	REGULATION 28 REPORTS TO PREVENT FUTURE DEATHS
1.	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2.	**CORONER'S LEGAL POWERS** I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INQUEST** An inquest into the death of Mr Tomas Ceida was opened on 16th August 2016. He had died on 9th August in hospital. The medical cause of death was 1a Burns and inhalation of fire fumes. (case ref: 139095 CIO) London Fire Brigade, Health & Safety Executive and Metropolitan Police Service investigations took place, but were not concluded until 2021. The inquest was concluded on 15th February 2023, heard before a jury with a narrative conclusion delivered.
4.	**CIRCUMSTANCES OF THE DEATH** Construction work was underway on a site being used by the public as a night club. Staff and construction operatives slept overnight on the site on occasions. The jury concluded that the following contributed to the death: Unsuitable composition and state of the acoustic wall Unsafe and inadequately supervised hot works Failure to agree and communicate roles and responsibilities for fire safety on the construction site, leading to inadequate fire alerts and failure to conduct orderly evacuation of the entire site. There were also inadequate fire risk assessments in place, covering Studio 338.

5. **This REPORT IS BEING SENT TO:**

1. [redacted] Chief Executive of the Royal Borough of Greenwich, Chief Executive Office, Woolwich Town Hall, Wellington Street, London SE18 6PW

2. [redacted] Commissioner of London Fire Brigade, LFB Headquarters, 169 Union Street, London SE1 0LL

3. [redacted], former director, JHS Contracts (JHS), 93b Oak Hill, Walthamstow, Woodford Green IG8 9PF

4. [redacted], Chief Executive, Health & Safety Executive, Redgrave Court, Merton Road, Bootle, L20 7HS; Caxton House, Level 7, Tothill Street, London SW1H 9NA

THE CORONER'S MATTER OF CONCERN

6. The following were established as facts, but do not necessarily represent failings:

- RLBG Building Control were aware of the composition of the acoustic wall compacted with hay or straw, and its fire risks and did not follow up the non-receipt of a building application after March 2013.

- RLBG Planning Division did not notify London Fire Brigade in 2016 when discovered that the wall was not a living wall as envisaged in the planning application.

- LFB visited the site in 2014 and the local team attended large night club events on the site, during construction from 2016, but there was no communication with fire enforcement

- JHS were initially documented as principal contractor and its subcontractor as site manager in 2016, but either did not create or did not retain documentation of the alleged change of role before the date of the fire, from discussions with the leaseholder of the site, who was the client.

	• Although steps were taken by JHS to mitigate fire risks through the subsequent management and supervision of hot works, there is no evidence of what steps are taken by JHS individuals now in the building trade in each case to ensure the responsibility for fire safety and evacuation has been competently adopted and implemented. • It is understood that changes in the law and duties of securing general fire precautions has changed since the fire. It is not clear that the public and future contractors are necessarily aware of the processes and duties. The coroner is concerned whether there is a lack of public awareness, which may be a risk to future deaths. This is brought to the attention of the HSE and LFB as enforcement authorities.
7.	**ACTION SHOULD BE TAKEN** The case is brought to the attention of four organizations involved, to enable them to review and report on the individual matters in which they may be able to mitigate further risks and to examine the current collaborative arrangements and ensure they are appropriate and safe.
8.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday May 4th, 2023. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted]

9.	**COPIES and PUBLICATION** I have sent a copy of my report to the following other interested persons: [redacted] for MPS [redacted], JHS Insurers [redacted] Director of Raduga Ltd [redacted] I am also copying it to The Fire Protection Association, who may have interest in the matter. I am also under a duty to send the Chief Coroner a copy of your response. He 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.
10.	**[DATE]** **[SIGNED BY CORONER]** **9th March 2023** **A N G Harris, Senior Coroner**