Kent and Medway Mental Health NHS Trust

Chief Executives Office
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[redacted]

Ms Sarah Clarke,
Kent and Medway Coroners' Service
Oakwood House
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ME16 8AE

6 March 2026

Dear Ms Clarke

Inquest into the death of Mr Stephen Taylor

Kent and Medway Mental Health NHS Trust response to the Regulation 28 report to prevent future death.

I write in response to the Regulation 28 Report dated 14 January 2026, sent to Kent and Medway Mental Health NHS Trust (KMMH) following the conclusion of the inquest into the very sad death of Mr Stephen Taylor on 26 May 2025.

In your report to the Trust, you raised the following matters of concern:

1. **Mr Taylor was in contact with multiple services during a period of escalating mental distress. Each service operated within its own framework, but there was no evidence of coordinated, real-time escalation or ownership of risk across services.**

   KMMH and NHS Talking Therapies Collaborative are currently in discussion facilitating a phased training and support package to mutually ensure patients are placed with the best service provider to meet needs of patients at point of referral.

   The aim is to improve communication of risk within referrals and action appropriately; to reduce number of patients passing between services before treatment is offered; and ensure patients are offered the right service, at the right time.

It is my understanding that points 2-5 inclusive refer to findings relating to the Trust Urgent Mental Health Helpline and therefore I have outlined our actions to resolve the issues which you have highlighted;

2. **Clinical decision-making consistently relied on Mr Taylor's denial of immediate intent and his stated ability to keep himself safe, despite significant indicators of elevated risk, including a previous serious suicide attempt, escalating distress, severe anxiety, sleep disturbance, reduced self-care, and repeated concerns raised by a close family member.**

   With regard to improving risk recognition within the Kent & Medway Urgent Mental Health Helpline, the staff from this service are undergoing a 2-day Clinical Risk Assessment & Management (CRAM) training event to support improved risk recognition and risk curiosity, and to promote deeper questioning of patients who present with elevated risks and/or risk factors. This will include a focus on creation of a co-produced care and risk management plan.

3. **Referrals to secondary mental health services were identified as necessary by more than one service but were treated as routine rather than urgent, and were not actioned immediately.**

   As a result of this very sad death, the Urgent Mental Health Helpline, has generated visual prompts at each call station to support clear identification and pathways for call handlers/clinicians to direct, where risk is of concern, a referral for a rapid assessment within 4 hours by our Rapid Response service. It is expected that our staff will not rely on a risk prompt tool but will be equipped to identify risk accurately and utilise a curious approach to seeking further risk information, from the patient, their families and referrers.

4. **Family provided information indicating heightened and escalating risk which did not result in a same-day escalation or urgent face-to-face clinical assessment.**

   The visual aid for urgent 4-hour assessment is now by each workstation to ensure it is an action the triage team must take.

5. **Responsibility for escalation became diffuse across multiple services, creating a foreseeable risk that no single service took ownership of urgent risk management**

   The Urgent Mental Health Helpline Standard Operating Procedure has undergone thorough review which has resulted in an update to:

   - staff training expectations for CRAM.
   - a clear list of high-risk categories for patients, for example veterans, and demographics with known associated risk factors, and those who have a history of impulsive or planned self-harm acts.
   - expectation of staff to review available clinical records that are practicable to access during the clinical triage e.g. CRAM documentations 'risk event log'.
   - an update for urgent referrals to be triaged within a shorter timeframe (from 72 hours to 24 hours).

- update to the ‘immediate risk to life’ response under Right Care Right Person. Staff are being trained to understand the appropriate pathway and method to request this emergency Police response.

I am sincerely sorry for the short fall in the care of Mr Taylor. KMMH are committed to ensuring that the improvements that have been implemented are sustained.

Thank you for bringing your concerns to my attention. I hope that the detailed information provided, including the attached timetable for action, offers you a level of assurance about both the seriousness with which we have received and responded to your concerns, and the significant improvements we have made since the sad passing of Mr Taylor.

Please do let me know if I can be of any further assistance.

Yours sincerely

Chief Executive