[redacted]

Sarah Clarke, Area Coroner
Kent and Medway Coroner Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE

10/03/2026

Dear Ms Clarke

We write in response to the Regulation 28 report dated 14 January 2026 following the tragic death of Mr Taylor.

Summary

The following detailed reply outlines the care that was provided by Vita Health Group for Mr Taylor, which was delivered in line with the NHS Talking Therapies for Anxiety and Depression Manual and NICE guidance for the management of Self-Harm (NG225). It describes how the assessment of associated risk factors was considered, resulting in a judgement that the case should be treated as 'non-urgent'; a process later repeated by Kent and Medway Mental Health NHS Trust leading to the same outcome. Learning from Mr Taylor's death is described with actions taken to reduce the risk of a similar outcome occurring in the future, including changes to operating procedures describing how onward referrals to secondary care should be managed.

The Service

Vita Health Group (VHG) is the lead provider of NHS Talking Therapies within the Kent and Medway region. The remit of NHS Talking Therapies is to provide a range of talking therapy interventions for people who experience common mental health problems such as anxiety and low mood, that fall within the mild to moderately severe range. Severity of symptoms is self-reported by people who access the service and validated by a range of routine outcome measures. These include the PHQ-9 and GAD-7 which measure the severity of symptoms for depression and anxiety respectively. Within the Kent and Medway NHS Talking Therapies Service, a separate internal 'Duty Team', also managed by VHG, are on hand to support clinicians if ad-hoc supervision is required, and are often used to support with clinical risk and/or safeguarding related queries, and to support with the administration of such queries where necessary. However, the Duty Team is not an out of hours service or crisis line; it is a team to support clinicians, rather than a patient facing team. If a patient or family member calls the administration team or reception with concerns, the Duty Team may become involved in dealing with those concerns as the service would look to assist.

Although risk assessment and management are an essential component of the care provided by NHS Talking Therapies Services, and services are expected to work with people who present with risks (in relation to self-harm and suicide), it is not the remit of NHS Talking Therapies to provide mental health crisis support, or to manage the care of people for whom risk is imminent and who cannot keep themselves safe from self-harm. In this context, immediate or imminent risk is often referred to as 'dynamic' risk.

In the event of a patient presenting with mental health needs beyond the remit of NHS Talking Therapies (typically if the presenting problems are out of scope, e.g. evidence of symptoms of serious mental illness, or if dynamic risk factors make treatment unsafe within primary care), the care pathway is for the person to be referred into the Adult, or Older Adult Mental Health Team. In Kent and Medway, these services are provided by Kent and Medway Mental Health NHS Trust. Urgent referrals are responded to within 72 hours whilst routine non-urgent referrals take longer. Emergency support is provided by 999 and the Crisis Support Team can be contacted and aim to provide support within 4 hours.

Assessment of Mr Taylor's risk

When Mr Taylor was initially assessed by VHG in 2024, part of the assessment included an extensive and holistic risk assessment, which in line with NICE guidance NG225 (Self-harm: assessment, management and preventing recurrence) identified risk factors as well as protective factors as part of a risk formulation. The main risk factors identified were a suicide attempt over 10 years ago, current unemployment and a sense of losing hope that support was available to help him with his current situation. Whilst this was of concern, it was in the context of Mr Taylor reporting that he wasn't currently experiencing suicidal thoughts and did not feel that he was a risk to himself. Positive factors were also identified in that he was motivated to engage with help; he felt lucky to be alive following his stroke, he reported that his wife was a strong protective factor, and he reported that should things change, he would be able to access support and ask for help. To support this, a risk management plan was devised with Mr Taylor outlining who he would contact and how he would access support if his situation (regarding feeling a risk to himself) changed.

Mr Taylor appeared to engage well with his subsequent treatment and on the final session he attended (29/4/25), his outcome measures indicated that he had recovered from his initial symptoms of depression. Mr Taylor cancelled his final scheduled session twice and sadly died before this took place. Clinical records show that the risk assessment was reviewed at every subsequent session, and no concerns were raised about escalating or new risk factors.

Mr Taylor's daughter subsequently contacted the Kent & Medway NHS Talking Therapies service, and on 22/5/25 spoke with the Duty Team. She disclosed that Mr Taylor had become acutely anxious, and she was concerned given his history. Additional risk factors were shared and considered, including current lack of sleep and worry about finances. It was also shared that she was not aware of any current planning or intent towards a suicide attempt.

In this scenario, where additional information is provided, the team will either note the information to be included in the assessment the next time the patient is seen or, if the information raises a concern, an assessment is made about what level of escalation is required. For instance, does it need Crisis Team within 4 hours, an urgent referral within 72 hours or longer via a non-urgent referral.

Although Mr Taylor had not been reviewed directly by the clinical team, the Duty Team noted the concerns shared by his daughter, and agreed a plan with her, that a non-urgent referral was most appropriate and would be made to the Older Adult Mental Health Team. The rationale for this was that whilst Mr Taylor's presentation had deteriorated and new risk factors had been reported, the absence of dynamic or immediate risk factors such as risky behaviour, or evidence of planning or intent towards a suicide attempt, meant that an urgent referral was not indicated and therefore unlikely to be accepted. However, due to an escalating presentation, additional support from the Older Adults Mental Health Team was still indicated.

VHG considered Mr Taylor's daughters concerns and reasonably assessed the risk that referral to the Older Adults Mental Health Team on a non-urgent basis was appropriate. The Duty Team understood at this time that Mr Taylor's daughter agreed with this plan. The duty worker wished to review the referral with the treating clinician so more information could be added to the referral before sending it which regrettably resulted in a delay, with the referral not being actioned prior to Mr Taylors tragic death, 4 days later.

In the meantime, we understand Mr Taylor's daughter called the Older Adults Mental Health Team directly on 23/5/25 who also agreed a non-urgent face-to-face assessment was required.

Learning

NHS Talking Therapy Services across the country are not medically led and do not provide an objective view of a person's presentation. Instead, assessment of the patient's presentation is based on what the patient reports and validated by self-reported outcome questionnaires (as set out in the NHS England Talking Therapies Manual). However, where necessary and indicated, clinicians within the service will consider factors that are inconsistent with that self-reporting, to inform the assessment process and subsequent decision making.

When assessing for risk of suicide, a person's self-reported view and reassurance are always important, but other risk factors are considered as part of the decision-making process. This weighing up of risk factors is ultimately a judgement call, and the judgement in this case was informed by Mr Taylor's denial of immediate intent, his stated ability to keep himself safe, alongside several other factors such as lack of risky behaviour. This was in line with NICE guidance NG225 which sets out that risk should not be stratified and should instead risk factors should be considered as part of a risk formulation. With hindsight, we know that tragically the judgement that Mr Taylor could keep himself safe was wrong.

VHG did escalate the risk but recognise that the decision of the Duty Team to review the case with the treating clinician led to a delay in the referral being made. The subsequent assessment of Mr Taylor by Kent and Medway Mental Health NHS Trust following referral by his daughter also concluded that a non-urgent referral was indicated. However, VHG recognise that there should have been more prompt action to raise the referral in a case such as this where there were significant concerns being raised by a family member. VHG is committed to learning. As such, the following actions have been taken as a result of Mr Taylor's tragic death:

- The Duty Standard Operating Procedure was reviewed and updated in November 2025 and now includes (1) an explicit reference to the management of routine referrals, and states these should be actioned on the day that the referral decision is made and consent received, and (2) reference to the importance of the careful consideration of family members' information within the clinical decision-making process.
- A reflective session with the Duty Team took place on 03/12/25 sharing the learning from this case and the changes that have made to the Duty Standard Operating Procedure as a result.

In closing, Vita Health Group wish to reiterate our shared commitment to ensure we are delivering high quality services for patients, carers and their families.

Yours sincerely,

[redacted]

Director of Clinical Services
On behalf of Vita Health Group Ltd.

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