REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

1. CORONER

I am James Thompson, Assistant Coroner, for the coroner area of Gateshead & South Tyneside.

2. DATE OF REPORT

6th July 2026.

3. 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.

4. THIS REPORT IS BEING SENT TO -

Secretary of State for Health & Social Care

You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st August 2026. I, the coroner, may extend the period if an appropriate
application is made.

5. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided.

I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6. SUMMARY OF CORONER'S CONCERNS

1. The lack of specialist tertiary centres across the United Kingdom for treatment resistant OCD.

7. ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

8. INVESTIGATION AND INQUEST

On 16th May 2023 I commenced an investigation into the death of Scott Alan Taylor, aged 49 years.

My investigation concluded at the end of his inquest hearing on 6th July 2026.

The medical cause of death was -

1a Pressure on neck
1b Hanging

Scott Taylor died on 12th May 2023 after suspending himself [redacted] This act caused his death and this was his intention.

A conclusion of suicide was recorded.

9. CIRCUMSTANCES OF DEATH

Mr Taylor at the time of his death was suffering with a profound and long standing mental illness. It was diagnosed as Obsessive Compulsive Disorder. He was receiving treatment in the community, but he had also been treated as an in patient. His condition was resistant to treatment at the time of his death.

Referrals had been made to a tertiary service to provide specialist treatment for his condition. Access to this service is dependant on the patient completing a certain amount of treatment in primary and secondary settings before a referral can be accepted.

It was heard in evidence that at the time of Mr Taylor's death, had he been successful in accessing this centre, there was a waiting list of over 12-15 months before treatment could begin.

The only centre to provide this care at the time was in London. Mr Taylor lived in the North East of England.

Mr Taylor, two days prior to his death had expressed his feelings of hopelessness due to the inability of accessing specialist treatment at such a centre and the timescales involved.

10. CORONER'S CONCERNS

During the course of the inquest I heard evidence 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:

At the time of writing this report it appears that only a small number of tertiary centres able to care for patients with treatment resistant OCD exist in the United Kingdom. They appear to be located in London and the South East.

The criteria to access these services and the limited capacity they have, it seems prevents clinicians treating patients being able to call upon specialist services that a tertiary centre/s can provide to they patients. Particularly, where a patient's case is complex and resistant to all that primary and secondary care services can offer in terms of treatment.

These centres are also not located across the whole of the United Kingdom for ease of access for those patients not residing in the immediate locality of the current centres.

11. COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:

1. The Family of Mr Scott Taylor
2. Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

12. SIGNATURE