Regulation 28: Prevention of Future Deaths report

Nicholas CORK (died 22 May 2023)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Chief Executive** **Sapphire Independent Living** **1 Holmes Road** **Kentish Town** **London** **NW5 3AA**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North London.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 15 June 2023, an investigation was commenced into the death of NICHOLAS CORK, then aged 57 years. The investigation concluded at the end of an inquest, heard by me, on 5 January 2024. The inquest concluded with a short narrative conclusion which set out that, "while substance misuse did not directly cause Mr Cork's death, it did more than minimally contribute to it." The medical cause of death was: 1a bronchopneumonia 1b chronic obstructive pulmonary disease II liver cirrhosis, substance misuse disorder, diabetes mellitus.
4	**CIRCUMSTANCES OF DEATH** Mr Cork lived in supported accommodation at Conway House, 18-22 Quex Road, London, NW6 4PL, which is a service operated by Sapphire Independent Housing. The funding for Mr Cork's placement at Conway House was provided by the Local Authority. Mr Cork had been resident at Conway House since 2022.

	Following his arrival at Conway House in 2022, staff assessed him as being 'at risk' due to a combination of his physical health conditions, his ongoing substance misuse issues, and his continued engagement with aspects of the criminal justice system. In the early morning of 22 May 2023, Mr Cork was found unresponsive in his room and an ambulance was called. Paramedics verified the fact of his death 06:28 on 22 May 2023.
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 could 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) 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. (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. (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. (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. I was not reassured that any proper investigation into these issues had been undertaken or that any action(s) required to bring about improvements in the system of undertaking and recording welfare checks have been identified and/or implemented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 the report, namely by 7 March 2024. 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 Chief Coroner and to the following: (a) Director of Adult and Social Care, London Borough of Camden. I am also under a duty to send the Chief Coroner a copy of your response. 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 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 by the Chief Coroner.
9	**Ian Potter** **HM Assistant Coroner, Inner North London** **11 January 2024**