Regulation 28: Prevention of Future Deaths report

Daniel Richard COLEMAN (died 14.02.20)

	THIS REPORT IS BEING SENT TO: **1. Mr [redacted]** **Head of Safer Homes** **Camden Council** **5 Pancras Square** **London N1C 4AG** **2. Mr [redacted]** **Chief Executive Officer** **First Response Group** **Head Office: Unit 2** **Gemini Business Park** **Sheepscar Way** **Leeds LS37 3JB**
1	**CORONER** I am: Coroner ME Hassell Senior 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 25 February 2020, I commenced an investigation into the death of Daniel Richard Coleman, aged 41 years. The investigation concluded at the end of the inquest earlier today. I made a narrative determination, which I attach. The medical cause of Mr Coleman's death was: 1a exposure to fire 2 methylamphetamine and ketamine intoxication.

4	**CIRCUMSTANCES OF THE DEATH** Mr Coleman was the construction site manager of Camden demolition site Aspen House, for which First Response provided the security. He died in an accidental fire caused by his own production of crystal meth.
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. I made findings of fact that Mr Coleman had been living on a site due for demolition, and that he had frequently been using illicit drugs there. 1. I heard evidence that neither Camden managers, who I was told visited the site frequently, nor First Response security officers, who were a constant presence, had noticed that Mr Coleman was living on site. Even a neighbour had seen a light on night after night in the flat where Mr Coleman had a bed, bedding, clothes hanging on a clothes rail, CD player and other personal items. 2. I also heard that Mr Coleman had previously lived on another Camden site at Bacton Low Rise, and that this too went unnoticed. 3. The evidence from the two First Response night time security officers who came to court was inconsistent and concerning. One said that he always patrolled twice an hour. The other said that each officer patrolled once every two hours. When I asked one officer what he did in between patrols (I was keen to exclude the possibility of security officers sleeping through the night), he said that it took him five minutes to write up each patrol, then he just sat and waited for the next patrol. The writing up he described was one line only, exactly the same line recorded with the time advanced by one hour as on the previous line. This would have taken a matter of seconds. One officer gave evidence that he photographed the building during every one of his patrols.

	It later emerged that this protocol of photographing was only introduced *after* 14 February 2020, though I had specifically asked about the situation *before* Mr Coleman's death. I was misled. This does not paint a picture of effective security. 4. The security officers were emphatic that Mr Coleman could not have lived on the site, saying that if he had been living there they would have noticed, most especially by way of the intruder alarm, and they had not noticed. I did not accept this evidence. 5. One of the security officers gave evidence that, whilst Mr Coleman occasionally dropped by in the evening, he had never been on site after 9pm, yet there was a written record of him visiting at 3am just before he died. 6. The Camden Council signing in/out record was incomplete, often not recording Mr Coleman's presence on site at all, and the last entry before Mr Coleman died on 14 February 2020 was dated 7 February 2020. 7. I heard evidence that not one of Mr Coleman's Camden managers or First Response colleagues noticed that he was in any way intoxicated or under the influence of drugs. 8. Evidence was given that Camden did not regard Mr Coleman's occupation as high risk for drugs because he did not operate heavy machinery, but he was in charge of a whole site. The explosion and fire he started accidentally could have resulted in other fatalities as well as his own. 9. I was told that a Camden drug and alcohol policy that had been in place for five months at the time of Mr Coleman's death had not resulted in a single attempt at a drug test.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 26 October 2020. 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 • Ms [redacted], mother of Daniel Coleman • Mr [redacted], brother of Daniel Coleman • Ms [redacted], wife of Daniel Coleman 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 25.08.20 *ME Hassell*