

Mrs Joanne Lees Area Coroner The Black Country Coroners Court Jack Judge House Halesowen Street Oldbury B69 2AJ

Dear Mrs Lees

Inquest touching upon the death of Keith Holmes

I am writing with reference to the Regulation 28/Prevention of Future Deaths Report dated 5 May 2022 sent to the organisation on 6 May 2022.

As a preliminary matter, the organisation would want it noted that the witness who gave evidence, discussion, did so against a background that in addressing the questions asked of her these were felt to be of a technical nature, more directed at a witness with a health and safety background which does not have and hence it is possible that her responses were such that this has given rise to the regulation 28 /PFD report which had someone with a more health and safety background been giving evidence this may not have been necessary. If the been summoned by the court rather than put forward by the organisation to give evidence. It became apparent on the day of the inquest during questions of that these were of a technical nature that were beyond scope of expertise and knowledge. Whilst did her best to assist the court this was from an operational background where her focus is on managing the licensees.

Further, in discussions post the conclusion of Mr Holmes' inquest, it has become apparent that the organisation had taken advice from public health authorities about how to manage the situation in the pandemic. Reflecting that advice, the organisation was having to balance obligations to the licensees in their premises and their duties to their employees. The organisation's maintenance staff had not been put on furlough on account of financial issues because the income streams that the organisation had come from health and local authorities and were therefore largely protected, but because of the practical consequences which was that the nature of the work that the maintenance staff undertook meant that they were coming into contact with licensees and other people increasing the risk of Covid. Reflecting the public health advice that the organisation received, they were told that this was not something that they should be encouraging. As such therefore, the organisation's maintenance department only undertook urgent maintenance during the pandemic.

Turning now to the three matters of concern within the Regulation 28/Prevention of Future Deaths Report, the organisation would respond as follows.

The organisation has sought advice from OHEAP, the Health and Safety Executive and the Fire Service to ascertain what advice they would given in light of the areas of concern raised. These enquiries were undertaken by the organisation's Head of Property Services.

The Fire Brigade responded to the organisation as follows:

[']During the pandemic and forced isolation periods, we did give advice about various aspects of peoples fire safety arrangements and more specifically, the regularity of maintenance.

The underlying theme to all of the advice, was what is the biggest risk to your organisation? Failing to lock down sufficiently and allowing the chance of Coronavirus entering your property was not only illegal, it was probably just as lethal as a fire turned out to be. These risks need to be balanced and decisions made accordingly. The legislation that we enforce, the Regulatory Reform (Fire Safety) Order 2005 looks at risk of death and/serious injury from fire or its effects, and more pertinently any steps taken to make a suitable and sufficient assessment of that risk and address it. It could be argued that you risk assessor made a suitable assessment based on the bigger risk of Covid 19'.

Reflecting this advice, the organisation has taken the view that whilst a risk assessment would be undertaken in the future, reflecting the response from the Fire Service above, it is likely that the public health considerations would outweigh the fire risks. As part of the organisation's response to the Covid pandemic, a risk assessment was undertaken on 17 April 2020 balancing the public health advice and the risks posed to the licensees, visitors and organisations staff. Furthermore, Wolverhampton Safeguarding Together produced guidance dated 30 June 2020. The available guidance that the organisation complied with very much focussed on the risks in relation to Covid that outweighed the risks that may be associated with a fire.

The organisation, following coming out of the Covid pandemic, has undertaken PAT tests on 10 January 2022 that did not identify issues with any electrical equipment (including fridges) within McHugh House. As **Example:** evidence at the inquest indicated, the organisation ordinarily undertakes PAT testing annually, notwithstanding that the regulations would only oblige it to undertake PAT tests once every 4 years on fridges.

As the organisation pointed out in its evidence at the inquest, it did through its staff undertake daily inspections of the property. A PAT test is of course only as good as the date on which it is undertaken.

As such, in the event that there was to be a similar lockdown situation similar to that experienced during 2020/2021, the organisation would be guided by advice received from several agencies including Public Health England and the Fire and Rescue Service. However, it would have to balance the respective risks that were posed and it seems reflecting advice that the organisation has received from the Fire Service, the balance of that risk, assuming of course the pandemic would be as severe as that experienced in 2020/2021, would appear to rest with public health guidance outweighing risks that may exist in relation to fire. As such whilst the organisation can give a commitment it will have a contingency plan in place, precisely what that plan will look like will be dependent on the advice available to the organisation.

As such, the organisation does not feel that at this stage it can produce a contingency plan but it will be guided by relevant advice to be sought at the time to determine its plan on managing any increased risks posed by the absence of PAT testing. Yours sincerely



Director of Services P3