

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>National Fire Chiefs Council (NFCC), West Midlands Fire Service Headquarters, 99 Vauxhall Road, Birmingham, B7 4HW for circulation to all fire & rescue services.</p> <p>London Councils, 59½ Southwark Street, London SE1 0AL</p> <p>National Landlords Association, 2nd Floor, 200 Union Street, London, SE1 0LX</p> <p>Secretary of State at MHCLG 2nd floor NW, Fry Building, 2 Marsham Street, London, SW1P 4DF</p> <p>Local Government Association, 18 Smith Square, Westminster, London SW1P 3HZ</p> <p>National Housing Federation, Lion Court, 25 Procter Street, London WC1V 6NY</p> <p>London Borough of Barking & Dagenham Council, Town Hall, Town Hall Square, 1 Clockhouse Ave, Barking IG11 7LU</p>
1	<p>CORONER</p> <p>I am Dr Shirley Radcliffe, Assistant Coroner for the area of Eastern Area of Greater London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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/ukxi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 2nd February 2016 an investigation was commenced into the death of Ms Mihaela Lazar and Ms Dorina Zangari. The investigation concluded at the end of the Inquest on the 20th November 2018.</p> <p>The conclusion was death accidental death due to inhalation of fire fumes</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The circumstances of the death was that a fire occurred at the home address of the deceased on 25th January 2017. The fire probably started from clothing overlying a heater on the lower level of the premises. This caused dense smoke to spread through the maisonette and the 2 deceased were unable to escape to safety before being overcome with fire fumes.</p>

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 maisonette in which Dorina Zangari and Michaela Lazar lived was let for use as a single private dwelling. As it happened, it was being used as a House in Multiple Occupation, but the fire safety issues of concern to LFB relate to any maisonette used as a single family dwelling. The lack of early detection and warning of fire (i.e. the provision of smoke alarms) and a protected means of escape from the upper floor of the maisonette (which was at too high a level for escape by windows) contributed to the occupants being unable to escape from the fire.

The problem is threefold:-

- i) Undermining of the originally provided fire safety measures i.e. missing kitchen door
- ii) Absence of functioning fire detection and warning in the hall or landing, which was not required at the time of construction of the block of flats but, at the time of the fire, was a statutory requirement both for flats in single family occupation and multiple occupation; and
- iii) The design of the alternative means of escape, which comprised the balcony on the upper level of the maisonette, shared with the next door maisonette. This was acceptable at the time of construction but this is not acceptable today (without additional measures such as smoke alarms in every room) as this will involve breaking in to a neighbour's flat.

There are many thousands of these types of maisonette across the country which have not been upgraded using options in line with best practice guidance (see below) and this is leaving people at a significant risk of death or injury from fire.

The recommendations below are relevant to all existing single family maisonettes (additional measures might be necessary if the maisonette is in multiple occupation). The adoption of the guidance referenced below would have given the occupants a greater chance of being alerted to the fire at an earlier stage by the fire detection system and would have afforded safe means of escape from the upper floor of the maisonette.

2. The Local Government Association Fire safety in purpose-built blocks of flats guidance

Flats with more than one storey, with a floor at more than 4.5m above ground level

56.31 The internal means of escape from flats with more than one storey (eg maisonettes and cross-over flats), with a floor at more than 4.5m above ground level, provide additional issues to those encountered in flats on one level. Nevertheless, the basic approaches of providing either a protected exit route or an alternative exit remain the same.

56.32 Current benchmark design guidance recommends four approaches to the planning of means of escape from these flats:

- 1. provide an alternative exit from each habitable room that is not on the entrance level*

- II. *provide a single alternative exit from each level, other than the entrance level, and provide a protected landing and hallway*
- III. *provide a protected route and install additional automatic detection*
- IV. *provide a protected route and install an automatic suppression system.*

56.33 The first solution (i) is that all habitable rooms not on the entrance level should be provided with an alternative exit (see figure 6). The stairway landing is not required to be protected in these situations. The entrance hall is only required to be protected if the maximum travel distance from any point in a room to the flat entrance door is more than 9m and there are no alternative exits from each of the rooms on that level.

56.34 The second solution (ii) is to provide a single alternative exit on the non entrance level, either within a room or on the landing. This could be accepted in any of the following situations.

- All habitable rooms open directly onto a protected entrance hall and landing (see figure 7).
- A fire-resisting partition is provided at the head or base of the stairway to separate the entrance level from the level with the alternative exit. (The landing need not be protected provided the maximum distance between any point in a room on the non-entrance level and the alternative exit does not exceed 9m.)
- The alternative exit is within a room on the non-entrance level. Pass doors are provided between habitable rooms on this level, so that residents do not have to enter the stairway enclosure to reach an alternative exit.

56.35 In some existing flats, none of the above solutions may be feasible. In these situations, an alternative option could be to provide a protected route only on the entrance level. It might not be necessary for there to be a protected landing, provided the maximum distance between any point in a room on the non-entrance level and the alternative exit does not exceed 9m.

56.36 Cross-over flats can sometimes present particular problems because of the complexity of design and layout. Cross-over flats are flats on more than one level and the principles set out above can be applied. However, the complexity of this arrangement will require careful consideration of the means of escape, and specialist advice may need to be sought.

56.37 The third solution (iii) is to provide a protected route and to install additional automatic fire detection. This applies to flats where the vertical distance between the entrance level of the flat and any floors above or below does not exceed 7.5m. The entrance hall, stairway and landing should be a protected route and additional automatic detection, in all rooms (other than toilets or bathrooms), should be provided (a Category LD1 system as defined in BS 5839-6).

56.38 The fourth option (iv) is to provide a protected route and install an automatic suppression system. The entrance hall, stairway and landing should be a protected route. A sprinkler or water mist system should be installed throughout the flat, together with an automatic detection in the circulation spaces (a Category LD3 system as defined in BS 5839-6).

3. Recommendations

London Fire Brigade believes that stakeholders within the housing sector are not sufficiently aware of the risk of death or injury associated with inadequate fire detection and alarm systems and inadequate protection of the means of escape within the flat, in

	<p>the event of a fire, presented by this type of premises. Consequently they have not adopted the guidance and recommendations in the Local Government Association publication 'Fire safety in purpose-built blocks of flats'.</p> <p>Registered Providers and private sector landlords to undertake a fire safety risk assessment for their flats, where these flats require an alternative means of escape from any storey level, such as escape via a linking balcony. Their assessment, and any remedial works, should follow the advice in the LGA Fire Safety in Purpose-Built Block of Flats guide, specifically Section 56.</p> <p>London Fire Brigade believes that a PFD letter outlining the circumstances of this incident and the best practice guidance above would contribute to greater awareness and action by housing stakeholders and would lead to premises upgrades which would prevent a repeat of this incident. Housing Authorities should specifically consider this issue under the Housing Health and Safety Rating System.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 15th February 2019. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner, to Osbornes Law acting on behalf of [REDACTED] (father of Mihaela Lazar and to the Director of Public Health Mr Matthew Cole</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>[DATE] 21st December 2018 [SIGNED BY CORONER] </p>