IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Emmett Alexander GILLAH
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Ms Helen Greatorex Chief Executive Kent and Medway NHS and Social Care Partnership Trust Farm Villa Hermitage Lane Maidstone Kent ME16 9PH
1	**CORONER** Mr Darren M. Stewart OBE, HM Assistant Coroner for the coroner area of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of 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 25 January 2016, an investigation was commenced into the death of Emmett Alexander Gillah, an inquest was then opened on the 01 February 2016 which concluded at the end of the inquest on 12 October 2018. The conclusion of the inquest was that Mr Gillah died as a result of 1a. Multiple Injuries. A Narrative Conclusion was recorded in this matter as follows; Emmett Alexander Gillah died due to injuries sustained as a result of being hit by a train around 2210 hours, 23 January 2016 between Redhill and South Nutfield Stations. Emmett Alexander Gillah had a history of mental illness. He had been discharged from Kent and Medway Partnership NHS Trust (KMPT) Early Intervention Service (EIS) on 24 April 2015 at his own request following a period of care which had commenced in November 2014 following his detention under section 2 of the Mental Health Act 1983. At discharge, inadequate arrangements were put in place by KMPT to communicate to his GP either the circumstances of his discharge or the nature of care delivered including the diagnosis of his mental illness. KMPT further failed to act in accordance with its policy to maintain telephone contact with discharged patients or their family at least every three months for a period of three years following discharge. No attempt to contact either Mr Gillah or his family was made by KMPT from the date of discharge up unto his death. It is possible that these failures may have contributed to the death of Mr Gillah.

	Following discharge Mr Gillah's mental health deteriorated further leading his mother to contact Mr Gillah's GP to seek assistance on 11 November 2015 and again in January 2016. On the second of these occasions, 21 January 2016, Mr Gillah's GP failed to refer Mr Gillah's case to Mental Health Services for urgent attention. It is possible that this failure may have contributed to the death of Mr Gillah.
4	**CIRCUMSTANCES OF THE DEATH** Mr Gillah was admitted to Pembury Hospital A&E on 13 November 2014 for the purposes of a MHAA following concerns raised by both his family and GP for his mental health. Following this assessment he was sectioned under Section 2 of the Mental Health Act 1983. He was subsequently transferred to the PICU, Little Brook Hospital, Dartford on 14 November 2014. During his admission at Little Brook Hospital Mr Gillah was assessed by Mental Health Services Staff and his condition appeared to stabilise and he was granted periods of leave. He was transferred to Brocklehurst Ward, Priority House, Maidstone on 26 November 2014. He remained in detention pursuant to section 2 of the MHA. Mr Gillah was discharged from Brocklehurst Ward on 28 November 2014 into the care of the SW Kent CMHT. Attempts by SW Kent CMHT to establish contact with Mr Gillah were unsuccessful. EIS became involved from 3 December 2014 and took on responsibility for Mr Gillah's care in relation to his mental health illness until he was discharged at his own request on 24 April 2015. During the time he was under the care of EIS, Mr Gillah was referred for a further MHAA on 28 January 2015. The outcome of this MHAA resulted in no recommendation for Mr Gillah to be sectioned and a care plan devised for his continued care in the community. During February 2015 contact was maintained with Mr Gillah by his care coordinator. Mr Gillah in the opinion of his care coordinator seemed to stabilize somewhat. Towards the end of February/early March 2015 Mr Gillah started to intimate to his care coordinator that he would like to be discharged from EIS. This became a formal request by Mr Gillah on 17 March 2015 and his CPA was reviewed by his care coordinator. The care coordinator did not feel at the time that Mr Gillah should have been discharged and that he would have benefited from a longer period of care from the EIS in order to avoid relapse, however Mr Gillah was insistent. The care coordinator discussed Mr Gillah's case separately with her supervisor and the psychiatrist treating Mr Gillah who both agreed that Mr Gillah should have remained with the EIS. A combination of factors including Mr Gillah's insistence on being discharged, the fact that he was assessed as having capacity led all involved in delivering his care at KMPT to conclude that there was not much which could be done in the circumstances to stop Mr Gillah's discharge at his own request. Mr Gillah's family was not involved in the discharge process and his mother was informed of the decision to discharge her son on 2 April 2015. Mr Gillah was formally discharged from EIS on 24 April 2015. KMPT did not have any form of information sheet/leaflet to provide to families or others advocating the interests of mental health sufferers which clearly outlined the circumstances of the discharge, contact details and pathways back to the service. Evidence received at Inquest indicated that hospital policy in relation to discharge decisions was not followed, particularly with respect to a plan for assertive follow up, and the details of the final care plan relating to clearly defining pathways back into the service if required. The consultation process engaged by the care coordinator would also have benefited from a more formal structured meeting where all those involved in Mr Gillah's care would have benefited from exchanging views together rather than a

	series of one to one conversations in isolation. In the circumstances, Mr Gillah's family should have been engaged as part of the process. In particular, and as part of the final CPA, arrangements should have been put in place for the care coordinator to either telephone Mr Gillah or his family at least every three months out to three years in line with Trust policy. This did not happen. The care coordinator's evidence at Inquest was that she was unaware of the policy at the time and did not carry this out. She further stated in her evidence that she was unaware of the policy underpinning the requirement now. At the time of Mr Gillah's discharge a letter dated 24 April 2015 was sent addressed to Mr Gillah copied to his GP. This brief letter acknowledged that he was being discharged at his own request, that he could re-refer himself to EIS until December 2017. Equally he could see his GP. It also provided a contact number for the crisis team for urgent/out of hours' support. Although there had been an attempt to personalise the letter, it had the appearance of being a proforma type letter. The letter was inadequate in conveying appropriate information to Mr Gillah's GP to enable him to perform the function which the letter alluded to in terms of facilitating Mr Gillah's mental health care. Following his discharge from mental health services Mr Gillah's mental health gradually deteriorated to a point where on 11 November 2015 his mother contacted Mr Gillah's GP with concerns over his mental health. Mr Gillah's GP advised that Mr Gillah should make arrangements to see him at his surgery. Mr Gillah did not see his GP following this, nor did Mr Gillah's GP follow up on his telephone conversation with Mr Gillah's mother. Subsequently on 20 January 2016 Mr Gillah was arrested on suspicion of being under the influence of alcohol or intoxicating drug. He was tested by a medical practitioner at Crawley Police Station and released without charge. Later that evening Mr Gillah's parents observed Mr Gillah's mood and became very concerned for his welfare. The next morning, 21 January 2016, Mr Gillah's mother contacted his GP relating these concerns. Again, the GP advised Mr Gillah's mother that Mr Gillah should attend his surgery so that he could see Mr Gillah. This did not occur and Mr Gillah's GP did not refer Mr Gillah's case to mental health services. Later that evening at around 2045 hours Mr Gillah was directed by railway staff to get off a train at South Nutfield station. Mr Gillah had been smoking on the train and had ignored previous advice from the driver that he could not smoke on the train. Mr Gillah subsequently moved onto the railway tracks and made off up the line in the direction of Redhill. A search was conducted along the tracks by Police and railway staff which was unable to locate Mr Gillah. Mr Gillah was subsequently struck by a train and died on the section of line between Redhill and Nutfield Stations at around 2210 hours on 21 January 2016.
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 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. – (1) The discharge letter written by KMPT on 24 April 2015 addressed to Mr Gillah, copied to his GP contained insufficient detail to assist Mr Gillah's GP to either

	understand the circumstances of Mr Gillah's discharge or the nature of the care delivered to Mr Gillah by KMPT, including the diagnosis of his mental illness. (2) KMPT failed to act in accordance with its policy to maintain telephone contact with discharged patients or their family at least every three months for a period of three years following discharge. This policy also states that within three years from discharge from the EIS, contact may be made by a discharged patient direct with Mental Health Services in order to receive treatment. KMPT procedures were inadequate in communicating this information to either the discharged patient, their family or others who may advocate for a patient's interests. No information is made publicly available, e.g. by way of leaflet or website, which explains the Trust's policy in this respect. (3) More broadly to those issues raised at (1) & (2), communication arrangements in existence within KMPT between staff engaged in the care of a patient and patient families who may be directly affected by decisions relating to the patient's treatment, were inadequate e.g. Mr Gillah's family were not consulted in relation to the decision to discharge Mr Gillah or received any formal communication in relation to the circumstances of Mr Gillah's discharge. (4) There was evidence received at Inquest which indicated that KMPT staff were unaware of KMPT policies relating both to the process of discharge and subsequent arrangements to be put in place concerning the maintenance of contact with patients and where appropriate their families.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 9 January 2019. 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 Persons; the Gillah family, [redacted] and the Care Quality Commission. 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	**16th November 2018** **Darren M. Stewart OBE**