Regulation 28: Prevention of Future Deaths report

Hilary Clare (Billy) Guedalla (died 30.10.2021)

	THIS REPORT IS BEING SENT TO: [redacted] **(Chief Executive)** **East London NHS Foundation Trust** **Robert Dolan House** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am: Coroner Edwin Buckett Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On the 11th November 2021 I commenced an investigation into the death of Hilary Clare (Billy) Guedalla who died aged 46 on the 30th October 2021 [redacted]. The investigation resulted in an inquest, which was conducted by myself over a period of 5 days and concluded on 19th May 2023. I made a determination at inquest that the deceased died as a result of suicide and returned a narrative conclusion as follows: 1. The deceased suffered from long standing psychiatric conditions of a Recurrent Depressive Disorder and complex Post Traumatic Stress Disorder. 2. On occasions, the deceased's psychiatric conditions led to

psychiatric in-patient admission to hospital, usually as a voluntary patient, on a number of occasions between 2013 and 2021. Those admissions were associated with the deceased exhibiting suicidal ideation and sometimes involved attempts to take their own life.

3. On the 26th October 2021, the deceased was admitted to Gardener Ward, Homerton Hospital, London E9 as a voluntary patient suffering a worsening of their psychiatric condition.

4. At a ward round at that hospital on the 28th October 2021, at around 11am, the deceased indicated to staff that they had tried to take her own life the night before in hospital and that they had equipment at home for the purposes of ending their life.

5. The deceased's condition worsened thereafter and staff at the hospital considered that the deceased should not be allowed out of the ward alone, for her own safety because, in effect they were a high risk of suicide. That decision was made in the morning of the 29th October 2021 but not communicated to all staff on the ward.

6. The deceased asked a member of the clinical staff to leave the ward, at around 6pm on the 29th October 2021. That member of staff was unaware of the decision that had been made that the deceased should not be allowed out alone. The member of staff carried out a brief assessment of the deceased, largely based on their appearance, but did not refer to any medical notes and records. The deceased was then allowed to leave the ward.

7. Sometime between leaving the ward and around 3pm on the 30th October 2021, the deceased took their own life by hanging themselves [redacted] No-one else was involved. The deceased was found by members of the London Fire Brigade between 3 and 4pm, on that day.

8. After the deceased had left the ward, night staff found the deceased to be missing at around 8pm on the 29th October 2021. Staff first contacted the police 2.10am and again at 2.46am on the 30th October, 2021 and requested that the police carry out a welfare check. They did not inform the police that the deceased was a serious suicide risk. They were advised to contact the London Ambulance Service but did not do this until 3pm on the 30th October 2021 and in any event, that request did not generate attendance at the deceased's home address.

9. At around 2pm on the 30th October 2021, the deceased's mother attended the ward having made a pre-arranged booking to visit the deceased. She was shocked to be informed that the deceased had left the ward. She enlisted support from family and friends which led to the attendance of emergency services at the deceased's home address, between 3-4pm on the 30th October 2021.

10. The deceased should not have been permitted to leave the ward alone. Had clinical staff observed the decision not to allow the deceased out without a staff member, the deceased would not have taken their own life when they did.

11. The decision that the deceased should not be permitted unescorted leave failed to be communicated to all staff members on the ward.

12. The information that the deceased had tried to end their own life on the ward on the evening of the 27th October 2021 was also not properly communicated to all staff on the ward or added to any document which concerned a proper risk of assessment of them. Also, the hospital staff did not fully comply with the patient admission policy when the deceased was admitted on the 26th October 2021 as records were not properly updated and no physical health assessment was made of the deceased within 24 hours.

13. The decision that the deceased was to receive 1:1 support following the ward round of the 28th October 2021 could not realistically be met because of staff shortages on the ward. There was a failure to recognise that this plan would could not realistically be achieved because of those staffing issues.

14. The assessment made of the deceased before the deceased was allowed to leave the ward at 6pm on the 29th October 2021 by that member of staff was inadequate as a risk assessment of the deceased's mental state for the purposes of assessing their safety. That member of staff relied solely on the deceased's presentation at that moment and did not consider any written record about the deceased or ask any other member of staff about how the deceased was.

15. There was a complete failure to appreciate the urgency of locating the deceased once the night staff found them to be missing at about 8pm on the 29th October 2021 and to follow the hospital policy which applied to missing patients.

16. Night shift staff took far too long to contact the emergency services and failed to contact the ambulance service as advised by the police in the early hours of the 30th October 2021.

17. When the police were contacted, staff completely failed to state the urgent and serious suicide risk which the deceased presented to themselves.

18. Hospital staff also failed to properly contact Billy's family and friends after they went missing from the ward or leave messages for them which could have enabled them to be located.

19. Staffing levels on both the 29th and 30th October 2021 were not

	adequate and this contributed to the failings set out above. 20. The failure set out above which relates to the staff member being unaware that the deceased should not leave the ward unaccompanied, amounts to a serious failure which directly caused or contributed to the deceased's death. 21. The other failures set out above amount to missed opportunities which may directly or indirectly, have prevented the deceased's death.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances surrounding the death are set out in Box 3 above.
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. Evidence was given by staff members of the East London Foundation NHS Trust that: 1. The deceased was allowed to leave Gardener 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 serious 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. 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 which 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 of the situation 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 record keeping generally. The summary of the evidence given, as set out above, sets out the matters of concern.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 the **4th August 2023**. I, the coroner, may extend the period in appropriate circumstances. 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 following. • HHJ Thomes Teague KC, the Chief Coroner of England & Wales. • The Care Quality Commission for England. • The parents of the deceased. I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. 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.
9	**DATE 8th June 2023** *Edwin Buckett* **ASSISTANT CORONER**