her condition was usually controlled by anti-psychotic medication. In 2021, the Community Mental Health Team (CMHT) administered regular depot injections. Diana suffered periodic relapses of her schizophrenia. It was known that Diana was at risk of self-harming and risky behaviour when she was suffering a relapse (as evidenced during previous relapses). Diana started to inject weight loss drugs under the supervision of UCLH NHS hospital clinic on the 14th October 2021, following a GP referral. The CMHT were not informed that treatment had started. Diana informed the weight loss clinic dietitian on the 1st November 2021 that she was hearing voices. The clinic did not relay this information to the CMHT, neither was this discussed with the treating consultant from the weight loss team. Diana was exhibiting clear signs of a relapse in late October/November 2021 (signs reported were: blocking her mother's calls, drinking more alcohol, and an incident of taking her clothes off in a nightclub). She attended the CMHT on the 8th November 2021 to receive her depot injection and no signs of relapse were noted. On the 12th November 2021, Diana's mother reported to the CMHT that she thought Diana was suffering a relapse. The CMHT responded by making a note to

review her at the MDT meeting on the 16th November 2021. In this meeting the consultant reported that Diana needed "to be reviewed soon". Probably, a referral to the First Response Team could have been made on the 12th November. Probably, the reported concerns could have been made to the consultant more urgently. These steps probably could have protected Diana at this stage. It could have led to further mental health assessments.

On the 17th November 2021, Diana's mother took her to the CMHT. It was judged by the nurse that she needed to be in hospital. The only arrangement that was made was for the First Response Team to see Diana the next day. Diana left the CMHT suddenly while these arrangements were being made.

Before any assessment was made, Diana attacked her mother with a kitchen knife. There is a probability that these actions were caused by her state of psychosis. Following the attack, Diana was arrested by the police for attempted murder and was taken to St. Mary's Hospital where it was agreed that Diana needed a Mental Health Act Assessment. A Mental Health Act Assessment should have been conducted in the hospital. The Consultant and/or Registrar should have assessed Diana in person.

There are several reasons why this did not happen: staff lack of clarity regarding protocols, and unclear responsibilities and poor decision making by the Psychiatric Liaison Team. There were also assumptions made without all the appropriate information being accessed and shared. There were multiple opportunities to initiate a Mental Health Act Assessment. The Approved Mental Health Professional (AMHP) possibly could have asked for more information.

If the Mental Health Act Assessment had taken place in hospital, Diana probably could have started treatment for her symptoms of relapse sooner and had increased observations, possibly reducing her risk of self-harm, and possibly been diverted from custody.

The Police probably should have utilised their powers under section 136 of the Mental Health Act to detain Diana in a health-based place of safety. Diana was taken from the hospital to Colindale Police Station custody in the early hours of the 18th November 2021. She was then seen later that morning by the Liaison and Diversion Service. The L&D nurse contacted the Barnet AMPH Team who directed her to the Brent Team. There was no capacity for Diana to be assessed that day for a Mental Health Act Assessment by that team. Diana was interviewed and charged with attempted murder.

	A member of the L&D team made her colleague at the Magistrates' Court aware of Diana and that she had not yet had a Mental Health Act Assessment with the view that a referral could be before she went to court. Diana was taken to Court and remanded into custody on the 19th November 2021. If a Mental Health Act Assessment had been arranged before the court appearance, Diana would possibly have been diverted to hospital instead of prison. Diana was not seen at Court by the Liaison and Diversion (L&D) Service. However, they made an urgent referral, via email, and followed this up with a phone call to the Bronzefield Prison's mental health in-reach team. The L&D service also issued a self-harm/suicide warning form (SASH). This was handed to SERCO. This referral reached the general nurse and Operations Manager at the prison. The referral requested: arranging an admission to the Health Care Unit and opening of an Assessment, Care in Custody and Teamwork (ACCT). Diana was taken to HMP Bronzefield and arrived on the early evening of the 19th November 2021. The SASH and Person Escort Record were handed over and received by the senior prison custody officer at the prison's reception. The SASH was misplaced and was not taken into account in the reception process. The reception nurse accessed the referral email but did not take into account all the email content which was available to him. He did not place Diana in the Health Care Unit and he did not open an ACCT. He should have done both. Diana was not seen by the reception Doctor. At no point in the reception process was an ACCT opened and it should have been. Diana was placed on ordinary location in cell D-23 on House Block 1. On her first night, she was up all night, unsettled and screaming. Diana was not seen by the prison General Practitioner on the 20th November 2021 because he had no contact details for her. He did not attempt to locate her. He did not read all the relevant information available to him. Had he seen her, he probably would have opened an ACCT and moved her to the Health Care Unit. Diana would have benefitted from being in the Health Care Unit because the nurses there were more familiar with mental health issues, there were fewer residents, and there was more chance of communication between residents and staff. She would have benefitted from being on an ACCT as this would have led to more frequent observations.

	None of the prison healthcare and operational staff were aware of the out-of-hours mental health service available to the prison. If they had been, it probably would have resulted in an out of hours referral for an assessment. Whilst on the houseblock, Diana was screaming and shouting, running around, and was behaving strangely in her cell. It is likely that she was experiencing psychotic episodes. Diana was locked in her cell at17.30 hours on the 20th November 2021. She was last seen alive at 19.50 hours by a prison custody officer. The forensic evidence suggests that Diana intentionally placed a foreign object (knickers) in her mouth. We are unable to ascertain whether Diana intentionally put the object in her upper airway. At the time of her death, it is probable that Diana was in a state of psychosis and was in a relapse of her schizophrenia and therefore we cannot ascertain her intentions leading up to her death. According to the forensic evidence, Diana died quickly due to her heart stopping following stimulation of the vagus nerve. Diana was found unresponsive in her cell at about 21.05 hours. It is likely she was dead when she was found. Her death was formally declared at 21.47 hours.
5	**CORONER'S CONCERNS** The evidence heard at the inquest raised a number of concerns that future deaths could occur. I received extensive evidence addressing the issues arising, including oral evidence at the hearing held on the 11th November 2025. As a result of that evidence, all my concerns have been addressed by reason of changes which have been made since the death, save for the concern below. In my opinion, the following concern does continue and there is a continuing risk that future deaths could occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows: The concern arises in relation to persons who are judged to need immediate admission to a mental health unit for assessment and/or treatment, but who are also judged to need admission to a secure unit because they are dangerous to others, whether by reason of being under arrest for, or charged with, a serious criminal offence or otherwise.

	The evidence I received established that, despite changes made since the Deceased's death, including the recent introduction of NHS England's "Mental Health Crisis Care for Londoners: London's Section 136 Pathway and Health Based Place of Safety Specification", it remains extremely unlikely that such a person will be granted immediate admission to a secure mental health unit. This is principally because of the restricted capacity of the secure mental health unit estate, but also because of an expectation that some element of pre-planning will take place before such an admission occurs. Consequently, for many persons in the circumstances described above, detention in prison prior to transfer to a secure mental health unit continues to be unavoidable. The evidence I heard at the inquest suggested that although the expectation, in those circumstances, is that transfer from prison to hospital should take place within 28 days, the low availability of beds actually results in transfers taking, on average, as long as 80 to 90 days. Detention in prison of persons requiring mental health unit admission raises a concern for risk of death. The evidence I heard established that this is because a mental health patient's needs cannot be fully met in prison, even in a prison's health care wing. This is by reason of the fact that there is a material difference in the physical environment, the nursing and therapeutic regimes, and the access to psychological and other therapeutic treatments. Further, whilst medication and treatment can be given compulsorily in hospital, that is not the case in prison. The witness from whom I heard, stated that he was not aware of any work or review currently being undertaken to address the lack of capacity within the secure mental health unit estate or to address how the above risk may be resolved or managed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **by the 19th January 2026**. I, as coroner, may extend the period.

	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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following: a. The Mother of Diana Grant, b. Central and North West London NHS Foundation Trust, c. HM Prison and Probation Service, d. HM Courts and Tribunal Service, e. The Commissioner of Police of the Metropolis, f. Sodexo Limited, g. Nurse [redacted], h. Med-co Secure Healthcare Services Limited, i. The City of Westminster, and j. Prison and Probation Ombudsman. I am also under a duty to send a copy of your response to the Chief Coroner. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**24th November 2025** **Richard Travers**