IN THE SURREY CORONER'S COURT

IN THE MATTER OF: MARY NABILIA GWANYAMA

The Inquest Touching the Death of MARY NABILIA GWANYAMA

A Regulation 28 Report – Action to Prevent Future Deaths

	• [redacted], **Chief Executive Surrey and Borders Partnership**
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An inquest into the death of Mary Nabila Gwanyama was opened on 1st June 2018, resumed on the 18th January 2021 and concluded on 10th February 2021. I found that the cause of death was:

	I a Multiple Injuries I concluded with a narrative conclusion as follows: Mary Gwanyama was admitted to the Abraham Cowley Unit as an informal patient on the 24th February 2018. She was suffering from severe depression. She was prematurely discharged on the 28th March 2018 to the home treatment team without a formal or adequate risk assessment having been undertaken, before it had been possible to assess whether her prescribed medications were effective and having been misdiagnosed immediately prior to discharge. She was not subject to medical review thereafter. On the 24th April 2018 she was discharged to the community mental health team. She was housed out of area in temporary accommodation which made it difficult for her to be visited by her care co-ordinator who did not see her in the 35 days prior to her death. On the 26th May 2018 she stepped down into the path of an oncoming train at Weybridge Station and was killed on impact. She intended to take her own life. Her death was therefore a result of suicide. I adjourned consideration of whether to write a report for the prevention of future deaths for further evidence to be provided by the 24th March 2021.
4	**CIRCUMSTANCES OF THE DEATH** i.) Mary held a British passport but had lived in America for a long period prior to coming to England in the autumn of 2017. She lived temporarily with her sister in Surrey. She was suffering from severe depression and was admitted to the Abraham Cowley Unit as an informal patient on the 24th February 2018. She was prescribed citalopram. ii.) She wanted to be rehoused in Surrey near her sister. As part of the discharge planning she was referred to Elmbridge Borough Council housing department who needed to undertake investigations to determine if she was eligible for housing. iii.) Mary was an experienced nurse and repeatedly said that the medication prescribed to her was not working. A date was fixed for her discharge from hospital. She did not want to be discharged. She feared being homeless. On the 21st March 2018 she expressed active suicidal thoughts and was placed on 1 to 1 nursing. iv.) On the 22nd March 2018 she was seen by her Responsible Clinician. Her

	medication was increased, her nursing observations were reduced to every 15 minutes and the discharge planned for the 26th March 2018 was moved to the 27th March 2018 to allow her to see the citizens advice bureau. The plan was for her to be discharged to the Home Treatment Team. v.) At that stage it had not been possible for the housing authority to determine if she was eligible for housing. Her care co-ordinator was not involved in the decision. No discharge planning meeting took place. vi.) On the 27th March 2018 she saw a member of the Home Treatment Team and expressed suicidal plans and refused Home Treatment Team involvement. She continued to say that the medication wasn't working. Her discharge was delayed until the following day. vii.) On the 28th March 2018 she agreed to work with the Home Treatment Team because she was reassured that she could have a medical review in the community. viii.) She was then seen in a ward round and her diagnosis was erroneously changed to probable mild depression with emotionally unstable personality disorder traits. ix.) The discharge plan was for her to be housed at the expense of the Unit for 7 days at a Travel Lodge. There was no certainty at that stage that she would be eligible for housing after that date. The plan was that she was to attend the housing authority as homeless at the end of that period. She was discharged on that basis. x.) No risk assessment was recorded on the 22nd March 2018 or the 28th March 2018 after the medical reviews and no formal risk assessments were undertaken. xi.) Mary was under the care of the Home Treatment Team from the 28th March 2018 to the 24th April 2018. On the 30th March 2018 she stopped taking medication and expressed suicidal ideation. Her case was discussed at the multidisciplinary team meetings on the 3rd April 2018 and the 17th April 2018 which include junior doctors. It was unclear which consultant psychiatrist was responsible for her care at that time. xii.) Despite a request by one of the junior doctors to change her medication on the 17th April 2018 this was refused by one of the psychiatrists at the Abraham Cowley Unit. Mary was not medically reviewed prior to this decision being taken. xiii.) Payment for the Travel Lodge was extended until the 7th April 2021.

	It was still unclear at that stage if she was eligible for housing so she returned to her sister's home until the matter was resolved. xiv.) Mary was found eligible for housing and given temporary housing out of area in Feltham on the 19th April 2020. The Home Treatment Team discharged her to the community team on the 24th April 2018. There was no discharge planning meeting with the care co-ordinator. The Care Programme Approach was not followed. xv.) Mary was seen on the 24th April 2018 by her care co-ordinator, he took an emergency supply of her medication with him. She sought a medical review and it was requested by the care coordinator on the 1st May 2018. xvi.) Mary was not seen for a medical review prior to her death on the 26th May 2018. She did not organise or collect a repeat prescription of her medication from the general practitioner in Surrey so would have been without medication prior to her death. Her care coordinator did not see her for 35 days before she died. xvii.) On the 26th May 2018 she stepped out in front on an oncoming train at Weybridge Station and died from the catastrophic injuries she sustained.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. Mary was discharged from the Abraham Cowley Unit without a discharge planning meeting taking place in circumstances where there was no confirmation that she was eligible for housing provision and with no plan was to what would happen after the Travel Lodge placement ended. There is no policy in place which prevents a vulnerable patient being discharged into homelessness from the Abraham Cowley Unit. 2. Mary was not subject to a medical review from the 28th March 2018 to the 26th May 2018. There is no policy in place which mandates when or if a patient should be subject to face to face review by a consultant

	psychiatrist after discharge from the acute unit. 3. No formal risk assessment was undertaken of Mary and no risk assessment was recorded in her records prior to her discharge from the Abraham Cowley Unit. 4. The informal risk assessments undertaken in the Abraham Cowley Unit prior to her discharge failed to place any weight on the impact on Mary of a discharge with an inchoate plan for her housing and arrived at an incorrect assessment of her risk. The risk assessments were not sufficiently rigorous and evidence based. 5. Mary was prematurely discharged from the Abraham Cowley Unit suffering from severe depression and before sufficient time had been taken to observe the effectiveness of her prescribed medication. This appears in part to have been because the imperative to discharge patients took precedence over adequate discharge planning and assessment. The CPA (" Care Programme Approach") was not followed. 6. Mary was discharged from the Home Treatment team on ineffective medication and without any coherent plan for her care in the community. Her care coordinator was not involved in the discharge planning. The CPA was not followed. 7. The fact that she was placed out of area made it difficult for her to participate in community based treatment and significantly impacted on the ability of her care coordinator and community psychiatrist to support her. There is no policy which governs how often a patient should be seen once in the community in order to review the risk assessment and monitor compliance with medication.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 16th June 2021. I, the coroner, may extend the period.

	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 Chief Coroner and to the following Interested Persons; [redacted] and Elmbridge Borough Council. I am also under a duty to send the Chief Coroner a copy of your response. 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	**Signed:** **Caroline Topping** **Dated this 21st April 2021.**