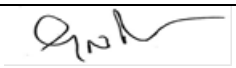
MISS N PERSAUD
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Head of Continuing Care, Redbridge Clinical Commissioning Group, 6th Floor, North House, St Edwards Way, Romford RM1 3AE** **Email: [redacted]**
1	**CORONER** I am Nadia Persaud, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12th November 2019 I commenced an investigation into the death of James Alexander David Taylor, 35 years old. The investigation concluded at the end of the inquest on 11th December 2020. The conclusion of the inquest was a narrative conclusion: *Mr Taylor died as a result of suicide. He took his own life following life changing injuries sustained during a road traffic collision. The injuries sustained in the collision caused a functional neurological disorder manifesting in refractory pain and sensory disturbances. These, in turn, led to psychological distress and suicidal ideation. Mr Taylor sought help for his pain and psychological distress. Long-term psychological therapy was required. The required help was not provided to him. In August 2019, Mr Taylor attended a long awaited multi-disciplinary programme for functional neurological disorder. He had*

	attended preparatory sessions for the in-patient programme, to determine his suitability. The extent of his pain was not explored at the preparatory sessions and his engagement in the programme was terminated after 4 days, due to pain limiting his engagement. It is clear from communication left by Mr Taylor that the feeling of rejection from this programme contributed to his decision to take his own life.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death can be seen from the narrative conclusion set out in section 3, above. In relation to psychological therapies, Mr Taylor underwent twenty sessions of individual psychotherapy in 2016. These were provided by the Redbridge Psychological Services. Mr Taylor was noted to have complex and severe mental health problems. The psychologist considered that Mr Taylor would need a longer term of psychological therapy, however twenty sessions was all that could be offered under the limits of the Redbridge service. The psychologist stated that in order for James to recover, he would require a minimum of a year of further sessions. As well as the psychologist specifying this need, James made further requests to the mental health trust, for the provision of further psychological therapy. The required therapy was never provided to him.
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 Inquest heard evidence that psychological therapy within Redbridge is provided on a limited basis. The Inquest heard that a maximum of twenty sessions would be provided and must be stopped when that number is reached. This is so, even where the patient requires ongoing psychotherapy. 2. The Inquest heard that psychotherapy can bring to the surface a number of distressing and traumatic events. If the therapy has not reached a therapeutic conclusion, then patients can be left with unresolved distress and trauma. 3. As well as the arbitrary cut-off for psychological therapies, the Inquest also heard that there can be extreme delays (of up to 9-10 months) for patients to receive the psychological therapy required.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that you 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 **15th February 2021** 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 the family of Mr Taylor, the CQC. I have also sent it to the Director of Public Health who may find it useful or of interest. 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	**21/12/2020** **SIGNED BY CORONER** 

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Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr [redacted], Senior Officer, Royal College of General Practitioners, 30 Euston Square, London NW1 2FB** **Email: [redacted]**
1	**CORONER** I am Nadia Persaud, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12th November 2020 I commenced an investigation into the death of James Alexander David Taylor, 35 years old. The investigation concluded at the end of the inquest on 11th December 2020. The conclusion of the inquest was a narrative conclusion: *Mr Taylor died as a result of suicide. He took his own life following life changing injuries sustained during a road traffic collision. The injuries sustained in the collision caused a functional neurological disorder manifesting in refractory pain and sensory disturbances. These, in turn, led to psychological distress and suicidal ideation. Mr Taylor sought help for his pain and psychological distress. Long-term psychological therapy was required. The required help was not provided to him. In August 2019, Mr Taylor attended a long awaited multi-disciplinary programme for functional neurological disorder. He had*

	attended preparatory sessions for the in-patient programme, to determine his suitability. The extent of his pain was not explored at the preparatory sessions and his engagement in the programme was terminated after 4 days, due to pain limiting his engagement. It is clear from communication left by Mr Taylor that the feeling of rejection from this programme contributed to his decision to take his own life.
4	**CIRCUMSTANCES OF THE DEATH** The immediate circumstances of the death can be seen from the narrative conclusion set out above. In relation to the primary health care provided to Mr Taylor, concerns were raised by his family and friends in relation to the number of different general practitioner surgeries involved in his care and the lack of continuity of care. Evidence was heard from his final GP, who confirmed that Mr Taylor had a very large volume of medical records due to his complex physical and mental health needs. The practice received an electronic transfer of records. There was no transfer letter or clear summary of his ongoing clinical needs.
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. – As a result of his complex health needs, Mr Taylor changed address on a number of occasions. This required a number of changes of general practitioner surgeries. In 4 years, Mr Taylor had changed surgeries 4 times. The Inquest heard evidence from his final general practitioner who confirmed that there was a large volume of records relating to Mr Taylor. The GP confirmed that no summary of care is provided to GP practices when transfer of patients take place. He confirmed the dangers of this, in that important clinical matters can be missed where a patient has a large volume of records. The general practitioner indicated that handover summaries should be provided to GPs when complex patients are transferred from surgery to surgery. Such transfer summaries could include a summary of past medical history and highlight acute, ongoing clinical conditions, together with any safeguards around prescribing of medication. Such summaries could ensure safety in the continuity of care
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **18 February 2021** 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 family of Mr Taylor. I have also sent it to the Director of Public Health, the CQC and the Liberty Road Bridge Practice, who may find it useful or of interest. 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	**23/12/2020** **SIGNED BY CORONER**