REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Marco Belinzona
Director,
Whirlpool UK Appliances,
Morley Way,
Peterborough,
Cambridgeshire.
PE2 9JB

Leon Livermore
Chief Executive,
Trading Standards Institute (CTSI),
1 Sylvan Court,
Sylvan Way,
Southfields Business Park,
Basildon,
Essex.
SS15 6TH

Office for Product Safety and Standards
c/o Rt Hon Greg Clark MP
Secretary of State for Business,
Energy and Industrial Strategy,
BEIS,
1 Victoria Street,
London.
SW1H 0ET

[redacted]
Head of Supported Housing Services,
c/o Wandsworth Watch Alarm,
Housing Customer Centre,
Housing and Community Services Department ,
90, Putney Bridge Road,
London.
SW18 1HR

Paul Martin,
Chief Executive,
c/o Watch Lifeline,
Supported Housing Services,
Wandsworth Borough Council,
Town Hall,
Wandsworth High Street,
London.
SW18 2PU

1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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 20th February 2018, evidence was heard touching the death of **Mrs Elizabeth Marion Griffin.** Mrs Griffin had died on 21st August 2017 in St George's Hospital following an admission for smoke inhalation from a house fire on 14th July 2017. She was 71 years old at the time of her death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Bronchopneumonia (b) Smoke inhalation injuries II Multiple Sclerosis; Diabetes Mellitus **How, when and where the deceased came by her death:** Mrs Griffin was wheelchair bound due to advanced multiple sclerosis. On 14/07/2017 she was alone at home in bed when a fire started in the dishwasher in the kitchen. She attempted to call for help at 08:11 via her pendant alarm. The call responder did not recognise the sound of the activated smoke alarm during the call and was unable to communicate effectively with Mrs Griffin. The London Fire Brigade was called at 08:15 by a local worker. This delay in calling LFB was not ultimately causative in the death. LFB recovered her unresponsive at 08:30. She was resuscitated at the scene and transferred to St George's Hospital, where despite all treatment she died as a result of smoke inhaled from the fire on 21/08/2017. The dishwasher, model number DWF30P17, was one of batch known to contain a component which could cause fires and the fire started within this component. **Conclusion of the Coroner as to the death** Accident
4	**Circumstances of the death.** Evidence was taken that Whirlpool UK were notified of potential fire hazard from the type of dishwasher which caused this fire in December 2010. However no campaign to repair or withdraw affected models was started by the company until November 2013, effectively 3 years later. Throughout this time the company was in communication with Trading Standards. There was no evidence that Mrs Griffin's household was ever contacted by Whirlpool in relation to the potential fire risk dangers from the dishwasher that ultimately caused the fire and led to Mrs Griffin's death, with no record held by Whirlpool UK of the address or owners of this dishwasher.

	There now exists a system which allows people to register on line the details of all and any appliances that they possess through one portal, through AMBIA, so that if a product is discovered to require repair or withdrawal the owners can be contacted by the manufacturer. Mrs Griffin had a contract with Wandsworth Watch Alarms, a "watch" telecare service, with which she could communicate either by activating a pendant alarm or telephoning if she required assistance. Mrs Griffin was in bed at the start of the fire and unable to help herself escape due to her mobility problems. She activated her pendant alarm which connected to Wandsworth Watch Alarms (WWA) and was answered by the call responder. She was sited within her accommodation a long way from the systems box of WWA. This may have impeded verbal communication between Mrs Griffin and the call responder from Wandsworth Watch Alarms. However when the call recording was played in court the smoke alarm from Mrs Griffin's home could clearly be heard. The call responder was heard to introduce herself and attempt to speak with Mrs Griffin but elicited no verbal response from her. The Call responder then telephoned Mrs Griffin back. Mrs Griffin did not respond to this call and the responder then rang Mrs Griffin's husband. He was driving and unable to speak, and so the responder visited the Mrs Griffin home address, arriving as she was being rescued. The responder never contacted the fire brigade. The responder stated that she did not recognise the smoke alarm sound actuating in the background when Mrs Griffin attempted contact via the pendant alarm, as it seemed to her like the noise the telecare electronic box system installed in the client's home may make if faulty, and was not like the alarm sound from alarms that she monitored for other clients who have system linked alarms. She had received no training in relation the sound of activated fire alarms other than her direct experience of system linked alarms.. At the time Mrs Griffin's home did not have system linked fire alarms. The protocol supplied by WWA in relation to how long to spend trying to contact a client if a fire alarm activates was not consistent with those of the British Standards Institution. WWA now encourage new clients to have fire alarms linked to the telecare system. Some monies have also been made available to provide linked alarms to existing clients and WWA possess data which allows then to identify clients who have at present unlinked alarms. WWA have approximately 1000 clients a considerable percentage of which will have alarms not linked to the telecare system. It was accepted in evidence that if the "watch" telecare company can insist on holding keys to homes of their clients which allow their responders to access the clients' property, by analogy they could also insist that the clients have fire alarms linked to the telecare system. Previously this has always been optional and would have cost the client almost as much on a weekly basis as the "watch" telecare response service itself. The LFB presented evidence which stated that following fatal fire reviews they have found a pattern of fire detection systems not being linked to telecare units and over reliance on persons activating their pendants in order to seek help in life critical emergency fire related incidents, rather than fire alarms in their homes being directly connected to a telecare system able to respond and call the fire brigade on their behalf.
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. It is for each addressee to respond to the matters that relate to their area of authority or control.

The **MATTERS OF CONCERN** are as follows:

NB: I use the term "telecare" here as a generic term to cover "watch only systems" as were being used in this case and more extensive services providing care via the use of sensors and other electronic devices in addition to pendant alarms and telephone contact and response services. **In my view, after consideration of the evidence, the concerns I raise apply equally to both "watch" only and wider electronic telecare services.**

1. That it simply took too long for Whirlpool UK to launch the repair/withdrawl campaign.

2. That there should be a safety campaign encouraging owners of appliances to register their details through a central portal such as AMBIA so that if concerns about an appliance arise they may be promptly contacted.

3. That any such campaign be also targeted at those who are less computer literate and consideration be given as to how to address their needs in relation to registration.

4. That there is an artificial distinction between service users and clients who are "watch" only services, and those with wider telecare support. Either type of client would be vulnerable to fire.

5. That users of telecare systems have the fire alarms in their homes directly linked to the telecare systems.

6. That telecare systems be organised such that a client operating a pendant alarm can talk with the responder no matter where the client is within their property such as to allow a client with mobility problems to be in proper communication with their telecare system operator at all times.

7. That telecare system operators and WWA in particular, apply the British Standards Institute requirement to call for the help of the fire brigade after 30 seconds maximum of trying to contact a client if the client's fire alarm goes off.

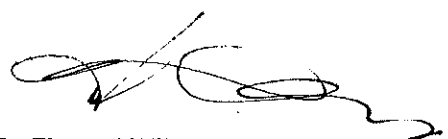
8. That telecare systems providers and WWA in particular, insist that their clients, who by definition are vulnerable, have linked fire alarms as a contractual requirement for both new and existing clients in the same way that such providers insist on the provision to them by the client of keys to the clients' homes.

9. That telecare systems providers and WWA in particular, take active steps to identify clients without linked fire alarms and arrange for them to be replaced with linked fire alarms and that this should be done in a timely and auditable fashion.

10. That telecare systems providers and WWA in particular, train their staff on the appropriate response to the activation of a fire alarm and that this should be according to the standards laid down by the British Standards Institute.

11. That telecare systems providers and WWA in particular, train their staff as to what fire alarm activation sounds like whether from a linked or unlinked alarm and that they should call the fire brigade appropriately if they are heard by the responder to be activated.

12. That telecare systems providers and WWA in particular, highlight on the front screen of the client details, if that client has an unlinked fire alarm, until such a time as the unlinked alarm is replaced by a linked one, so as to alert call responders that sounds heard in the back ground of a contact or call may

	represent an activated fire alarm and thus the fire brigade may need to be called to the client's home by the call responder. 13. That telecare systems providers and WWA in particular, develop working relationships with their local fire brigades to facilitate fire risk assessments visits to the homes of the clients by the fire brigade being offered to telecare clients and accepted by them.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 Interested Persons : 1. [redacted] 2. [redacted] Watch Manager- Red Watch, Fire Investigation Team, London Fire Brigade, 94/5 Upper Thames Street, Dowgate, London. EC4R 3UE. 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 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 by the Chief Coroner.
9	**7th March 2018**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**