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PRESS RELEASE

Henok Gebrsslasie: Inquest concludes ward failures contributed to death of Eritrean asylum-seeker

Before HM Area Coroner Delroy Henry
Coventry Coroner's Court
17 February – 5 March 2025

Henok Zaid Gebrsslasie, aged 23, died on 12 August 2021 whilst detained under the Mental Health Act on Sherboune Ward, a Psychiatric Intensive Care Unit ('PICU'), at the Caludon Centre, Coventry.

An inquest jury has now concluded that multiple failures in respect of Henok's clinical supervision and care contributed to his death.

The nature of the evidence heard at the inquest was such that the jury were left to consider unlawful killing as a potential conclusion in respect of a nursing staff's actions and observations of Henok carried out very shortly before his death. The leaving of such a conclusion, in the context of a self-inflicted death in psychiatric detention, is in itself rare and marks a significant precedent.

Henok arrived in the UK in May 2020 and claimed asylum on arrival. He was a much-loved son and brother, Henok liked making jokes, football, and supporting his family. He was kind and principled, always trying to help others even when he had little.

On 2 August 2021, Henok was detained under the Mental Health Act at Spencer Ward, the Caludon Centre. This followed his arrest earlier that day, after being found on a bus with a plank of wood in a state of extreme distress. On admission, the significant language barrier between staff and Henok was noted. Henok's native language was Tigrinya, and he was only able to speak very limited English. Despite this, and the initial care plan documenting the need to arrange an interpreter, Henok was not clinically assessed with a Tigrinya interpreter until 11 August, having already been on the ward for 9 days: this was his final clinical review, the day before his death.

During his admission to Spencer Ward, Henok presented as highly delusional and dysregulated. He required numerous episodes of sedation under restraint. He was assessed as likely suffering from acute psychosis, against a background of past trauma and stressors. On 5 August 2021, Henok absconded from the ward through his bedroom window; he was found by police the following day, holding a knife and stating he wanted to harm himself. Henok was consequently transferred to the PICU, Sherboune Ward, on 7 August 2021. He was placed in seclusion on arrival where he self-harmed and damaged the room. In response, he was placed in specialist rip-proof clothing, with the recorded rationale being to reduce his risk of ligature to self and staff. Henok's normal clothing was returned to him on the morning of 12 August 2021, despite the absence of any in-person clinical assessment and any record being made of the rationale for this.

The jury was shown footage from 12 August 2021, taken from the Trust's Oxevision system, which captured Henok's actions within his bedroom in the half-hour

preceding his death. This footage showed Henok's last interaction with a member of staff, a student nurse, which took place at around 13:55, some minutes before his death. The footage showed the student nurse speaking to Henok from the doorway of his room, whilst Henok was sitting on the floor, behind his bed, bare-chested, with a ligature tied around his neck. The student nurse maintained in her evidence at inquest that she did not notice anything around Henok's neck. She observed that Henok appeared low in mood, that he stated that staff did not understand him, and that he "*wanted to sleep forever".* However, whilst accepting that this picture signalled an increase in risk, the student nurse was unable to say whether she took any immediate steps to act on Henok's presentation or escalate her concerns. The footage showed Henok proceeding to take his own life minutes after the student nurse left his room.

The jury heard how Henok was supposed to be on Level 2 15-minute therapeutic observations, meaning that he should have been checked at or just after 14:00. This observation however was missed by staff, as were all successive observations from 14:00-17:00, leaving Henok entirely unobserved for three hours. This led to a significant delay in Henok being discovered and the emergency response being commenced. The jury heard how ward staff members falsified the observation records for these three hours. One healthcare assistant involved in the missed observations told the jury how she had a 'habit' of rewriting observation notes 'to get out of a situation'. Another healthcare assistant said they had been directed to falsify the notes by a more senior member of staff.

The Coroner considered there was a sufficiency of evidence on which to leave it open to the jury to find unlawful killing, in addition to neglect. The jury consequently returned a critical narrative conclusion, determining that Henok died by suicide contributed to by (i) the insufficiency of the observations and actions carried out by the student nurse at 13:55, and (ii) the inadequate ward supervision, leading to staff non-compliance with policies and procedures. The jury also criticised the inadequacy of the therapeutic Level 2 observations.

The Coroner also issued a Prevention of Future Deaths report in respect of the failure by the Caludon Centre to take action to mitigate the ligature risk posed by the gaps in the tops of the doors on the Sherbourne Ward. This was a known ligature risk at the time of Henok's death, with the Trust's internal investigation advising of the need to implement door top alarms to mitigate such risk. Despite this, the inquest heard evidence that, some three and a half years on, the alarms had still not been installed on the PICU.

Speaking after the inquest, Henok's family said "*It has been so painful and shocking to learn of the lack of care and attention that was afforded to Henok when he was at his most vulnerable. He was entirely alone, in hospital in an unfamiliar country, surrounded by clinical staff he could not properly understand or communicate with. We cannot imagine the confusion and fear he must have felt in the final weeks of his life. The ward staff failed to take basic steps – such as helping Henok to contact his family or arranging interpreters for clinical reviews – which would have helped alleviate Henok's distress. They failed to intervene on 12 August 2021 when he was in a state of such obvious crisis. The Caludon Centre abjectly failed him and us.*

Henok was a dearly loved son and brother. He was the light of our family, filling it with such happiness and love. Whilst nothing can be done to bring him back, our biggest hope is that lessons can be learned from his experience so that no other family has to go through the unbearable devastation that we have suffered."

Sarah Robson, Director of Da'aro Youth Project which has worked with the family said: "*These heartbreaking events underscore the urgent need for a support network tailored to the unique challenges faced by young, unaccompanied asylum-seekers and refugees from the Horn of Africa, some of them under 18. We hope that this case highlights the urgency to act and encourages policy makers to implement infrastructure to keep these vulnerable young people safe*"

The family were represented by Charlotte Haworth Hird and Emily Hobhouse of Bhatt Murphy solicitors, and Laura Profumo of Doughty Street Chambers.

The family are supported by INQUEST caseworker Jordan Ferdinand-Sargeant and by Da'aro Youth Project.

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