Mid Kent and Medway Coroners' Service
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Telephone: [redacted]
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Date: 7 February 2025
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Secretary of State for Health and Social Care, [redacted], Chief Executive NHS England and the Kent and Medway Integrated Care Board.

1. CORONER

I am Mrs. Catherine Wood, Area Coroner for Mid Kent and 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 23 November 2023 I commenced an investigation into the death of Ella Louise Murray who was 13 years old at the time of her death. The investigation concluded at the end of the inquest . The conclusion of the inquest was suicide plus a narrative "Ella died as a consequence of hanging herself shortly after being seen by mental health care professionals. She intended to end her life and had told the mental health team she would do so or would harm others so that she would go to prison. There was a failure to undertake an adequate, or any, risk assessment and take any further steps to ensure Ella's safety on 14 November 2024."

1a Asphyxia due to Hanging

1b

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

Ella was 13 years old when she died at Kings College hospital on 15 November 2023 as a consequence of asphyxia due to hanging.

Ella had a history of self-harm and had taken 2 overdoses, the first in December 2022 and the second in August 2023, with a self inflicted burn in February 2023 requiring treatment at a specialist burns unit. Ella's home life was complicated and she had been involved with social services in the form of Early Help intervention in the Autumn/Winter 2022/2023 although their involvement ended in February 2023. She had also been referred to school counselling services due to concerns about her mental health with low mood and suicidal ideation and was seen by a counsellor between April and July 2023. Her counsellor was able to provide some support but referrals made to the child and health adolescent mental health services were not progressed further. She was seen by the Crisis team from mental health services after her August overdose but declined further support from them and it was unclear if this was Ella or a combination of Ella and her parent's choice.

A referral had been made by her school to social services in July 2023 when Ella disclosed a sexual assault to a member of staff at the school. Social services did not speak to Ella in July and having spoken to her mother considered that she did not reach their threshold for engagement and the school raised their concerns about this at the time. In the Autumn term there were clear signs that Ella was struggling at school and had said she wanted to move schools, a further referral was made to social services in September 2023 and Ella disclosed the name of the person who she said had assaulted her and the member of staff was duty bound to act on this disclosure and involved police. This led to some friction and there were discussions about how to support Ella but some conflict arose between school and home about the best way to deal with this and Ella's behaviour at school, including not attending lessons.

Over the weekend of 10-12 November 2023 Ella had been out with friends and had a sleepover and came back tired and her parents found some messages on her phone which were deemed inappropriate by them. On 13 November 2023 Ella disclosed to a member of staff at school that she wanted to kill herself. The school completed a high risk mental health form for Ella to take with her to hospital and made arrangements for her to be picked up and taken by family to hospital.

Ella was taken to Medway Maritime hospital by her stepfather and triaged and referred to the Crisis Team at a separate Mental Health Trust and a member of their team came to assess her in the emergency department. She was seen and reported her mood as low but denied intent to end her life but reported ongoing self-harm and suicidal ideation and requested an admission to hospital. She was assessed as being of medium risk of harm and a decision was made to see her at home by other members of the mental health team.

That evening she argued with her parents and ran away from home barefoot and a stranger called the police on her behalf. She told police she was frightened of her stepfather and was worried about returning home. Whilst on the call to police her Mum arrived and took her home giving the call handler their address as she left. The police followed up the next morning.

Ella was kept off school the next day and a member of the mental health home treatment team visited in the afternoon. Her documentation shows that she was aware that Ella had run away from home and that she said she would harm herself or others in order to go to prison and was documented as being suicidal and was hearing derogatory voices. The nurse contacted the safeguarding team at 16.02 after she had seen Ella and made a referral to social services.

Ella's mother was on the telephone after the nurse had visited and went up to Ella's room where she found her hanging [redacted]. She called an

ambulance and began cardiac massage on her daughter. The ambulance arrived and the crew continued with resuscitation attempts and a return of spontaneous circulation was obtained. Ella was taken by helicopter to Kings College hospital and was deeply unconscious on arrival and was admitted to critical care where she died shortly after 2pm on 15 December 2023.

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 will 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)During the course of the inquest it became clear that Ella was a child in a complex family situation and showing signs of deterioration of her mental health. Her school had raised concerns about her with social services and taken steps to make sure she was seen by healthcare professionals when she indicated to staff at school she wanted to end her life on 13 November 2023. She was assessed by mental health nursing staff and accepted to the caseload of the Intensive Home Treatment Team. She was seen the following day and told the staff nurse who saw her that she was frightened of her stepfather and had run away from home barefoot and police called but she was brought back home by her mother who "grabbed her face" the morning she was seen. She told the nurse that she did not want to be in the family home and would rather go to prison and would harm herself or others is she had to stay at home.

(2) This disclosure led to the nurse making a Safeguarding Referral but this was made after she left Ella's home and no urgent steps were taken to remove Ella either to a hospital bed or to ask social services to consider if she should be removed from the family home. Her school had raised concerns about her and she herself had indicated she wished to end her life. Evidence heard at the inquest was that this was the procedure in place and there is no shared access to records for all agencies and no way to convene an urgent multi-agency meeting to determine if Ella was safe to remain at home. Had steps been taken to share information between her school, social services and the mental health providers when she attend the emergency department on 13 November 2023 or early the following day rather than leave her at home she may have been removed from her home and may still be alive today.

(3) Whilst there were concerns about the level of risk assessment undertaken on 14 November 2023 senior staff at the Trust gave evidence that she did not meet the criteria for admission to a hospital bed. This was difficult to reconcile with the documentary evidence as she was clearly crying out for help and her school had recognised this. No one agency involved had access to all the relevant information and concerns about Ella across the health, social care and education arenas. Evidence given suggested that shared records would assist but the ability to respond to urgent concerns would require a system change.

(4)It was brought to the court's attention that the new Children's Wellbeing and Schools bill includes a duty to share information to promote safeguarding. In addition the local authority may convene a strategy meeting under s47 of the Children Act 1989 although the speed of convening a meeting would depend on availability and would obviously not be as swift as for example attending an accident and emergency department. If a multiagency meeting had been convened this may have prevented Ella's death and such action may reduce the risk of death for other children being in a similar position.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 4 April 2025. 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 Ella's parents and grandparents, North East London NHS Foundation Trust, Kent Social Services Department, Medway MNHS Foundation Trust, Kent Police and Highstead School and to the Kent and Medway Safeguarding Board.

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.

7 February 2025

Signature 

Catherine Wood, Area Coroner for Mid Kent and Medway