Emma Serrano
Area Coroner for Staffordshire and Stoke on Trent
Stoke on Trent and North Staffordshire Coroners Service
Stoke Town Hall
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[redacted]

National Medical Director
NHS England
Wellington House
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[redacted]

6th January 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Lynsey Ellen Dearden who died on 11th March 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 18th November 2025 concerning the death of Lynsey Ellen Dearden on 11th March 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Lynsey's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Lynsey's care have been listened to and reflected upon.

Your Report raised concerns that there is no policy, guidance or framework in place for how or when appointments with community psychiatric nurses, including standard assessments, should take place.

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 NHS England has shared draft guidance with systems, the Personalised Care Framework, that sets out the core aspects of care for people who require help from secondary or integrated primary care services, the Voluntary Community and Social Enterprise (VCSE) and secondary care mental health services. The draft has been shared to facilitate early adoption.

The guidance 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 be able to quickly re-access help when they need to (such as when their mental health deteriorates following a period of stability).

This builds upon the groundwork laid through the increased investment in services, alongside the development of new waiting times measures for accessing community mental health services. NHS England also continues to work with systems to improve the data quality of the Mental Health Services Data Set (MHSDS) submissions for this measure, which records how many people receive meaningful help within 4 weeks of referral.

North Staffordshire Combined Healthcare NHS Trust have informed NHS England's Midlands regional team that they have identified improvements as a result of this Report, which they will outline in their separate response to you. However, they have detailed the immediate actions they have taken, which include a process to contact patients awaiting Standard Assessment Framework assessments, a requirement that key workers are not allocated until an appointment date is confirmed, and clarification of timescales and expectations for transition between teams.

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 Lynsey, 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