Regulation 28: Prevention of Future Deaths report

Grazyna WALCZAK (died 26.09.20)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **Camden & Islington NHS Foundation Trust (C&I)** **4th Floor, East Wing** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE**
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 14 October 2020, one of my assistant coroners, Edwin Buckett, commenced an investigation into the death of Grazyna Walczak, aged 61 years. The investigation concluded at the end of the inquest earlier today. I made a determination at inquest of death by suicide.
4	**CIRCUMSTANCES OF THE DEATH** Grazyna Walczak jumped three storeys from her flat on 25 or 26 September 2020. She was suffering an acute depressive illness.

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. Ms Walczak was seen by a psychological wellbeing practitioner from the Camden and Islington iCope service two or three days before her death. She was assessed as being at low to moderate risk to herself. However, she was not asked if she would agree to her family being notified of the situation and of her current mental ill health. Her son would dearly like to have been told what was happening and would have acted accordingly. I heard evidence that iCope does not routinely ask their patients if families may be involved. This seems to be a policy worthy of reconsideration. 2. The 72 hour investigation report that should be produced within 72 hours of death, to enable fast learning that may be of immediate benefit to other patients, was not completed until last week, some five months after Ms Walczak's death. That is obviously not acceptable and could put others at risk by a potential failure to learn.
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 4 May 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] son of Grazyna Walczak • Dr [redacted], team leader, iCope • 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** 04.03.21 *ME Hassell*