

Mr James Puzey
HM Assistant Coroner for Worcestershire
Worcestershire Coroner's Court
The Civic
Martin's Way
Stourport-on-Severn
Worcestershire
DY13 8UN

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

[REDACTED]
7 April 2026

[REDACTED]
Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Timothy Thomas Reading who died on 9 January 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21 November 2025 and received by NHS England on 24 February 2026, concerning the death of Timothy Thomas Reading on 9 January 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Timothy's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Timothy's care have been listened to and reflected upon.

Your Report raised concerns around the absence of formal documented [Section 117](#) plan agreed upon by all those responsible for a patient's care and treatment upon discharge into the community from a lengthy inpatient stay. This creates a risk of disjointed, disorganised and inadequate support for vulnerable people suffering serious mental health conditions which may cause them to feel unsupported and helpless. Your report also raised concerns around lack of national guidance from the NHS or other sources that explain what a Section 117 plan should address. This represents a gap which gives rise to concern that mental health providers are unclear as to the component elements for a Section 117 plan and the degree or depth of planning required for individual patients.

NHS England Mental Health colleagues have advised that there is clear guidance set out in the [Mental Health Act Code of Practice](#) on Section 117 aftercare which includes planning based on the person's individual needs. It includes examples such as ensuring the person's wider social, cultural and spiritual needs are met and specifies that after care should aim to support people in regaining or enhancing their skills, or learning new skills, in order to cope with life outside of hospital. Before deciding to discharge or grant more than a very short-term leave of absence to a patient, or to place a patient onto a Community Treatment Order (CTO), the responsible clinician should ensure that the patient's needs for after-care have been fully assessed, discussed with the patient (and their carers, where appropriate) and addressed in their care plan. If the patient is being given leave for only a short period, a less

comprehensive review may be sufficient, but the arrangements for the patient's care should still be properly recorded

In addition to this, the [Community Mental Health Framework](#) states that 'every person who requires support, care and treatment in the community should have a co-produced and personalised care plan that takes into account all of their needs, as well as their rights under the Care Act and Section 117 of the Mental Health Act when required'.


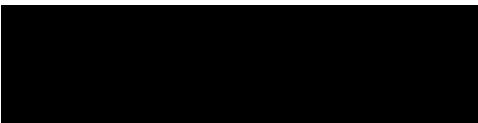
There is also statutory [discharge guidance](#) which covers Section 117 care. This states that 'a [personalised care and support plan](#), as a result of a 'what matters to me' conversation with the patient, should be prepared and available to support discharge with input, where relevant, from family members, chosen carers and relevant professionals.' This is underpinned by the [NHS England guidance on comprehensive model of personalised care](#). NHS bodies and local authorities in England have a statutory duty to have regard to the statutory discharge guidance as well as the Mental Health Act Code of Practice.

We note that your report has also been addressed to the Trust who will be better placed to respond to the concerns raised around the absence of Section 117 plan provided by the Trust despite it being requested.

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 Timothy, 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