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[redacted]

National Medical Director
NHS England
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20th July 2026

Dear Mr Lane,

Re: Regulation 28 Report to Prevent Future Deaths – John Edward Brynmor Phillips who died on 29th October 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 22nd June 2026 concerning the death of John Edward Brynmor Phillips on 29th October 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Phillip's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Phillip's care have been listened to and reflected upon.

Your Report raised concern that the national SystmOne electronic patient record (used in the prison service) operates in an unsafe way, owing to the ability for records to be activated/deactivated at different organisations at any time, with little or no safeguards, which is likely leading to unsafe clinical practice.

By way of providing some background information, the electronic patient record used for people in prison in England is known as Health and Justice Information System (HJIS) and currently uses SystmOne (by TPP). There is an established process for transferring a prisoner's healthcare record to the receiving prison's healthcare organisation when prisoners transfer between prisons.

During this inquest there was concern that the SystmOne electronic patient record allows for healthcare professionals previously involved with a patients care to access their records and that this automatically deactivates the patient's active record in the organisation currently involved in their care. NHS England's National Health and Justice Team have reviewed this case. This review identified that a member of staff at HMP Parc did access Mr Phillips' notes after he had transferred to HMP Dartmoor, and during this access, they manually registered Mr Phillips back to HMP Parc despite the fact that he was residing at HMP Dartmoor. This was reflected in the information that was in the task section of SystmOne. SystmOne did not automatically register Mr Phillips' record when it was retrieved in HMP Parc's SystmOne. Following this, a member of staff at HMP Dartmoor, believing that Mr Phillips had been transferred back to HMP Parc, actioned the outgoing transfer task, which then removed Mr Phillips from the HMP Dartmoor Mental Health Triage waiting list.

Once a patient has transferred between prisons and their SystmOne record is accessed for purposes such as updating, it does not automatically pull the patient and records back to the previous site when they are accessed. A request to re-register the patients record is required for this. If the re-register request is made, the deduction or deactivation of the record at the “new” prison then takes place. This appears to be what happened in this case and was human error, not an automatic process. We therefore do not believe that the events in this tragic case were due to a systemic issue within SystmOne.

To further reassure you, this does not impact on clinical care and treatment plans. Once the request to correct the re-registration is made, the patient’s records remain as they were and are unaffected by this movement of their clinical record.

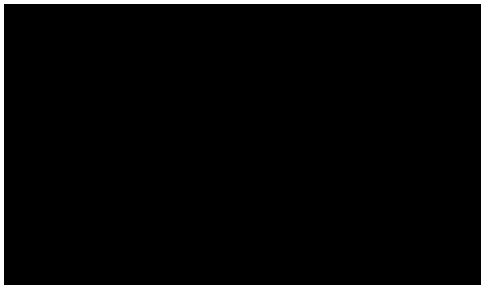
In order to ensure that all healthcare providers are aware of this investigation and any learning, we will be sharing the findings with the NHS England Regional Health and Justice Commissioning Teams, the Welsh Health Board and HMP Parc. We will highlight to them that when accessing the records of a patient who has left a prison, healthcare staff are mindful of the movement of records and not requesting the re-registering of the patient that is no longer a resident in that prison.

In addition, the findings, information and any learning from this case will be shared with NHS England’s 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 with HJDOG members, and assurance is sought from regions where learning and action is identified.

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 Mr Phillips, 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

NHS England