

IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Suzanne Julia ELLERBY
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: 1. [REDACTED], Chief Executive Officer, NHS England: 2. [REDACTED], Parliamentary Under-Secretary for Patient Safety, Women's Health and Mental Health, 39 Victoria Street, London SW1H 0EU
1	CORONER Ms Anna Loxton, HM Assistant Coroner for Surrey
2	CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	INVESTIGATION and INQUEST Suzanne Julie Ellerby died on 4th January 2025, aged 57. Her inquest was opened on 23rd January 2025. The inquest took place on 6th November 2025 and Findings and Conclusion were given on 10th November 2025. I recorded a conclusion of Suicide. I found the medical cause of death to be: [REDACTED]
4	CIRCUMSTANCES OF THE DEATH I recorded the following circumstances in relation to Ms Ellerby's death: <i>On the afternoon of 4th January 2025, Suzanne Ellerby was found deceased in [REDACTED] her Father's home in Addlestone, Surrey, where she had been residing, and her death was confirmed by an attending paramedic at 14.40. Ms Ellerby had a history of mental health vulnerabilities, but had been stable for a number of years prior to a downturn in her social circumstances, which included the loss of her home and necessitated relocation to Surrey and the loss of her employment. She suffered a mental health crisis on 29th November,</i>

	<i>following which she was under the care of the Home Treatment Team, Surrey and Borders Partnership, from 30th November 2024. She was discharged from the Home Treatment Team to the care of her new General Practitioner, who she had not previously seen, on 13th December 2024. Ms Ellerby was not seen by any mental health or medical practitioners between 13th December and her death, and she did not seek further help or highlight a further deterioration in her mental state to her Family. She ended her life [REDACTED] and there was no evidence of third-party involvement in her death. No prescription or other drugs or alcohol were detected, and she was not therefore compliant with her antidepressant medication. A handwritten letter was found in her bedroom, expressing the extent of her mental decline and her hopes for her Family following her death.</i>
5	CORONER'S CONCERNS Ms Ellerby's mental health care was transferred from the Home Treatment Team, Surrey and Borders Partnership NHS Foundation Trust ("Surrey and Borders"), to the care of her General Practitioner at Madeira Medical Practice, West Byfleet, Surrey on 13th December 2024. Ms Ellerby did not follow up her care with the GP, and had never been seen at the Practice as she had recently relocated. She had no contact with mental health or medical clinicians prior to her death on 4th January 2025, and the onus was on her to arrange an appointment with the GP. Toxicology showed she had not been compliant with her anti-depressant medication. Surrey and Borders and Madeira Medical Practice have both recognised the risk of the transfer period from secondary to primary mental health care in vulnerable patients, and have put in hand changes within their organisations to address this. However, as highlighted by Madeira Medical Practice: "there is no expectation from NHS England or mental health services to following up these patients urgently", and therefore no universal guidance for all mental health trusts and GP practices. There are no safety netting guidelines or policies in place to ensure vulnerable mental health patients are followed up within a timely period by primary care services on transfer from secondary services, nor expectations on secondary services to ensure this has been undertaken by primary care services. Patients are therefore being relied upon to ensure this takes place, at a time when they are particularly vulnerable. The MATTERS OF CONCERN are: - Vulnerable patients are often transferred back to primary care by

	mental health services for their onward care, which is effected by way of a Discharge Letter; - NHS England has not provided any guidance in respect of expectation for follow up by primary care services when this transfer takes place; - In the absence of such guidance, 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. Consideration should be given as to whether any steps can be taken to address the above concerns.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	COPIES I have sent a copy of this report to the following: 1. See name in paragraph 1 above 2. [REDACTED] 3. Surrey and Borders Partnership NHS Foundation Trust 4. Madeira Medical Practice, The Health Centre, Madeira Road, West Byfleet, Surrey KT14 6DH 5. The Chief Coroner In addition to this report, I am 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 at the time of your response, about the release or

	the publication of your response by the Chief Coroner.
	Signed: ANNA LOXTON DATED this 14th day of November 2025