Regulation 28: Prevention of Future Deaths report

John Joseph Jennings (died 18/010/20)

	THIS REPORT IS BEING SENT TO: Ministry for Housing and Local Government 2 Marsham Street, Westminster London SW1P 4DF
1	**CORONER** I am: H.M. Coroner and Senior Coroner Mr Andrew Walker Senior Coroner for North London Barnet Coroner's Court 29 Wood Street, London EN5 4BE
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 21st October 2019 I commenced an investigation into the death of John Joseph Jennings. The investigation concluded at the end of the inquest held on the 24th November 2020. The conclusion of the inquest was a short narrative conclusion; Consequences of a fire at home.

4	**CIRCUMSTANCES OF THE DEATH** On the Eighteenth of October 2019 at 01.04 hrs a line was opened to Mr Jennings from an alarm monitoring company to his home following the activation of a smoke alarm. This call did not result in the London Fire Brigade being called until 01.21 hrs . The Code of Practice for Remote Centres Receiving Signals from Alarm Signals British Standard Code of Practice, if followed, would have resulted in a call to the London Fire Brigade being made after 90 seconds from the line being opened which would, in this case, have resulted in the Fire Brigade arriving whist Mr Jennings was still connected. Had the installation complied with British Standard 5839 at LD1 Maximum Protection level there would have been more measures taken to protect Mr Jennings who had only a single fire detector in the hall at his home. Mr Jennings died at his home from smoke inhalation before the Fire Brigade arrived.
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. Evidence was heard expressing concern that the above Code of Practice and British Standard 5839 LD1 Maximum Protection level were not currently statutory requirements.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 20th January 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 following. ● The Family, ● The Deputy Assistant Commissioner London Fire Brigade ● London Borough of Barnet ● Medvivo Group Ltd ● Telecare Services Association ● National Fire Chiefs Council ● All London Local Authorities ● Care Quality Commission ● British Standards Institute 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	**26th November 2020.** **H M Coroner and Senior Coroner**