Regulation 28: Prevention of Future Deaths report

Nonie ATSHIKI (died 13.07.24)

	THIS REPORT IS BEING SENT TO: **1. Chief Executive Officer** **St Mungo's** **3 Thomas More Street** **London E1W 1YW**
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 31 July 2024 I commenced an investigation into the death of Nonie Atshiki, aged 35 years. The investigation concluded at the end of the inquest on 2 December 2024. I made a determination at inquest that death was drug and alcohol related.
4	**CIRCUMSTANCES OF THE DEATH** Nonie Atshiki was found in the stairwell of the hostel where she lived, St Mungo's in Endell Street, shortly after 4am on 13 July 2024. Her medical cause of death was: 1a acute cardiac failure 1b cocaine use and long term alcohol excess.

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. I heard evidence at inquest that the night concierge who found Ms Atshiki had not had any first aid training from St Mungo's. He said that he had undergone first aid training elsewhere in the past, but he did not know whether the hostel had a defibrillator. It did not. Whilst not relevant in this case, I was told that the hostel does stock naloxone (used in the emergency treatment of opiate/opioid toxicity), but that the night concierge is not trained in its use. The evidence at inquest was that there are only ever two members of staff working at the hostel at night, of which the night concierge is one. After Ms Atshiki's discovery, the night concierge stayed with her as she lay across the stairs, while the other member of staff stayed by the front door to open it when the ambulance service arrived. Nobody at the hostel attempted to perform cardiopulmonary resuscitation on Ms Atshiki. There is no evidence that if CPR had been performed it would have changed the outcome for Ms Atshiki. However, in another situation it might. And in another situation it might be the second member of staff who falls ill. That would only leave the night concierge to attempt resuscitation.
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 10 February 2025. 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. • The father of Nonie Atshiki • HHJ Alexia Durran, 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. She may send a copy of this report to any person who she 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** 12.12.24 *ME Hassell*