Bhatt Murphy Solicitors

PRESS RELEASE

20 March 2026

Coroner finds "fraudulent" conduct and "dangerous culture" at Elysium Healthcare Farndon Unit where Molly-Star Kirk died

Before HM Area Coroner Miss Laurinda Bower
Nottingham Coroner's Court
9-20 March 2026

Molly-Star Kirk died on 29 May 2022, aged 20, after having been found unresponsive in her bedroom at the Farndon Unit, where she had been an inpatient detained under the Mental Health Act. The Farndon Unit is operated by Elysium Healthcare. Today, an inquest into her death has concluded. The Coroner found that:

- The failure to perform observations in line with Molly's care plan and the extent of fraudulent completion of the handwritten observation record, was "shocking".
- The systems of training and quality assurance were not as robust as they ought to have been and this had allowed a culture of a lack of care to develop, which was dangerous on a ward with patients of that degree of complexity and vulnerability.
- This dangerous culture was allowed to prevail due to a lack of ward oversight, lack of second Nurse in Charge to keep alert of happenings on the ward, and a lack of robust system of quality assurance.
- The unsafe practice of missing observations and the fraudulent practice of making false entries in the observation charts was endemic on Aster Ward and that whatever system of operational governance was in place, it was insufficient to ensure the safety of Molly prior to her death.
- The training of staff was treated with the same cursory attitude.
- The high use of agency staff likely contributed to the lack of care demonstrated towards observations.

Molly-Star had been admitted to Aster Ward on the Farndon Unit on 14 October 2021. She had diagnoses of Post-Traumatic Stress Disorder, Emotionally Unstable Personality Disorder, having survived trauma as a young person. She had also been diagnosed with non-epileptic attack disorder, which causes the person to experience dissociative seizures. These seizures can look like epileptic seizures, but, as in Molly-Star's case, they are thought to have a psychological cause. It is not something done on purpose by the person, and the seizures are involuntary. Molly-Star also suffered with health anxiety, which was worsened by an incident in November 2021, when Molly-Star had asked to be taken to hospital as she was feeling very unwell after having swallowed an object. Her request was refused, until she was eventually conveyed to hospital where it was found that the object had perforated her colon, and a stoma bag was fitted.

Evidence heard that Molly-Star appeared to be in crisis on 28 May 2022, the day before her death. She experienced a number of prolonged seizures, serious self-harm which should have given rise to concerns that Molly-Star had sustained a potential head injury, and was subject to intramuscular medication without the input from the doctor and close monitoring that was required.

Over the course of the hearings, the inquest heard evidence that Molly-Star was in crisis on 28 May 2022, the day before her death. Although the medical evidence could not establish the cause of Molly-Star's death, the Coroner made detailed findings of fact about the care provided to Molly-Star and events leading up to her death, which she considered was especially important given she died in the care of the state. The Coroner found that:

- In the two days prior to her death, Molly was not observed every 5 minutes, contrary to her care plan and the care provider's own policy. However, the observation log was deliberately and falsely completed to appear as if checks had been undertaken at the prescribed level. This was not detected by any level of management prior to Molly's death.
- Molly was prescribed and administered high dose antipsychotic medication both as a regular prescription and on an 'as required' basis. Staff did not always follow the healthcare provider's Rapid Tranquilisation policy when administering intramuscular forms of sedation, including on the day prior to her death. This was likely due to a lack of training.
- On 28 May 2022 at 14.00 hours, Molly dialled 999 reporting that she had experienced a number of seizures. No enquiry was made by staff of Molly as to why she felt she required an ambulance, but she told the operator she had experienced 4 or 5 seizures that day. That call was terminated in the course of Molly handing the telephone to staff at the request of the call handler. When the ambulance service returned the call, staff at the unit explained the call was a "prank". This was contrary to basic medical practice and was a serious failing in the care of a vulnerable patient.
- At 17.49 hours Molly ran towards a glass door and struck it with her head. No medical advice was sought, no care plan was put in place, and this incident was not recorded in Molly's records or on handover to night staff.
- There was a dangerous culture that prevailed on the unit which harboured a lack of care, non-adherence to care plans and a lack of management oversight.
- On 29 May 2022, at some time between 13.00 and 14.30 hours, Molly probably suffered a medical event while in her bed which brought about her death.
- Without knowing the cause of her death, it is impossible to link any of the gross failings in her care as causative or contributory to her death with any degree of certainty. To attempt to do so would be speculative.

Molly-Star's family said:

Molly was a loving and gentle person. She was a cherished daughter, niece, granddaughter, sister, partner, and aunt. Her death has left a hole in our family that can never be fixed.

For us, Molly's move to the Farndon Unit was the beginning of the end. Over the months that she spent there, we witnessed her light slowly go out. As a family, we felt shut out of Molly's care, and like our visits were not welcome.

Everything we have heard about what happened the day before Molly's death has been devastating. It causes us immense pain as a family to think about how desperate and

powerless she must have felt when her calls for help were shut down. Given everything that happened the day before, it's incomprehensible to us that no one was concerned when she didn't wake up the next day.

Ultimately, although the medical evidence can't prove what killed her, we as a family know our truth.

The full statement by Molly-Star's family can be read in our web post.

Amy Ooi, Solicitor at Bhatt Murphy, representing the family, said:

Aster ward is a high dependency unit, and was opened to treat patients with complex needs, and whose care is funded by the NHS. Despite Elysium having previously been alerted to problems with observations by the CQC, when it opened the new ward it failed to follow its own policy which required that observations be monitored by checking the CCTV.

But the failings in Molly-Star's care are not confined to the issue of observations. There was also a failure to deliver rapid tranquilisation appropriately, to monitor Molly-Star's physical health given the medications she was prescribed, to escalate incidents and ensure medical intervention was sought given the level of self-harm that occurred on the day before her death. We also heard evidence of a culture of ridicule, hostility, and neglect.

For years in this case, Elysium have been saying that they were let down by the agency care workers who failed to do their jobs. In reality, it is Molly who was failed – catastrophically, and across so many aspects of her care – and the failure on the part of Elysium to confront that fact speaks to a defensiveness which has no place in services designed to treat and protect our most vulnerable. Until that defensiveness is faced head-on, they will be unable to learn from what happened to Molly-Star, and patients will continue to suffer.

NOTES TO EDITORS

For further information please contact Amy Ooi at Bhatt Murphy on 020 7729 1115 or a.ooi@bhattmurphy.co.uk.

The family is represented by Amy Ooi of Bhatt Murphy, Stephen Clark and Stephen Simblet KC of Garden Court.

Journalists should refer to the Samaritans Media Guidelines for reporting suicide and self-harm and guidance for reporting on inquests.