Bhatt Murphy Solicitors

PRESS RELEASE

1 March 2023

Coroner concludes that failings by Barnet, Enfield and Haringey NHS Trust contributed to the death of transgender woman Sophie Williams and that more should be done to provide mental health support for trans people waiting to access the gender identity clinic

Before Assistant Coroner John Taylor
North London Coroner's Court
29 Wood Street, Barnet, EN5 4BE
17 – 19 January 2023, conclusion handed down 20 February 2023.

Sophie Williams, a 28 year old transgender woman activist and artist from Belfast, died on 20 May 2021 in Tottenham, North London from an overdose of prescription medication.

Sophie was under the care of Barnet, Enfield and Haringey (BEH) Mental Health Trust and had been waiting for nearly five years for a first appointment from a Gender Identity Clinic (GIC), a fact that caused her significant distress.

Sophie suffered from psychosis and dissociation and had a diagnosis of emotionally unstable personality disorder (EUPD). After Sophie moved to London in July 2020, her experiences of psychosis and dissociation became more frequent and severe, during which Sophie would lose capacity. She had a history of self-harm whilst experiencing dissociation or psychosis and had taken a number of previous overdoses in similar circumstances, most recently in March 2021 less than two months prior to her death.

Two days before her death Sophie was informed by the Tavistock GIC that the four years that she had spent waiting for a first appointment at Belfast's equivalent GIC service would not be recognised by the Tavistock, news that was devastating to Sophie. Sophie died on 20 May 2021 having taken an overdose of prescription medication.

Coroner's Conclusions

After hearing three days of evidence, Assistant Coroner John Taylor returned a damning narrative conclusion that failings in the clinical care provided to Sophie by BEH Trust contributed to her death. He concluded that Sophie died whilst in a psychotic or dissociative state in which she was not capable of forming the intention to take her own life. He found that there had been a failure to assess Sophie or to take reasonable steps to protect her from her risk of self-harm in the context of dissociation and psychosis. He also found that her symptoms were exacerbated by her distress at the delays in accessing a first appointment at a GIC.

He concluded that the following factors contributed to Sophie's death:

- Sophie's anxieties about the failure on the part of BEH to have in place a long-term care plan or provide her with a key worker or care-coordination;

- Inappropriate comments made by her therapist at BEH including misgendering her and asking her when she decided to be trans;

- The failure on the part of BEH to undertake their own diagnosis of Sophie's condition including whether she may have dissociative identity disorder or dissociative amnesia, and to treat her accordingly;

- The failure on the part of BEH to carry out any risk assessment of the ever present risk of overdose posed to Sophie during her psychotic and dissociative episodes;

- The inappropriate therapy she was referred to which was not capable of addressing the risks connected with Sophie's dissociation and self-harm;

- The confirmation by the Tavistock two days before her death that the time that Sophie had been waiting for treatment in Belfast would not count towards the time waiting for a first appointment at the Tavistock. The Coroner found that the news was '*devastating'* for Sophie and left her '*raging'*.

Prevention of Future Deaths

The Coroner has also made a report to prevent future deaths to BEH, NHS England and the Tavistock requesting improvements to the provision of care to trans patients. The report to the Tavistock identified a risk of further deaths if improvements were not made to provide mental health support to those on the waiting list for a first appointment and for there to be better liaison with other mental health services.

The report addressed to BEH identified concerned the failure to provide clinicians with training around the needs of trans people and gender affirming care, as well as diagnosis and risk assessment of dissociation and a single point of contact.

Toby Attrill, Sophie's friend & informal advocate, said on behalf of himself and Sophie's partner Rupi Bond:

Sophie was an astounding woman. She was a renaissance woman in that she applied her talents across a number of disciplines, all of which she excelled at. She was dedicated to the liberation of all people, a feminist, a believer in a united Ireland, and the co-founder of We Exist, an organisation which supports the trans community with grants towards vital health-care and living expenses. She was kind, gentle and generous and had a deep will to survive. She wanted desperately to engage with any treatment offered to her. Sophie was failed by the institutions which were meant to provide care for her and which were meant to keep her alive.

I hope that the outcome of this inquest prompts BEH Trust to seriously engage with the family and carers of their clients; whether biological or chosen. I hope that they address the transphobia within their institution. I hope that NHS England provides the adequate resources to GICs such that other trans people aren't stuck on seemingly endless waiting lists to access life saving care. I hope that I will be able to take small comfort in the fact that Sophie's death will prompt positive change in the institutions that were meant to care for her. I hope that others will not have to die in this way.

More than anything I wish that Sophie was still here. I wish I could hear her voice again, hold her, and care for our community with her.

Sophie Naftalin, solicitor for Rupi Bond said:

"The Coroner's findings have entirely vindicated Sophie's loved ones agonising concerns about Barnet, Enfield and Haringey NHS Trust's failure to provide her with an acceptable level of care. He has also recognised the specific distress and pain Sophie suffered for 5 years on the waiting list for a first appointment at a Gender Identity Clinic, and that this was a factor that contributed to her death.

Sophie was failed by a mental health system that attributed her very real symptoms of psychosis and dissociation – and risk of self-harm in that context - to personality disorder therefore never meaningfully addressing the ever-present risk to her life. The clinical care that Sophie received was also hampered by a lack of understanding by clinicians of the specific challenges that she faced as a trans woman waiting for a first appointment. The Coroner has identified that without change, other lives are at risk".

NOTES TO EDITORS

The Prevention of Future Death Report can be found here.

For further information or request for comment please contact **Sophie Naftalin** at Bhatt Murphy on 020 7729 1115 or s.naftalin@bhattmurphy.co.uk

Rupi Bond is represented by **Sophie Naftalin and Christina Bodenes** of Bhatt Murphy Solicitors and Jude Bunting KC of Doughty Street Chambers