Essex County Council

Children, Families & Education
County Hall
Market Road
Chelmsford
CM1 1QH

Area Coroner | Date: 25/04/2023

Dear Area Coroner

Re Regulation 28: Prevention of Future Deaths Report – Molly Sergeant

Thank you for your Regulation 28 report in relation to the death of Molly Ann Sergeant dated the 19th of February 2023, which was received by Essex County Council on the 1st of March 2023.

We would again take this opportunity to express our sincere condolences to Molly's family in respect of Molly's very sad death

You have raised your concerns in the Regulation 28 report that there is a risk of future deaths unless actions are taken. As requested, the information provided below is intended to describe the actions taken or being planned to significantly lessen the risk of the future deaths of young people through suicide.

Teenage Suicide is an area where there can be no guarantees or assurances that young people can be prevented from killing themselves through suicide. There have been 18 young people in Essex who have killed themselves through suicide over the past five years. The Essex Safeguarding Children Board carried out a detailed Thematic Review of Teenage Suicide in 2018 and are about to undertake a further review of the 18 deaths in the Spring of 2023.

You identified six Matters of Concern in the report, of which two (points 5 and 6) were specifically addressed to Essex County Council. These were:

(5) Essex County Council did not:

a. act on appropriate referrals to Social Care by Essex Partnership NHS Trust

b. conduct required assessments of Molly during her detention

c. did not appoint a social worker until after Molly was discharged. There was a lack of understanding of the impact of Molly's detention on her right to assessment as a child in need and how this changed during her detention under the Mental Health Act, and

(6) A lack of understanding of Section 117 Mental Health Act rights and potential for consideration for entitlements to meet Molly's needs related to her mental disorder, by Essex County Council:

a. compelling Molly to choose between family members as part of her discharge planning and then as a consequence changing Molly's status during her detention from homeless

b. Lack of assessment for any s117 needs to facilitate discharge; and

c. Lack of appreciation of the impact of Molly's autism diagnosis in a background of chronic suicide risk on decision-making and Molly's potential to understand the decisions being made.

We have taken on board your comments and criticism which you have set out in the Prevention of Future Deaths report. We accept that we do not always get it right, but we do continually strive to improve the way that we work with and interact with children, young people and their families, and how we deliver services to our families.

We fully acknowledge, as we did within the evidence submitted to the Inquest, that there were areas where we could and should have acted differently.

In summary, these were that

- Social Care should have remained involved with Molly as a child-in-need from April 2020 onward at the completion of the Children and Families assessment.
- Social Care should have become involved again earlier in the planning processes for Molly in respect of her discharge plans and arrangements, and to have been involved in the planning of the Section 117 after-care arrangements.
- Social Care should have responded to the requests from EPUT /EWMHS to allocate a Social Worker to Molly when she was still an in-patient; that a Social Worker should have been allocated to Molly in preference to the Family Solutions Service.
- The financial supports for Molly and her grandmother should have been clarified at a much earlier stage.
- All agencies needed to have more understanding about Section 85, Section 117 duties and responsibilities, and importantly clarity about the meaning of "financial support" within Section 117

It is not our view that these shortcomings. which we have fully acknowledged and have taken significant steps to ensure do not happen again, were causation factors or contributory factors which led to Molly's very sad death.

I think it is accepted that Molly lived within complex family circumstances and that there were a range of issues for Molly that were particularly difficult for her

It is not our view that Molly was made to choose between family members as part of her discharge planning; the only other feasible alternative for Molly would have been independent supported living accommodation, and no professional working with Molly thought this would be an appropriate option.

We described the national context in relation to young peoples' mental health in our previous submission to the Inquest, and that the Association of Directors of Children's Services had published a thematic report on children's mental health in November 2022 – which described a growing body of evidence that the mental health system was in need of urgent attention, investment and change. Despite these national concerns about the children's mental health system, we have in Essex made significant

changes in relation to our levels of awareness and developments in practice since 2020 when Molly died.

I will highlight the significant changes in awareness and practice which should ensure that the acknowledged shortcomings have been addressed and do not happen again

There are now weekly partnership meetings (from April 2022) at Senior Management level which specifically look at autistic young people and those with learning disabilities in Tier 4 (inpatient) beds. This meeting is chaired by the Director for Commissioning and Policy, Essex County Council and has representation from the Learning Disability /Autism Health Equalities Team (including Commissioners and Case Managers) , the Assistant Director of the Provider Collaborative (Mental Health), Regional NHS England representation , ECC's Head of Permanency and Placements, ECC's Director from Children and Families, the Head of Individual Placements (Health) and the Matron for the local Tier 4 beds. The meeting ensures regular oversight and governance of all the children and young people currently in a Tier 4 in-patient unit, including co-ordination of the multi-agency system to effect statutory obligations required to facilitate safe and sustainable discharge.

As part of the ongoing development of the Dynamic Support Register in Southend, Essex and Thurrock, "Of Concern" meetings are held regularly (monthly in Southend and Thurrock and weekly in Essex). During these meetings, young people and their families are considered to look at the co-ordination of support and whether additional support is necessary for those who might be at risk of escalation to hospital admission. This provides community-based oversight of risk management for those young people diagnosed with Learning Disabilities and/or Autism with complex mental health presentations.

There is a Mental Health Resolution Forum which meets monthly – this focuses on liaison and resolution issues between Children and Families, EWMHS and Tier 4 Specialist Commissioning. Core agencies are represented at Director / Head of Service level. This was established in 2018

There is now agreement that there will be a Child and Family Assessment for every young person admitted to an in-patient Tier 4 bed. This has been in place since January 2022 but has been re-emphasised to the Children and Families Hub and all operational social work teams since the Inquest. The initial communication stated that any young person admitted to a psychiatric in-patient unit is a child in need (by definition) and will receive a Child and Family Assessment. There is a specific audit being undertaken this Spring 2023 by our Professional Standards Unit to ensure that these are always taking place. The expectation is that the Young Person will have an allocated social worker throughout their stay as an in-patient.

There is a Mental Health Working Group which was set up in August 2021 within Children and Families (Social Care) with a wider focus on young people at different levels of need in relation to their mental health. This group meets bi-monthly. It is chaired by the Director with responsibility for Mental Health and has three main strands, focusing on mental health training, Section 117 planning, and Policy and Guidance. This Working Group feeds into the All-Age Mental Health Transformation Board and the EWMHS Board.

The re-write of the Practice Guidance and Care Pathway for Children and Young People who are admitted to in-patient units has been agreed by all the stakeholders - the Local Authorities, EPUT and EWMHS. All relevant agencies have been involved in the re-writing of this document and this has been incorporated into agencies' practice. There have been unforeseen delays in the formal sign off but this document will be published in late April 2023.

There is a pan-Essex SET Section 117 Protocol which was published in April 2022. This highlights the primary purposes of Section 117 and is intended to articulate a clear process by which multi-agency care planning in the context of Section 117 should be undertaken. It makes clear reference to the provision of accommodation issues within the Section 117 arrangements. It is currently a 26-page document.

There is also an internal Section 117 guidance working group which has been developed by the Leads for Mental Health within ECC. This is due to be published in Spring 2023. This will cover Section 117 duties and responsibilities, the Section 117 process, the Section 117 Panel.

There is also a specific Steering Group which oversees Section 117 responsibilities for ECC

Given the relatively small number of young people to whom Section 117 applies, we are proposing that whilst it is important that all operational front-line staff are clearly aware of the Section 117 duties and responsibilities, that there is a Single Point of Contact – at Service Manager level - to support social work staff in respect of the detail and the processes involved

In relation to training and awareness-raising sessions across Children and Families in respect of Section 117, Section 85 and autism awareness, there has been extensive mental health training that has taken place throughout 2021 and 2022 and the dates of this training were previously submitted to the Coroner. Further Section 117 training sessions took place in January 2023 and further courses are due to take place in May and July 2023. The Essex Social Care Academy is currently working on additional commissioning options in relation to further mental health training and autism awareness

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In relation to future developments, the pan-Essex Learning Disability / Autism Health Equalities Commissioning Team have successfully commissioned and launched a new Keyworker Service for autistic children and young people, and those with a learning disability, whom are on the Dynamic Support Register (a register which hold a list of those individuals most at risk of a Tier 4 admission) on behalf of the Southend, Essex and Thurrock Transforming Care Partnership. Keyworkers are allocated to each young person based on risk stratification and work on behalf of the child, young person and their family to help them navigate the system whist holding the system to account in respect of their statutory duties, e.g. development / execution of plans of care. The Service launched on schedule in March 2023, and all individuals currently in an in-patient bed have been offered /allocated a Keyworker.

This is a nationally mandated requirement overseen by NHS England as part of the Long-Term Plan and is managed locally through the Transforming Care Programme.

The Learning Disability / Autism Health Equalities Team are commissioning a new all-Age Autism Outreach Service across 2023/24. This is in response to the acknowledged commissioning gap for autistic people, and will be an offer of specialist support (including a crisis response) sitting within community-based Tier 3 services

The draft Section 117 practice guidance will be completed in the Spring 2023, and a “Thinking Practice Tool “will be produced to assist staff in relation to the issues involved in Section 117 planning.

The consideration of funding for the needs of young people in respect of Section 117 now goes to the Multi-Agency Resources Forum jointly chaired by Social Care and EWMHS.

There was a Child Safeguarding Practice Review in respect of Molly conducted on behalf of the Essex Safeguarding Children Board and chaired by an Independent Lead Reviewer who gave evidence to the

Inquest. This report was published on the ESCB website on the 2nd of March 2023 and there are de-briefing sessions, both Countywide and in North Quadrant where Molly lived, in April and May 2023

In summary,

5 a. We have undertaken training and awareness raising with the Children and Families Hub (first point of contact) and our operational teams that referrals to Social Care must be forwards to the appropriate team for assessment

5 b. We have clarified that every young person in an in-patient unit is (by definition) a child-in-need and will have a Children and Families assessment; and the young person needs to remain open to Social Care, who must be involved in the planning for the discharge arrangements

5 c. as per 5b above - this is clearly understood. In our view the child in need status does not change during the period that the young person is an in-patient, but what changes are the rights and entitlements under Section 117

6 a. There has been widespread focus and awareness raising in relation to Section 117 and Section 85 as a result of the Child Safeguarding Practice Review and the Inquest itself

6 b. We have emphasised to all staff that Social Care has an integral part to play in the discharge planning and arrangements for any young person subject to Section 117

6 c. The current practice developments and the future plans will ensure that all young people with autism in an in-patient bed will have a keyworker from the specialist Learning Disability /Autism Team

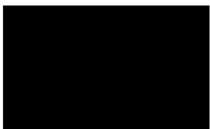
We hope that this has been a detailed response that will re-assure you as to the seriousness with which we have treated this matter and the importance of learning from Molly's sad death.

Thank you for bringing these important issues and your concerns to our attention

I hope this response helps to address the concerns set out in your report

If any further information or assurance is required, please do not hesitate to contact me

Yours sincerely



Director for Safeguarding

Essex County Council