Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
Fax 0208 447 7689

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. London Borough of Brent. 2. Network Homes Housing Association. **3.** Barnet Assist.
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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.
3	**INVESTIGATION and INQUEST** On the 29th April 2021 I opened an investigation touching the death of Sean Ennis , aged 79 years old. I opened and inquest on the 16th June 2021. The inquest concluded on the 16th November 2021. The conclusion of the inquest was " Consequences of a fire at home", the medical case of death was 1a Multi Organ Failure, 1b Smoke inhalation following a house fire and under paragraph 2 Ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** On the Nineteenth of April 2021 shortly after 9.50 hrs Sean Ennis was found in his flat at on the floor beside his bed. It is likely that a fire had started when a match had been dropped into refuse to the side of an armchair and from there to a coat hanging on the living room door. The risk assessment form for Mr Ennis did not identify the number of cigarettes smoked the method of lighting the cigarettes and the area where smoking took place. There was no smoke alarm in the bedroom. The alarm center did not know that Mr Ennis was a smoker which they should have done as this was a fire risk. Following the alarm activating a call was put through to the Flat but during the first call Mr Ennis did not reply. The call responder at the alarm center attempted to call Mr Ennis on his phone but he did not reply. Mr Ennis was taken to hospital where he died from the consequences of smoke inhalation from a fire.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. All Responsible Persons should carry out a comprehensive fire risk assessment that details the fire safety provisions that are in the property and where identified ensure

	that the recommended safety measures have been applied. It is not appropriate to 'carry over' identified actions from one fire risk assessment to another, without addressing those risks. 2. The London Fire Brigade believe that a review should be undertaken with regards to Telecare legislation and regulations. Currently this is an unregulated area and although there are British Standards and industry guidance, these are not compulsory. Legislation should clearly identify a Local Authority's or responsible person(s) acting on behalf of the Local Authority's responsibility to assess vulnerable individuals for telecare. This should include a checklist of factors, which should be assessed at regular intervals, with a clearly defined trigger for recommendation for telecare including linking to smoke detection and personal pendants. Legislation should also ensure minimum standards are enforced, practices are standardised and sanctions are available for serious breaches. 3. Telecare is not always offered to vulnerable people or if individuals do receive it, is not always linked to smoke alarms or AFSS. Telecare is often at the cost of the individual or Local Authority which may be why a full telecare system is not offered or installed. The Telecare Services Association should consider exploring a sustainable funding source to enable all vulnerable residents in need of telecare to be provided with a full system. 4. Barnet Assist are not Telecare Services Association (TSA) accredited, it is recommended that they become accredited. TSA accreditation ensures that companies agree to providing telecare that meets a set of standards, can receive additional training and encourages consistency in the industry. This should positively impact all service users. 5. For those properties housing vulnerable people (such as Sheltered Housing and Assisted Living) Landlords should consider the requirement for a home fire safety visit by the local fire and rescue service as part of tenancy agreement. 6. Person Centred Risk Assessments should have been carried out for the residents of Knightleas Court and should be carried out as best practice for residents in Sheltered Accommodation /Assisted Living properties to ensure that needs are met and appropriate measures are in place to safeguard them. PCRAs should be reviewed on a regular basis, no less than every 12 months or when circumstances for the individual change, to ensure that support is appropriate to the individual's current level of need. 7. Premises that knowingly house and provide a service for vulnerable individuals should ensure that their fire prevention, detection and response systems are adequate and appropriate.
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 Tuesday the Nineteenth of 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;- - Telecare Services Association (TSA) - The Home Office (Fire Policy team) - Care Quality Commission

	- All London Local Authorities - National Fire Chiefs Council Department of Health 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	**21st February 2022**