REGULATION 28: REPORT TO PREVENT FUTURE DEATHS FOLLOWING THE INQUEST TOUCHING UPON THE DEATH OF STEPHEN TAYLOR

THIS REPORT IS BEING SENT TO:
1. Kent and Medway Mental Health Trust (KMPT)
2. Vita Health Group – Kent and Medway Talking Therapies

CORONER

I am Sarah Clarke, Area Coroner, for the coroner area of North East Kent.

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.

INVESTIGATION and INQUEST

On 26th May 2025 I commenced an investigation into the death of Stephen Taylor. The investigation concluded at the end of the inquest on 5th January 2026. The conclusion of the inquest was Suicide. The medical cause of death was recorded as: 1a. Multiple Injuries.

CIRCUMSTANCES OF THE DEATH

Stephen Taylor experienced a significant deterioration in his mental state in the week preceding his death. He was acutely distressed about work-related issues and his financial situation, expressing fear that he could lose both his job and his home. He had a significant history of mental ill health, including a serious and impulsive suicide attempt in 2013.

On 19 May 2025, Mr Taylor attended his GP surgery in a state of acute distress. Medication was prescribed and a review was planned for ten days later. No immediate referral to secondary mental health services was made.

Between 20 and 24 May 2025, Mr Taylor's mental state deteriorated further. His daughter repeatedly contacted health services including Talking Therapies and the Kent and Medway Urgent Mental Health Helpline, reporting escalating distress, sleep disturbance, reduced self-care, and behaviours consistent with his previous suicide attempt.

On 24 May 2025, a telephone triage assessment took place. It was determined that there was no immediate risk and that a routine referral to the Older Adult Mental Health Team would be made. No urgent or in-person assessment occurred.

On 26 May 2025, Mr Taylor died after deliberately jumping from Louisa Bay Cliffs, Broadstairs, Kent.

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) 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.

(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.

(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.

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

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

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that you and/or your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the Interested Persons. I have also sent it to those organisations 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.

The Chief Coroner may publish either or both in a complete or redacted or summary form.

DATE AND SIGNATURE

Dated: 14th January 2026

Signed: [redacted]