Signed by Geoffrey Sullivan
Title HM Senior Coroner
Jurisdiction Hertfordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Rt. Honourable Michael Gove MP, Secretary of State for Levelling Up, Housing, Communities and Minister for Intergovernmental Relations
1	**CORONER** I am Geoffrey Sullivan HM Coroner for Hertfordshire.
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 10 April 2017 I commenced an investigation into the deaths of Daphne Holloway and Ivy Spriggs who died on the 8th April 2017 in a fire at Newgrange Residential Care Home in Cheshunt, Hertfordshire. My investigation was suspended due to criminal proceedings being brought and resumed once they had been concluded. An inquest was held with a jury between the 1st February 2022 and the 9th February 2022. The Jury found the following in respect of both of the deceased: **Cause of Death:** 1a) Fourth Degree Burns 1b) Fire **Circumstances:** On 8th April 2017 in the early hours of the morning a fire started at Newgrange Residential Home, Cheshunt. At 0551 the fire service was called, they arrived at the scene at 05.57. The fire service commenced both the evacuation of the building and fighting the fire. The fire was caused by resistive heating in the electrical wiring in or around the ceiling level of the linen cupboard. Inadequate compartmentation in the roof space allowed the fire to spread more rapidly than expected, leading to the collapse of the roof. Daphne Holloway was found deceased in Room 18; another resident was found deceased in Room 23*. Both died as a result of fourth degree burns and neither appeared to have attempted to leave their room. (*The resident in room 23 was Ivy Spriggs.) **Conclusion:** Accidental fire contributed to by inadequate compartmentation in the roof space at Newgrange Residential Home.

4	**CIRCUMSTANCES OF THE DEATH** The fire at Newgrange was a major incident involving 12 fire engines and multiple entries by fire fighters with breathing apparatus to evacuate the building. At the time of the fire, there were 35 residents in occupation. Each of the residents was either unable to mobilise independently or had limited mobility, several had symptoms of dementia. The fire fighters evacuated the first floor by carrying residents downstairs. They protected the residents from burning debris falling from the roof above with their backs, as the roof collapsed around them. 33 of the residents were successfully rescued from the blaze, sadly the two deceased were not. I heard evidence from a number of witnesses from Hertfordshire Fire & Rescue Service: Deputy Chief Fire Officer – [redacted]; Group Commander and Fire Investigation Officer - [redacted]; Temporary Group Commander and Community Protection Manager – [redacted]; Station Commander and Fire Protection Manager - [redacted] (The job titles set out above were held by the witnesses at the time of writing their statements). I also heard evidence from an independent fire safety expert – [redacted]. All of the witnesses listed above expressed concern that sprinkler systems are not a mandatory requirement for care homes such as Newgrange, in which many residents have either limited or no independent mobility. The fire investigator [redacted] gave evidence that had there been such a system in place, the deceased would very likely have survived. I also heard evidence that care homes such as Newgrange, despite their residents having either limited or no independent mobility, do not fall under the national definition of 'Higher Risk Buildings'. I heard that if a building is classified in this way, it brings about greater consultation with fire authorities and building control regarding its design, management and construction and implications for the Responsible Person and how the Fire Risk Assessment is conducted. I understand that for a care home to be classified as a High Risk Building it must be over 18m in height (or at least 7 storeys). The focus on the height of the building does not appear to take into account the increased risk brought about by the inability of certain occupants to self-evacuate from a building in case of fire, whatever its height.
5	**<u>CORONER'S CONCERNS</u>** 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) That sprinkler systems are not a mandatory requirement for care homes whose occupants have either limited or no independent mobility and are therefore at higher risk from fire. (2) That care homes whose occupants have either limited or no independent mobility, and are therefore at higher risk from fire, are not deemed to be 'Higher Risk Buildings' unless they are at least 18m in height or at least 7 storeys high.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Rt. Hon. Michael Gove 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 7th April 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 Daphne Holloway; The family of Ivy Spriggs; Legal representatives of Hertfordshire Fire and Rescue Service; Legal representatives of Newgrange Residential Home; Hertfordshire Building Control. 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	10 February 2022 Signature  Geoffrey Sullivan HM Senior Coroner for Hertfordshire