INQUEST
Truth Justice Accountability

6 January 2023

MEDIA RELEASE

Chris Nota: multiple significant failures in care by EPUT contributed to the death of a remarkable young man with autism and learning difficulties

Before HM Coroner Sean Horstead
Essex Coroner's Court, Seax House
Opened 12 September 2022
Concluded 6 January 2023

Chris Nota, 19, had been under the care of Essex mental health services when he died on 8 July 2020, after falling from a height in Southend. An inquest has now concluded finding that multiple significant failures in his care contributed to his death.

The inquest which initially opened on 12 September 2022, was abruptly adjourned on 30 September as a result of a failure by Essex Partnership University NHS Foundation Trust (EPUT) to provide thousands of pages of correspondence between clinicians and other professionals about Chris and his care to independent investigators.

Chris was from Southend on Sea, Essex. His family describe him as a beautiful soul, a streak of light who was full of love, laughter and gentleness. They say Chris had "an aura of sunshine and innocence" around him, but in later years clouds too. Chris loved Chelsea Football Club and Southend United, as well as trains and airplanes.

Chris had an autism diagnosis, learning disability, epilepsy and experienced mental ill health. His family say it sometimes felt as if the world was the wrong shape for Chris. Chris remained in mainstream school, but faced many challenges and suffered from depression and anxiety throughout his teens.

At the start of 2020, Chris found it increasingly difficult to cope, turning to cannabis for relief. On 6 April 2020 he was reported missing by his family and later that day he was found sitting on the edge of a bridge. He was detained briefly in hospital (under section 136 of the Mental Health Act), but he was discharged the following day.

In the following 11 weeks, Chris spent only 13 days in the community. The remainder of that period was taken up by repeated failed discharges from hospitalisations in A&E and on mental health wards.

The independent investigators described that Chris' *"brief periods in the community following discharge were characterised by… high risk behaviours (particularly being found on bridges or overpasses)"*, and that indicators suggested *"such behaviours were likely to be repeated each time he was discharged"*. Despite this, Chris was repeatedly permitted to discharge himself from hospital.

His final admission was to the Basildon Mental Health Assessment Unit on 27 June 2020, after Chris was able to leave the residential placement, Hart House in Southend-on-Sea, to which he had previously been discharged, without challenge by staff. He was found on a nearby bridge by a concerned member of the public who alerted emergency services and was taken to hospital by paramedics.

The Coroner noted that email exchanges between consultants discussing making Chris homeless were "*inappropriate and unprofessional*", and specifically noted that this was not the first occasion that he had encountered inappropriate and disparaging comments of that kind being made in inquests involving EPUT clinicians. He agreed with the independent investigators that "*inappropriate judgements*" were made about Christopher's mother "*with little or no understanding of the complexities of the home environment that she was managing*". This lead to the identification of and admission to Hart House being rushed, given the lack of expertise and experience of staff there in how to manage Chris and mitigate his risks.

On 29 June, Chris asked for his antidepressant medication to be stopped, and to be discharged. Dr Blaga Carr, the lead Consultant Psychiatrist for the unit who assessed Chris on 29 June, said that she had previously been told about Chris visiting the bridge, but had not been aware he was on the wrong side of the railings before being taken away. Dr Carr told the inquest that *"I really didn't have grounds to keep him in hospital because he had improved in his mental state and he didn't display psychosis or depression or intent to hurt himself in any way."*

During the inquest, however, Area Coroner Sean Horstead referred to a document titled "Irregular Discharge Against Medical Advice", apparently signed by Chris on 29 June, confirming he was discharging himself against the advice of Dr Carr and that he would accept responsibility for his actions. Dr Carr accepted in evidence that she might have "forgotten" about the document, which contradicted her evidence –which the Coroner said "impossible to reconcile", noting that asking such a vulnerable young man to sign a self-discharge form was "a cause for concern".

Notwithstanding the level of concern expressed by ESTEP clinicians that day, Chris's discharge summary from hospital recorded he had "*low risk of self-harm and suicide*" – which the Coroner described as a "*breakdown of communication*". The Coroner described Chris's discharge as "*flawed*" in the absence of a formal capacity assessment which was "*both sensible and required in the context of risks which had been self-evidently escalating over a number of weeks and days*". Both the Coroner and the independent investigators concluded that Chris was allowed to leave hospital without all avenues for keeping him safe having been explored.

The inquest heard that, by June 2020, EPUT's Essex Support and Treatment for Early Psychosis team (ESTEP) who had the lead for Chris's care, were seriously concerned about their ability to keep Chris safe in the community.

On 29 June, the ESTEP clinical lead, Richard Weidner, emailed various professionals involved in Chris' care after the decision to discharge him, stating *"No amount of expertise and/or intensive monitoring can safeguard someone who will act in this way without any trigger or warning."*

In an email to ESTEP colleagues on 29 June, Dr Villa (the ESTEP Consultant Psychiatrist) stated that "*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… God forbid [we are] going to the Coroner's court"*. In her evidence at the inquest, Dr Villa told the coroner: *"There were no contingency plans in place to meet Chris' needs in the community."*

Despite this, Mr Weidner's assessment of Chris on 1 July 2020 recorded that there was "*no evidence of imminent risk and therefore no grounds on which to request an MHA assessment*" – which was never done.

Both the Coroner and the independent investigators concluded that *"the absence of [this] information in Chris' clinical record would have led staff to underestimate the risks that Chris was presenting with, and the degree of concern held by staff in his community team"*.

Ten days later, Chris was able to leave Hart House again and returned to the same bridge. Emergency services were called, but he ultimately fell and died.

Throughout the months preceding this tragic event, Chris' mother, Julia Hopper, repeatedly raised concerns about the lack of tailoring of Chris' care to reflect the challenges presented by his dual diagnoses of autism and learning difficulties. The Coroner found that these "*vociferous, ferocious and consistent requests for appropriate treatment"* by Chris's mother, Julia Hopper, were not acted upon, and clinicians failed to treat her as an "*invaluable resource in the care and treatment of her son*" as they should have done. This, said the Coroner, was a "*significant shortcoming*" in Chris's care. Julia's, said the Coroner, was a voice that should have been heard, and was not.

The Coroner concluded that a senior clinician with expertise in autism and learning disability should have been involved in Chris's care at an early stage; and that the failure to do so led to "*a weight of responsibility*" on Chris's Care Co-ordinator, Kirsty Lister, that would "*inevitably overwhelm her*" and left her with "*an unmanageable responsibility*" for Chris's care, despite the "*incredibly risky behaviours he was demonstrably engaged in*".

In their evidence at the inquest, investigators echoed this, stating *"having proactive involvement from someone with expertise in learning difficulties and autism, in our view, would have made a substantial difference to Chris' care management and treatment"* and gave evidence regarding the research on the links between autism and mental health needs, including suicidality which is 7 to 9 times more likely in those diagnosed with autism (which did not feature in any of the assessments of Chris' risk).

Concluding that "some basic elements of care management and treatment were missed" in his case, the Coroner found that Chris' death was contributed to by the following issues:

a) The lack of autism-focused approach to the assessment of Chris's mental health and his care planning, including:

    i. Insufficient consideration of the impact of Chris's autism on his presentation and communication, leading to inappropriate decisions being made about his mental health care and treatment;

    ii. A lack of understanding of the increased risk of suicidality in those with autism, which did not feature in any of his risk assessments and meant he did not have an appropriately targeted safety plan;

    iii. A failure to make reasonable adjustments to account for Chris's autism;

    iv. A lack of understanding as to how learning disability/autism-informed input could be provided on the issue of Chris's substance use;

b) A failure to give sufficient consideration to detaining Chris under Section 3 of the Mental Health Act (MHA) 1983, in light of the need for rapid re-admission following Chris's previous failed hospital discharges; his very high-risk behaviour in the community; and the fact that less restrictive options (i.e., community treatment and continued placement at Hart House) were recognised as being insufficient to maintain his safety from at least 16 June

2020. Absent a formal assessment of capacity the decision to allow Chris to discharge himself from the Basildon Mental Health Assessment Unit on 29 June 2020, without all avenues which could have kept him safe on the ward being explored was flawed.

c) Inadequate assessments of Chris's capacity, including:

i. Poorly documented and confusing mental capacity assessments, which did not adequately set out the salient information for each decision separately, and did not explicitly consider Chris 'masking' or his executive functioning;

ii. The lack of any autism specialist input into assessments of Chris's mental capacity, and a lack of leadership and peer review from any consultant-level practitioner with appropriate expertise to support Chris's care co-ordinator and the professionals assessing his capacity, was a significant failure leading to assessments being undertaken by professionals who were insufficiently experienced in understanding the impact of autism on Chris's presentation, particularly in relation to his substance misuse;

d) Insufficient consideration of the views and concerns of Chris's family, including the lack of involvement of Chris's mother in the capacity assessments (alongside her express concerns about the inadequacy of the assessments of Chris's capacity and her concerns regarding the ability of Hart House staff to keep Chris safe) *possibly* contributed to the death;

e) Inappropriate and unprofessional judgements being made about Chris's mother with little or no understanding of the complexities of the home environment that she was managing, leading to the inappropriately expedited placement of Chris at Hart House *possibly* contributed to the death;

f) A serious failure to include, in terms, the level of concern about Chris's safety expressed in emails exchanged by the ESTEP team, including most particularly those of the 29th June 2020, in contemporaneous entries in Chris's medical records or in assessments of his risk, led other clinical staff (and staff at Hart House) to underestimate the risks that Chris was presenting with, and the degree of concern held by staff in his community team. The failure to communicate the nature and extent of the very grave concerns held by the community team beyond that team including to the Consultant Psychiatrist prior to the flawed discharge from the assessment Unit on the 29th June, the staff at Hart House, Chris's mother or those attending the Professionals' Meeting on the 7th July 2020 was a significant failure.

The Trust issued an apology expressing their *"sincere apologies for the inadequate standard of care provided to Chris"*, and confirming that the recommendations of the independent investigation were accepted and that *"the Trust has prepared a service improvement plan to take on board and implement the learning set out by the NICHE report".*

These changes, as reported by EPUT in the inquest include:

- An adaptation to the system of processing complaints and concerns raised by the families and carers of patients to ensure they are documented and escalated where necessary;
- New autism training for staff appropriate to their role; and
- Regular reviews of patients who are admitted within 28 days of discharge from hospital.

Julia Hopper, Chris' mother said: *"This has been a gruelling process for our family. Sitting through over three weeks of evidence I have been shocked, horrified, and terrified by some of the failings that have come to light.*

We as bereaved families know too well that Chris' case is not a unique one, and that the failures that characterised his care are reflective of a wider culture within EPUT that includes issues with disclosure and record keeping, repeated difficulties accessing specialist expertise or co-produced care planning for those who need it, and dismissive attitudes towards concerns raised by families and carers who are repeatedly treated as a problem to be "managed" and siloed.

The proposed changes do not go far enough to address these concerns, and only reinforce the need for a full independent statutory public inquiry into the deaths under EPUT."

Nyarumba Nota, Chris' father said: *"Throughout this inquest we have heard from clinicians involved in Chris' care how complex his case was, but the reality is that Chris' complexity was that he was a young man with autism who also had significant mental health needs.*

It was made clear by the evidence of the independent investigators that an autism-focused approach to Chris' care would have made a substantial difference to the treatment he received.

I am particularly concerned that EPUT's proposed response does not include any front-lining of dual diagnosis experts, which Chris' case has shown should be fundamental in the care of anyone who engages with the service.

These sorts of issues which focus on commissioning and matters of policy are areas that any inquest, fulsome though it may be, is not capable of addressing, and is precisely why we need a statutory public inquiry."

Rachel Harger of Bindmans LLP, said: "*In the course of this inquest, and through the independent investigation by Niche, we have heard research findings that 80% of people with autism experience issues with their mental wellbeing and that the risk of suicidality for adults with autism is seven to nine times higher than for the neurotypical community.*

The tragic circumstances of Chris' death have highlighted a significant lacuna of adequate autism-focused mental health provision which is wholly inadequate and this must now be addressed given the Coroner's recognition today that "the nature and scale of the emerging and continuing development of this cohort of vulnerable people."

Jodie Anderson, Senior Caseworker at INQUEST, said: "*INQUEST has been campaigning for a national statutory public inquiry into the state of mental health care in this country. It is quite clear that this is now a necessity.*

The failures by EPUT and other agencies to support and care for Chris demonstrate deep dysfunctions within health and social care. Previous critical inquests, inspections and

investigations of mental health services have failed to compel the transformation in culture and leadership that is needed.

A statutory public inquiry is urgently justified given the compelling conclusions, and with it some hope that lessons will one day be learnt, and life-saving changes made to ensure young people like Chris receive the care they need."

ENDS

NOTES TO EDITORS
For further information please contact Leila Hagmann on leilahagmann@inquest.org.uk.

The family are represented by INQUEST Lawyers Group members Rachel Harger and Khariya Ali of Bindmans Solicitors and Tom Stoate of Doughty Street Chambers. The family are supported by INQUEST caseworker Jodie Anderson.

Other Interested persons represented are Essex Partnership University NHS Trust (EPUT), Hart House, Mid & South Essex NHS Partnership Trust (MSEPT), Southend Borough Council and Southend Safe-Guarding Partnership Adults.

Journalists should refer to the Samaritans Media Guidelines for reporting suicide and self-harm and guidance for reporting on inquests.

Deaths in Essex mental healthcare
See the Essex Mental Health Independent Inquiry website and INQUEST's response to the latest update, March 2022. Also see the petition for an alternative Statutory Public Inquiry, made by bereaved families.

Darian Bankwala was 22 years old when he was discharged from EPUT mental health services at Rochford Hospital four months prior to his death on 27 December 2020. Darian had learning difficulties and some autistic traits which an inquest heard were never properly investigated or diagnosed. Media release.

Bethany Lilley was 28 when she died whilst an informal patient on Thorpe Ward at Basildon Mental Health Unit on the evening of Wednesday 16 January 2019. The inquest in March concluded that her death was contributed to by neglect due to a plethora of failings by Essex University Partnership Trust. Media release.

Other relevant cases: *Deaths of people in the care of Essex mental health services*, November 2020