NHS England

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28 March 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Ella Louise Murray who died on 15 November 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 7 February 2025 concerning the death of Ella Louise Murray on 15 November 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Ella's family and all those who loved and cared for her. NHS England are keen to assure the Coroner and Ella's family that the concerns raised about Ella's care have been listened to and reflected upon.

My response to the Coroner focuses on those areas of concern that sit within NHS England's national policy or programme remit. It would not be appropriate at this juncture for NHS England to provide comment on actions taken by Kent & Medway Integrated Care Board, Kent Social Services or the Local Authority involved in Ella's care.

You have raised various concerns in your Report, including that there was a failure to undertake an adequate, or any, risk assessment and take any further steps to ensure Ella's safety, including urgently removing Ella either to a hospital bed or otherwise liaising with social services. You have also raised the concern that there was no shared access to records for all agencies and no way to convene an urgent multi-agency meeting.

Your Report echoes recommendations made from previous reviews into suicides of children and young people (CYP). The 2020 Kent Safeguarding Children Multi-Agency Partnership Review of Suicide in Children and Young People noted concerns about the risk assessment process and warned against using short-cuts or abridged assessments in place of more thorough processes. The review also recommended that school teaching staff were better integrated into interprofessional safeguarding networks, a change that HM Coroner's Report suggests would have better supported Ella.

Both the Kent Safeguarding Review and the 2021 National Child Mortality Database (NCMD) Suicide Report, published in October 2021, recommended improved information sharing between agencies. Across the 108 deaths included in the NCMD

Report, the most common issue reported was poor communication and information sharing between professionals. The second most common issue was poor quality referrals.

As your Report raises, the 2024-25 Children's Wellbeing and School's Bill will address these concerns. The Bill strengthens the role of education in multi-agency safeguarding arrangements as well as creating a clearer legal basis for information sharing. This is facilitated by the inclusion of a common identifier.

Ella's case includes learnings for teams across NHS England and local organisations, as well as more broadly. It is NHS England's understanding that Kent and Medway Integrated Care Board will be responding to the Coroner separately with a system-level response detailing the local actions taken. NHS England will consider the ICB's response in due course. My colleagues from national NHS England teams have also provided the below input.

National CYP Mental Health Team

Integrated Care Systems (ICSs) are a vehicle for integrated planning, to ensure that those who need it have access to comprehensive mental health support which is integrated across health, social care, education, and the voluntary sector. The vision for greater local system integration and autonomy is being implemented for specialised mental health, learning disability and autism services, by giving responsibility for a given population to Provider Collaboratives. Provider Collaboratives will improve links to other care settings, to improve the whole pathway and reduce reliance on the most specialised services by reinvesting in community provision.

National Safeguarding Team

The NHS England South East regional safeguarding team will, through established governance arrangements, have oversight of Kent and Medway Integrated Care Board's actions to implement the learning to improve safeguarding at both the Local Safeguarding Children Partnership and within all commissioned services.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Ella, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]
National Medical Director