REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Lord Greenhalgh** **Minister of State for Building Safety, Fire and Communities** Ministry of Housing Communities & Local Government and Home Office Fire Safety Unit, Home Office, 2 Marsham Street, Fry Building London SW1P 4DF
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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	**INVESTIGATIONS and INQUESTS** Mr Henry Boddy died on 4 November 2020 at University College London Hospital. I concluded an inquest to his death on 25 June 2021, with the following wording: *Mr Boddy died form the consequence of a fire at his own residence. This arose from recognised risks, on the background of health conditions from which he suffered. There were missed opportunities to address these risks but that does not amount to neglect.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Boddy was found collapsed on 4 November 2020 in his own property, at which there was a significant fire ongoing. He was rescued by London Fire Brigade, resuscitated by London Ambulance Service and treated in hospital. However, he died later the same day from the consequences of this fire, which was later found to have been caused by either unsafe use of candles for lighting or unsafe use/disposal of smoking materials. The condition of his flat had previously been recognised to pose a fire risk, owing to the accumulation of a fire load because of hoarding behaviour. This had been ongoing for many years. Multiple concerns had been raised about this risk and steps taken to address it. However, his hoarding behaviour continued and the risk recurred. Much of the evidence I heard at the inquest related to steps taken or not taken, in order to address these ongoing risks. I was satisfied that the London Borough of Camden have taken or are taking steps to address the matters of concerns raised. However, one issue remained unaddressed, as it relates to matters outside of the council's control. I heard evidence that statutory powers do not exist to address concerns regarding

	fire risk as a consequence of hoarding, in a residential property. A witness from the council set out that fire safety issues can only be addressed through contemporaneous enforcement of Environmental Health powers, under legislation intended to address infestation. In this circumstance, Environmental Health officers did not attend the property nor address concerns about infestation with rodents, as it was (in retrospect inappropriately) felt that there was insufficient evidence provided.
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: 1. I am aware that the Government has recently consultant on and responded to potential additional fire safety measures. However, from the evidence I heard at this inquest and from my review of the Government's response, I am concerned that there is a gap in enforcement powers, as they relate to addressing fire risks in residential properties; specifically in this circumstance, the risks of a fire load arising from hoarding behaviour.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressees 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 27 August 2021. 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, Mr Boddy's family, London Borough of Camden – Social Services department, London Fire Brigade. 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	Dated: 2 July 2021  **Assistant Coroner R Brittain**