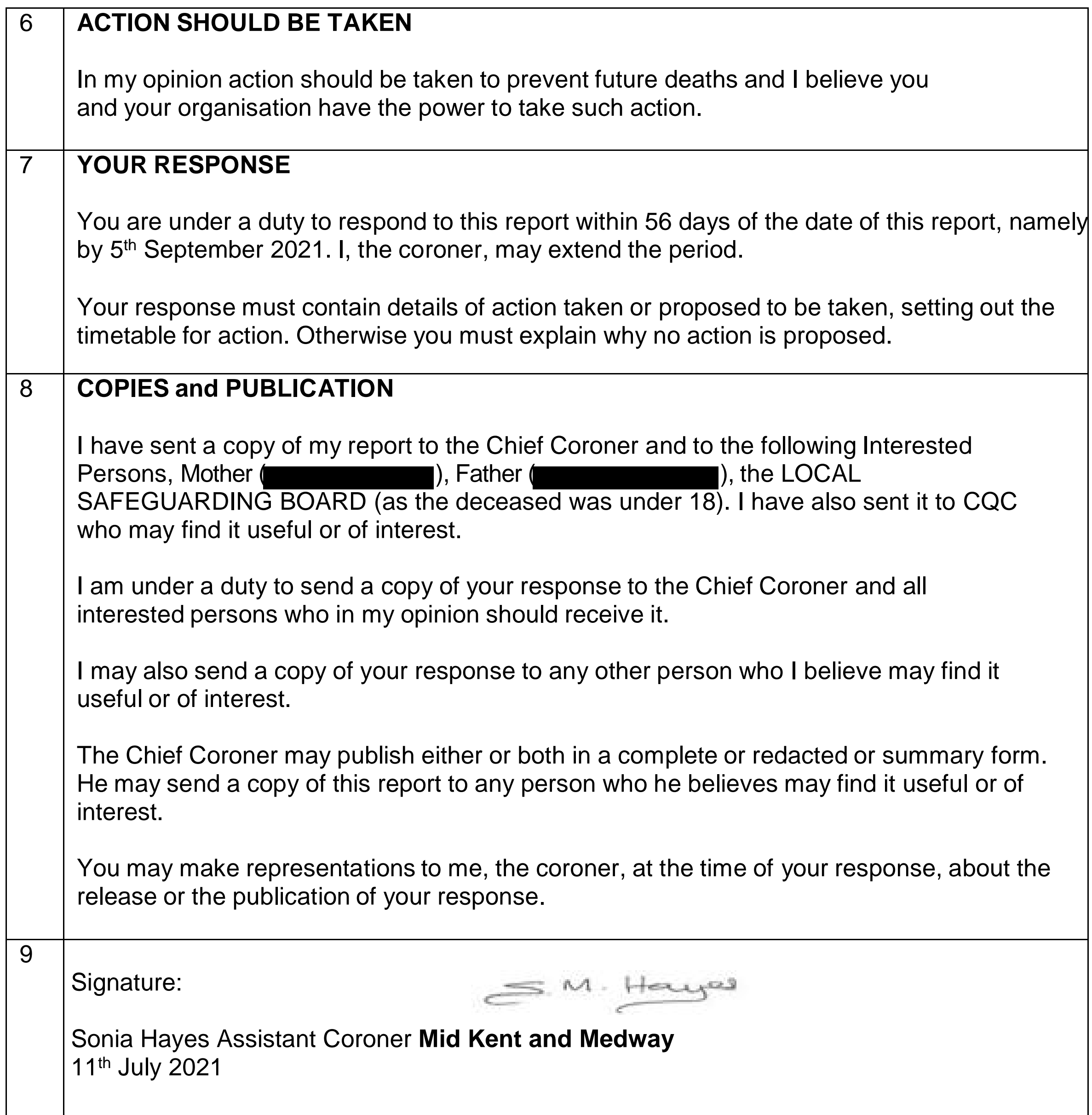
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used ***after*** *an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Officer North East London NHS Foundation Trust – Child & Adult ,Mental Health Services**
1	**CORONER** I am Sonia Hayes assistant coroner, for the coroner area of Mid Kent & Medway
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14 October 2020 an investigation was commenced into the death of ELEANOR ROSE MURPHY-RICHARDS otherwise ELLIS MURPHY-RICHARDS. The investigation concluded at the end of the inquest on 7th June 2021. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Ellis died on 30th September 2020 at Brielle Way, Sheerness, Kent of multiple traumatic injuries not compatible with life. Concerned bystanders on a footbridge Queensbury and Sheeress Stations spoke to Ellis for about five minutes but he refused to climb back to safety. He jumped from the footbridge onto a railway track into path of an oncoming train with the intention of ending his life, at approximately 16:41. Ellis had a history of self-harm and suicidal ideation including thoughts of and attempts to end his life overdose, ligatures and with attempts to jump from a footbridge and in front of an oncoming train that required informal admission to hospital for approximately four months. Ellis had been diagnosed with depression and emotional instability and continued to have episodes of self-harm and thoughts of suicide. Ellis was under the care of Child and Adolescent Mental Health Service on discharge in June 2020, with support from Assessment and Liaison Outreach and had an agreed safety plan in place that included Ellis attend Accident and Emergency at hospital if he could not keep himself safe, even with the support of others. Ellis engaged with community mental health services, was taking prescribed medication, disclosed thoughts of suicide and did seek support to keep himself safe.

	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 instructed Ellis and his family to attend a pre-scheduled appointment at 15:00 with his care coordinator. This was a deviation from the safety plan that was not risk assessed and the care coordinator was provided with limited information of a self-harm attempt. When Ellis was assessed at the Seashells Unit he was found to be suicidal requiring a mental health assessment for admission to hospital. The care coordinator sought advice from her manager about the plan should Ellis refuse to go to hospital and was informed that she should call the police. Ellis refused to go to hospital and insisted he did not want to live and left the centre, leaving behind his telephone and tablet device so he could not be contacted The care coordinator telephoned the police at approximately 16:05 who reported Ellis was missing and at imminent risk of killing himself and that he may attempt to travel by train to Faversham, his risks associated with jumping from bridges and in front of trains was not shared. The police updated British Transport Police at 16:28 that Ellis may attempt to board to go to Faversham.
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. Evidence was heard at the Inquest that: The Child & Adolescent Mental Health Centre provides services to children and young people, some of whom may require Mental Health Act assessment. There is no protocol or policy for those that require Mental Health Act assessment and will not voluntarily attend hospital Accident & Emergency. There was a Safety Plan in place for Ellis that included that he should go to Accident & Emergency if he could not keep himself safe, even with support. The **MATTERS OF CONCERN** are as follows. – (1) Ellis's 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 30th September 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's 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.



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 5th September 2021. 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, Mother (██████), Father (██████), the LOCAL SAFEGUARDING BOARD (as the deceased was under 18). I have also sent it to CQC who may find it useful or of interest. I am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent and Medway** 11th July 2021