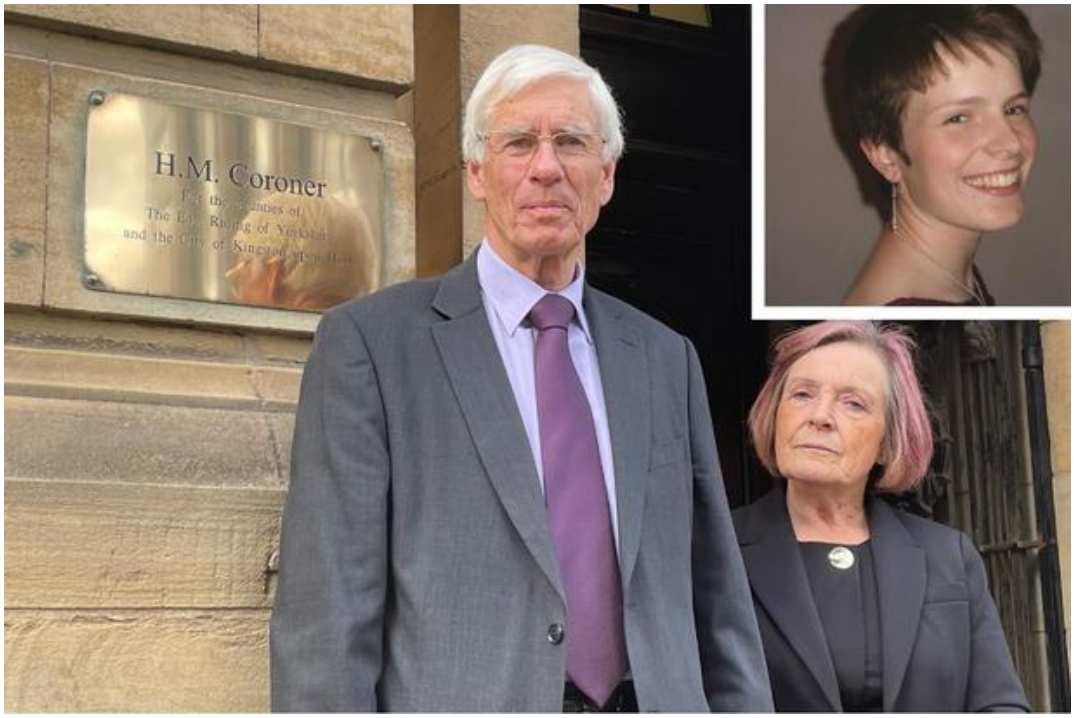
The parents who refused to give up on truth behind daughter's tragic death

Exhausting ordeal for parents of Sally Mays who died after being turned away from mental health unit

By James Campbell Reporter 05:00, 29 SEP 2022 Updated09:09, 29 SEP 2022



Angela and Andy Mays battled for seven years to get answers about daughter Sally's death

The family of Sally Mays have spoken of the “extraordinary” lengths they had to go to in order to get all the facts around the 22-year-old’s death.

Angela and Andy Mays have expressed their relief after the final hurdle in a seven-year legal battle to find out all the circumstances around Sally’s death was finally overcome. They had to take the rare step to go to the High Court in order to quash the original inquest into Sally’s death in 2015 for a new one to take place.

That new inquest has been held this week and concluded on Wednesday with the focus on new evidence related to a conversation between consultant psychiatrist Dr Kwame Opoku-Fofie and community psychiatric nurse Laura Elliot in a car park shortly after Sally was refused admission which was never disclosed.

Coroner Professor Paul Marks upheld the findings from the original inquest when he was highly critical of the Humber NHS Foundation Trust’s crisis team who refused Sally admission to a mental health unit. However, in relation to the conversation between Ms Elliot and Dr Opoku-Fofie, he found it was not a clinical discussion and, therefore, did not amount to a missed opportunity nor constitute any neglect.

After the inquest, Angela and Andy reflected on their long and exhausting battle to find all the answers around exactly how Sally came to take her own life.

They said: “We are relieved the coroner has reached his conclusion. The Humber NHS Foundation Trust has never sought to accommodate our requests. As parents we wanted to know all the details, including what was said in the car park.

“We were still getting information disclosed to us as late as last week. It has not been unfeasible to get this information but we have had to go to extraordinary lengths to get it.”

But they are also frustrated that it ever got to this point and feel the authorities involved had the opportunity to disclose information about the conversation long before they had to resort to seeking a new inquest.

Sally, 22, who had mental health issues, died at home in Hull on July 25, 2014 shortly after she was refused a bed at Miranda House. Her parents Angela and Andy have fought for the last eight years for improvements to be made and lessons to be learned from Sally’s death.

Sally Mays killed herself after she was turned away by Humber NHS Foundation Trust’s crisis team. Sally as a teenager (Image: Angela Mays)

Sally took her own life after two nurses from Humber NHS Foundation Trust's crisis team – Paddy McKee and Gemma Pearson - refused to admit her to hospital following a 14-minute assessment despite her being a suicide risk.

An eight-day inquest in 2015 heard Sally, who had emotionally unstable personality disorder, died from an overdose and mechanical asphyxia after Yorkshire Ambulance Service took 99 minutes to reach her west Hull flat – they should have been there within 30 minutes.

Bridget Dolan KC had successfully argued at the High Court in December 2021 that the conversation between Dr Opoku-Fofie and Ms Elliot represented significant evidence never disclosed at the original hearing which required the original inquest to be quashed and a new one held.

While the new inquest found there was no missed opportunity, the family said they are happy all the information has now come out.

Angela and Andy said: "We welcome the outcome of this second inquest into Sally's death. This process has given us the opportunity to finally obtain and consider the details of information previously withheld from the first inquest by staff from the Humber NHS Foundation Trust.

"Had this information been disclosed at the previous inquest seven years ago, as it should have been, none of this tortuous process would ever have been necessary.

"The avoidable death of our much-loved daughter Sally, in July 2014, was the result of clinical negligence on the part of the trust and Yorkshire Ambulance Service. Additionally, the unconscionable behaviour of staff from the trust's crisis team was ruled as neglect by the coroner at the time.

"All we have ever wanted was the truth about the circumstances of Sally's death. However, none of this additional information was made available to us. Our only option was to apply to the High Court for a fresh inquest.

"Significantly, at no time in the past seven years, until today, had we received an apology from the trust itself or the staff involved regarding the non-disclosure of the information at the original inquest or for the additional unnecessary trauma this has caused."

Angela and Andy Mays have battled for seven years to get answers into their daughter Sally's death

The inquest heard the conversation was not a clinical discussion and it did not represent a missed opportunity. But the Mays family simply did not know the significance of the meeting which is why it was so important to find out what was said.

Mrs Mays said: “This has been a cruel situation for us. I understand there are processes in place but we are a family who lost a much-loved daughter and there has been no recognition of that.

“We are fortunate in our life circumstances to be in a position to have the time and money to fight to get this information. My concern other families who end up in a similar situation will not be in a position to be able to do that.

“Families have a right to expect NHS staff involved in inquests to disclose all available information and both the Humber trust and other NHS trusts across the country need to make this obligation clear to their staff. Ultimately, it is up to the coroner, and the coroner alone, to decide on the relevance of that information.

Michael Rawlinson, representing the trust, apologised to the family on Wednesday for the failure to disclose all the information but said the conversation itself did not represent any missed opportunity.

He said: “We apologise unreservedly to Mr and Mrs Way that there has had to be a second inquest and that details of this conversation did not emerge earlier. To say it is regrettable is an exercise in understatement.

“But the decision not to disclose the conversation was taken in good faith by all those involved. The trust has to balance the wishes of the family with protecting staff. There are processes that have to be undertaken, as unwieldy and unsatisfactory as they are. There is no evidence the conversation was hidden behind confidentiality deliberately.

“The conversation by those involved was not deemed clinical nor was there an opportunity to escalate the situation.”

The inquest previously heard how mental health nurse Laura Elliot was present on the day Sally was assessed by the crisis team on July 25, 2014 at Miranda House in Hull. Sally was turned away and just hours later killed herself.

Sally Mays killed herself after she was turned away by Humber NHS Foundation Trust’s crisis team. (Image: Angela Mays)

Ms Elliot had referred Sally to the crisis team although she was not involved in the decision to turn Sally away. She told an inquest in Hull how she was “upset and angry” by the way Sally had been treated by the crisis team.

As she left for the day a short time later in tears, she bumped into consultant psychiatrist Dr Opoku-Fofie where she explained why she was so upset. Both Ms Elliot and Dr Opoku-Fofie say they never mentioned it to bosses because it was an informal chat. They felt raising it would have made the meeting seem more significant than it actually was.

However, both Ms Elliot and Dr Opoku-Fofie denied there was any deliberate attempt to withhold any information. They say they felt there was no clinical value in the conversation which merited disclosing the meeting to senior management or other during a number of investigations.

Following Sally's death, a police investigation into possible corporate manslaughter and other offences was launched but resulted in no charges. However, McKee was struck off by the Nursing and Midwifery Council (NMC) earlier this year following a Fitness to Practice hearing.

McKee was employed in the crisis service of the Humber NHS Foundation Trust at the time he dealt with Sally. The NMC found his actions to refuse Sally admission contributed to her death.

The inquest in Hull in 2015 heard Sally asked to be admitted to hospital as her mental health deteriorated in the last few days of her life. Three nurses from her community team and her psychotherapist recommended a short stay in hospital in line with her care plan.

However, nurses McKee and Pearson refused to admit her after carrying out what Professor Paul Marks described as a "lamentable" assessment. Instead, they called police when Sally started banging her head off a wall and tried to strangle herself in her distress.

Sally Mays killed herself after she was turned away by Humber NHS Foundation Trust's crisis team. Sally dressed for her prom (Image: Angela Mays)

However, police officers knew Sally needed to be in hospital to keep her safe and had a “stand-up fight” with the two nurses outside Miranda House to persuade them to change their minds. But they were forced to take Sally home when the nurses refused to reconsider.

Prof Paul Marks delivered a narrative conclusion containing many of the same findings he delivered in 2015. He said the decision not to admit Ms Mays constituted "neglect" which bore "a direct causal relationship to her death later that evening". He said that she had been admitted following an initial assessment she "would have survived and not died when she did".

A further missed opportunity to save her life came from the 69-minute delay to an ambulance arriving at Sally’s flat after her 999 call was not categorised appropriately, the coroner said. He has since written a prevention of deaths report raising concerns about the coding system used by the Yorkshire Ambulance Trust to determine the priority of the call made the Sally shortly before she died.

He concluded the failure to admit Sally that day was “illogical, unconscionable and quixotic” and that Sally had “not been treated with respect or dignity” by the crisis team. But he said the car park conversation between Ms Elliot and Dr Opoku-Fofie was “not a clinical consultation and “did not represent a further missed opportunity”.

He concluded by saying: “The Mays family have had, for years, not had all the answers they were entitled to. I hope they have now obtained some degree of closure after eight years of bereavement.”