

**Ms Anna Loxton,**  
**HM Assistant Coroner**  
Surrey Coroner's Court  
Station Approach,  
Woking  
GU22 7AP

**National Medical Director**  
NHS England  
Wellington House  
133-155 Waterloo Road  
London  
SE1 8UG

[REDACTED] [REDACTED]  
**26th January 2026**

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Suzanne Julie Ellerby  
who died on 4<sup>th</sup> January 2025.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 14<sup>th</sup> November 2025 concerning the death of Suzanne Julie Ellerby on 4<sup>th</sup> January 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Suzanne's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Suzanne'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 Suzanne'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 that vulnerable patients are often transferred back to primary care by secondary mental health services for their onward care, which is effected by way of a discharge letter. Your concern was that NHS England has not provided any guidance in respect of expectations for follow up by primary care services when this transfer of care takes place. As such, the onus is on vulnerable patients to ensure they follow up their care with their GP, without any safety netting in place should they fail to do so.

**Transfer of care by mental health services**

NHS England continues to support systems to improve care for people with mental health problems needing help from secondary mental health services. NHS England has drafted guidance called the Personalised Care Framework (PCF), that sets out the core aspects of care for people who require help from secondary or integrated primary health services, the Voluntary Community and Social Enterprise (VCSE) and secondary care mental health services. It has been shared as a draft with systems to facilitate early adoption.

The PCF sets out the core principles that all people using NHS commissioned community mental health, crisis and inpatient services should:

- have a care and support plan that is current and that is reflective of the needs of the person at that point;
- have a person within the service responsible for their care and support plan and for developing a trusted therapeutic relationship;
- be able to have their care and support plan reviewed when things change, as well as being able to quickly re-access help when they need to (such as when their mental health deteriorates following a period of stability).

The PCF guidance will also emphasise the responsibility of all services to support effective transitions, including between secondary and primary care, and that where a person is transferring away from a service, the transferring service should be satisfied that the receiving service are ready to continue the care and support plan.

### **Primary Care Follow Up Guidance**

If secondary mental health services feel that there is any risk that a patient may not engage with their GP, such as where the patient has relocated and is not known to a GP practice, then it would be important that they follow the patient up and support the patient to engage with the GP. However, patients with significant risk should not be discharged back to their GP - this is difficult to define with criteria and is best based on personal risk assessment.

As set out above, the PCF stipulates that every patient seen by specialist mental health services should be able to quickly re-access help when they need to (such as when their mental health deteriorates following a period of stability), or when transferred to another service.

The PCF also makes it clear that family members should be involved in the development of the care and support plan – which should include details of what to do if a person's mental health is deteriorating, for example how to access appropriate help and support, and should include signs of a potential relapse.

The PCF states:

*Where a person is transferring away from a service, that service has a responsibility to support the transition, sharing important information including how best to engage the person, the care and support plan including relapse indicators, risk assessment and safety plan and formulation. The transferring service should be satisfied the receiving service are ready to continue the care and support plan.*

Where a patient is being discharged from the community mental health service to primary care, a care planning meeting should take place which should include the patient (and/or a family member, carer or support network member where the person

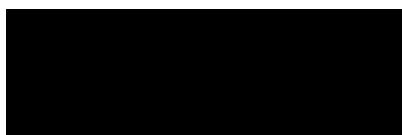
lacks capacity) and their GP. At the point of transition, the patient and GP should be provided with written confirmation of:

- the reason for the change in care;
- a discharge plan that details how they can re-access support from the community mental health service;
- information about other available community support which may be relevant for the patient;
- details of ways to contact the service – including a working hours telephone number and email address;
- a copy of the patient's updated care and support plan and other relevant plans developed as part of their care and treatment;
- medicines reconciliation (a list of a patient's current medications).

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 Suzanne, 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]  
National Medical Director  
NHS England