Regulation 28: Prevention of Future Deaths report

Ellen Eileen Margaret Kelly (died 16.7.2016)

	THIS REPORT IS BEING SENT TO: **Mr Mike Cooke** **Chief Executive** **London Borough of Camden** **5 Pancras Square** **London N1C 4AG**
1	**CORONER** I am: Edwin Buckett Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 20th July 2016 Senior Coroner Hassell began an investigation into the death of Ellen Eileen Margaret Kelly who died aged 86 on the 16th July, 2016 at St Mary's Hospital Paddington. The investigation concluded at the end of the inquest on 12th December 2016 conducted by myself, Assistant Coroner Edwin Buckett. I made a determination at inquest that the deceased died as a result of smoke inhalation injuries sustained as a result of a house fire at [redacted] which occurred on the 7th July, 2016.
4	**CIRCUMSTANCES OF THE DEATH** On the 7th July, 2016 Ellen Eileen Margaret Kelly had a cigarette at her

	home address [redacted] which she did not fully extinguish. She placed it into a carrier bag containing other cigarette butts and this caught fire. An extensive fire then occurred at the flat and she suffered smoke inhalation injuries and died on the 16th July, 2016 at St Marys Hospital, Paddington.
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. Evidence was given by Watch Manager [redacted] from the London Fire Brigade that: 1. [redacted] is a block owned by London Borough of Camden. 2. At the time of the fire, the front door of Flat 13 was left open whilst the occupant went to raise the alarm. This caused the fire to spread more quickly than would have been the case had the door been shut. It also caused smoke to disperse in the common parts of the building. 3. Another family was trapped in Flat 15 (above Flat 13) until the London Fire Brigade attended. 4. The front door of Flat 13 should have been fitted with a self-closing mechanism but was not. 5. Other front doors in the block identified by the London Fire Brigade when they attended were not of a suitable standard in that they did not comply with the 30 minute fire resistant British Standard. I consider that it is likely that there are front doors of flats within Kilburn Gate which do not have: a. A proper self-closing mechanism in accordance with legal requirements as this was the case with the door to Flat 13, and b. Do not comply with the relevant British Standard, in that they are not fire resistant for 30 minutes or more.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 **6th February 2017**. 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: • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • [redacted], Commissioner, London Fire Brigade • London Fire and Emergency Planning Authority 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	**DATE 12.12.2016 SIGNED BY ASSISTANT CORONER EDWIN BUCKETT**