East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 JANUARY 2022

Title	**Coroner Regulation 28 Report -Prevention of Future deaths**
Author/Role	Christina Helden, Interim Associate Director of Legal Affairs.
Accountable Executive Director	Dr Paul Gilluley, Chief Medical Officer

Purpose of the report

In May 2021, Ms Glausciusz died in the Royal London Hospital after jumping from a height. Her father called the City and Hackney Crisis Line the week prior to death. The Serious Incident Investigation identified several areas of care that were below acceptable standards. The subsequent Coroner's Inquest found that Ms Glausciusz's death was likely not to have been preventable. However, HM Coroner delivered a Regulation 28 report on actions to Prevent Future Deaths (PFD) as concerns were raised about the following areas in relation to patient care.

1) This is not the first time that HM Coroner has made a PFD Report in relation to the City and Hackney Crisis Line.

2) The Crisis Line call handler did not make a note of the call in the medical record, and his manager told him not to make an appropriately dated retrospective note in the record.

3) The lead SI reviewer could not be confident that the Trust had taken all appropriate actions in respect of the Crisis Line call handler.

HM Coroner also noted the following unacceptable delays in document disclosure that she felt impeded her investigation.

1) The Court only received a copy of the recording of the call (without a transcript) the day before the inquest.

2) The Court received a statement from the clinician who took the call the day before the inquest.

3) The Court received statements from other ELFT clinicians in dribs and drabs earlier this month.

4) The Court received a copy of the SI report the day before the inquest.

5) The Court never received a copy of the 48 hour hot de-brief.

This report is an update on progress to address the shortcomings in these areas of practice.

Committees/meetings where this item has been considered

Date	Committee/Meeting
10.01.22	Quality Assurance Committee

Key messages

A new system of oversight, training and recruitment practice has been introduced to improve provision of care by Crisis Line call handlers.

Changes to the City & Hackney Crisis Line policy are being made to ensure that call handlers appropriately consider safety concerns raised by families and friends.

Additionally, there is an improvement plan for the City & Hackney Crisis Pathway which has been developed.

Capacity is being increased in both the Governance and Risk and Legal Affairs Team.

Strategic priorities this paper supports

Improved population health outcomes	☐	
Improved experience of care	☒	The report outlines the action taken in response to the Coroner's concern on how the quality of care has been improved to prevent further incidents in the future.
Improved staff experience	☒	The report outlines what training hand support has been provided for staff to prevent future incidents occurring in the future, Gives clearer expectations and process for staff to follow
Improved value	☐	

Implications

Equality Analysis	The effective operation of the crisis line is an important element of the service response to mental health crisis across the communities in Hackney.
Risk and Assurance	This report summarised actions taken to respond to risk-related interventions and an assurance of the processes for safe practice and oversight
Service User/ Carer/Staff	Delivery of safe reliable care is a priority for the Trust. Service users will benefit high quality response with good risk assessment when they

	contact Crisis line. Greater staff confidence how they respond compassionately will improve their experience of delivering care. Carers will have greater confidence in the safety of their loved ones.
Financial	There is cost associated with the improvements of the Crisis Line which have been agreed. There is also cost involved in recruitment to extra post in legal has been agreed.
Quality	The issues highlighted are related to patient safety. Patient safety is the cornerstone of high-quality health care.

1.0 Background/Introduction

1.1 In May 2020, Ms Glausciusz died in the Royal London Hospital after jumping from a height. Her father called the City and Hackney Crisis Line the week prior to death. The Serious Incident Investigation identified several areas of care that were below acceptable standards. The subsequent Coroner's Inquest found thar MS FG's death was likely not preventable. However, HM Coroner delivered a Regulation 28 report on actions to Prevent Future Deaths (PFD) as concerns about the following areas in relation to patient care.

1.1.1 This is not the first time that HM Coroner has made a PFD Report in relation to the City and Hackney Crisis Line.

1.1.2 The Crisis Line call handler did not make a note of the call in the medical record, and his manager told him not to make an appropriately dated retrospective note in the record.

1.1.3 The lead SI reviewer could not be confident that the Trust had taken all appropriate actions in respect of the Crisis Line call handler.

1.2 HM Coroner also noted the following unacceptable delays in document disclosure that impeded her investigation.

1.2.1 The Court only received a copy of the recording of the call (without a transcript) the day before the inquest.

1.2.2 The Court received a statement from the clinician who took the call the day before the inquest.

1.2.3 The Court received statements from other ELFT clinicians in dribs and drabs earlier this month.

1.2.4 The Court received a copy of the SI report the day before the inquest.

1.2.5 The Court never received a copy of the 48 hour hot de-brief.

1.3 This report is an update on progress to address the shortcomings in these areas of practice.

2.0 ISSUES RELATING TO MS GLAUSCIUZ'S CARE

2.1 Prior to compiling the PFD response. The Legal Affairs Team compiled all Regulation 28 reports issued by HM Coroner to the Crisis Line and the relevant responses provided for five years. There had been two previous PFD relating to this service (one five years ago and one four years ago). The Coroner had also raised concerns regarding the service in a case in 2020 although did not formally issue a Section 28 PFD. As a result of this the team carried out a root and branch review off all issues that had been raised.

2.2 A plan has been put in place that addresses HM Coroner's current concerns as well as those issues that have arisen over the last 5 years.

2.3 **IMMEDIATE ACTIONS TAKEN**

2.4 ***Increased Oversight***

2.5 In May 2020, immediately, after Ms Glausciusz's death, the Deputy Borough Director listened to calls by each staff member to assess the quality of the care being provided. The results showed improvement was required.

2.6 Now, senior staff supervisors (registered mental health nurses, social workers or occupational therapists at a Band 7 level) listen to a sample of each Crisis Line clinician's calls (with them) on a monthly basis to assess the quality of their care.

2.7 In July 2021, the Deputy Borough Director listened to recorded calls from each staff member working on the Crisis Line. The standard was overall good. However, the outcome was that the contract of an Agency Nurse was terminated and another nurse was commenced on a performance management process.

2.8 Between 20 November 2021 – 28 November 2021, the CCG conducted a 'mystery shopping' audit of the Crisis line to measure responsiveness to calls. 70% of calls were answered in one minute or less, with 20% less than two minutes. The qualitative feedback was that staff were pleasant and polite.

2.9 From January 2022, a larger Trust-wide Crisis Line call quality audit will take place. The audit tool has already been devised.

2.10 Finally, there is a plan for the Crisis Line to change its crisis line provider to a service which allows staff supervisors in-call listening so that supervision can occur in real-time.

2.11 ***Recruitment***

2.12 Two significant changes have been made to the Crisis Line recruitment process. Since August 2021, all interviews for new staff include telephone call role playing as selection criteria.

2.13 As of October 2021, a Crisis Line specific induction checklist was introduced and all staff (whether bank or permanent) need to undertake a minimum of 6

supervised calls before they can work independently. Importantly, all supervisors will be senior Band 7 qualified mental health clinicians.

2.14 ***Training***

2.15 The Crisis Line is a stressful environment. There is a high number of calls involving difficult topics. Therefore, training that takes into consideration staff wellbeing and resilience should lead to better quality calls.

2.16 With this in mind, the Crisis Line call handlers have attended specialised training provided by the Samaritans. Training sessions took place between 29 November and 16 December 2021.

2.17 Further, a Quality Improvement Project addressing issues of Crisis Line Staff well-being was commenced in October. It will focus on increasing staff resilience with a focus on skills, process, workload and stress management and supervision.

2.18 ***Policy Changes***

2.19 The City and Hackney Crisis Line Operational Policy has been updated to include a section on how call handlers should deal with concerned relatives and family members. This will be ratified on 17th December at the ELFT London Crisis Strategy Group and the updated content will be discussed with staff members at their team business meeting on 6 January 2022.

2.20 **LONG TERM CHANGES**

2.21 By the end of 2022, the City and Hackney Crisis Pathway will undergo a complete transformation. Currently, the Home Treatment Team, Crisis Assessment Team and Crisis Line are managed as one team with staff working between all three. The new service envisions a separately managed Home Treatment and Crisis Assessment Team. The latter will comprise the Crisis Line and Urgent Assessment Team. It is envisaged that smaller, focused teams this will enable better management and supervision, more focussed training and development.

2.22 Part of the transformation involves reviewing all job descriptions, operational policies and introducing a training programme tailored specifically to the needs of Crisis Practitioners. Standardised assessment and care planning tools will be introduced across the pathway, including the Psychiatric Liaison Team in the Emergency Department and the Crisis Café. A crisis hub will be established as an alternative to the Emergency Department. It is hoped staff will be able to work flexibly across the pathway in order to increase staffing in a specific area in the immediate demand becomes high. The Crisis Pathway services will work more closely with our voluntary sector colleagues to improve access to crisis services and care which is better focussed around the needs of specific communities.

2.23 ***Medical Records Concerns***

2.24 Medical records training for all senior nurses was provided on 24 November 2021 to all senior nurses and managers at the Trust. The focus of the training was good record keeping, observations and retrospective record keeping.

2.25 The Crisis Line managers that attended this training have now shared this learning with all staff at the next away day on 6th January 2022.

3.0 ISSUES RELATING TO DOCUMENT DISCLOSURE

3.1 ***SI Report Delays***

3.2 The Trust has hired four new SI investigators. They start work beginning in November and are tasked with clearing the current backlog of SI reports that have accumulated throughout the pandemic. It is estimated that this will be completed by the end of 2021.

3.3 I have sought assurance from the Associate Director of Governance and Risk that until that time, SI investigations with inquest dates will be prioritised and that HM Coroner is provided with realistic due dates if SI reports are going to be submitted to the Coroner's Court late.

3.4 Additionally, in the instance that SI reports are late, HM Coroner will be provided with the 48 Hour report.

3.5 ***Witness Evidence Delays***

3.6 The Trust has also agreed to hire an additional solicitor in order to increase the Legal Affairs Team's capacity which has been affected by long term sickness absence and the increase in inquests. A new solicitor will join the team by late March.

3.7 In the interim, the Legal Affairs Team have reviewed their processes to ensure that witness statements are received in a timely manner, and will provide realistic deadlines to the Coroner's Officers if issues such as clinician sick leave hinder progress.

3.8 Of note, the Trust had provided the recording of the call 1 week prior to the inquest and HM Coroner has not previously requested transcripts of recordings of calls. Going forward, the Interim Associate Director of Legal Affairs, upon becoming aware of such recordings, will liaise with the Coroner's Officer's to discuss whether or not a transcript is required.

4.0 Action being requested

4.1 The Board/Committee is asked to NOTE the actions taken and CONSIDER any other action or assurance required.