IN THE INNER NORTH LONDON CORONER'S COURT

AND IN THE MATTER OF A REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER TOUCHING UPON THE DEATH OF THE LATE REGINALD CAUTHERY

SUBMISSIONS ON BEHALF OF THE LONDON BOROUGH OF HACKNEY

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1 This matter concerns the circumstances of the death of the late Reginald Cauthery, which were investigated by Senior Coroner Hassell, leading to an inquest on 18th and 19th August 2022 ('**the Inquest**') in which His Majesty's Coroner ('**HMC**') recorded a conclusion that primary cause of death multi organ failure as a result of 36.5% burns to the body. Those burns were the result of a fire that was found to have started in Mr Cauthery's bed on 20th February 2022.

2 These submissions are made on behalf of Council of the London Borough of Hackney ('**the Council**') in response to HMC's report of 4th October, 2022, made pursuant to paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, with the objective of reducing the risk of future deaths ('**the PFD Report**'). The report was not received until 29th December 2022 and HMC's officer kindly extended the date by which the Council could reply until 31st January, 2022. The Council apologises for the slight delay in its submission and the short extension kindly given by HMC's officer.

3 The Council was a properly interested party (**'PIP**') in the Inquest because of its responsibility for commissioning and providing care to Mr Cauthery. At the outset, the Council and those social workers and officers who have been engaged in this case extend their deepest sympathy to Mr Cauthery's family for his sad death.

4 The circumstances of Mr Cauthery's death are set out in part 4 of the PFD Report and are not repeated.

5 At part 5, HMC set out the following matters of concern:

(1) There was no review of the telecare service provided to Mr Cauthery despite the agencies working with him being aware of his increased fire risk and deteriorating mobility.

(2) The ability of frail and vulnerable people to get urgent help in a fire situation will often depend upon other people recognising that a smoke alarm has triggered and calling the Fire Brigade. This raises particular problems if the person lives alone and their smoke alarm is not connected to their telecare system.

(3) If Mr Cauthery's smoke alarm had been connected to his telecare system, the call would have been answered as a priority. In addition, the call handler would not have spent several minutes seeking confirmation that the smoke alarm was going off before making a 999 call.

6 The Council notes that HMC, in making her findings and in expressing her concerns about the circumstances of Mr Cauthery's death has expressly not made any findings about the civil liability of any party, which is not the function of an inquest. Similarly, nothing in this reply or in the document exhibited with it should be taken as an admission of civil liability in respect. While the Council does accept that its procedures could and should be improved to reduce the risk of these sad circumstances recurring, that does not and should not be taken as equating to such an admission.

7 Following the hearing and service of the PFD, the Council's officers and social workers engaged in this case considered with their legal representatives ways in which HMC's above concerns can be addressed so as to reduce the risk of future deaths from fire; and particularly fire caused by vulnerable persons, particularly those such as Mr Cauthery who are at greater risk. In his case, it is recognised that the following increased his risk individually and (particularly) conjunctively: that he was bed-bound; that he was a heavy smoker; that he drank heavily.

8 These discussions led to the Council setting out a number of ways in which it might address its procedures and guidance that could reduce the risks to vulnerable individuals such as Mr Cauthery. The procedures and guidance are those that are set out in the Council's 'Mosaic' system.

9 The Council attaches a table in which it sets out, by column, its identification of what could be done better, learning from the circumstances of Mr Cauthery's death, the action it intends to take and the time-frame for that action.

10 The Council hopes that HMC can be assured that its officers, staff and agents have taken careful account of the circumstances of Mr Cauthery's death, the evidence considered in the Inquest and her concerns. It is submitted that the changes to their procedures and guidance will have the effect of reducing the risk to vulnerable people in Mr Cauthery's situation and of deaths in particular.

2nd February, 2023

[redacted]

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