



Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	<p>THIS REPORT IS BEING SENT TO:</p> <p>████████████████████ Executive Directors of Supporting Communities London Borough of Camden</p>
1	<p>CORONER</p> <p>I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE</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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 27 November 2018 I commenced an investigation into the death of Tony Goodridge (aged 55 years). The investigation concluded at the end of the inquest on 27 March 2019.</p> <p>The conclusion of the inquest was that: Mr Goodridge died in a fire at his home on 19 November 2018.</p> <p>The medical cause of his death was: 1a inhalation of fire fumes and airway burns</p> <p>I recorded a short-form conclusion that Mr Goodridge's death was an accidental death.</p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Goodridge was the tenant of [REDACTED]. The landlord is the London Borough of Camden. He returned home to his flat around 2 am on 19 November 2018. At about 4 am a neighbour to the rear of the property noted that there was a fire in a 2nd floor flat on Brassey Road. Firefighters were called to the scene and identified that the fire was located in Mr Goodridge’s flat. They forced entry to the flat by removing the front door. Mr Goodridge was found unresponsive on the floor behind the front door to the flat. He was recovered from the property and attempts were made to resuscitate him initially by firefighters, then paramedics and ultimately a doctor from the HEMS service. He did not recover consciousness. His death was confirmed shortly after 5 am. The fire was investigated by the London Fire Brigade. It is evident that the fire was intense and caused extensive damage to the property including a partial collapse of the roof. The Fire Investigator’s view was that the fire started in Mr Goodridge’s bedroom. The likeliest cause of the fire related to smoking materials, incense sticks or an electric heater coming into contact with combustible materials. There was no smoke alarm in the property. The evidence from the fire service was that smoke alarms can alert occupiers to the existence of a fire earlier and therefore possibly improve their prospects of escaping from a property.</p>
5	<p>CORONER’S CONCERNS</p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) Mr Goodridge did not have a smoke alarm in his property. (2) The London Fire Brigade had some difficulty reaching the property due to parked vehicles in the vicinity.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 23 May 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>

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COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [REDACTED] (daughter)

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.

Sarah Bourke
Assistant Coroner
28 March 2019