

Adults and Health (DASS)
London Borough of Newham
1000 Dockside Road
London
E16 2QU

Nadia Persaud
Area Coroner
Walthamstow Coroner's Court
124 Queens Road
Walthamstow
E17 8QP

29 November 2024
Our ref: [REDACTED]

Dear Ms Persaud

Re: Regulation 28 Report concerning Gabrielle Sarah Anne Steel

Response from the London Borough of Newham

Thank you for sharing the conclusion of your Inquest into the death of Gabrielle Sarah Anne Steel, and the subsequent Regulation 28 Report. May I start by expressing my sincere regret and disappointment to learn of the circumstances surrounding Ms Steel's passing. On behalf of the Council I wish to place on record our deepest condolences to her family, her friends and all those that knew her. We fully acknowledge the findings from the Inquest and are fully committed to putting actions in place to address the concerns raised in the Prevention of Future Deaths report.

A core group of Senior Officers from the department were involved in a detailed review of Ms Steel's case following her death. The review resulted in an action plan with a focus on prevention, this emphasised a number of interventions including smoking cessation. We have updated our action plan following the Inquest findings; please see below for details of this.

	Action:	By who:	By when:
1	A reflective case discussion at the Fire Safety Group on 10/12/24. The Fire Safety Group is the multi-agency group responsible for fire safety issues in the Borough. This discussion will involve a review of previous reflective sessions	Strategic Safeguarding Adviser	10/12/24
2	To further improve training for social care staff by holding a training session on fire safety risk assessment and risk management plans. This session will complement the joint training session which took place on 25/04/24	Workforce Development and Strategic Safeguarding	30/01/25
3	Produce a '7 minute briefing on the development of fire safety risk management	Workforce Development and	24/12/24

	plans. The 7 minute briefing will address the following issues: 1) Escalation procedures regarding fire risks 2) How to obtain feedback from LFB about fire safety risk assessments 3) Reviews of risk assessments and risk management plans	Strategic Safeguarding	
4	Enhanced monitoring where there is an established risk of fire for people known to Adult Social Care. The monitoring will take place for the next year with the objective of ensuring learning is embedded	Strategic Safeguarding	Monitoring to start from 2025

Governance and Oversight

The following people have been sighted on the action plan:

- [REDACTED] Corporate Director of Adults (DASS), Commissioning, Health & Social Care
- [REDACTED] Director of Quality Assurance, Safeguarding and Workforce Development
- [REDACTED] Head of Service - Older People & Disability, Operations
- [REDACTED] Head of Service - Older People & Disability, Operations

All elements of the plan are linked to specific teams with accountability for their delivery. Oversight of the action plan is being held by the Strategic Safeguarding Team who will monitor progress against the stated timescales and then report back to the Directorate Management Team. We also recognise that the overall plan will need to remain agile and be adapted if further information comes to light

Thank you again for raising this matter with us. I hope this response gives adequate assurance on the actions we have taken on the improvements required.


Please do not hesitate to come back to me if you require further information or updates.

Yours sincerely,

[REDACTED]

CC:

[REDACTED] Chief Executive
[REDACTED] Corporate Director of Adults and Health
[REDACTED] Director of Change, Improvement and Control

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Director of Quality Assurance, Safeguarding and Workforce Development
Head of Law (Community)