Regulation 28: Prevention of Future Deaths report

Freeda GLAUSIUSZ (died 17.05.21)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 25 May 2021 I commenced an investigation into the death of Freeda Glausiusz, aged 32 years. The investigation concluded at the end of the inquest yesterday. I made a determination at inquest of death by suicide whilst suffering a psychotic episode.
4	**CIRCUMSTANCES OF THE DEATH** Freeda Glausiusz jumped from her [redacted] home on 15 May 2021. Her father had called the crisis line in desperation the day before. His call was not treated with the seriousness it deserved. It is unclear whether any alternative action by the crisis team would have changed the outcome.

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.

1. I was shocked when I listened to the recording of the call that [redacted] made to the crisis line the day before his daughter died.

   The East London NHS Foundation Trust (ELFT) serious incident (SI) report observed that the clinician did not elicit clear risks during the conversation; did not listen to [redacted]; talked over him; did not appear empathic; and dismissed his distress about his daughter, even though she was a patient known to services after a first episode of psychosis.

   In reaching my conclusion at inquest that the call was not treated with the seriousness it deserved, I agreed with all of those observations. [redacted] was not taken seriously, he was not treated respectfully and he was not treated kindly. He was clearly desperate about his daughter's mental health and, as we now know, he was right to be desperate. He rang the crisis line and he was belittled.

   The clinician then made no note of the call in the medical records, even retrospectively.

   I note the many recommendations of the thoughtful SI report, but I remain concerned on three counts.

   - This is not the first time that I have made a PFD report to ELFT about its crisis line.

   - Not only did the clinician in question not make a note of the call in the medical record, he told me in court that, after Freeda Glausiusz's death his manager had told him not to make an appropriately dated retrospective note in the record. He said that he had made a note on a piece of paper, but he did not now have that piece of paper.

   - When I asked the lead SI reviewer if the trust is confident that it has taken all appropriate actions in respect of that clinician, she was not able to give me that assurance.

	2. I heard at inquest that the clinician and his manager had listened to the recording of the call within days of the death and had recognised very significant shortcomings. However, the recording was not then volunteered to my coroner's officer. I was aware of the existence of the call only because [redacted] told my officer about it. • I received a copy of the recording of the call (without a transcript) the day before the inquest. • I received a statement from the clinician who took the call the day before the inquest. • I received statements from other ELFT clinicians in dribs and drabs earlier this month. • I received a copy of the SI report the day before the inquest. • I never received a copy of the 48 hour hot de-brief. • Freeda Glausiusz died five months ago. My officer first requested witness statements and a copy of any internal investigation on 7 June, over four months ago, and asked for the statements to be provided by 20 August. This chronology does not demonstrate an eagerness to promote a learning culture by ELFT. The failure to provide prompt and candid co-operation with my office obstructs the coronial inquiry, an inquiry that includes the function of learning from deaths. And it does not demonstrate respect for the family of the deceased.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have 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 20 December 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 following. • [redacted] • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 20.10.21 *ME Hassell*