East London
NHS Foundation Trust

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Trust Headquarters
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Private & Confidential

HM Assistant Coroner Edwin Buckett
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4 August 2023

Dear Sir

RE: Regulation 28 Response for Billy Guedalla

This is a formal response to your Regulation 28 report sent on 12 June 2023 where you set out concerns relating to the care of Billy Guedalla whilst under East London NHS Foundation Trust's **(the Trust's)** care.

I understand that at the inquest into Billy's death you heard evidence from the Clinical Director for City and Hackney outlining the learning that has taken place as a consequence of their death. However, you remained concerned about the risk of future deaths in relation to the following areas:

1. The deceased was allowed to leave Gardner Ward ("**the unit**") which was part of a secure facility of the hospital alone, when a clinical decision had been taken that they should not be allowed to leave the unit unaccompanied by staff, because they posed a risk of suicide.

2. The decision that the deceased should not be allowed unescorted leave was not communicated to all members of staff working in the unit such that the person who allowed the deceased to leave was unaware that the decision had been made.

3. The relevant information gathered during the Ward Round on the 28th October 2021, which included the fact that the deceased had attempted to take their own life, the night before, was not adequately communicated to all staff on the unit.

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4. The “Sign in/Sign Out” book which was supposed to record the movements of service users in the unit was frequently not completed, particularly when service users went out for short periods.

5. There was no proper system for identifying whether a service user should be permitted to leave the unit.

6. The member of staff who allowed the deceased to leave the unit made a brief risk assessment of them before deciding whether they should be allowed to leave. That person did not consult any medical notes or records about the deceased when making that assessment. Had that member of staff consulted the deceased’s medical notes and records, the serious suicide risk that they posed would have been evident.

7. Once the deceased was found to be missing from the unit, there was an unexplained delay in informing the police and ambulance service, a failure to inform either of the serious suicide risk which the deceased posed to themselves and a lack of appreciation of the urgency by staff generally.

8. The hospital policy which applied to missing patients was not properly adhered to by staff and there was confusion about who should be contacted and in what manner, once a patient was found to be missing.

9. No proper efforts were made to contact members of the deceased’s family once the deceased was found to be missing.

10. The unit was short staffed and this affected the care provided to the deceased, the assessment of the deceased whilst in the unit and recording generally.

I would like to offer my sincere apologies to Billy’s family on behalf of the Trust. I would also like to assure Billy’s family and the Coroner that the Trust has reviewed the issues highlighted by the Regulation 28 report and has planned or undertaken the actions outlined below.

1) The clinical decision made, that Billy should not leave Gardner Ward unescorted was not followed and 2) this decision was not communicated to all members of staff.

I share your concern that critical information surrounding clinical decision making in relation to Billy’s leave was not followed nor passed on to all Gardner Ward staff members.

Expected practice at the Trust is that all clinical decisions made in relation to all inpatient service users’ leave should be recorded on RIO (the Trust’s electronic patient record) by the relevant clinician. I understand that this information was not recorded nor was it reviewed or disseminated amongst the Gardner Ward staff.

In order to ensure that this does not occur again, at the next Gardner Ward away day on 23 August 2023 all staff will be reminded again of the importance of properly recording clinical decisions (whether made by themselves or in Ward Management Meetings or Ward Rounds) as well as reviewing the RIO notes prior to making important clinical decisions. This same discussion will be repeated at the next away days for all City and Hackney inpatient wards. Considerations about the differences in recording such information between formal and informal service users will be discussed. A memo has been sent out to all ward staff on 27 July 2023 by the Clinical Director reinforcing these expectations too.

Additionally, the Clinical Director for City and Hackney has updated the junior doctor induction programme to include this information.

In order to provide an additional safety net to ensure that appropriate information sharing occurs, a daily Safety Huddle comprised of the entire multi-disciplinary team now takes place on all City and Hackney inpatient wards each morning. Critical clinical information about all service users is shared during the Safety Huddles. Important clinical decisions and risk information discussed at the Safety Huddles are expected to be documented on RIO (this expectation will also be further reinforced at the away day and junior doctor induction).

Additionally, all inpatient leave arrangements (for both formal and informal service users) are now documented on the relevant nursing office whiteboard in each City and Hackney inpatient ward. The leave arrangements are reassessed at every shift handover and the whiteboard is updated accordingly. It is expected that all staff members check the whiteboard before allowing leave of any type.

Further, junior stuff members are now required to speak to the shift co-ordinator (the most senior staff member) prior to allowing patient leave.

3) The information from the ward round that Billy made a serious suicide attempt the previous night was not communicated to staff members.

I was also troubled to hear that important risk information about Billy, highlighted at a Ward Round was not communicated to staff members.

As mentioned above, I anticipate that the daily Safety Huddles will assist in ensuring that important new risk information about service users is passed onto all staff members.

4) The 'Sign in/Sign Out book was frequently not completed.

I have been provided with assurances that the process for managing the Sign In/Sign Out book (the "**book**") on all inpatient units in City and Hackney has been improved. The book is now located at the nursing office to enhance completion. It has been revised to include the following information: service user name, whether leave is escorted (and by whom) or not, location of planned leave, time left and time returned, the validity of Section 17 leave papers for detained patients, description of items taken, and whether search on return was completed.

Presently, either the nurse in charge or the shift coordinator spot checks the book to ensure completion one time per shift. However, work is being done to develop a more robust audit system.

5) There was no proper system for identifying whether a service user is permitted to leave.

The Trust's approach to address this via the whiteboard system, the Safety Huddles and the additional expectations on junior staff members to check leave with the shift co-ordinator prior to allowing leave are explained under point 1 and 2 above.

6) The medical notes were not reviewed prior to deciding that Billy should be allowed to leave.

The Gardner Ward away day outlined above, will highlight the importance of regularly reviewing RIO notes. Further, the implementation of Safety Huddles, the whiteboard system and the requirement to seek approval of senior staff members prior to allowing service user leave will ensure only those patients permitted to take leave are allowed to do so.

7) Once Billy was found to be missing, there was a delay in informing the police and ambulance service, a failure to convey suicide risk to the police and ambulance service, and lack of appreciation of the urgency by staff. And 8) The policy which applied to missing patients was not properly adhered to by staff and there was confusion about who should be contacted

I acknowledge that the delay in notifying the police, ambulance and family when they were discovered missing should not have occurred. Further, when emergency services were notified, there was a failure to convey Billy's suicide risk.

The following actions have taken place to ensure that this does not occur again:

a. On the 13 July 2022, staff from Gardner Ward attended the "Time to Think" forum. There, the Trust's Health, Safety and Security Planning Manager led the meeting and reinforced the correct escalation processes to use when a service user is missing.

b. In June 2023, the Trust's Missing and Absent without Leave policy was reviewed and it is now awaiting ratification.

c. The Trust is now engaged at a senior level with the Metropolitan Police to develop a strategy around, "Right Care, Right Person" which is anticipated to lead to improvements in the coordination of response to missing inpatients by both organisations.

9) No efforts were made to contact Billy's family once it was discovered they were missing

I am aware that you heard oral evidence at inquest that a single attempt was made to call Billy's family when they went missing. However, this call took place well after it was discovered and no further attempts were made to contact their family. The Trust wholeheartedly acknowledges that this response was not commensurate to the situation.

I can confirm that explicit information about contacting family members is provided in the updated policy and was discussed with Gardner Ward staff during its review of the policy.

Staff also specifically reflected upon the impact of not contacting Billy's family promptly when they were discovered missing at the Time to Think Forum on 13 July 2022.

10) Gardner Ward was short staffed and this affected the care provided to Billy.

Although there is a particular need to focus on the staffing levels of nurses, the issue of staffing levels across the full multi-disciplinary team is relevant to the care provided on a ward. The current vacancy rate, as of June 2023, for all staff in City & Hackney Mental Health Directorate is 4.4%. This rate varies amongst different staff groups, for example:

a) Nursing staff: 8.4%
b) Doctors: 5.7%
c) Psychologists and social workers: 3.2%
d) Allied Health Professionals (e.g. occupational therapists, art therapists): 14%
e) Support to nursing staff (e.g. Life skills recovery workers): 1.2%

As highlighted at inquest, there are currently national challenges with staffing in the NHS which impact on the Trust's efforts to achieve full recruitment with substantive staff. But, I can assure Billy's family that the Trust is making best efforts to achieve this across all staff groups.

City and Hackney is currently managing nursing staff vacancies using the following strategies:

a) Staffing levels across the directorate are discussed face to face at a daily Huddle every Monday – Friday at a designated venue. The Duty Senior Nurse, Borough Lead Nurse, Ward Managers and matrons are present. The Psychiatric Liaison Teams and Home Treatment Team also feed into the Huddle. Safe staffing levels are considered alongside appropriate actions such as redeployment, booking temporary staff and block booking Trust bank staff.

b) A Band 5 registered nurse is currently responsible for 'red flag' reporting (reviewing staff shortages on the daily rota and the numbers of service users

requiring enhanced observations). This information is fed into the daily Huddle (outlined above) and to the Borough Lead Nurse for consideration of a planned response. It also supports matrons in planning.

c) Twilight Shifts have been introduced. Band 6 nursing colleagues from the community teams attend between 5.30 to 9 pm when the wards are busiest to ensure smooth transitions to night shifts.

d) A live spreadsheet is maintained and reviewed weekly by the ward matrons to highlight recruitment gaps and support the recruitment process

e) There is a recruitment drive in City and Hackney for band 5 and 6 nurses.

A recent Trust-wide review of the Trust's inpatient activity (clinical demand and benchmarking against national standards for comparable services) was undertaken in January 2023. This review contributes to ensuring the Trust meets Safer Staffing expectations for services. In particular, that the right staff with the right skills are in the right place at the right time. The review has resulted in an increased investment in inpatient staffing based on the identified needs of the services. Since April 2023, an £800,000 investment for Safer Staffing has been provided to the City and Hackney directorate within ELFT. The benefits of the increased investment will be reduced reliance on temporary staffing at times of high acuity and better resourced teams to meet the needs of service users. In addition to this we have reviewed our recruitment strategy and processes.

I hope I have provided reassurance to you and Billy's family about the learning that has taken place as a consequence of their sad death.

I offer my sincere and heart-felt condolences to the family at this difficult time.

Yours sincerely,

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Chief Medical Officer

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