Mr Jeremy Chipperfield
Senior Coroner for Durham and Darlington
County Durham and Darlington Coroners Service
Crook Coroners Court
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Crook
DL15 9ES

[redacted]

National Medical Director
NHS England
Wellington House
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London
SE1 8UG

[redacted]

7th October 2026

Dear Mr Chipperfield,

Re: Regulation 28 Report to Prevent Future Deaths – Angela Mary Montgomery who died on 25th February 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 1st September 2026 concerning the death of Angela Mary Montgomery on 25th February 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Angela's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Angela's care have been listened to and reflected upon.

Your Report raises concern that there is an absence of a reliable safeguard for identification and communication of safety-critical information in SystmOne.

You are concerned that information may be missed in SystemOne because it is buried within a lengthy record, is not appropriately coded or highlighted, or is not captured by a particular search. Although SystemOne has search functionality, there is no automated or other system-level safeguard to identify safety-critical information and prompt its communication to custodial staff when the necessary human action fails.

You are also concerned that custodial decisions may therefore be made or omitted due to lack of material information and affect the management of a prisoner's risk.

SystmOne is an electronic clinical record system used across a range of NHS care settings, including general practice, community services, mental health services and secure settings such as prisons. It supports the recording, storage and retrieval of healthcare information. In prisons, an initial health assessment is undertaken when a person arrives at the establishment (the reception health screen), followed by a more detailed secondary health assessment, usually within the first few days. Information gathered through these assessments is recorded in structured clinical templates. These templates use SNOMED CT, the nationally required clinical terminology that

enables information such as symptoms, diagnoses, risks and treatments to be recorded consistently and understood by clinicians and clinical systems.

As noted in the inquest findings, Angela's statement of intent was recorded within SystmOne. This indicates that the clinical system functioned as intended and that the information was captured within her healthcare record. The information would have remained available to healthcare professionals accessing the record and could have been identified through routine clinical review and search functionality within the system.

In this case, the issue identified relates to the subsequent communication and escalation of that information rather than the operation of the clinical record system. Custodial staff do not have access to the health records of those detained in prisons and so cannot access SystmOne directly. The Assessment, Care in Custody and Teamwork (ACCT) process operates separately from the clinical record. Commencement of an ACCT, and the transfer of relevant risk information into custodial processes and records, relies upon professional assessment, communication and the completion of established operational procedures on an individual basis, rather than through any automated function within SystmOne.

The HM Prison & Probation Service's (HMPPS) Prison Safety Policy Framework details the requirements, roles and responsibilities of all staff, including healthcare, in the ACCT process. This includes attendance at first case review where any key information would be shared.

The Prison Safety Policy Framework states: Healthcare or mental health staff must attend the first case review. If in exceptional circumstances they cannot attend, a verbal or written contribution must be provided. A further ACCT case review must then be convened as soon as possible to allow for their attendance where there are physical or mental health issues.

Accordingly, the tragic circumstances described in Angela's case appear to reflect a failure in the communication and transfer of safety-critical information between healthcare and custodial processes, rather than a failure of the electronic care record system: SystmOne, to record, store or make available the relevant clinical information.

Accordingly, the findings, information and learning from this Report will be shared and discussed with HMPPS as part of partnership learning, to facilitate sharing the learning with all operational staff. This will also include a review and consideration of the other PFD reports provided in the annex of your Report.

All Preventing Future Deaths relating to health and justice are shared with all health and justice commissioning teams as part of NHS England health & justice Learning from Deaths process.

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 Angela, 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]

[redacted]
National Medical Director
NHS England