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

The Inquest Touching the Death of Zachary KLEMENT
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted] Chief Executive Officer, NHS England and NHS Improvement, PO Box 16738, Redditch B97 9PT, England.contactus@nhs.net
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** The inquest into the death of **Zachary KLEMENT** was opened on 18th March 2021. Evidence was heard between 4th and 6th October 2022, and it was concluded on 2nd December 2022. I found the medical cause of death to be: 1a. Suspension I determined that Zachary took his own life by suspension during a crisis of deteriorating mental health and increasing suicidal ideation. I recorded a narrative conclusion, detailing the following:- *On 2nd March 2021, Zachary Klement was found suspended in his bedroom at his supported living accommodation in Woking, Surrey, and was pronounced deceased by attending paramedics at 19:37. He had a long history of mental health issues from childhood and was diagnosed with Autistic Spectrum Disorder, Emotionally Unstable Personality*

	Disorder, general anxiety disorder and Bipolar Affective Disorder. *On 26th January 2021, Zachary was admitted to Farnham Road Hospital as an informal patient following an escalation in his self-harm and suicidal ideation. He was discharged back to his supported living accommodation on 1st February 2021, initially under the care of the Home Treatment Team and then the Community Mental Health Recovery Service. He continued to have fluctuating mood and episodes of self-harm, and he sought help from Safe Haven and the Psychiatric Liaison Service at St Peter's Hospital on 4th, 22nd, 24th and 28th February.* *On the last occasion, 28th February 2021, he expressed concern he could not keep himself safe. He requested inpatient admittance and then agreed to Home Treatment Team care before changing his mind. On this occasion his immediate risk was assessed as low and he was discharged back to the Community Mental Health Team. This was a missed opportunity to contain and manage his risk whilst exploring his needs.* *The lack of availability of psychological therapies and resources tailored to the needs of patients with Autistic Spectrum Disorder which could be offered to Zachary by Surrey & Borders Partnership NHS Foundation Trust also represented a missed opportunity to provide therapeutic care.* *On the afternoon of 2nd March, Zachary sent a text message to his Care Coordinator stating that he wanted to discharge himself from mental health services as he felt they were not helping him. A support worker found him suspended in his bedroom at around 18.45. Suicide.*
4	**CIRCUMSTANCES OF THE DEATH** Zachary was found suspended in the bedroom of his supported accommodation on 2nd March 2021, and was pronounced deceased by attending paramedics.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: - Zachary had a history of mental illness from childhood. His diagnosed conditions of Autistic Spectrum Disorder (ASD) and

	Emotionally Unstable Personality Disorder required care tailored to his neurodiverse needs. Concern was expressed by two Consultant Psychiatrists who cared for him in life, and the Court appointed Expert Consultant Psychiatrist, regarding the lack of consideration for those with neurodiverse conditions in the care options available, and the lack of availability of appropriate therapies; - Inpatient mental health units adversely affect those with neurodiverse conditions since they require calm and structure. There are no inpatient options tailored to patients with neurodiverse conditions presenting in acute crisis; - Home Treatment Teams do not offer continuity of staff or set appointment times, as they are a crisis team allocated according to demand. This stability is required by those suffering from ASD; - There is a lack of availability of psychological interventions, being the main treatment for neurodiverse conditions, including art therapy, Dialectical Behaviour Therapy (DBT) and Systems Training for Emotional Predictability and Problem Solving (STEPPS) (Zachary was placed on a waiting list) Consideration should be given 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 names in paragraph 1 above 2. [redacted] 3. Surrey and Borders Partnership NHS Foundation Trust,

	[redacted] 4. 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 26th day of January 2023**