REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Director General Chief Executive Officer of His Majesty's Prison and Probation Service (HMPPS)** **2. Chief Executive Officer of NHS England** **3. Chief Executive Officer of the College of Policing & Chair of the National Police Chiefs' Council** **4. Chief Executive Officer of NHS Dorset**
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 16th December 2020, I commenced an investigation into the death of Marta Elena Vento, born on the 26th March 1993 who was aged 27 years at the time of her death. The investigation concluded at the end of the Inquest on the 28th February 2025. The medical cause of death was: Ia Multiple blunt force head injuries The conclusion of the Inquest was the following narrative conclusion: "Marta Elena Vento was unlawfully killed by another who at the time of her death was unmedicated for a diagnosed mental health illness because of a failure to sufficiently plan and ensure the continuity of his mental health care upon his release from prison 6 weeks prior to Marta's death, and because he was not adequately managed as a sex offender in line with national guidance upon his release from prison."
4	**CIRCUMSTANCES OF THE DEATH** On the 9th December 2020, Marta was working alone as a receptionist at the Travelodge Hotel, 43 Christchurch Road, Bournemouth, when at 05.12 hours she

	was relentlessly beaten in the most violent manner by another in a sudden and unprovoked attack in the bar/café area at the hotel. At the time of Marta's death, the perpetrator was actively psychotic due to being unmedicated for psychosis. The perpetrator of Marta's death was released from prison on the 27th October 2020, 6 weeks prior to her death. His release was unexpected at that time to those working in the prison and prison healthcare. Whilst in prison he was diagnosed with psychosis and when unmediated was unpredictable and violent. He was treated with medication for this mental health illness which resolved the psychotic symptoms and violence. Upon his release from prison a discharge summary was not sent to his GP, nor was there a referral to the mental health team to continue care. At this time there was no integrated mental health policy in place within the healthcare department at the prison, there was a lack of comprehensive care planning infrastructure across prison healthcare nationally and the prison healthcare team were experiencing pressures arising from reduced staffing following the mobilisation of the healthcare contract at the prison and the impact of the unprecedented COVID-19 pandemic. The perpetrator was issued with medication for his mental health illness upon release from prison, however, as there was no continuity of the mental health care and treatment following his release, the perpetrator's medication ran out on the 24th November 2020 leading to a relapse of his psychosis. Upon his release from prison the perpetrator was managed as a sex offender in the community. There was incomplete information gathering to identify, assess and manage his risks in the community and no ARMS risk assessment was completed or management plan put into place in respect of the perpetrator prior to Marta's death.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The perpetrator of Marta's death was a remand prisoner at HMP Winchester between the 9th of July and the 27th of October 2020. He was released on the 27th October 2020 unexpectedly after a video link hearing before the Magistrates Court at which he was sentenced and immediately released. During the period of his remand, the perpetrator was diagnosed with serious mental health illness for which he received medication. This treated his psychotic symptoms, one of which was that he undertook violent acts when unmedicated. During the period of remand he assaulted 4 individuals, including two prison officers, whilst unmedicated. The evidence revealed that this behaviour would increase a persons risk of

harm to the public. There is no evidence that these incidents were known to the sentencing Court on the 27th of October 2020.

Evidence was given by the Head of the Offender Management Unit (OMU) at HMP Winchester, a Senior Probation Officer, that there is currently no formal process or guidance in place for the sharing of information by a prison with the Criminal Courts to provide an update of the person's behaviour in prison which may increase their risk of harm or risk offending.

It was explained that the person who could enquire about this at Court, if asked, would be the duty Probation Officer, and that this is especially more challenging to complete when a fast delivery report is requested.

There is currently no process from a prison perspective to share information to the sentencing Court other than that contained within the Prison Escort Record (PER), which is not provided to the sentencing Judge, the lawyers at Court or Probation staff.

I am concerned that the full extent of a remanded prisoner's risk of harm to the public may not be appreciated by the sentencing Judge, which could impact upon the sentence imposed upon a prisoner and I am concerned that this lack of sharing of information could lead to future deaths.

(2) When the perpetrator was released from HMP Winchester, there was a lack of continuity of care provided to him in relation to his severe mental health illness.

A considerable amount of work has been undertaken by Practice Plus Group (PPG) since Marta's death to ensure continuity of care to prisoners upon release in the prisons where PPG provide health care, such as ensuring the care is discharged to the prisoner's GP and, if required, a referral to the relevant health care providers completed. There are, however, other healthcare providers in prisons in England and Wales.

There is a lack of national guidance to assist all healthcare providers to ensure continuity of care for a prisoner with health care needs, whether physical or mental health needs, upon release from prison. There are national standards of care and NICE guidelines in place, however none of these provide practical guidance around the delivery of care to ensure continuity of care.

The perpetrator of Marta's death was released homeless on the 27th October 2020 which led to an additional complication around the referral of his care to a Community Mental Health Team (CMHT). Processes are in place between HMP Winchester and Dorset Healthcare University NHS Foundation Trust, who provide the mental health care in Dorset, to ensure that when a person is released homeless a referral for that person's continued mental health care will be accepted by DHUFT if that person's GP is registered in Dorse.

Evidence was given that this is not the process nationally in that some mental healthcare trusts will not accept a referral if a person is homeless. There is no national guidance about the continuity of care for prisoners upon release from prison when homeless.

	I am concerned that this lack of continuity of care could lead to future deaths. (3) Evidence was given extensively throughout the Inquest about the management of sexual and violent offender (MOSOVO) unit within Dorset Police. Each police force in England and Wales has a MOSOVO unit with a team of staff managing sexual and violent offenders. Evidence was given that predominantly this is for the management of sexual offenders. There is Approved Professional Practice (APP) guidance issued by the College of Policing regarding the operation of MOSOVO units. This guidance details the risk assessments to be undertaken which are a crucial stage in the management of these offenders. The risk assessments detailed in the guidance are aimed at the assessment of the sexual risk of offenders and evidence was given that there is no bespoke risk assessment tool or guidance to assess the violence of such offenders to assist staff within MOSOVO units to undertake their role. There is, therefore, a lack of guidance on how to risk assess and manage offenders who are managed under MOSOVO when they present with the risk of violence, or an escalating risk of violence. I am concerned that this will result in a failure to identify the risk of violence, or the increasing risk of violence, in those being managed by MOSOVO which may lead to a further death. (4) The National Record Locator (NRL) allows health or social care workers to find and access patient information shared by other health and social care organisations across England to support the direct care of a patient. Evidence was given by the Head of Clinical Development and Organisational Development at South West Ambulance Service NHS Foundation Trust (SWAST) that in the South West region all Integrated Care Boards (ICBs), apart from the ICB in Dorset, NHS Dorset, are at some stage of implementing the use of NRL so that SWAST can access this information to assist in the provision of care to those they treat. Evidence was given that as this would limit the information SWAST had access to about a patient in Dorset, this would impact upon the care provided to those in Dorset by SWAST which could lead to a future death.
“6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have 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 6th May 2025. I, the 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 Interested Persons via their legal representatives: (1) Marta's Family (2) Dorset Healthcare University NHS Foundation Trust (DHUFT) (3) Universities Hospital Dorset NHS Foundation Trust (UHD) (4) Dorset Council (5) Chief Constable of Dorset Police (6) [redacted] and Orchid House Surgery (7) Chief Constable of Hampshire Police (8) Practice Plus Group (PPG) (9) South West Ambulance Service NHS Foundation Trust (SWAST) (10) Travelodge (11) HMP Winchester and the Ministry of Justice I am also under a duty to send the Chief Coroner a copy of your response. 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	**Signed**  **Rachael C Griffin** **HM Senior Coroner for Dorset** **11th March 2025**