ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. **The Chief Executive of the Birmingham and Solihull Mental Health Foundation Trust ("BSMHFT")** 2. **The Chief Executive of NHS England**
1	**CORONER** I am James Puzey, assistant coroner, for the coroner area of Worcestershire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 20 January 2025, Senior Coroner, David Reid, commenced an investigation into the death of Timothy Thomas Reading. The investigation concluded at the end of the inquest on 12 November 2025. The conclusion of the inquest was that death was due to suicide and the medical cause of death was hanging.
4	**CIRCUMSTANCES OF THE DEATH** Timothy Thomas Reading died on 9 January 2025 at 54 Red Lion St Alvechurch. [redacted] He was 48 years old. He had a history of mental illness dating back to his 20s. in 2023 he was arrested for an offence of stalking under s.4A of the Protection from Harassment Act 1997. Initially he was in prison but later transferred to hospital in December 2023. Ultimately he pleaded guilty and he was made subject of a hospital order pursuant to the provisions of s.37 the MHA 1983. He was an inpatient on the intensive care ward at BSMHFT's Meadowcroft facility then on the acute ward at Mary Seacole House in Birmingham. He was released back into the Community under the provisions of a CTO dated 9.10.24. A planning meeting was held at Mary Seacole House on 20.8.24 to formulate plans to support Tim pursuant to the provisions of s.117 of MHA. On 22.10.24 Tim was discharged to the Bromsgrove CMHT. They had not been involved in planning support for Tim with BSMHFT. They and Tim's GP asked for a copy of the s.117 support plan from BSMHFT but did not receive one. The minutes of the meeting of 20 August 2025 referred to a plan but no plan was drafted and what was being proposed in the meeting was general, non-specific and inaccurate as to who would be responsible for mental health provision in the community.

	I found that there was no s.117 plan created; also, • That such a plan was necessary to chart Tim's reintegration into community living. • The handling of the transition for Tim from inpatient to care in Worcestershire was slow and disjointed; • There was no handover between the responsible clinicians in Birmingham and Bromsgrove; Those who knew him best, namely his family, concluded that he was not coping and they told BSMHT in November 2024. Their view, which I accept, was that Tim struggled without meaningful activity and structure.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The absence of a formal documented s.117 plan agreed by all those responsible for a patient's care and treatment upon discharge into the Community from a lengthy inpatient stay creates a risk of disjointed, disorganized and inadequate support for vulnerable people suffering serious mental health conditions. This, in turn, may cause them to feel unsupported and helpless. BSMHFT did not provide a Plan despite requests to do so. S.117 is intended to ensure that patients receive planned and structured support tailored to their requirements. Such planning was absent in this case. (2) I was informed by the Representative of BSMHFT that there is no national guidance from the NHS or other source that explains what a s.117 plan should address. If so, this represents a lacuna which gives rise to concern that mental health providers are unclear as to the component elements for a s.117 plan and the degree or depth of planning required for individual patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe BSMHFT and the NHS generally have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report,

	namely by 16 January 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: BSMHFT HWHCT. I have also sent it to the Chief Executive of NHS England as it raises a matter of concern to the Health Service generally I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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, the coroner, at the time of your response, about the release or the publication of your response.
9	**21 November 2025 James Puzey**