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PRIVATE AND CONFIDENTIAL

Ms Sonia Hayes
Assistant Coroner
Mid Kent and Medway Coroner's Court

[redacted]

Sent via email to:
kentandmedwaycoroners@kent.gov.uk

17 August 2021

[redacted]

[redacted]

Dear Ms Hayes

Re: Inquest Touching Upon the Death of Ellis Murphy Richards

I refer to the Regulation 28 report dated 11th July 2021, issued in respect of your concerns regarding the risk of future deaths.

Concerns

The concerns that you have detailed within Regulation 28 report include as follows:

"(1) Ellis' Safety Plan did not set out:
a. the responsibilities of the Child & Adolescent Mental Health Team
b. did not contain a contingency plan should Ellis agree to go to Accident & Emergency

(2) On 14th October 2020 there was a deviation from the agreed Safety Plan without an updated risk assessment.

(3) Not all relevant information was shared between the Child & Adult Mental Health Team about the circumstances disclosed of events on the night of 29th September of Ellis' failed attempt at hanging as part of a risk assessment.

(4) Ellis was found to be in need of a Mental Health Act assessment. Management advice was sought about risk and what action should be taken should Ellis refuse to go to hospital, the advice was contact the police. This advice did not take into account that Ellis had a history of absconding and that he could not be prevented leaving the centre."

I am extremely saddened by the death of Ellis and wish to express my heartfelt condolences to the family of Ellis. I appreciate that we cannot do anything to bring Ellis back. However, I can reassure you that we are taking the learning from this sad incident very seriously and provided our detailed response to each of the concerns raised by you as follows.

(1) Ellis' Safety Plan did not set out:

a. the responsibilities of the Child & Adolescent Mental Health Team

b. did not contain a contingency plan should Ellis not agree to go to Accident & Emergency

Responsibilities of CAMHS

The purpose of a Safety Plan in Mental Health services is to document, communicate what interventions have been agreed to be provided by the health care teams to address the clinical needs of the patient. The Safety Plan (also referred to as Crisis & Safety Plan or Care Plan) can be used as an aide memoire in respect of care that the patient can expect to receive. The Safety Plan also assists the healthcare teams in ensuring the continuity of care.

I have reviewed the paginated medical records bundle ('the bundle') which was submitted to the Court and confirm that the safety plans indicate responsibilities of the Child & Adolescent Mental Health Services (CAMHS) (i.e. what was the agreed and expected input from CAMHS).

CAMHS Crisis & Safety Plan dated 11th February 2020 (Page N.379 of the bundle) provides that the agreed actions were for Ellis to "…*remain on Dolphin Ward to complete NAC treatment and observation on his physical health… Crisis team to screen on Wednesday on Dolphin Ward Mum spoke of not being able to keep him safe at home...*"

CAMHS Crisis & Safety Plan dated 12th February 2020 (Page N.381 of the bundle) provides that agreed actions for the responsible Health Care Practitioner at CAMHS was to liaise with CAMHS Crisis Team whilst Ellis is in under the crisis team care. It also provides that a joint review had been arranged for 19th February 2020. It also provides that CAMHS Crisis Team should consider inpatient admission if they feel that safety cannot be maintained in the community.

CAMHS Crisis & Safety Plan dated 19th February 2020 (Page N.383 of the bundle) provides that CAMHS Crisis Team should remain involved with daily visits by a qualified member of the team. It also provides that CAMHS should discuss bed availability with bed management team on a daily basis.

CAMHS Crisis & Safety Plan dated 22nd June 2020 (Page N.227 of the bundle) provides that ALOT or CAMHS can provide additional support if needed.

The most recent care plan agreed on 23rd June 2020 (Page N.224 of the bundle) provides that Ellis' risk will be assessed on a weekly basis by a Health Care Practitioner from CAMHS.

Contingency plan

Ellis safety plan dated 22nd June 2020 (Page N.227 of the bundle) provides that, if he is unable to keep himself safe, even with the support of others, he is to attend A&E for further assessment in a place of safety.

In the event that Ellis did not agree to attend A&E and the health care team were concerned about his safety in the community, they would have had an option to raise their concerns with the police who have statutory power to detain patients under Section 136. In this case, the Trust notified the police as soon as it became apparent that he was not willing to attend A&E.

In the circumstances the Trust acted within their remit as prescribed by law. The Trust had no legal power to hold Ellis. Given this, the Trust considers that it did comply with its safety plan for Ellis. The Trust also consider that the contingency plan would have been, at the correct time, to have called the police, which did occur. However as a learning organastion the Trust fully accepts that there are always elements of cases that can be used for learning it will continue to reflect on its practice and procedures for all cases going forward.

(2) On 14th October 2020 there was a deviation from the agreed Safety Plan without an updated risk assessment.

Ellis sadly died on 30th September 2020; therefore I believe that the date of 14th October 2020 within your expressed concern is an error.

If you are referring to the risk assessment and safety plan effective on 30th September 2020 and the alleged deviation from the agreed Safety Plan by the psychiatrist. I note that there was no deviation from Ellis' safety plan and the risk assessment was carried out by the psychiatrist.

The safety plan effective on 30th September 2020 is documented on page N.227 of the bundle which provides that if Ellis is unable to keep himself safe, even with the support of others, he is to attend A&E for further assessment in a place of safety.

Based on the audio recording of the evidence (morning of inquest day 3) I understand that on 30th September 2020 the psychiatrist made the decision to not ask Ellis to attend to A&E. This decision was based on the dynamic risk assessment which the psychiatrist conducted while speaking to Ellis on the telephone at around 10am on 30th September 2020. This decision was also made in the knowledge there was a prebooked appointment with his care coordinator later that day, which Ellis attended. I understand that, before making the decision not to ask Ellis to attend A&E at the point of their assessment, the psychiatrist weighed up risks and benefits of Ellis being asked to attend the A&E. The decision was made on the basis of clinical judgement at the time of the telephone assessment, considering the information available to them and their assessment of Ellis' mental state, that it would be appropriate for Ellis' to be assessed face to face by his care coordinator, with whom he had a well-established therapeutic relationship, rather than a healthcare practitioner at an A&E who he did not know. I understand that the psychiatrist was concerned that Ellis may not be as cooperative and forthcoming with an unfamiliar health care practitioner as he would otherwise be with his care coordinator. The face-to-face appointment with his care coordinator had been scheduled for 3 pm on 30th September 2020.

I have been advised that as part of their consideration of how to proceed at the time, the psychiatrist recognised that Ellis might well have a wait of several hours at A&E and was aware that Ellis had a history of selective engagement with healthcare professionals. I have also been advised that it is customary practice that young people are seen by the team clinicians during working hours unless there are concerns about immediate safety or indications that the young person cannot be kept safe by the family in which case they are advised to seek A&E support.

I have been advised that the psychiatrist was aware that such an approach had been adopted in the past. The family had been informed of the safety plan previously and had taken Ellis to A&E at times of crisis. Ellis' grandmother confirmed that she would accompany him to the planned appointment with the care co-coordinator on 30th September 2020, which I understand she did.

I understand that the psychiatrist stated in their oral evidence that, had Ellis had not been subject to pre-scheduled face-to-face appointment, they would have asked him to attend A&E. As above however, Ellis did attend that face-to-face appointment. I also understand that at the inquest there was no evidence that Ellis showed or indicated suicidal ideation or self-harm between the telephone call at 10am and the face-to-face appointment.

As above, the risk assessment was a dynamic one, based on an evolving situation, clinical judgement and experience. As per the response below, a discussion between the psychiatrist and the care coordinator occurred later that day. On that basis, a risk assessment was undertaken, albeit, not a formal one, however, we fully accept that there are always elements that can be used for learning and whilst the Trust considers it acted reasonably, it will continue to reflect on its practice and procedures.

(3) Not all relevant information was shared between the Child & Adult Mental Health Team about the circumstances disclosed of events on the night of 29th September of Ellis' failed attempt at hanging as part of a risk assessment.

It is my understanding that the psychiatrist contacted the care coordinator after the telephone assessment of Ellis. The psychiatrist shared the information that was available to them at the time. The psychiatrist informed the care coordinator about the incident the previous night involving a ligature. The psychiatrist was not aware at that time of the second incident at the Youth Club. The psychiatrist also discussed their assessment of Ellis' suicide risk. They explained to the care coordinator that Ellis did not want to talk to them about the incident, which impacted on the ability to risk assess and establish if there were ongoing suicidal thoughts, intent or plans. The psychiatrist shared their consideration of whether to refer Ellis to A&E as well as their reasons for concluding that Ellis meeting with his care coordinator would on balance allow for a better risk assessment and therapeutic outcome. The psychiatrist and care coordinator agreed that a decision could be taken regarding the next course of action after the review by the care coordinator. The psychiatrist had documented their findings in Ellis' medical records, which were accessible to the care coordinator. Paragraph 54 of the witness statement of the psychiatrist dated 15th December 2020 (Page A194 of the inquest bundle) provides as follows:

"I shared my concerns about recent ligature, and my difficulty in assessing risk as Ellis was not engaging. A agreed to assess risk and to update ALOT, following A's appointment with Ellis, later that afternoon."

I also note that Paragraph 54 of the witness statement of the care coordinator, dated 15th December 2020 (page A178) provides the following:

"*On 30 September 2020, I received a call at 2pm from* [redacted] *who advised me that* [they] *had carried out a review with Ellis over the telephone at 10am.* [They] *said he had tied a ligature round his neck the previous evening. Nan had said he was OK and that he would be attending the appointment at 3pm with me".*

I understand that immediately on commencement of the pre-scheduled appointment with the care coordinator at 3pm on 30th September 2020, the care coordinator explored the self-harming incident with Ellis and his grandmother to establish the full facts surrounding the incident the previous evening and to review the current risk status established (paragraph 56 of the witness statement of the care coordinator dated 15th December 2020 (page A179 of the inquest bundle). It was at this point that Ellis disclosed for the first time the details of the second incident at the Youth Club and discussed this with the care coordinator.

If your concern relates to the second incident at the Youth Club, I understand that when speaking to the psychiatrist, prior to the appointment with the care coordinator, Ellis did not disclose information about this incident to the psychiatrist. Therefore, the psychiatrist could not have been expected to have the knowledge of this information when sharing her concerns regarding the risk to the care coordinator.

Given this, it is felt by the Trust that appropriate information was disclosed to the care-co-ordinator and that it was appropriate for the care co-ordinator to elicit further information from Ellis at the face-to-face appointment.

(4) Ellis was found to be in need of a Mental Health Act assessment. Management advice was sought about risk and what action should be taken should Ellis refuse to go to hospital, the advice was contact the police. This advice did not take into account that Ellis had a history of absconding and that he could not be prevented leaving the centre."

I understand that once the care coordinator completed the assessment of Ellis' risks they appropriately sought advice from the Team Manager as stated in their statement, paragraph 66 (page A180 of the inquest bundle):

"My manager agreed regarding hospital admission and said that I should refer Ellis for this support from the Crisis Team and also said to ask Nan to take him to A&E immediately. I checked with my manager what I should do if Ellis did not get into the car with Nan and she advised to call the police.'

The management advice did take into account the possibility that Ellis may not agree to co-operate to go to the A&E, as it included the instruction to contact the police, should he not agree to go to the A&E.

The care-coordinator and their Manager were acutely aware that it would not be legal and could be alleged to be an assault on the person or unlawful imprisonment, should restraint or deprivation of liberty techniques have been used, by the community mental health nurses to restrain or detain an individual.

The police have powers under Section 136 of the Mental Health Act to detain a person who is in a public place and appears in immediate need of care or control; the police would thereby take them to a place of safety for assessment.

As soon as Ellis left the premises and refused to attend A&E the care coordinator contacted the police immediately to inform them of the incident, risks and concerns of safety. This was the first indication that Ellis was not willing to attend A&E and so the first opportunity to update the police. Had the police been telephoned before, when there was no indication that he would not attend A&E, there is no evidence they would have attended.

We wish to provide clarification of a statement within the section 'Circumstances of death', on page 2 of the Regulation 28 report:

"Ellis was rescued from an attempt to hang himself at home on the night of 29th September and had planned telephone psychiatric review the next morning with details of the failed attempt, that Ellis wanted to kill himself and could not keep himself safe"

The psychiatrist has explained that Ellis did not report to them that he wanted to kill himself. As above, Ellis did not want to talk to the psychiatrist about the incident, which impacted on the ability to risk assess and establish if there were ongoing suicidal thoughts, intent or plans. At the time of the psychiatrist's review it was not evident that Ellis had ongoing suicidal intent or plans. In addition, he did not express that he would not be able to keep himself safe, as he did to the care coordinator at the appointment later that afternoon. During the meeting with the care coordinator, Ellis explicitly indicated that he had not wanted others to keep him safe.

As part of our internal review of the findings of inquest and feedback from the family of Ellis we have identified incidental learning (detailed in the Serious Incident report in the bundle) to ensure continuous improvement of our services. We have arranged a meeting with the family for 6th September 2021 to share our incidental learning and provide further reassurance in respect of improvements made within the service.

I hope that my detailed response to your concerns raised, cross referenced with various documentary evidence, appropriately addresses your concerns. As stated above the Trust fully accept that there are always elements of cases that can be used for learning. I am mindful of the incredible personal loss to all those that loved Ellis, we will continue to ensure that anything we can do to prevent future loss of lives will be implemented across our services.

I understand that your Regulation 28 report may be shared with the Chief Coroner which in turn may be published on the Judiciary website, although we note that the responses to such reports do not tend to be published. Should the Chief Coroner decide to publish your Regulation 28 report, the trust requests (pursuant to the Regulation 29(8) of the Coroner (Investigations) Regulations 2013) that it may be in the public interest for our response to be published alongside your Regulation 28 report in an anonymised manner.

If you have any further queries, please contact my office on [redacted].

Yours sincerely

[redacted]

Chief Executive