



Kent and Medway

Chief Nursing Officer's Directorate

NHS Kent and Medway

2nd Floor, Gail House

Lower Stone Street

Maidstone

ME15 6NB

Mrs Catherine Wood
Area Coroner,
Mid Kent and Medway

Sent via email

Dear Mrs Wood,

Inquest into the death of Ella Louise MURRAY

I write in reference to the Prevention of Future Death Report made on 7th February 2025 to [REDACTED] Secretary of State for Health and Social Care, [REDACTED] Chief Executive NHS England and the Kent and Medway Integrated Care Board (ICB).

Thank you for sharing your concerns with us. We have liaised with Medway Foundation Trust (MFT) and North East London Foundation Trust (NELFT - who are the provider for children's and young people's mental health services in Kent & Medway) in the compilation of this response.

NHS Kent and Medway is a commissioner of health services and the health lead statutory safeguarding partner for both children and adults. Please note that neither the ICB Safeguarding team or the Child Death Review team had direct contact with Ella or her family.

Ella was known to North East London Foundation Trust's Children and Young People (NELFT) services who are commissioned by NHS Kent and Medway to provide child and adolescent mental health services.

I outline below the chronology of events following notification of Ella's death, from a Child Death Review perspective, which the ICB Safeguarding Team participates in.

The Kent and Medway Child Death Review Service (CDR) were notified on 16/11/23, within 24 hours of Ella's death, by both Police and Kings College Hospital, in line with statutory guidance. The Initial CDR standard operating processes were followed; a notification of death was sent out to all known involved partners, and involvement summaries requested.

A Joint Agency Response (JAR) meeting was scheduled for 20/11/23 (delayed only by the weekend). A patient summary was received from her general practitioner (GP) on 16/11/23, as well as information from social care, stating that Ella was known to Kent Integrated Children's Services, and with contact details for the relevant team. Social care informed the Child Death Review team that an initial strategy meeting had already taken place and details from the meeting were shared.

'With You' charity identified to the Child Death Review (CDR) team on 16/11/23, a summary of their involvement, and Kent Community Health Foundation Trust (KCHFT) shared that Ella was not open to any KCHFT services at the time of her passing, but that she had recent school health involvement for counselling. From KCHFT records they believed Ella was also known to mental health services. It has been confirmed that Ella was known to North East London Foundation Trust (NELFT) who provide mental health services.

On 20/11/23 the named nurse for safeguarding at Maidstone & Tunbridge Wells Trust (MTW) informed the Child Death Review team that Ella had not been seen by this Trust in any capacity.

The Joint Agency Response was well attended on 20/11/23 and chaired by the Designated Doctor, supported by the Child Death Review team, including specialist nurse and family liaison team. There was representation at the Joint Agency Response from NELFT; Primary Care; Kings College London NHS Hospitals Trust (King's College Hospital); Education - Safeguarding; Designated Nurse for Safeguarding Children, South East Coast Ambulance Service (SECamb); Kent Children's Social Care; Police and Schools. Actions from the Joint Agency Response were that there would be a further strategy meeting on 23/11/23; that NELFT would send chronology reports to CDR team; that there was a Section 47 (A Section 47 Enquiry is initiated to decide whether, and what type of, action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm) now in place for all children; and a request for clarity on the location of Ella's death.

At the Joint Agency Review the link to Ella potentially knowing two other young people through school/ the local rugby club, who sadly died by suspected suicide, were identified by Police/ school. Joint Agency Review attendees were informed that the school were already seeking support for students and staff, and Police were going to reach out to the rugby club to ensure they had access to support for other rugby club members.

For all suspected child death by suicides, the Child Death Review team routinely links with the Kent and Medway Integrated Children's Services Suicide Prevention Programme Manager, based in Kent County Council's Public Health Team, for the purpose of monitoring, prevalence, and intelligence across Kent. Ella's case was shared and the suspected link with two other recent deaths also noted.

The Child Death Review team were notified by Kent Safeguarding Children Multiagency Partnership (KSCMP) on 27/11/23 that a notification for a Local Children Safeguarding Practice Review (LSCPR) had been received and that a Rapid Review would be convened.

On 01/02/24 the coroner's office confirmed that Ella did not have a post-mortem; the cause of her death had been confirmed as asphyxia due to hanging and that the coroner would bring Ella's case to inquest.

06/02/25 Child Death Review team informed by Designated Nurse that Local Children Safeguarding Practice Review had been published on the Kent Safeguarding Children Partnership Board (KSCPBoard) and link to the report.

25/03/25 – Ella's case was presented at a Child Death Review Meeting, which convened and was chaired by Kings College Hospital for the purpose of review and analysis, and identified matters relating to the death, contributory and modifiable factors. Kent and Medway Child Death Review team and Designated Doctor attended, alongside representation from Kent Safeguarding Children Multi-Agency Partnership, North East London Foundation Trust, and Education. Matters of concern from the Preventing Future Deaths (Regulation 28), were discussed and reviewed, and details from the published Local Safeguarding Children's Practice Review were shared and action updates given. Following the Child Death Review Meeting, Ella's case review will be presented at Kent & Medway Child Death Overview Panel.

The specific action for the Child Death Review Team from the published Local Safeguarding Child Practice Review (LSCPR) for Ella and her older sibling was as follows:

The Kent and Medway Child Death Review team will ensure any groups e.g. any sports teams/ etc. are routinely considered as part of the Child Death Review process to meet this recommendation.

In response to this, the Kent and Medway Child Death Review team have confirmed that it is already routine practice to involve known organisations in child death processes as soon as they are identified following a death, as per the Child Death Statutory Guidance. In order to evidence this further, the Child Death Review Team will be undertaking an audit within this cohort of children.

Work has commenced a system wide Child Death Review process, to ensure appropriate gap analysis is mapped to the new NHS England Child Death Protocol and in preparation for the soon to be published Independent Review into Kent & Medway's Child Death arrangements.

Feedback from the Rapid Review following notification for a formal Local Safeguarding Child Practice Review (12/12/23)

Following the Joint Agency Review on 20/11/2023, NHS Kent and Medway Designated Nurse for Safeguarding Children made a Serious Incident referral for Ella's death, as per the local Kent Safeguarding Children's Partnership process. As a statutory safeguarding partner, NHS Kent and Medway, have a responsibility to inform the other safeguarding partners of serious incidents they think should be considered for a practice review.

Following notification to Kent Safeguarding Children Multi-Agency Partnership (KSCMP) of Ella's suspected death by suicide, where neglect may have been a feature, a decision to notify the Child Safeguarding Practice Review Panel was made. Requests for agency information were sent on 27/11/2023. This included requests to NHS Kent and Medway (for GP information) and Health Providers across Kent and Medway. Summaries were presented to a virtual Rapid Review Group on 13/12/2023 and the Groups recommendation was sent to the Child Safeguarding Practice Review Panel. Single agency summaries from health identified learning and actions, such as practitioners to employ professional curiosity during assessments and, where there is disparity between the voice of the child and parent wishes, that practitioners should make a conscious effort to explore and explain the potential impact of non-engagement of the child to the parent.

A Local Child Safeguarding Practice Review (LSCPR) was undertaken. The period under review and scope was June 2019 and November 2023. The Local Child Safeguarding Practice Review considered Ella and her sister, it focused on multi-agency safeguarding practice and the factors that support good practice, as well as identifying what areas of safeguarding practice might have been different to enhance future practice. Four themes were identified that the analysis draws upon. Within theme one there is a section on including making referrals or requests for support and decision making as well as identified learning.

The Local Child Safeguarding Practice Review overview report was published on 30th January 2025. Recommendations within the report are being actioned and monitored via the multi-agency safeguarding arrangements in place within the Child Death Overview Panel and via the Learning Implementation Group.

Kent and Medway safeguarding team have been supporting NELFT in response to an outstanding recommendation for a related Rapid Review which may support the Regulation 28 response for Ella.

NELFT held a multi-agency meeting and have agreed to formulate a child focussed safety plan, this will be shared with the child's school (and social worker, if identified) for every child who has a safety plan. Alongside this, NELFT have agreed to develop an escalation flow chart for professionals, to include a Single Point of Access contact and Multi-Disciplinary Team meeting escalation process. This would include the sharing of the safety plan with other necessary agencies and points, in which referrals to social care for escalation should be completed. Once rolled out an audit will be completed, which will meet the recommendation outlined in another Local Child Safeguarding Practice Review.

As part of the ICBs response to a number of suicides of children and young people during 2023, a series of learning events have taken place. The first focused on North East London Foundation Trust (NELFT - our children and young people mental health services provider) and their learning as an organisation. The second focused on the patients' and their families' perspective to ensure their voices were engaged as part of wider learning. The third focused on system wide/inter agency working in November 2024. This event will culminate in a system wide improvement plan that will include a focus on agency information sharing, risk assessments and decision making among others. Work on a shared risk protocol across system partners has already commenced.

The work undertaken by NELFT as part of the system wide action plan is summarised below and relates specifically to how they are enhancing information sharing processes: -

- A Professional Consultation line is now operational in their Single Point of Access
- Raising staff awareness of the need to share information with other agencies as per risk management and safeguarding principles
- Delivery of training around Consent, GDPR, Mental Capacity Act and Gillick Competence
- Gathering consent (from young people and their families) to share information with other agencies at point of referral (through our single point of access)
- Training programme for Risk Formulation developed for rollout across the organisation for children and young people, moving away from risk stratification
- Safety planning advice sheet developed and shared with partner agencies to enhance access to NELFT services for consultation regarding cases of concern
- Safety planning advice developed for young people, their families and carers to highlight the support NELFT offer and how to access other suitable agencies
- Work with Kent and Medway Care Records colleagues to enhance the information available on this platform to other healthcare providers

In addition, Kent & Medway ICB has implemented the Kent and Medway Care Record (KMCR), which supports inter agency access to health and social care records. The level of visibility recommended is largely in place, although continued work to support use of the system is ongoing. There are no current plans to have a direct interface between education and the KMCR, but Kent County Council front door teams, who act as a single point of contact for requests for support at an intensive level or above for children, young people and families, ensuring these requests are directed to the appropriate service for ongoing support

and intervention all have access and can communicate information, where applicable to colleagues

I hope this letter provides you with assurance that actions have been taken to address the concerns raised.

Yours sincerely

[Redacted Signature]

Signed on behalf of

[Redacted Name]

Chief Nursing Officer
NHS Kent and Medway ICB

Chair | [Redacted]
Chief Executive | [Redacted]

Together, we can



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