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HM Area Coroner for Essex
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National Medical Director
NHS England
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16th December 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Jack Mathew Peatling who died on 5th June 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 13th October 2025 concerning the death of Jack Mathew Peatling on 5th June 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jack's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Jack'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 to Jack'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.

Your Report raised concerns that there were no inpatient mental health beds available for Jack despite him being determined as a high risk of suicide and unable to be managed safely in the community. You were concerned that this lack of bed availability is a chronic and ongoing issue nationally.

Mental Health Beds

NHS England is aware of the issues in some systems around high bed occupancy and limited local bed availability. This is related to long lengths of stay and high numbers of patients clinically ready for discharge but unable to be discharged, leading to flow pressures across systems. To improve this, in 2025/26, NHS England made £75 million of additional capital available for local systems to invest in improving local bed capacity and reduce the use of Out of Area Placements.

However, given increasing lengths of stay and the increased number of patients clinically ready for discharge, providing more beds will be considered as part of a whole system transformation approach. This was supported by the NHS Long Term Plan (LTP), which saw an additional £2.3 billion funding invested in mental health services from 2019/20 – 2023/24, around £1.3 billion of which was for adult community, crisis and acute mental health services to help people get quicker access to the care they need and prevent avoidable deterioration and hospital admission.

NHS England's 2025/26 priorities and operational planning guidance reinforces this focus on improving patient flow as a key priority – with systems directed to reduce the average length of stay in adult acute mental health wards in order to deliver more timely access to local beds. NHS England is taking steps to address current operational pressures driving these issues.

If local beds are not available, Out of Area Placements are currently used to ensure patient care is delivered in an inpatient setting if needed. NHS England plans to reduce and eliminate the use of Out of Area Placements as they can result in poorer outcomes for patients and provide additional risk to patient safety.

Essex Partnership University NHS Foundation Trust

Essex Partnership University NHS Foundation Trust (EPUT) has advised that when there is insufficient capacity to meet all hospital admission demands, the Chair of the twice-daily situation report meetings is mandated to seek assurance that sufficient community mitigation and safeguards are in place to continue with community intervention as an alternative to admission. Furthermore, Home Treatment Teams (HTTs) are instructed to raise as a priority for admission those individuals for whom the HTT is unable to provide adequate mitigation and/or where there is an escalating risk presentation.

If a patient's clinical need is escalated and indicates an urgent inpatient admission is required, and if there is insufficient mitigation to support a community alternative, a bed will be sourced. This commitment extends to actively scoping and securing out-of-area provision when local capacity is exhausted, ensuring that every effort is made to provide the necessary level of care.

EPUT recognises that the lack of available inpatient beds for high-risk mental health patients, who cannot be managed safely in the community, is an ongoing challenge. They are committed to addressing this system-wide issue and preventing further avoidable deaths.

Since the time of this incident, EPUT has implemented a series of significant changes aimed at improving patient flow, bed management and overall patient safety:

Clinical Patient Flow Lead: They have introduced a clinical patient flow lead whose role is to review admission requests against bed demand and support clinical formulation and decision-making when prioritising beds.

Clinical Director in Flow and Capacity Team: A clinical director has been recruited to the flow and capacity team. This director is a Consultant Psychiatrist who reviews complex and high-risk cases, supports the prioritisation of beds against demand and provides oversight of patients in out-of-area beds.

Surge Management Tool: A Surge Management Tool (SMART) has been implemented to support patient admission demand and repatriation. This platform provides a local and system-wide overview of operational pressures, enabling them to track patient flow between care settings, view current demand and capacity, and map all patient admission referrals and repatriations from a range of providers and services.

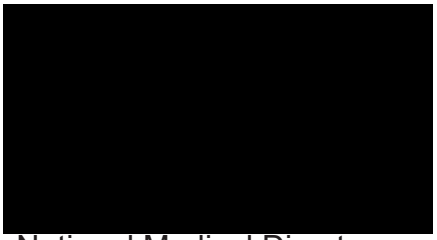
Therapeutic Acute Inpatient Operating Model: A new, innovative operating model for inpatient care, the therapeutic acute inpatient operating model for adults and older adults, will be introduced. This model aims to provide consistent quality of care 24/7, integrated with place-based community models and the wider system. It is designed to enhance patient experience by working in partnership with patients and carers, reduce health inequalities and increase Trust capacity to provide high-quality therapeutic care. The model is informed by national and best practice guidance, developed by multi-professional clinicians, colleagues with lived experience, and wider system stakeholders.

These changes detail EPUT's commitment to learning from past incidents and to the continuous improvement of their systems and processes to ensure the safest possible care for patients. Should HM Coroner require any further detail, we would recommend contacting EPUT directly.

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 Jack, 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