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Barnet, Brent, Enfield, Haringey and Harrow,
Barnet Coroner's Court,
29 Wood Street, London, EN5 4BE

MR. J. TAYLOR
H.M. ASSISTANT CORONER
NORTH LONDON

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. Barnet Enfield and Haringey Mental Health NHS Trust 2. NHS England 3. Tavistock and Portman NHS Foundation Trust
1	**CORONER** I am JOHN TAYLOR, Assistant Coroner for the Coroner area of North London.
2	**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.
3	**INVESTIGATION and INQUEST** On 24 May 2021, the Senior Coroner commenced an investigation into the death of SOPHIE GWEN WILLIAMS, aged 28. The investigation concluded at the end of the inquest (heard before me) on 19 January 2023. The conclusion of the inquest was: **Medical cause of death:** 1a Fatal toxic consumption of citalopram, propranolol, and quetiapine **How, when and where and, for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by her death** In the early hours of 20 May 2021, Sophie Gwen Williams died at her home, after taking a fatal overdose of prescription medications. She did so in the circumstances set out under 4 below. **Conclusion of the Coroner as to the death** Sophie Gwen Williams took the fatal overdose in consequence of being in a psychotic or dissociative state, in which she was not capable of forming (and did not form) any intention to take her own life. To an indeterminate extent, each of the circumstances identified above contributed to her death.

4 **CIRCUMSTANCES OF THE DEATH**

(a) Sophie lived her life against the backdrop of being diagnosed with Emotionally Unstable Personality Disorder ("EUPD"), and of having had traumatic experiences, including separation from her family (in more ways than one), the effect of all of which stayed with her, even though some had happened many years ago.

(b) As a trans person, she was particularly vulnerable to stress.

(c) After she moved to London, Sophie came to experience episodes of psychosis and dissociation which became increasingly frequent and intensive, during which she lacked capacity freely to make decisions, and was liable not only to self-harm (as happened frequently) but also, in particular, to take an overdose of the drugs prescribed for her (as she did on 23 March 2021).

(d) She "stockpiled" her prescription drugs, but Barnet, Enfield and Haringey Mental Health NHS Trust ("the Trust") gave her no warning not to do so, and did not take steps to alert her GP that she was doing so, which contributed to Sophie having access to enough drugs to amount to an overdose.

(e) The trauma and stress experienced by Sophie could cause or contribute to a dissociative episode, and were a strong risk factor for someone with a personality disorder (as Sophie was).

(f) The stress, and hence the risk of further psychotic and dissociative episodes - with the risk to her life that those entailed - was present and continuing, and was exacerbated by the following:

(1) Her concern that the Trust had not provided her with, or with certainty that she had, a long-term care plan.

(2) Her anxiety that the Trust had not provided her with a key-worker, and that she had very limited prospects of quickly and easily getting short-term, crisis help, if she were to need it.

(3) The Structured Clinical Management (SCM") practitioner at the Trust made remarks to Sophie, as a trans woman, which were highly inappropriate. Sophie may have forgiven her for doing so, but the negative effect of those remarks remained.

(4) Although the Trust recognised "The risks of withdrawing the antipsychotic completely would be that Sophie would experience a deterioration in her symptoms:....an increase in paranoia," it advised Sophie to stop her antipsychotic medication, which she had done by 12 May 2021.

(5) The Trust did not conduct its own diagnosis of Sophie's condition, or conditions. There was thus no check on whether Sophie did (in fact), have dissociative identity disorder, or dissociative amnesia (as was not suspected until after her death), and the treatment which the Trust did provide was determined accordingly.

(6) The Trust did not carry out any, or any adequate, assessment of the ever-present risk of overdose death posed to Sophie by the consequences of the psychotic and dissociative episodes, and by the other stress factors in her life, and thus did not actively consider, and hence did not take, steps to address that risk.

(7) The SCM provided by the Trust was, objectively, appropriate, in relation to certain aspects of the EUPD, but it was not adequate to, and did not, address that present and continuing short-term risk, which was also a recognised aspect of it. Sophie herself did not find it helpful.

	(8) The mental health practitioner who conducted the SCM sessions did not fulfil the function of the key-worker to which Sophie had become accustomed in Belfast, and whose support she had found helpful. **(9)** The announcement (made twice) by the Tavistock and Portman NHS Foundation Trust ("the GIC") (that time which Sophie had spent waiting for treatment by the Brackenburg GIC in Belfast would not count towards her waiting-time. for the GIC) was "devastating" and left her "raging". Those effects were not negatived by the call which the GIC had promised to make to Sophie, and which she was expecting to receive.
5	**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 will occur, unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN,** for trans persons on a Personality Disorder Pathway, arise out of the lack of provision of the following: (A) by local NHS Trusts: (1) The assignment of a single, named point of contact, available (aside from holiday and sickness absence) when needed by the patient (2) The training of staff assigned to provide care and treatment to such persons, both at the time of their appointment, and annually thereafter, with a focus on: (a) the needs of trans persons (b) gender-affirming care (c) dissociation and psychosis (3) Scrutiny of the delivery and implementation of such training, by way of quality assurance. (4) The absence from the assessment protocol of a provision to ensure that full account is taken of: (a) any previous diagnosis and treatment (b) all other information (including information from those who have previously provided care and treatment to the patient) available to members of the team (c) the risks to (and effects on) patients with (or likely to develop) conditions of dissociation and/or psychosis including, in particular, the risks of self-harm and loss of life (d) the views of those who are close to the patient, including the patient's carers, family and advocates (both formal and informal), who should be contacted, for that purpose (B) By clinics providing gender-identity treatment (and in relation to both current and prospective patients): (1) a help-line, available when needed by patients (2) the direction of patients to specialist carers (3) provision of mental health care for those patients on waiting-lists (4) liaison (at both local and national levels) among all clinicians concerned (or expected to be concerned) in the care and treatment of such patients (5) the setting and implementation (where practicable) of criteria for deciding whether (and, if so, which) patients (other than those terminally ill) should be given priority for receiving treatment
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths, and I believe your respective organisations 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 24 April 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 Person: Rupi Bond. I am also under a duty to send the Chief Coroner a copy of your response. 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	 **John Taylor** **Assistant Coroner** **27 February 2023**