FAO Ian Potter
HM Assistant Coroner
Inner North London
Camley Street
London
N1C 4PP

[redacted]

[redacted]

12 April 2024

Dear Sir

Regulation 28 Prevention of Future Deaths report issued 11th January 2024, following the inquest into the death of Nicholas Cork

We write to respond on behalf of Sapphire Independent Housing ('Sapphire') pursuant to the receipt of your Regulation 28 report dated 11th January 2024, identifying concerns arising from the death of Nicholas Cork.

We would like to take the opportunity at the outset to extend our sincere condolences to the family and friends of Mr Cork. He was a well-liked and much-appreciated member of Conway House, where he had been resident since 2022; he has been sadly missed by support staff and other residents. The company has taken the circumstances of his death extremely seriously, and has carefully considered the contents of the Regulation 28 report.

The inquest proceedings

Sapphire was not legally represented at the hearing before you nor do we understand that the company was designated an Interested Person. We have taken care, therefore, to understand what transpired at the hearing and what evidence was placed before you, in order to fully respond to the contents of the Regulation 28 report. It is unfortunate that it appears a full recording of the hearing is not available; in particular there is reference to material being placed before you in evidence concerning Conway House, that does not appear to have been captured on an audio tape or transcript[1].

[1] It appears that the witness, [redacted], was asked during her evidence for a record of welfare checks and indicated that this could be provided. Her evidence was suspended while this material was obtained. We understand that it was resumed at some point prior to the commencement of the police evidence but there is no record of this.

We understand that a witness, [redacted], who is not a Sapphire employee but had worked at Conway House for around 3 years as an agency worker, gave evidence on oath regarding the checks performed on Mr Cork prior to the tragic discovery of his body in the morning of 22nd May 2023. It also appears that [redacted], a manager at Conway House, who was present at the inquest hearing though not previously designated a witness, and not (it appears) sworn in as such, provided some information on an *ad hoc* basis as to the systems and processes in place at Conway House. There had been no prior disclosure requests made of the company, but it appears some documentary material was located and provided during the course of the hearing, either by [redacted]; this appears to have included a digital copy of the welfare check record spreadsheet ('the spreadsheet'), which records (for each resident subject to regular checking) the time they were seen, the person completing the check and any additional comments. Plainly, there was more information available that Sapphire now believes would have assisted you and perhaps allayed some of your concerns about the procedures in place at Conway House, and it is regrettable that this was not before you at the hearing.

With this in mind, our approach in this response is twofold; both to (where appropriate) clarify the systems and processes in place at the time of Mr Cork's death *as well as* to identify what actions have been taken since then to improve matters and guard against the risk of future deaths arising.

Independent investigation

Following the death of Mr Cork, and prior to the commencement of the inquest before you, Sapphire undertook its own internal investigation into what had occurred. This culminated in a post-death review meeting on 28th July 2023. All agencies who had worked with Mr Cork were invited to the meeting, including a member of the commissioning team from Camden Council and any next of kin. Several Sapphire employees and at least one representative of the Camden commissioning team attended. The outcome of this review meeting included recommended improvements in how the process for checking residents operated, review of the weekend cover arrangements at Conway House and review of the handover procedure between shifts.

Sapphire also commissioned an independent investigation by Homeless Link into the circumstances of the death and any wider cultural and governance observations pertaining to Sapphire and Conway House. Homeless Link are well-respected experts in improving services linked to supporting people experiencing homelessness; they offer training and consultancy services to this end. Homeless Link carried out the review in early July 2023 and provided a report to the company in August 2023, making a number of recommendations. The report was shared with the Sapphire Board in September 2023. An action plan and timetable for the implementation of these recommendations, which incorporated those that followed the internal review, was set. The action plan was shared with Camden Council and they have maintained some oversight of progress, not least through quarterly review meetings which take place between Sapphire and Camden. As may be expected, many of the recommendations mirror the concerns expressed in the Regulation 28 report and therefore we address these below in the context of actions taken or proposed under each of the matters of concern identified by the report.

It is of note that the Homeless Link report concluded that the Conway House service has a strong culture of care.

Matters of concern

The matters of concern raised in the Regulation 28 report are set out and addressed in turn below.

1. *There was evidence that staff at Conway House were significantly concerned for Mr Cork's welfare, which is why he was deemed as 'at risk'. As a result of being 'at risk' I was told that welfare checks were required to be undertaken, at least every 24 hours. Such checks required a staff member to physically see and interact with Mr Cork or, in the alternative, to telephone him and speak to him. Welfare checks were then required to be recorded on a spreadsheet. Despite this, I was told in evidence that welfare checks would only be recorded if the resident in question was actually 'seen' by the staff member undertaking the check; this raises the concern that there is disparity about what constitutes a welfare check and what will or will not be recorded*.

The At Risk procedure at Conway House has been in place for a number of years (last reviewed in July 2020), and Sapphire understands it is consistent with procedures in place in other, similar, supporting housing settings. Sapphire does not believe that any external agency has ever questioned the content of the procedure; it is known to Camden Council who have not raised concerns.

The procedure may properly be summarised as follows. All residents are reviewed on arrival as to their specific needs and vulnerabilities, and whether they should be included on the At Risk Register. If they are, the At Risk procedure requires welfare checks to be conducted on those residents once every 24 hours. A welfare check may include physically seeing and interacting with a resident, or speaking to him/her via telephone. The mode of check does not affect the necessity to record it on the spreadsheet; whether conducted in person or via telephone, the welfare check ought to be recorded. Unless the resident has been seen and interacted with, or spoken to on the telephone, an adequate welfare check has not been completed. If the daytime shift workers have not been able to complete a welfare check, this negative should be noted on the spreadsheet and the negative welfare check passed onto night staff at handover. If no welfare check is achieved by the night staff, the missing persons procedure will be triggered in the morning[2].

Sapphire considers that this policy, if understood and followed correctly, properly provides for the welfare checking of the vulnerable persons within its care and includes appropriate mechanisms for failed safety checks to result in an escalation of checks and, if necessary, the triggering of the missing persons procedure.

[2] This is set out in policy document 'Missing Persons Produced – Supported' approved in 2013, and last reviewed in 2016

Notwithstanding this, Sapphire has reviewed the At Risk procedure set out above subsequent to Mr Cork's death. This review was completed on 1st January 2024. The procedure was looked at in the round and it was decided that it remained fit for purpose but that improvements needed to be made in relation to its implementation and operation, including as to training, oversight and accountability. These are addressed below.

2. *I heard evidence that prior to Mr Cork being found unresponsive in his room on 22 May 2023, the last recorded welfare check for Mr Cork was during the early shift of Saturday 20 May 2023. The concern here is that Mr Cork, despite being required to have welfare checks at least once every 24 hours, was not properly checked upon for between 36-48 hours prior to his death.*

3. *A night project worker at Conway House told me in evidence that they had opened Mr Cork's door at about 20:35 on Sunday 21 May 2023, but did not enter the room to see or assess Mr Cork. The only reason for opening the door appears to have been the arrival of the 'EMS team' who were required to check that Mr Cork was at home for the purposes of conditions imposed by the criminal justice system. Having heard what they believed to be snoring, the staff member closed the door and left. This fact was verified by Metropolitan Police Officers who checked CCTV footage as part of their initial investigation following Mr Cork's death. The concern here is that staff made assumptions that the 'snoring' noise was coming from Cork's room and not an adjoining room, and that the noise was snoring, without investigating further. This was a missed opportunity to properly check on Mr Cork's welfare, as required.*

Points 2 and 3 are, respectfully, dealt with together as they raise the same issues as to the adequacy of the welfare checks performed in this case between 20th and 22nd May 2023.

It is accepted that the At Risk procedure was not adequately followed by support staff in the days prior to Mr Cork's death, and that this was not identified contemporaneously by any management checks. It is accepted that the check that was conducted on Mr Cork during the evening on 21st May 2023 was not an adequate welfare check because it did not involve interacting with him, merely hearing him snoring and assuming he was therefore sleeping.

Sapphire has therefore fully recognised the need for improvement in how the At Risk procedure is implemented, followed and managed. As the Homeless Link report also emphasised, it should form the foundation of the interaction of the staff team daily. Sapphire has reset its priorities in this regard.

In particular, the handover process has been reviewed to place further emphasis on the At Risk procedure. This review was completed on 8th August 2023. There has, as a result, been an increase in the working hours of night shift workers, thereby extending the handover period between shifts to ensure an appropriate face to face interaction to discuss any incidents that have occurred. There is an expectation that any failed welfare checks, or any problems with the At Risk procedure, will be highlighted at this handover. There is a

handover template that must be completed prior to every shift handover; this includes a specific section for recording issues concerning At Risk register checks.

Further training provision has also been (and continues to be) implemented in relation to the At Risk procedure with a view to offering staff an increased level of support and knowledge. Training in complex needs, dual diagnosis and personality disorder was delivered by Homeless Link on 22nd September 2023 for all resident-facing colleagues. A workshop covering welfare checks and risk management was attended by all Conway House staff in February 2024. Following a Homeless Link recommendation that Sapphire services are reflective of psychologically informed environment approaches, as these environments naturally reduce the levels of incidents and are more conducive to positive residential operations, the Camden Commissioning team are providing training in this area and regular refresher courses to all staff in Pathways. Training needs are now discussed as part of one to one supervision and appraisals and training needs are identified for each staff member's development.

Since October 2023, there has been greater focus on revisiting the guidance derived from policies and procedures to support day to day practice; not just at induction but on a continuing basis, through team meetings, team away days, and a wider organisational approach. The At Risk procedure, while well-established as a precursor to the Missing Persons policy, has not historically been set out fully in a written policy document. A standalone policy document is in the process of being drafted and is expected to be presented to the Sapphire Board in May, for wider publication in June 2024. All staff receive online training in policies and procedures with periodic refresher training. There is also an easily accessible online hub where a policy library is available.

Sapphire has recognised that there needs to be a greater level of management review of the At Risk procedure, and greater accountability for proper checks being carried out. The Homeless Link report noted that if the completion of the At Risk checks was a process for which managers were forensically held to account by the Executive Team and reviewed at Board level, culturally the missing of checks would be far less likely to happen, whatever the chaotic dynamic of the service. This culture of accountability has been implemented through, for example, a housing operations team away day in April 2024, which focused on discussing Key Performance Indicators (KPIs), including in relation to the operation of the At Risk procedure, which are to be introduced and monitored monthly as part of the Operational Management meeting. Senior management performance meetings are to commence from April 2024. Any service incidents are to be reported at Board level, along with any failures to meet KPIs.

Sapphire is therefore confident that the risk of staff error in the conduct of welfare checking and the operation of the At Risk procedure as a whole should be considerably reduced, and that if errors occur, they are more likely to be identified at the time.

4. *In evidence, I was taken through the spreadsheet that is used to record all checks and/or welfare checks required for any residents of Conway House. The record system appears to have been a basic Microsoft Excel spreadsheet devised by staff. I was told that the computer and/or spreadsheet often 'crashed', which led to data sometimes not being able to be recorded. I also*

observed that some fields of the spreadsheet were often left blank. Staff undertaking and recording checks regularly appeared not to input their name(s) or the time at which checks were undertaken. I was also told that while there was some training on how to undertake and record welfare checks, this was not needed because it was a simple task. The concern here is that the recording system for welfare checks may not be adequate and that the approach taken to filling in the data required on the spreadsheet varied from one staff member to another, which may also indicate that there is a training need.

At the time of May 2023, the spreadsheet used to record welfare checks was considered to be adequate, insofar as it allowed for the timing of the check, the identification of who had completed it and any additional comments to be recorded. It is recognised that its use was dependent on the computer that stores it being functional, but technical issues were extremely rare and there was a manual workaround about which staff were fully informed. Any manual records were promptly recorded on the digital spreadsheet.

Serious consideration has been given to an alternative method of recording welfare checks but, following a thorough review, it has been decided to maintain the current format, with which staff are familiar, and which has functionality to record all the required information relevant to welfare checks. The additional focus on training, management oversight and accountability that has been a feature of revisions to the At Risk process as a whole, equally applies to the record-keeping of the welfare checks on the spreadsheet and should ensure operational improvement. The spreadsheet is currently reviewed by a manager every Friday. Additionally, a recruitment process is underway for a new administration assistant to assist with housing management tasks, which will include the oversight of the spreadsheet with qualitative checks and sample testing. The recruitment process is expected to complete in April 2024, with employment to commence in May 2024.

That the current format of the record is fit for purpose will be kept under review. Enquiries are ongoing as to whether the record of welfare checks could be integrated into wider support software used by staff on the Inform system. This review is likely to continue throughout 2024.

Sapphire is confident that the increased prioritisation on the recording of welfare checks will place that record front and centre of staff work objectives, with oral communication between different shift teams also of paramount importance alongside the written record.

5. *I was told in evidence that the same spreadsheet is still used to record any checks and/or welfare checks required for residents. I was told that the issues identified with a lack of checks for Mr Cork were caused by the fact that there were a significant number of agency staff on duty and that Conway House no longer uses agency staff. However, the staff member that opened Mr Cork's door at 20:35 (without entering the room or seeing Mr Cork) on 21 May 2023 and subsequently found him unresponsive on the morning of 22 May 2023 was a substantive member of staff.*

[redacted] was not a substantive member of staff but, it is accepted, had worked at Conway House as a member of agency staff for a prolonged period. Sapphire continue to use agency staff at Conway House. However, there have been material improvements in how this is managed and how the processes to be followed are communicated; in particular a thorough written contractor induction package has been formulated, which focuses both on the conduct of welfare checks and their recording.

Of the three staff members (two permanent members of staff, one agency staff) with particular responsibility for conducting welfare checks on 20th and 21st May 2023, and therefore most accountable for the failures that occurred, the agency contractor had their contract terminated. The two permanent members of staff were both subject to disciplinary procedures concerning the failure to conduct adequate checks, the failure to record this on the welfare check spreadsheet and the failure to complete an adequate handover to night staff in this regard.

It has been recognised that the weekend is the lowest level of staffing at Conway House due to the nature of the funding, rota and management working pattern. The Homeless Link report suggested that consideration be given to whether there should be management checks taking place at these times, for example, the organisational on-call system could incorporate a management check of the At Risk register during the weekend with a view to tightening the safety net of checks so that they are not missed. A shift leader position has now been introduced for each shift, tasked (in part) with ensuring that the At Risk procedure has been complied with and that an effective handover is completed with the next shift. There is also now a Monday morning meeting between managers and staff in order to facilitate a thorough handover of any issues that have arisen over the weekend; there is an expectation that this will include a focus on any issues with the At Risk procedure.

Permanent night staff have been recruited by Sapphire (with a start date of the end of April 2024) with a specific job description that incorporates the At Risk procedure, which should increase continuity of knowledge and experience across the staffing body.

In September 2023, Sapphire completed a review of working shift patterns and how the removal of a ‘7 days in a row’ shift pattern and its replacement with a more balanced working pattern may mean staff are more refreshed and less prone to burnout (which could have lead to an increased risk of missed checks). Smaller more frequent working patterns have been implemented across the board.

Discussions also remain ongoing with the London Borough of Camden as to the support and care needs of referrals into Conway House, along with a review of the Pathway to consider where the most vulnerable and those with the most complex needs are most appropriately housed.

In conclusion

We reiterate that the death of Mr Cork was a source of considerable sadness and concern to Sapphire. The company has made focused efforts to understand the circumstances of his death and to make improvements to the operation of the At Risk procedure in light of the

failings that were identified internally, by an independent review and by you the Coroner. The company is confident that the improvements that have been, and continue to be, implemented will meet the concerns expressed during the inquest into Mr Cork's death, and guard against the risk of future deaths. We sincerely hope that this response is of assistance to you, and would welcome the opportunity to provide any further clarification or information that you may require.

Yours faithfully

Devonshires Solicitors LLP