MENTAL HEALTH

Track records

A CORONER has had to stop an inquest into the death of a young man after it emerged that the mental health trust in charge of his care had failed to disclose potentially vital information to investigators.

The coroner for Essex, Sean Horstead, said it was not the first time Essex Partnership University NHS Foundation Trust (EPUT) had been found to be sitting on records which clearly should have been disclosed. Postponing the inquest of 19-year-old Chris Nota *(pictured)* until the new year, he said it was "beyond disappointing" that the hearing, which had been subject to repeated pre-inquest reviews, had not been able to conclude, adding to the distress of his family.

It is even more astonishing that it should happen when EPUT is already under the spotlight. A government-ordered, non-statutory inquiry is under way into the deaths of 1,500 people, including children and young adults, who have died unexpectedly since 2000 while mental health inpatients in Essex or within three months of discharge. Adding to the trust's woes, last week an undercover report by Channel 4's *Dispatches*, filmed over three months, revealed abuses of distressed and vulnerable patients on two of its acute mental health wards.

The inquest at Chelmsford had been examining exactly what care and support Chris, who had been diagnosed with autism and learning disabilities, had been receiving when on 8 July 2020 he fell from a height in Southend. Following concerns raised by his mother, Julia Hopper, EPUT had commissioned a "serious incident" investigation by Niche Health and Social Care Consulting.

However, after 13 days of inquest evidence it emerged that Niche investigators had not been provided with key correspondence between clinicians about Chris. That included an email from Dr Carla Villa, a consultant psychiatrist in the psychosis team, to colleagues just eight days before Chris's death. It said: "Plans have failed too many times in the last few weeks, [Chris] can't keep himself safe, we are not able to help him remain safe either… It will be [us] (God forbid) going to the Coroner's court…" Chris's mother had also repeatedly raised concerns about her son being discharged into community accommodation.

Lynnbritt Gale, EPUT's director of community delivery, offered a "humble apology" to the court and to the family for the "inconvenience, upset and delay that this omission has caused". She said she would have expected clinicians to bring all relevant evidence to the attention of the internal investigators when they were interviewed.

Although the coroner did not identify the other case where the trust had been criticised for failures of candour and transparency, it is believed he was referring to the inquest he conducted into the death of Bethany Lilley, a 28-year-old Essex healthcare assistant. Bethany died in January 2019 from a ligature while a patient at the Basildon Mental Health Unit. An inquest jury concluded that neglect by the trust had contributed to her death. She had experienced complex mental health difficulties and had been diagnosed as having an emotionally unstable personality disorder. She suffered a serious deterioration in her mental health following the unexpected death of her father in late October 2018. That led to a rapid escalation of self-harming and suicidal behaviours and repeated hospital admissions.

Her final stay began on 9 January 2019. She was able to take her own life just a week later, after the level of observations she was supposed to be under was reduced. Among a catalogue of neglect identified by the jury were failures in carrying out risk assessments and in relation to record-keeping and documentation, which were not admitted and only uncovered during the inquest.

Jodie Anderson, senior casework at Inquest, which has supported many of the bereaved Essex families, said: "It is deeply concerning that this trust, already subject to an inquiry, has now twice in the space of six months also been criticised by a coroner for disclosure failures which have been revealed by chance during the inquest process. Such conduct is indicative of a deeply rooted culture of defensiveness, delay and denial. The government must act now to commission a full statutory public inquiry with powers to compel evidence and witnesses, and make robust findings and recommendations for change."