MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] – CEO of Sequence Care Group, Sequence Care Ltd, First Floor, Highbury Crescent Rooms, 70 Ronalds Road, London, N5 1XA [redacted] 2. District Assistant Commissioner [redacted], London Fire Brigade Head Office, 169 Union Street, London, SE1 0LL [redacted] 3. [redacted] - Chair of the National Fire Chiefs Council, West Midlands Fire Service Headquarters, 99 Vauxhall Road, Birmingham, B7 4HW [redacted] 4. [redacted] – CEO of The British Standards Institution, 389 Chiswick High Road, London, W4 4AL [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3	**INVESTIGATION and INQUEST** On 20th April 2018 Ms Nadia Persaud opened an investigation touching upon the death of Ms Ashlie Claire Liana Timms Ms Persaud opened an inquest on 1st June 2018, the inquest was heard, before a jury commencing on 21st March 2022 and concluding on 12th April 2022. The jury arrived at a narrative conclusion. *"Ashlie Claire Liana Timms died from the effects of burns and inhalation of fire products on 20 April 2018, whilst a resident within a supported living setting at 20 B Connington Crescent Chingford London.* *Due to the ignition of fabric materials by a fan heater, a significant fire developed within the premises.* *The presence of a fire detection system, which was not installed to alert the emergency services, alerted staff employed to support and care for residents, to the presence of the fire.* *As a result of staff interpreting the address location on the alarm display, which was known by the wider organisation to be incorrect, staff departed from basic fire evacuation procedures. This resulted in up to a 45 minute delay to summon emergency services, demonstrating a significant lack of urgency to do so.* *With the additional actions of staff resetting the fire alarm on at least two occasions and the absence of implementing the deceased's personal emergency evacuation plan, the deceased was not evacuated.* *The presence of an electronic code disabling locking mechanism for the deceased to navigate, at the main point of escape, presented additional obstacles for the deceased in an already highly stressful situation. All of which contributed towards her death.* *With the absence of an effective fire safety audit in 2017. The discovery of departures from British fire standards and recommendations, conflicting organisational fire policies and fire risk assessments went unchallenged.* *All areas identified above, in combination with the lack of a bespoke fire related policy and fire risk assessments contributed towards her death."* The medical cause of death was found to be; 1.a. Burns and inhalation of the products of fire
4	CIRCUMSTANCES OF THE DEATH Ashlie Timms was a 46 year old woman who lived in a self-contained flat in a supported accommodation unit. Ms Timms suffered from, physical disabilities, a moderate learning disability, and a borderline personality disorder. On 20th April 2018, a fire broke out in Ashlie's bedroom at a time between 01.30 and 02.00 hrs. The most likely cause of the fire was combustible material coming into contact with a portable electric fan heater located near the foot of Ashlie's bed.

	Fire detectors in Ashlie's room triggered a fire alarm system which sounded in the unit. Staff at the unit inspected the fire alarm panel which directed them to a room at the opposite side of the building to Ashlie's flat. Staff did not evacuate the building or call for the emergency services in contravention of the operator's policies and national guidance. The fire alarm in the unit was not capable of automatically calling the fire and rescue services. Staff searched the premises for signs of a fire and when they were unable to locate smoke or flames, they reset the fire alarm. Staff later inspected Ashlie's flat and discovered a well-established fire. Thick smoke prevented them from entering and extracting Ashlie. 999 was called at 02.13 hrs. Staff actions led to a delay of between 43 and 28 minutes in calling 999. Firefighters attended the premises within 5 minutes of the 999 call. The fire spread throughout the building and was eventually brought under control at 05.30. Ashlie was found deceased in the hallway of her flat, in front of the front door. A fire investigation found that the lock on Ashlie's door was operated by a 4 digit key-pad both internally and externally. Despite the presence of a fail-safe, activated by the fire alarm which would have deactivated these locks. The presence of a key-pad on an exit was described as both unusual and dangerous. Fire safety procedures, policies and risk assessments in place at the unit were found to be unfit for purpose. A London fire brigade fire safety audit of the premises on 3rd October 2017 found that staff training and fire risk assessments were suitable and sufficient. The audit was determined to have been flawed
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. The operator of the premises failed to ensure that staff on duty were competent to carry out a fire evacuation. Despite reflection and remediation in policies, processes and training, multiple staff members who gave evidence to the inquest, remained unable to describe the proper action to take in the event of a fire alarm. 2. Fire Alarms in three units operated Sequence Care Group remain non-compliant with the 2013 British Standard Guidance, which recommends that they should have a link to an Alarm Receiving Centre ("ARC") which automatically contacts the emergency services when a fire alarm is activated. 3. The London Fire Brigade conducted fire safety audits at the premises which assessed the unit as displaying the highest standard of fire safety compliance. These findings were found to be entirely incongruent with procedures,

	equipment and staff training in place before and at the time of the fire. The London Fire Brigade have reviewed and changed processes since 2018 but they remain incomplete. 4. No clear and practical guidance exists on how specialist housing operators should manage the use of high-risk electrical devices such as portable electric fan heaters. 5. No clear guidance exists regarding the fitting of digital key-pad locks on doors in specialist housing. 6. Insufficient emphasis is placed upon recommendations contained within British Standards regarding automatic connections to ARCs in fire alarms fitted in specialist accommodation.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **21st June 2022**. 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 the family of Ms Timms and to the Care Quality Commission. I have also sent it to the Director of Public Health who may find it useful or of interest. 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. 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.
9	**[DATE] 26th April 2022** GRAEME IRVINE. **[SIGNED BY CORONER]**