

## Regulation 28: Prevention of Future Deaths report

Lorraine KARAT (died 16.06.21)

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. [REDACTED] <b>Group Chief Executive Clarion Housing Group Level 6 6 More London Place Tooley Street London SE1 2DA</b></p>
1	<p><b>CORONER</b></p> <p>I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 25 June 2021, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Lorraine Karat, aged 68 years. The investigation concluded at the end of the inquest on 25 October 2021.</p> <p>I determination made at inquest of accidental death.</p> <p>The medical cause of death was: 1a multiple injuries 2 recent alcohol use.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p>

	<p>Lorraine Karat fell from a second floor balcony outside her flat, possibly in her sleep. She had been drinking heavily. The balcony parapet was only 36cms high and not contained by any railing. One of her sons had warned her that it was dangerous for her to go out there, but she did sleep on the balcony on warm nights.</p> <p>The housing company from which she rented her flat did not intend the balcony to be used by the resident of the flat. However, there is no evidence that the company ever told her this, and there was no warning sign. There were no bars on the window that she had used to access the balcony, nor were there any window restrictors.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows.</p> <p>Clarion Housing is the company from which Lorraine Karat rented her flat. There are 17 flats in the building, in a complex for the over 55s. All residents have been nominated for occupation by the local authority.</p> <p>Clarion is responsible for the fabric of the building. The property is staffed by a Clarion building manager/concierge who undertakes fire and health &amp; safety checks, and may assist residents in reading correspondence and so forth. There is no restriction on visitors, including children.</p> <ol style="list-style-type: none"> <li>1. No evidence was provided at inquest of a risk assessment having been undertaken of Ms Karat's flat, most especially including the window that opened over a metre high onto the balcony, thereby rendering the balcony accessible from within the flat.</li> <li>2. I was told by Clarion's group health, safety and wellbeing manager at inquest, that the building manager did not know that there had been any unauthorised use of the balcony. However, the manager did not enter the flat to check, nor was there any evidence that Ms Karat had actually been told that use of the balcony was not authorised, still less been asked about this during her tenancy.</li> <li>3. The balcony was not contained by a railing or other structure to make it safe for use.</li> </ol>

	<p>4. There was no sign near the window warning the occupant not to go out onto the balcony and, most importantly, there were no bars on the window or window restrictors to prevent access to the balcony.</p> <p>5. I do not know whether this situation is replicated in other Clarion properties. Wikipedia describes Clarion as the largest housing group in the UK, with 350,000 properties across 170 local authorities.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 January 2022. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the following.</p> <ul style="list-style-type: none"> <li>• [REDACTED], sister of Lorraine Karat</li> <li>• [REDACTED], director of housing mgt, Camden Council</li> <li>• Care Quality Commission for England</li> <li>• HHJ Thomas Teague QC, Chief Coroner of England &amp; Wales</li> </ul> <p>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.</p> <p>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.</p>

9	<b>DATE</b> 29.10.21	<b>SIGNED BY SENIOR CORONER</b> <i>ME Hassell</i>
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