



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1 [REDACTED], CEO, Southern Health Foundation Trust.2 [REDACTED], Mental Health, Learning Disabilities & Autism and Childrens Care Director and Deputy Chief Delivery Officer, Hampshire and Isle of Wight Integrated Care Board.3 NHS England
1	<p>CORONER</p> <p>I am Christopher Campbell Wilkinson, Senior Coroner for the coroner area of Hampshire, Portsmouth and Southampton.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 04 July 2022 I commenced an investigation into the death of Kirsty Clare TAYLOR aged 33. The investigation concluded at the end of the inquest on 09 June 2023. The conclusion of the inquest was that the Deceased impulsively took her own life (by hanging) whilst suffering increased emotional dysregulation against a background of Emotionally Unstable Personality Disorder.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The Deceased was found in a lifeless state in the garage at her family home at approximately 09.15 on the morning of 25 June 2022 by her partner, who had last seen her alive when the couple went to bed at approximately midnight on the evening of 24 June 2022. She was found suspended [REDACTED]. The evidence indicted that she had secured the ligature herself before lowering herself into it. The evidence established that she had died at some point in the early hours of the morning - it was known that she was not sleeping. There were no suspicious circumstances concerning the death. The Deceased was diagnosed with EUPD and ADHD and was receiving therapy and support from the community mental health team and from her GP in respect of physical pain. She had been struggling in the months prior to her death with emotional dysregulation, reflective of her EUPD but influenced in part by a programme of gradual reduction in her medications, which she had requested. The evidence was not able to establish that the change in her medication had chemically caused an instability in her emotions (and it was recognised that both the long term and concomitant use of her various prescription medications were clinically indicated and without contra-indications). However, the psychological impact of reduction, coupled with increasing social stressors and an increasingly subjective feeling of isolation, abandonment and lack of being heard in the last few weeks of her life are believed to have all contributed to an increasing internal narrative which led, on the evening of 24 June 2022, and without warning, to a spontaneous and impulsive act against an increasing background of emotional dysregulation. There was no evidence to indicate that her death had been an accident or a cry of help (given the timing and nature of the act). In the context of her complex diagnosed conditions however, the risk of dangerous and impulsive acts with impulsive intent was recognised, but not in all the circumstances expected.</p>



5 CORONER'S CONCERNS

During the course of the investigation my inquiries 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. It was recognised in evidence and in submission to the Court by representatives of the Trust, that there is and remains a fragmented relationship between mental health and physical health services, with little inter-service connectivity. It was recognised that ideally services for those with both mental and physical health diagnoses should be connecting in a seamless, timely and collaborative manner - specifically through the joint commissioning of services, to support patients of all ages.

Nationally it is recognised that co-morbidity, especially with ADHD (as was the case in this death), impacts on both treatment compliance and treatment response. Whilst local initiatives have been explored by SHFT and by the ICB - Project Fusion I understand is such an example - much of the development of such services falls outside of scope and commissioning. Consequently, there is a significant and pressing need for connectivity between mental health services and those services supporting neurodivergent patients.

It was noted in evidence e.g. that SHFT do not currently have a comorbidity policy that would provide guidance to staff regarding patients who have a mental health condition and a learning difficulty. There are no ADHD services within SHFT or other NHS organisations within the Southampton (or in fact the wider Hampshire) area - save for private clinics, which many cannot afford.

The facts in this case have highlighted that progress on initiatives and connectivity between services is still too little and too slow. More needs to be done, and with greater integration, if the needs and support of patients such as Kirsty Taylor are to be sufficiently and appropriately met in the future and similar deaths prevented.

2. Evidence before this inquest indicated that SHFT has recognised that the mental health provision for those with personality disorders must move towards an individual, therapeutic and trauma-informed approach, which is both compassionate and recovery focused. It is evident that the 'Personality Disorder Pathway' currently being developed is an important step towards that, enabling practitioners and services to take a more holistic and person-centred approach, reducing risk and improving outcomes. I am aware that SHFT have been encouraged to review and further develop the Pathway. I am concerned that that must occur, and at pace.
3. I remain concerned (as it is a matter I have raised on many occasions at inquest and again as a result of the experiences of the family in this case), that communication with the families of patients with mental health difficulties is still not being effectively achieved. Nor are such families being sufficiently, effectively and meaningfully listened to or understood when they voice concerns, based on their experience of the patient outside of a treatment or assessment environment. Consequently, I am concerned that such matters are not being reflected sufficiently or frequently enough in the onward treatment of those patients or in the clinical curiosity afforded to their conditions.

There remains an over-focus on patient centric assessments and patient only responses. It is recognised that patients can present quite differently to and in the presence of their families, who know them intimately, to how they may (or may be able to) present to assessing clinicians - with or without the intent to mask their condition.



	<p>Whilst consent to share is an understandable barrier in some cases, there should not be a bar to listening to or to actively encouraging feedback and input from families, especially where a family's concerns are heightened by any sudden or marked changes in the behaviours, mood or presentation of their relative outside of the clinical/assessment environment - particularly in the case of neurodiversity.</p> <p>Unless all concerns are heard and considered and all available information is taken on board, holistically, there is a continuing risk that the masking of mental health conditions and the deterioration of them may occur or that significant red flags are missed. In this case, the family's increasingly desperate concerns voiced about their daughter's evident mental health deterioration in her final days went un-responded.</p> <p>4. Finally, I am concerned that more needs to be done to inform and assist families, particularly in cases of patients with neurodiversity. In this particular case, the evidence found, for example, that the family were never briefed on what EUPD and ADHD really meant or on the difficulties which could present as a result of their daughter's joint diagnoses. Being unaware as to what they were to expect, they were consequently often at a loss to know how to interact with or to help her. Neither they nor their daughter received advice on possible medication withdrawal symptoms.</p>
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 17 October 2023. 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 ██████████, Southern Health Foundation Trust ██████████ ██████████ ██████████ 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 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 by the Chief Coroner.
9	Dated: 28 July 2023.



Coroner, C C Wilkinson
Senior Coroner for
Hampshire, Portsmouth and Southampton