IN THE INNER SOUTH DISTRICT OF GREATER LONDON CORONER'S COURT

IN THE MATTER OF INQUESTS TOUCHING THE DEATHS OF

CATHERINE HICKMAN
DAYANA FRANCISQUINI
FELIPE FRANCISQUINI CERVI
THAIS FRANCISQUINI
HELEN UDOAKA
MICHELLE UDOAKA

Before Her Honour Frances Kirkham sitting as Assistant Deputy Coroner

Requirement that composite panels in window sets be Class O but not fire resistant

1. During the course of the hearing, I received written submissions on the question whether any conditions imposed pursuant to section 20 London Building Acts (Amendment) Act 1939 ("the 1939 Act") continued to have effect at the time of the substantial refurbishment of Lakanal House undertaken in 2006/07. Mr Hendy QC and Mr Edwards, on behalf of bereaved families, submit that section 20 conditions remained in place in relation to Lakanal House, with the consequence that the composite panels below the bedroom windows in the maisonettes of Lakanal House ("the panels") installed as part of the 2006/07 refurbishment should have been fire-resistant to 60 minutes ("FR60"). Their submissions are supported by Ms Al Tai and Mr Dowden, also acting for the bereaved.

2. Mr Matthews QC and Ms Sanderson (for London Borough of Southwark) Mr Compton QC (for Apollo Property Services Group Ltd) and Ms Canby (for SAPA Building Systems Ltd) submit that there was no legal requirement for the panels installed in 2006/07 to have been FR60.

3. I thank all for their helpful submissions.

4. On Wednesday 20 March 2013 (day 44 of the hearing) I said that I had concluded that there was no legal requirement for the panels to be FR60, that I would be directing the jury on that basis, and that I would in due course provide my reasons for that decision. I now set out those reasons.

5. Lakanal House was constructed in the late 1950s. In 1978/79 work was undertaken including window replacement. In 2006/07 substantial refurbishment work was carried out, including installation of the panels. Before 1985, building control issues were governed, broadly, by the London Building Acts and byelaws, including the 1939 Act.

6. Relevant provisions of section 20 of the 1939 Act provide as follows:

> "20 (1) Unless the Council otherwise consent
> (a) no building shall be erected with a storey or part of a storey at a greater height than—
> (i) one hundred feet; or
> (ii) eighty feet if the area of the building exceeds ten thousand square feet;
> (b) no building of the warehouse class and no building or part of a building used for purposes of trade or manufacture shall be of a

cubical extent exceeding two hundred and fifty thousand cubic feet unless it is divided by division walls in such manner that no division of the building or part of the building as the case may be is of a cubical extent exceeding two hundred and fifty thousand cubic feet: Provided that the Council shall not withhold consent under paragraph (a) of this subsection if they are satisfied that having regard to the proposed use to which the building is to be put proper arrangements will be made and maintained for lessening so far as is reasonably practicable danger from fire in the building.

(2) In granting consent under this section the Council may without prejudice to any other power to attach terms and conditions to the consent give the consent subject to conditions restricting the user of the building or part of the building or relating to the provision and maintenance of proper arrangements for lessening so far as is reasonably practicable danger from fire in the building or part of the building."

7. The London Building Acts and byelaws remained in place until 1985, when the national system of building regulations was introduced in London. The byelaws were repealed by the Building (inner London) Regulations 1985 SI No. 1936 ("the 1985 Regulations"). Section 20 of the 1939 Act was amended by Schedule 3 of the 1985 Regulations. Section 20, as amended, remained in force until 9 January 2013. Section 144 of the 1939 Act had been concerned, amongst other matters, with the power to impose conditions to consents. Section 144 (1) (2) and (3) were amended by paragraph 16 of schedule 3 of the 1985 Regulations.

8. Mr Hendy QC and Mr Edwards make a number of assumptions as to conditions and waivers applicable to consent for the original design and construction of Lakanal House, and as to conditions applicable to the 1978/79 work. So far as the original design and construction are concerned, they assume that consent under section 20 is likely to have had conditions attached, namely that there should be compliance with relevant byelaws – in this case, the 1952 byelaws. Mr Hendy QC and Mr Edwards assume that section 20 consent would have been granted for the 1978/79 work by reference to the 1972 byelaws; these would have required the replacement window sets to be Class IIC, which requires FR60. Accordingly, they say, there was a requirement that external walls be FR60, at the time both of original construction in the late 1950s and of work undertaken in 1978/79. Mr Hendy QC and Mr Edwards also assume that no application was made to revoke or vary any section 20 conditions which applied to Lakanal House.

9. Although those assumptions have not been challenged, the evidence has not been examined. I make no findings but proceed on the basis that those assumptions are correct.

10. The issue here is whether (1) any conditions imposed under section 20 of the 1939 Act were swept away by the 1985 Regulations, with the consequence that the panels were subject to the requirements of the post 1985 regime which did not require panels to be FR60 or (2) any conditions were preserved until expressly revoked or varied, with the consequence that the panels should have been FR60.

11. It is common ground that the effect of the 1985 Regulations was to amend section 20 of the 1939 Act, to remove reference to compliance with any byelaws made in pursuance of the London Building Acts and to remove the power to impose conditions on buildings over 100ft "relating to the provision and maintenance of proper arrangements for lessening so far as is reasonably practicable danger from fire in the building or part of the building."

12. The effect of the amendment to section 20 was to restrict the application of that section in effect to the provision and maintenance of fire alarms, automatic fire detection systems, fire extinguishing appliances and installations, effective means of removing smoke in case of fire, and adequate means of access for fire brigade personnel and appliances.

13. Mr Hendy QC and Mr Edwards submit that there is a valid distinction to be made between (1) the byelaws which (they accept) were swept away by the 1985 Regulations and (2) conditions imposed under section 20. They submit that the 1985 Regulations are explicitly prospective and contain no provision for retrospective application; there is no provision revoking existing conditions imposed in reliance on section 20. Their case is that although the byelaws were swept away by the 1985 Regulations, the section 20 conditions imposed in 1978/79 were never varied. These conditions were made "in reference" to the 1972 byelaws. The fact that the 1972 byelaws were subsequently revoked does not mean that any section 20 conditions imposed in reference to them became a nullity.

14. I am not persuaded by those submissions.

15. Section 20 as amended by the 1985 Regulations made no requirements in relation to fire resistance or fire performance of external walls

16. The purpose and effect of the amendment to section 144 of the 1939 Act was to permit the continuation of conditions of consent imposed directly under section 20 but not the continuation of any conditions imposed pursuant to byelaws. The conditions assumed by Mr Hendy QC and Mr Edwards all related to the 1952 or 1972 byelaws; they were not conditions imposed directly by section 20. I am not persuaded that conditions imposed "in reference" to the 1972 byelaws (as Mr Hendy QC and Mr Edwards put it) were not swept away by the 1985 Regulations. The requirement to comply with those byelaws was removed by the 1985 Regulations. Any conditions imposed pursuant to byelaws prior to 1985 ceased to have effect after the 1985 Regulations came into effect.

17. Subject to exemptions irrelevant to this issue, regulation 2(1) of the 1985 Regulations provides: "The Building Regulations 1985 ..... shall apply in Inner London." It thus provides in the clearest of terms for the general application of the Building Regulations to Inner London. Since then the relevant applicable legislation has been the Building Act 1984, which is the enabling Act for preparation, by the Secretary of State, of the Building Regulations. After 1985, requirements as to fire resistance or fire performance of external walls were governed solely by the Building Regulations and the guidance offered by Approved Document B.

18. By the time of the 2006/07 refurbishment work at Lakanal House, the relevant applicable legislation was the Building Act 1984 and Building Regulations 2000. The requirement for the panels was that they be Class 0 but not fire resistant. It was on that basis that I directed the jury.

Frances Kirkham
Assistant Deputy Coroner

4 April 2013

Fire Sector Federation

Her Honour Frances Kirkham CBE
Assistant Deputy Coroner
Inner Southern District of Greater London
The Coroner's Court
1 Tennis Street
London
SE1 1YD

4 April 2013

Dear Madam

Lakanal House fire 3 July 2009 – response to Rule 43 letter

Thank you for your letter dated 30 March in connection with the above.

On behalf of the Federation I would like to confirm that a number of groups are currently being convened to address and comment on the findings made. We will be liaising with DCLG, London Fire Brigade and the London Borough of Southwark on the outcomes and any recommendations and will be reporting on this in due course.

Yours faithfully

Brian Robinson CBE
Chairman

Inner Southern District of Greater London

The Coroner's Court
1 Tennis Street
London SE1 1YD

Her Honour Frances Kirkham CBE
Assistant Deputy Coroner

28 March 2013

The Rt Hon Eric Pickles MP
Secretary of State for Communities and Local Government
Department of Communities & Local Government
Zone G9, 4th floor
Eland House
Bressenden Place
London
SW1E 5DU

Dear Secretary of State

Lakanal House fire 3 July 2009

I write concerning the inquests into the tragic deaths of Catherine Hickman, Dayana Francisquini, Thais Francisquini, Felipe Francisquini Cervi, Helen Udoaka and Michelle Udoaka, who all died in a fire at Lakanal House, Camberwell, London, on 3 July 2009.

The jury brought in Narrative Verdicts in respect of each of the deceased.

I write to you pursuant to Rule 43 of the Coroners Rules (as amended) which provides:

"(1) Where
(a) a coroner is holding an inquest into a person's death,
(b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
the coroner may report the circumstances to a person who the coroner believes may have power to take such action."

I announced at the end of the inquests that I would be sending a report to you, as evidence adduced at the inquests gave rise to concern of the type identified in Rule 43. I believe that your Department has power to take action as set out in this report.

Different sections of this report will be relevant to different sections of your Department. I ask you, please, to ensure that the report is drawn to the attention of all relevant sections.

Fire safety, fire fighting and search and rescue

Evidence adduced at these inquests indicates that there is insufficient clarity about advice to be given to residents of high rise residential buildings in case of fire within the building. It is recommended that your Department publish consolidated national guidance in relation to the "stay put" principle and its interaction with the "get out and stay out" policy, including how such guidance is disseminated to residents.

It is recommended that consideration be given to review of Generic Risk Assessment 3.2 "High Rise Firefighting" to provide consolidated national guidance as to the following:

- matters which should be noted by fire brigade crews making familiarisation visits and visits pursuant to section 7(2)(d) Fire and Rescue Services Act 2004, including the gathering of information regarding high rise residential buildings with unusual layouts, and access for aerial ladder platforms and other specialist vehicles at an incident
- awareness that fire can spread downwards and laterally in a building
- awareness of the risk of spread of fire above and adjacent to a fire flat
- awareness that insecure compartmentation can permit transfer of smoke and fire between a flat or maisonette and common parts of high rise residential buildings, which has the potential to put at risk the lives of residents or others.

It is further recommended that Government give consideration to requiring high rise residential building owners or occupiers to provide relevant information on or near the premises, such as premises information boxes or plates. Such information must be accessible by and tailored to the requirements of the fire and rescue service and kept up to date by the premises owner or occupier.

Fire risk assessments pursuant to Regulatory Reform (Fire Safety) Order 2005

The evidence adduced indicated that, notwithstanding publication of your Department's 2006 guide (Fire safety Risk, sleeping accommodation) and of the Local Government Association's August 2011 guide, there remains uncertainty about the scope of inspection for fire risk assessment purposes which should be undertaken in high rise residential buildings. Evidence was adduced which indicated that inspection of the interior of flats or maisonettes in high rise buildings was necessary to enable an assessor to identify possible breaches of the compartment which have the potential to impact on the fire safety of the resident or others.

It is recommended that Government provide clear guidance on

- the definition of "common parts" of buildings containing multiple domestic premises
- inspection of a maisonette or flat which has been modified internally to determine whether compartmentation has been breached
- inspection of a sample of flats or maisonettes to identify possible breaches of the compartment.

Retro fit of sprinklers in high rise residential buildings

Evidence adduced at the inquests indicated that retro fitting of sprinkler systems in high rise residential buildings might now be possible at lower cost than had previously been thought to be the case, and with modest disruption to residents.

It is recommended that your Department encourage providers of housing in high rise residential buildings containing multiple domestic premises to consider the retro fitting of sprinkler systems.

Building Regulations and Approved Document B

During these inquests we examined Approved Document B (2000 edition incorporating 2000 and 2002 amendments) ("AD B"). I am aware that AD B has subsequently been amended, and believe that a further amendment is due to be published soon. The introduction to AD B states that it is " ... intended to provide guidance for some of the more common building situations". However, AD B is a most difficult document to use. Further, it is necessary to refer to additional documents in order to find an answer to relatively straightforward questions concerning the fire protection properties of materials to be incorporated into the fabric of a building.

It is recommended that your Department review AD B to ensure that it

- provides clear guidance in relation to Regulation B4 of the Building Regulations, with particular regard to the spread of fire over the external envelope of the building and the circumstances in which attention should be paid to whether proposed work might reduce existing fire protection
- is expressed in words and adopts a format which are intelligible to the wide range of people and bodies engaged in construction, maintenance and refurbishment of buildings, and not just to professionals who may already have a depth of knowledge of building regulations and building control matters
- provides guidance which is of assistance to those involved in maintenance or refurbishment of older housing stock, and not only those engaged in design and construction of new buildings.

Response

Rule 43A of the Coroners Rules requires that you give a written response within 56 days beginning with the day on which the report is sent. If you are unable to respond within that time, you may apply to me for an extension. The response is to contain details of any action that has been taken or which it is proposed will be taken whether in response to this report or otherwise, or an explanation as to why no action has been taken.

As required by rule 43, I shall send a copy of this report to the Lord Chancellor.

Yours sincerely

Frances M Kirkham

Inner Southern District of Greater London

The Coroner's Court
1 Tennis Street
London SE1 1YD

Her Honour Frances Kirkham CBE
Assistant Deputy Coroner

28 March 2013

The Mayor and Burgesses of The London Borough of Southwark
160 Tooley Street
London
SE1 2QH

Dear Mayor

Lakanal House fire 3 July 2009

I write concerning the inquests into the tragic deaths of Catherine Hickman, Dayana Francisquini, Thais Francisquini, Felipe Francisquini Cervi, Helen Udoaka and Michelle Udoaka who all died in a fire at Lakanal House, Camberwell, on 3 July 2009. The jury brought in Narrative Verdicts in respect of each of the deceased.

I write to you pursuant to Rule 43 of the Coroners Rules (as amended) which provides:

"(1) Where

> (a) a coroner is holding an inquest into a person's death,
> (b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner may report the circumstances to a person who the coroner believes may have power to take such action."

I announced at the end of the inquests that I would be sending a report to you as evidence adduced at the inquests gave rise to concern of the type identified in Rule 43. I believe that your authority has power to take action as set out in this report.

It has been drawn to my attention that your authority has taken some steps to address fire safety in relation to high rise residential buildings. I understand (1) that fire risk assessments have been undertaken in relation to all high rise residential buildings within the Borough, and it was your intention that any fire safety work be completed by March 2012; and (2) that fire safety information and advice have been given to residents of such buildings. I therefore make no recommendations in relation to such matters. I do however make the following recommendations.

Information and guidence to occupiers of flats and maisonettes in high rise buildings

Of those former residents of Lakanal House who gave evidence at the inquests, few recognised the extract from your authority's handbook containing advice about fire safety in the home and few knew about the fire safety features of the maisonettes.

It is recommended that, in relation to residents of high riss residential buildings, your authority:

- demonstrate to those who are about to enter into occupation of a flat or maisonette the fire safety features of their dwelling and of the building generally; this should include walking residents through relevant features such as escape balconies and demonstrating how to open fire exit doors and where these lead
- give residents clear guidance as to how to react if there is a fire in the building, namely to explain whether they should attempt to get out of their flat or maisonette and leave the building, or whether they should remain in their flat; that guidance should explain clearly how to react if circumstances change, for example, if smoke or fire enter their flat or maisonette
- consider additional ways in which information might be disseminated to residents, for example, by fixing inside each flat and maisonette a notice about what to do in case of fire.

Signage in high rise residential buildings

It is recommended that your authority review signs in common parts of high rise residential buildings to ensure that these are sufficiently prominent and provide useful information. It is recommended that signage:

- in common areas explain whether residents should normally remain in their flats or maisonettes or whether they should evacuate the building, in which case evacuation procedures should be explained
- provide clear information to residents to enable them to find escape routes
- use pictograms to assist those for whom English is not their first language
- provide information to those in the emergency services which would assist them to understand a building's layout and enable them quickly to find a particular flat or maisonette once inside the building.

It is also recommended that your authority liaise with London Fire Brigade regarding use of premises information plates and boxes.

Policies and procedures concerning fire risk assessment

The Regulatory Reform (Fire Safety) Order 2005 ("FSO") which came into force in October 2006, imposed obligations in relation to fire risk assessments in certain buildings.

It is recommended that your authority review its policies and procedures concerning fire risk assessments of high rise residential buildings.

- prioritising such buildings for regular rigorous review
- considering the skills and experience needed to undertake an assessment of higher risk residential buildings

- considering the training required for members of staff considered to be competent to carry out assessments
- identifying when individual flats or maisonettes should be inspected and how these should be selected for inspection
- ensuring that assessors have access to relevant information about the design and construction of high rise residential buildings and refurbishment work carried out to enable an assessor to consider whether compartmentation is sufficient or might have been breached.

Training of staff engaged in maintenance and refurbishment work on existing building

It is recommended that your authority consider the training needs of personnel who will be involved in procuring or supervising work to existing high rise residential buildings – whether maintenance, refurbishment or rebuilding of parts of buildings - to ensure that materials and products used in such work have appropriate fire protection qualities. Staff should, for example, be trained to understand the significance of the compartmentation principle end to appreciate when Building Control should be notified about work to be undertaken.

Access for emergency vehicles

It is recommended that your authority liaise with emergency services to consider access for emergency vehicles to high rise residential buildings, having particular regard to obstructions such as vehicle parking in locations which emergency services might need to use.

Retro fitting of sprinklers

Evidence adduced at the inquests indicated that retro fitting of sprinkler systems in high rise residential buildings might now be possible at lower cost than had previously been thought to be the case, and with modest disruption to residents.

It is recommended that your authority consider the question of retro fitting of sprinkler systems in high-rise residential buildings.

Response

Rule 43A of the Coroners Rules requires that you give a written response within 56 days beginning with the day on which the report is sent. If you are unable to respond within that time, you may apply to me for an extension. The response is to contain details of any action that has been taken or which it is proposed will be taken whether in response to this report or otherwise, or an explanation as to why no action has been taken.

As required by rule 43, I shall send a copy of this report to the Lord Chancellor.

At your request, I am copying this report to Ms Eleanor Keily, Chief Executive.

Yours sincerely

Frances Kirkham

Inner Southern District of Greater London

The Coroner's Court
1 Tennis Street
London SE1 1YD

Her Honour Frances Kirkham CBE
Assistant Deputy Coroner

28 March 2013

Mr Ron Dobson CBE QFSM FIFireE
London Fire Commissioner
London Fire Brigade
London Fire Brigade Headquarters
169 Union Street
London, SW1 0LL

Dear Mr Dobson

Lakanal House fire 3 July 2009

I write concerning the inquests into the tragic deaths of Catherine Hickman, Dayana Francisquini, Thais Francisquini, Felipe Francisquini Cervi, Helen Udoaka and Micheile Udoaka, who died in a fire at Lakanal House, Camberwell, on 3 July 2009.

The jury brought in Narrative Verdicts in respect of each of the deceased.

I write to you pursuant to Rule 43 of the Coroners Rules (as amended) which provides:

"(1) Where

> (a) a coroner is holding an inquest into a person's death,
> (b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner may report the circumstances to a person who the coroner believes may have power to take such action."

I announced at the end of the inquests that I would be sending a report to you as evidence adduced at the inquests gave rise to concern of the type identified in Rule 43. Your Brigade has power, I believe, to take action as set out in this report.

Before I set out my recommendations, I acknowledge that London Fire Brigade have already undertaken extensive work to learn from their experience with the fire at Lakanal House, have introduced new policies and have reviewed existing policies in respect of a number of matters of significance, including:

- guidance to crews making risk assessments for sites in their area
- guidance as to matters which should be noted by crews making familiarisation visits and visits pursuant to section 7(2)(d) Fire and Rescue Services Act 2004, including the gathering of information regarding flats or maisonettes with unusual layouts and access for aerial ladder platforms and other specialist vehicles
- cooperation with three London Boroughs to develop a pilot scheme for the provision of "premises information plates" at buildings
- awareness that fire can spread downwards and laterally in a building and that burning debris might fall through open windows or on to balconies
- awareness of the risk of spread of fire above and adjacent to a fire flat
- procedures for moving a bridgehead
- communication between Brigade Control and those at an incident
- guidance as to the handling of fire survival guidance calls and training for officers dealing with such calls
- introduction of Mobile Data Terminals
- introduction of a forward information board.

I therefore do not make any recommendation in relation to such matters. I do, however, make the following recommendations.

Public awareness of fire safety

A number of former residents of Lakanal House gave evidence. There was little awareness of fire safety advice published by London Fire Brigade, whether through leaflets, the website or home fire safety visits. Residents of high rise residential buildings need to be aware of the dangers associated with fire in such buildings and to have a clear understanding of what they should do in case of fire. Whilst this is a matter which concerns housing providers, it is recommended that your Brigade also consider how to improve dissemination of fire safety information to achieve effective communication with residents of such buildings.

Visits made pursuant to section 7(2)(d) Fire and Rescue Services Act 2004, general familiarisation visits and home fire safety visits

I note that the Brigade now has guidance as to how such visits should be conducted and the type of information which crews should gather. As you recognise, "gathering of operational knowledge has little value unless it can be stored, disseminated, accessed and updated when most needed ie at incidents when the use can save valuable time and inform critical command decisions."

It is recommended that the Brigade review procedures for sharing information gained as a result of section 7(2)(d), familiarisation and home fire safety visits with crews both within the station in question and at other local stations.

Incident Commanders

During the Lakanal House fire there were six changes of Incident Commander (IC) with some serving as IC for brief periods.

It is recommended that the Brigade review its policy and procedures concerning incident command, having regard to whether it is effective for the choice of IC to be tied closely to the number or type of appliances attending an incident and the effectiveness of a policy which

may result in rapid and frequent changes of IC. It is also recommended that consideration be given to training of ICs and potential ICs to enhance their performance in relation to the following

- use of the Dynamic Risk Management model and other management tools to enable ICs to analyse a situation, and to recognise and react quickly to changing circumstances
- to recognise when to escalate attendance by more experienced ICs
- to anticipate that a fire might behave in a manner inconsistent with the compartmentation principle
- to be aware of the risks to those above and adjacent to the fire flat
- handover from one IC to the next and effective deployment of outgoing ICs
- the collection of information from all possible sources
- use of methodical search patterns.

Brigade Control

I note the steps already taken by the Brigade in relation to guidance to and training for those at Brigade Control who are involved in handling calls from members of the public, and fire survival guidance calls in particular.

It is recommended that the Brigade consider whether training be given to operational crews about Brigade Control practices and procedures.

Communications

It is recommended that the Brigade consider whether it would be beneficial to use additional breathing apparatus radio communications channels and personal radio channels at major incidents to reduce the amount of traffic on each channel.

Response

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As required by rule 43, I shall send a copy of this report to the Lord Chancellor.

Yours sincerely

Frances Kirkham

Inner Southern District of Greater London

The Coroner's Court
1 Tennis Street
London SE1 1YD

Her Honour Frances Kirkham CBE
Assistant Deputy Coroner

30 March 2013

Mr Brian Robinson CBE
Chairman
Fire Sector Federation
London Road
Moreton in Marsh
Gloucestershire GL56 0RH

Dear Mr Robinson

Lakanal House fire 3 July 2009

I write concerning the inquests into the tragic deaths of Catherine Hickman, Dayana Francisquini, Thais Francisquini, Felipe Francisquini Cervi, Helen Udoaka and Michelle Udoaka, who all died in a fire at Lakanal House, Camberwell, on 3 July 2009.

The jury brought in Narrative Verdicts in respect of each of the deceased.

I write to you pursuant to Rule 43 of the Coroners Rules (as amended) which provides:

"(1) Where

(a) a coroner is holding an inquest into a person's death,
(b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner may report the circumstances to a person who the coroner believes may have power to take such action."

Following these inquests I sent reports pursuant to Rule 43 to the Department of Communities and Local Government (DCLG) and London Borough of Southwark (LBS).

Evidence adduced at these inquests indicated that fire brigades generally assume that compartmentation of individual flats or maisonettes in high rise residential buildings would prevent the spread of fire from one dwelling to others or to common parts. However, the

evidence aiso indicated that, particularly with older housing stock, compartmentation might be breached as a consequence of, for example, maintenance or refurbishment work undertaken by building owners or modification to individual dwellings undertaken by occupiers.

Evidence was also given that a fire risk assessor should inspect individual flats or maisonettes within a high rise residential building to be able to inspect any features which could be seen inside, but not outside, the flat or maisonette and which might indicate that compartmentation had been breached.

I understand that your Federation seeks to give voice to and exert influence in shaping future policy and strategy related to the UK fire sector. I also understand that the Fire Risk Assessment Competency Council ("the Council") works within your Federation. My attention has been drawn to the Counoil's guides "Competency Criteria for Fire Risk Assessors", published on 21 November 2011, and "Choosing a Competent Fire Risk Assessor", published on 1 February 2013. These indicate that your Federation is able to offer guidance as to some aspects of fire risk assessment.

It appears that your Federation is well placed to shape policy, at a national level, relating to the scope of fire risk assessment, and in particular with regard to assessment of high rise residential buildings, and to offer guidance as to how assessments should be carried out. I trust that your Federation will consider whether it has a roie in clarifying the scope of fire risk assessments and in offering further guidance as to training of fire risk assessors.

I therefore, pursuant to Rule 43(4)(b), enclose copies of my reports to DCLG and LBS and draw to your attention the recommendations set out in those reports concerning fire risk assessments to be undertaken pursuant to the Regulatory Reform (Fire Safety) Order 2005.

I hope that this is helpful.

Yours sincerely

Frances Kirkham

INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

At Southwark on the 15th day of July 2009 and by adjournment on the 28 day of March 2013

Her Majesty's Assistant Deputy Coroner for the Inner South District of Greater London

The following matters were found:

1. Name of Deceased: Felipe Francisquini Cervi

2. Injury or disease causing death

[a Inhalation of fire fumes

b

c

II

3. Time, place and circumstances at or in which injury was sustained

See attached narrative verdict.

4. Conclusion of the Coroner as to the death

See attached narrative verdict.

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth: 19.09.05 London	
(b) Name and Surname of deceased: Felipe Francisquini Cervi	
(c) Sex: Male	(d) Maiden surname of woman who has married: n/a
(e) Date and place of death: 03.07.09 Flat 81, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	
(f) Occupation and usual address: n/a Flat 81, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	

Signature of Her Majesty's Coroner

Signature of Jurors (if present)

Felipe Francisquini Cervi

Felipe Francisquini Cervi died in the bathroom of flat 81 of Lakanal House on 03/07/09 between 1745 and 1800 hours. Fatal injuries were sustained by the inhalation of fire fumes generated from the initial fire in flat 65 and subsequent fires in flats 79, 37 and 53.

After the fire started in Flat 65, the flames spread through the composite panels of Flat 79.

Whilst sheltering in Flat 81 Felipe Francisquini Cervi was overcome by smoke from the numerous fires in Lakanal House.

Smoke entered Flat 81 from the 11th floor corridor, as well as from the bathroom ventilation duct. This duct was directly connected to secondary fires lower down the building.

Evidence suggests these fires were caused by flaming debris falling from Flats 65 and 79.

When the front door of Flat 79 collapsed into the 11th floor corridor, smoke and fire were able to spread along the corridor and enter Flat 81 because:

(a) The 'boxing in' under the stairs of Flat 81 failed to provide the required 60 minutes fire resistance;

(b) There were no fire seals on the front door of Flat 81;

(c) There was a lack of fire-stopping on internal pipework from previous renovations;

(d) The panel above the door of Flat 81 failed to provide adequate resistance.

All of these factors, in addition to the interconnected bathroom ducts contributed to a serious failure of compartmentation.

Had a fire risk assessment been carried out at Lakanal House, it is possible that these features may have been highlighted for further investigation.

The installation of a new heating system in the 1980s would have been an opportunity to ensure that the fire-stopping around pipes leading into Flat 81, and segmentation within the suspended ceiling, offered adequate protection from fire.

The 2006/7 refurbishment provided numerous opportunities to consider whether the level of fire protection of the building was adequate.

If the panel above the door of Flat 79, and the boxing in of both Flats 79 & 81 had been fire resistant to 60 minutes, the spread of fire and smoke into the roof cavity of the 11th floor

corridor would have been greatly limited.

If the roof cavity had been adequately protected, the occupants of the bathroom in Flat 81, including Felipe Francisquini Cervi, would in turn have had significantly less exposure to smoke.

In addition, fire fighters could have channelled resources more heavily towards search and rescue rather than active fire fighting.

Finally, it would have extended the period in which Felipe Francisquini Cervi could have escaped to the east balcony via the internal stairs of Flat 81.

With regard to firefighting operations, the initial attack on Flat 65 was both adequate and timely.

The extensive smoke logging in the communal corridors led to the bridgehead being moved, and firefighters becoming involved in rescuing residents from flats other than Flat 81.

Rescue attempts to Flat 81 were significantly hampered by the effects of smoke logging.

By moving the bridgehead further down the building on account of secondary fires in Flats 37and 53, the firefighters had further to go to reach Flat 81 on the 11th floor, and used more oxygen from their BA due to the efforts involved in doing so.

The unprecedented move of the bridgehead placed demands on time, resources, and manpower, which hampered rescue attempts.

If firefighters had been aware of the precise location of Flat 81 a rescue may have been effected before Felipe Francisquini Cervi sustained fatal injuries.

When speaking with the adults in Flat 81, it would have been appropriate for London Fire Brigade personnel to follow standard guidance advising persons to 'stay put', had they not been affected by smoke or fire. Given the worsening smoke, it would have been appropriate for the LFB to have used such a call to explore potential routes and means of escape.

There was a clear expectation by Brigade Control that trapped persons would be rescued by firefighters.

Their advice to the caller relied heavily on this assumption.

The training of brigade control officers failed to promote active listening or encourage operators to react to dynamic or unique situations.

Between 16.36 and 17.32 there were numerous calls made between Brigade Control and members of the public concerning families trapped in Flat 81.

Although Brigade Control informed firefighters of Flat 81, insufficient efforts were made to prioritise the flat and to deploy BA wearers specifically to this location in time to save the occupants.

Several of Felipe Francisquini Cervi's family members also spoke in person to members of the London Ambulance Service and the London Fire Brigade, communicating the whereabouts of Felipe Francisquini Cervi and his family members.

As was the case with other flats in the building, the firefighters had little knowledge of the layout and numbering system of Lakanal House. Thus, Flat 81 was not reached in time to save the occupants.

Consideration was given to the safety of those in flats above the fire in Flat 65.

However, confusion about the layout and the rescuing of residents elsewhere meant that flats directly above the fire were not actually reached in time.

Given the young age of Felipe, it would be unrealistic to assume he could have escaped unassisted. It would have been possible for Felipe Francisquini Cervi, accompanied by an adult, to have left the bathroom of flat 81 without assistance from the fire brigade up until approximately 17.15 using the escape balcony on the east side of the building.

Unfortunately, evidence suggests that the adults with Felipe Francisquini Cervi were unaware of escape routes such as this, and where they led to.

INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

At Southwark on the 15th day of July 2009 and by adjournment on the 28 day of March 2013

Her Majesty's Assistant Deputy Coroner for the Inner South District of Greater London

The following matters were found:

1. Name of Deceased: Michelle Udoaka

2. Injury or disease causing death

Ia Inhalation of fire fumes

b

c

II

3. Time, place and circumstances at or in which injury was sustained

See attached narrative verdict.

4. Conclusion of the Coroner as to the death

See attached narrative verdict.

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth: 13.06.09 London	
(b) Name and Surname of deceased: Michelle Udoaka	
(c) Sex: Female	(d) Maiden surname of woman who has married: n/a
(e) Date and place of death: 03.07.09 Flat 81, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	
(f) Occupation and usual address: n/a Flat 82, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	

Signature of Her Majesty's Coroner

Signature of Jurors (if present)

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Michelle Udoaka

Michelle Udoaka died in the bathroom of flat 81 of Lakanal House on 03/07/09 between 1745 and 1800 hours. Fatal injuries were sustained by the inhalation of fire fumes generated from the initial fire in flat 65 and subsequent fires in flats 79, 37 and 53.

After the fire started in Flat 65, the flames spread through the composite panels of Flat 79.

Whilst sheltering with her mother in Flat 81, Michelle Udoaka was overcome by smoke from the numerous fires in Lakanal House.

Smoke entered Flat 81 from the 11th floor corridor, as well as from the bathroom ventilation duct. This duct was directly connected to secondary fires lower down the building.

Evidence suggests these fires were caused by flaming debris falling from Flats 65 and 79.

When the front door of Flat 79 collapsed into the 11th floor corridor, smoke and fire were able to spread along the corridor and enter Flat 81 because:

(a) The 'boxing in' under the stairs of Flat 81 failed to provide the required 60 minutes fire resistance;

(b) There were no fire seals on the front door of Flat 81;

(c) There was a lack of fire-stopping on internal pipework from previous renovations;

(d) The panel above the door of Flat 81 failed to provide adequate resistance.

All of these factors, in addition to the interconnected bathroom ducts contributed to a serious failure of compartmentation.

Had a fire risk assessment been carried out at Lakanal House, it is possible that these features may have been highlighted for further investigation.

The installation of a new heating system in the 1980s would have been an opportunity to ensure that the fire-stopping around pipes leading into Flat 81, and segmentation within the suspended ceiling offered adequate protection from fire.

The 2006/7 refurbishment provided numerous opportunities to consider whether the level of fire protection of the building was adequate.

If the panel above the door of Flat 79, and the boxing in of both Flats 79 & 81 had been fire resistant to 60 minutes, the spread of fire and smoke into the roof cavity of the 11th floor

corridor would have been greatly limited.

If the roof cavity had been adequately protected, the occupants of the bathroom in Flat 81, including Michelle Udoaka, would in turn have had significantly less exposure to smoke.

In addition, fire fighters could have channelled resources more heavily towards search and rescue rather than active fire fighting.

Finally, it would have extended the period in which Michelle Udoaka could have escaped with an adult to the east balcony via the internal stairs of Flat 81.

With regard to firefighting operations, the initial attack on Flat 65 was both adequate and timely.

The extensive smoke logging in the communal corridors led to the bridgehead being moved, and firefighters becoming involved in rescuing residents from flats other than Flat 81.

Rescue attempts to Flat 81 were significantly hampered by the effects of smoke logging.

By moving the bridgehead further down the building on account of secondary fires in Flats 37and 53, the firefighters had further to go to reach Flat 81 on the 11th floor, and used more oxygen from their BA due to the efforts involved in doing so.

The unprecedented move of the bridgehead placed demands on time, resources, and manpower, which hampered rescue attempts.

If firefighters had been aware of the precise location of Flat 81 a rescue may have been effected before Michelle Udoaka sustained fatal injuries.

When speaking with the adults in Flat 81, it would have been appropriate for London Fire Brigade personnel to follow standard guidance advising persons to 'stay put', had they not been affected by smoke or fire. Given the worsening smoke, it would have been appropriate for the LFB to have used such a call to explore potential routes and means of escape.

There was a clear expectation by Brigade Control that trapped persons would be rescued by firefighters.

Their advice to the caller relied heavily on this assumption.

The training of brigade control officers failed to promote active listening or encourage operators to react to dynamic or unique situations.

Between 16.36 and 17.32 there were numerous calls made between Brigade Control and members of the public concerning families trapped in Flat 81.

Although Brigade Control informed firefighters of Flat 81, insufficient efforts were made to prioritise the flat and to deploy BA wearers specifically to this location in time to save the occupants.

Several of Michelle Udoaka's family members were also in contact with the London Fire Brigade, communicating the whereabouts of Michelle and her mother.

As was the case with other flats in the building, the firefighters had little knowledge of the layout and numbering system of Lakanal House. Thus, Flat 81 was not reached in time to save the occupants.

Consideration was given to the safety of those in flats above the fire in Flat 65.

However, confusion about the layout and the rescuing of residents elsewhere meant that flats directly above the fire were not actually reached in time.

It would have been possible for Michelle Udoaka to have been taken out of the bathroom of flat 81 to safety without the assistance of firefighters up until approximately 17.15 using the escape balcony on the east side of the building.

Unfortunately, evidence suggests that the adults with Michelle Udoaka were unaware of escape routes such as this, and where they led to.

INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

At Southwark on the 15th day of July 2009 and by adjournment on the 28 day of March 2013

Her Majesty's Assistant Deputy Coroner for the Inner South District of Greater London

The following matters were found:

1. Name of Deceased: Helen Udoaka

2. Injury or disease causing death

Ia: Inhalation of fire fumes

b:

c:

II:

3. Time, place and circumstances at or in which injury was sustained

See attached narrative verdict.

4. Conclusion of the Coroner as to the death

See attached narrative verdict.

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth: 31.05.75 Nigeria	
(b) Name aod Surname of deceased: Helen Udoaka	
(c) Sex: Female	(d) Maiden surname of woman who has married: Ojeyokan
(e) Date and place of death: 03.07.09 Flat 81, Lakanal House, Sceaux Gardens, Camberwell SES 7DP	
(f) Occupation and usual address: Management consultant Flat 82, Lakanal House, Sceaux Gardens, Camberwell SES 7DP	

Signature of Her Majesty's Coroner

Signature of Jurors (if present)

Helen Udoaka

Helen Udoaka died in the bathroom of flat 81 of Lakanal House on 03/07/09 between 1755 and 1805 hours. Fatal injuries were sustained by the inhalation of fire fumes generated from the initial fire in flat 65 and subsequent fires in flats 79, 37 and 53.

After the fire started in Flat 65, the flames spread through the composite panels of Flat 79.

Having left her own home, Flat 82, Helen went into Flat 81with her neighbours. Whilst sheltering in Flat 81 she was overcome by smoke from the numerous fires in Lakanal House.

Smoke entered Flat 81 from the 11th floor corridor, as well as from the bathroom ventilation duct. This duct was directly connected to secondary fires lower down the building.

Evidence suggests these fires were caused by flaming debris falling from Flats 65 and 79.

When the front door of Flat 79 collapsed into the 11th floor corridor, smoke and fire were able to spread along the corridor and enter Flat 81 because:

(a) The 'boxing in' under the stairs of Flat 81 failed to provide the required 60 minutes fire resistance;

(b) There were no fire seals on the front door of Flat 81;

(e) There was a lack of fire-stopping on internal pipework from previous renovations;

(d) The panel above the door of Flat 81 failed to provide adequate resistance.

All of these factors, in addition to the interconnected bathroom ducts contributed to a serious failure of compartmentation.

Had a fire risk assessment been carried out at Lakanal House, it is possible that these features may have been highlighted for further investigation.

The installation of a new heating system in the 1980s would have been an opportunity to ensure that the fire-stopping around pipes leading into Flat 81, and segmentation within the suspended ceiling offered adequate protection from fire.

The 2006/7 refurbishment provided numerous opportunities to consider whether the level of fire protection of the building was adequate.

If the panel above the door of Flat 79, and the boxing in of both Flats 79 & 81 had been fire

resistant to 60 minutes, the spread of fire and smoke into the roof cavity of the 11th floor corridor would have been greatly limited.

If the roof cavity had been adequately protected, the occupants of the bathroom in Flat 81, including Helen Udoaka, would in turn have had significantly less exposure to smoke.

In addition, fire fighters could have channelled resources more heavily towards search and rescue rather than active fire fighting.

Finally, it would have extended the period in which Helen Udoaka could have escaped to the east balcony via the internal stairs of Flat 81.

With regard to firefighting operations, the initial attack on Flat 65 was both adequate and timely.

The extensive smoke logging in the communal corridors led to the bridgehead being moved, and firefighters becoming involved in rescuing residents from flats other than Flat 81.

Rescue attempts to Flat 81 were significantly hampered by the effects of smoke logging.

By moving the bridgehead further down the building on account of secondary fires in Flats 37and 53, the firefighters had further to go to reach Flat 81 on the 11th floor, and used more oxygen from their BA due to the efforts involved in doing so.

The unprecedented move of the bridgehead placed demands on time, resources, and manpower, which hampered rescue attempts.

If firefighters had been aware of the precise location of Flat 81 a rescue may have been effected before Helen Udoaka sustained fatal injuries.

When speaking with Helen Udoaka, it would have been appropriate for London Fire Brigade personnel to follow standard guidance advising persons to 'stay put', had they not been affected by smoke or fire. Given the worsening smoke, it would have been appropriate for the LFB to have used such a call to explore potential routes and means of escape.

There was a clear expectation by Brigade Control that trapped persons would be rescued by firefighters.

Their advice to the caller relied heavily on this assumption.

The training of brigade control officers failed to promote active listening or encourage operators to react to dynamic or unique situations.

Between 16.36 and 17.32 there were numerous calls made between Brigade Control and members of the public concerning families trapped in Flat 81.

Although Brigade Control informed firefighters of Flat 81, insufficient efforts were made to prioritise the flat and to deploy BA wearers specifically to this location in time to save the occupants.

Several of Helen Udoaka's family members and acquantainces were in contact with members of the London Fire Brigade, communicating the whereabouts of Helen Udoaka and her baby.

As was the case with other flats in the building, the firefighters had little knowledge of the layout and numbering system of Lakanal House. Thus, Flat 81 was not reached in time to save the occupants.

Consideration was given to the safety of those in flats above the fire in Flat 65.

However, confusion about the layout and the rescuing of residents elsewhere meant that flats directly above the fire were not actually reached in time.

It would have been possible for Helen Udoaka to have left the bathroom of flat 81 without assistance up until approximately 17.15 using the escape balcony on the east side of the building.

Unfortunately, evidence suggests that Helen Udoaka was unaware of escape routes such as this, and where they led to.

INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

At Southwark on the 15th day of July 2009 and by adjournment on the 28 day of March 2013

Her Majesty's Assistant Deputy Coroner for the Inner South District of Greater London

The following matters were found:

1. Name of Deceased: Dayana Francisquini

2. Injury or disease causing death

Ia Inhalation of fire fumes

b

c

II

3. Time, place and circumstances at or in which injury was sustained

See attached narrative verdict

4. Conclusion of the Coroner as to the death

See attached narrative verdict

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth: 14.12.82 Brazil	
(b) Name and Surname of deceased: Dayana Francisquini	
(c) Sex: Female	(d) Maiden surname of woman who has married: Francisquini
(e) Date and place of death: 03.07.09 Flat 81, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	
(f) Occupation and usual address: Bank clerk Flat 81, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	

Signature of Her Majesty's Coroner

Signature of Jurors (if present)

Dayana Francisquini

Dayana Francisquini died in the bathroom of flat 81 of Lakanal House on 03/07/09 between 1750 and 1800 hours. Her fatal injuries were sustained by the inhalation of fire fumes generated from the initial fire in flat 65 and subsequent fires in flats 79, 37 and 53.

After the fire started in Flat 65, the flames spread through the composite panels of Flat 79.

Dayana Francisquini was sheltering in the bathroom of Flat 81 and was affected by smoke from the numerous fires in Lakanal House.

Smoke entered Flat 81 from the 11th floor corridor, as well as from the bathroom ventilation duct. This duct was directly connected to secondary fires lower down the building.

Evidence suggests these fires were caused by flaming debris falling from Flats 65 and 79.

When the front door of Flat 79 collapsed into the 11th floor corridor, smoke and fire were able to spread along the corridor and enter Flat 81 because:

(a) The 'boxing in' under the stairs of Flat 81 failed to provide the required 60 minutes fire resistance;

(b) There were no fire seals on the front door of Flat 81;

(c) There was a lack of fire-stopping on internal pipework from previous renovations;

(d) The panel above the door of Flat 81 failed to provide adequate resistance.

All of these factors, in addition to the interconnected bathroom ducts contributed to a serious failure of compartmentation.

Had a fire risk assessment been carried out at Lakanal House, it is possible that these features may have been highlighted for further investigation.

The installation of a new heating system in the 1980s would have been an opportunity to ensure that the fire-stopping around pipes leading into Flat 81, and segmentation within the suspended ceiling offered adequate protection from fire.

The 2006/7 refurbishment provided numerous opportunities to consider whether the level of fire protection of the building was adequate.

If the panel above the door of Flat 79, and the boxing in of both Flats 79 & 81 had been fire resistant to 60 minutes, the spread of fire and smoke into the roof cavity of the 11th floor

corridor would have been greatly limited.

If the roof cavity had been adequately protected, the occupants of the bathroom in Flat 81, including Dayana Francisquini, would in turn have had significantly less exposure to smoke.

In addition, fire fighters could have channelled resources more heavily towards search and rescue rather than active fire fighting.

Finally, it would have extended the period in which Dayana Francisquini could have escaped to the east balcony via the internal stairs of Flat 81.

With regard to firefighting operations, the initial attack on Flat 65 was both adequate and timely.

The extensive smoke logging in the communal corridors led to the bridgehead being moved, and firefighters becoming involved in rescuing residents from flats other than Flat 81.

Rescue attempts to Flat 81 were significantly hampered by the effects of smoke logging.

By moving the bridgehead further down the building on account of secondary fires in Flats 37and 53, the firefighters had further to go to reach Flat 81 on the 11th floor, and used more oxygen from their BA due to the efforts involved in doing so.

The unprecedented move of the bridgehead placed demands on time, resources, and manpower, which hampered rescue attempts.

If firefighters had been aware of the precise location of Flat 81 a rescue may have been effected before Dayana Francisquini sustained fatal injuries.

When speaking with Dayana Francisquini, it would have been appropriate for London Fire Brigade personnel to follow standard guidance advising persons to 'stay put', had they not been affected by smoke or fire. Given the worsening smoke, it would have been appropriate for the LFB to have used such a call to explore potential routes and means of escape. There was a clear expectation by Brigade Control that trapped persons would be rescued by firefighters. Their advice to the caller relied heavily on this assumption.

The training of brigade control officers failed to promote active listening or encourage operators to react to dynamic or unique situations.

Between 16.36 and 17.32 there were numerous calls made between Brigade Control and members of the public concerning families trapped in Flat 81.

Although Brigade Control informed firefighters of Flat 81, insufficient efforts were made to prioritise the flat and to deploy BA wearers specifically to this location in time to save the

occupants.

Dayana Francisquini's friend and several family members also spoke in person to members of the London Ambulance Service and the London Fire Brigade, communicating the whereabouts of Dayana and her two children.

As was the case with other flats in the building, the firefighters had little knowledge of the layout and numbering system of Lakanal House. Thus, Flat 81 was not reached in time to save the occupants.

Consideration was given to the safety of those in flats above the fire in Flat 65. However, confusion about the layout and the rescuing of residents elsewhere meant that flats directly above the fire were not actually reached in time.

It would have been possible for Dayana Francisquini to have left the bathroom of flat 81 without assistance up until approximately 17.15 using the escape balcony on the east side of the building.

Unfortunately, evidence suggests that Dayana was unaware of escape routes such as this, and where they led to.

INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

At Southwark oa the 15th day of July 2009 and by adjournment on the 28 day of March 2013

Her Majesty's Assistant Deputy Coroner for the Inner South District of Greater London

The following matters were found:

1. Name of Deceased: Thais Francisquini

2. Injury or disease causing death

Ia Inhalation of fire fumes

b

c

n

3. Time, place and circumstances at or in which injury was sustained

See attached narrative verdict.

4. Conclusion of the Coroner as to the death

See attached narrative verdict.

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth: 25.09.02 Brazil	
(b) Name and Surname of deceased: Thais Francisquini	
(c) Sex: Female	(d) Maiden surname of woman who has married: n/a
(e) Date and place of death: 03.07.09 Flat 81, Lakanal House, Sceaux Gardens, Camberwell SES 7DP	
(f) Occupation and usual address: n/a Flat 81, Lakanal House, Sceaux Gardens, Camberwell SES 7DP	

Signature of Her Majesty's Coroner

Signature of Jurors (if present)

Thais Francisquini

Thais Francisquini died in the bathroom of flat 81 of Lakanal House on 03/07/09 between 1745 and 1800 hours. Her fatal injuries were sustained by the inhalation of fire fumes generated from the initial fire in flat 65 and subsequent fires in flats 79, 37 and 53.

After the fire started in Flat 65, the flames spread through the composite panels of Flat 79.

Whilst sheltering in Flat 81 Thais Francisquini was overcome by smoke from the numerous fires in Lakanal House.

Smoke entered Flat 81 from the 11th floor corridor, as well as from the bathroom ventilation duct. This duct was directly connected to secondary fires lower down the building.

Evidence suggests these fires were caused by flaming debris falling from Flats 65 and 79.

When the front door of Flat 79 collapsed into the 11th floor corridor, smoke and fire were able to spread along the corridor and enter Flat 81 because:

(a) The 'boxing in' under the stairs of Flat 81 failed to provide the required 60 minutes fire resistance;

(b) There were no fire seals on the front door of Flat 81;

(c) There was a lack of fire-stopping on internal pipework from previous renovations;

(d) The panel above the door of Flat 81 failed to provide adequate resistance.

All of these factors, in addition to the interconnected bathroom ducts contributed to a serious failure of compartmentation.

Had a fire risk assessment been carried out at Lakanal House, it is possible that these features may have been highlighted for further investigation.

The installation of a new heating system in the 1980s would have been an opportunity to ensure that the fire-stopping around pipes leading into Flat 81, and segmentation within the suspended ceiling offered adequate protection from fire.

The 2006/7 refurbishment provided numerous opportunities to consider whether the level of fire protection in the building was adequate.

If the panel above the door of Flat 79, and the boxing in of both Flats 79 & 81 had been fire resistant to 60 minutes, the spread of fire and smoke into the roof cavity of the 11th floor

corridor would have been greatly limited.

If the roof cavity had been adequately protected, the occupants of the bathroom in Flat 81, including Thais Francisquini, would in turn have had significantly less exposure to smoke.

In addition, fire fighters could have channelled resources more heavily towards search and rescue rather than active fire fighting.

Finally, it would have extended the period in which Thais Francisquini could have escaped to the east balcony via the internal stairs of Flat 81.

With regard to firefighting operations, the initial attack on Flat 65 was both adequate and timely.

The extensive smoke logging in the communal corridors led to the bridgehead being moved, and firefighters becoming involved in rescuing residents from flats other than Flat 81.

Rescue attempts to Flat 81 were significantly hampered by the effects of smoke logging.

By moving the bridgehead further down the building on account of secondary fires in Flats 37and 53, the firefighters had further to go to reach Flat 81 on the 11th floor, and used more oxygen from their BA due to the efforts involved in doing so.

The unprecedented move of the bridgehead placed demands on time, resources, and manpower, which hampered rescue attempts.

If firefighters had been aware of the precise location of Flat 81 a rescue may have been effected before Thais Francisquini sustained fatal injuries.

When speaking with the adults in Flat 81, it would have been appropriate for London Fire Brigade personnel to follow standard guidance advising persons to 'stay put', had they not been affected by smoke or fire. Given the worsening smoke, it would have been appropriate for the LFB to have used such a call to explore potential routes and means of escape.

There was a clear expectation by Brigade Control that trapped persons would be rescued by firefighters. Their advice to the caller relied heavily on this assumption.

The training of brigade control officers failed to promote active listening or encourage operators to react to dynamic or unique situations.

Between 16.36 and 17.32 there were numerous calls made between Brigade Control and members of the public concerning families trapped in Flat 81.

Although Brigade Control informed firefighters of Flat 81, insufficient efforts were made to prioritise the flat and to deploy BA wearers specifically to this location in time to save the

Catherine Hickman

Catherine Hickman died in the lounge of flat 79 of Lakanal House facing east betweeen 1650 and 1700 hours on 03/07/09 of inhalation of fire fumes and burns. These fatal injuries came as a result of an initial fire in flat 65 and its subsequent developments.

Evidence suggests that the fire within Flat 65 was of medium growth.

The fire spread up into Flat 79 through the panels under the bedroom windows of Flat 79.

The aluminium window frames were distorted by the flames from Flat 65, creating gaps through which the curtains of Flat 79 caught alight.

Combustible items within Bedroom 1 of Flat 79 facilitated the fire spread within the flat up to the internal staircase.

Smoke spread from the windows, across the bedroom, up the staircase, and into the upstairs open plan lounge.

Gaps around window sets allowed external winds to push smoke back into Flat 79, facilitating smoke spread under and through floorboards.

These factors all contributed to rapid and extensive smoke-logging within Flat 79 alongside severe heat and flame which created non-survivable conditions. Catherine Hickman was overcome by heat, smoke and later flame.

The panels under the bedroom windows of Flat 79 were not Class 0, although they required to be.

This was due to a serious failure on the part of SBDS, its contractors, and its subcontractors.

The evidence suggests alterations made to Flat 79 may have made more than a minimal contribution to the death of Catherine Hickman as the removal of the staircase wall facilitated the spread of smoke up the internal staircase.

However, in October 2006 SBDS was informed that the modifications of Flat 79 were approved. This information included the suggestion that SBDS check the work for fire safety.

This fire safety check did not happen, and was therefore a missed opportunity to consider the adequacy of fire protection.

In the 1980s, the pipework for the heating system was installed in the ceiling cavity above the communal corridors.

This would have been an opportunity to ensure that the fire stopping around pipes leading into flats, and segmentation within the ceiling itself, offered adequate protection from fire.

The 2006/7 major refurbishments, which involved material alterations to Lakanal House, provided numerous opportunities to consider whether the level of fire protection at the building was adequate.

Asbestos removal and replacement with composite panels had a significant impact on the fire resistance of the external wall of Lakanal House.

Despite a proactive approach by the Health and Safety advisors to the London Borough of Southwark, the Council's housing department did not prioritise carrying out fire risk assessments in all of its properties.

As a result, by July 3rd 2009 Lakanal House had not been assessed.

Catherine Hickman made a 999 call to Brigade Control at 16.21, and remained on the line receiving fire survival guidance until she became unconscious around half an hour later.

In regard to training (and refresher training) received by Brigade Control officers, there are no records of minimum training requirements being met between 1994 and 2009.

Evidence suggests that existing training documents are contradictory and inconsistent, particularly in regard to either 'staying put' or 'getting out' when there is a fire in the building.

There was a clear expectation by Brigade Control operators that persons trapped would be rescued by firefighters.

Their advice to the caller relied heavily on this assumption.

The training of Brigade Control officers failed to promote active listening, or encourage operators to react to dynamic or unique situations.

Early on in her call, Catherine Hickman gave important information to Brigade Control about the layout of the building, as well as her own whereabouts.

Catherine also described how she was being affected by smoke and fire.

This information was not shared effectively with, or acted on, by London Fire Brigade personnel on the fireground.

With regard to firefighting operations, the initial attack on Flat 65 was both timely and adequate.

The extensive smoke logging in the communal corridors led to the bridgehead being moved, and firefighters becoming involved in rescuing residents from flats other than Flat 79.

Although Brigade Control and firefighters were aware of Flat 79, insufficient efforts were made to prioritise and locate the Flat and to deploy BA wearers specifically to this location.

Confusion about the layout of the building, including the numbering system, and speed with which the fire spread, prevented fire fighters from reaching Flat 79.

Despite the Incident Commander at the time prioritising flats above the fire, the aforesaid confusion concerning the layout and numbering of Lakanal House, as well as the rescue of other residents, meant that Flat 79 was not reached in time.

Evidence suggests that Catherine Hickman would have been able to escape without assistance, using the east balcony, until approximately 16.40. However, conditions on the east balcony were quite difficult by this time, with extensive smoke from the fire in Flat 65.

Escape would have been daunting, but not impossible.

Within 3 minutes of the first London Fire Brigade appliance arriving at the scene, the composite panels below the bedroom windows of Flat 79 were already alight.

Issues such as smoke-logging in communal areas, and the need to undertake difficult rescues elsewhere in the building, would have made it impossible for firefighters to extinguish the fire before it created non-survivable conditions in Flat 79.

However, had it been possible to deploy BA crews to the flats immediately above and adjacent to Flat 65, at the same time as the BA crew was deployed to fight the fire in Flat 65, it may have been possible to rescue Catherine Hickman before she sustained fatal injuries.

Even if the composite panels under the bedroom windows of Flat 79 had been Class 0, they would not have prevented the spread of fire from Flat 65 to Flat 79.

However, if they had been Class 0, the spread of fire within Flat 79 would have been slower.

Due to the non-invasive nature of Fire Risk Assessments at the time of the fire, if one had been carried out it would not have made a significant difference to the outcome of this situation. However, it may have highlighted features of the building that required further investigation.

INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

At Southwark on the 15th day of July 2009 and by adjournment on the 18 day of March 2013

Her Majesty's Assistant Deputy Coroner for the Inner South District of Greater London

The following matters were found:

1. Name of Deceased: Felipe Francisquini Cervi

2. Injury or disease causing death

Ia Inhalation of fire fumes

b

c

II

3. Time, place and circumstances at or in which injury was sustained

See attached narrative verdict.

4. Conclusion of the Coroner as to the death

See attached narrative verdict.

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth: 19.09.05 London	
(b) Name and Surname of deceased: Felipe Francisquini Cervi	
(c) Sex: Male	(d) Maiden surname of woman who has married: n/a
(e) Date and place of death: 03.07.09 Flat 81, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	
(f) Occupation and usual address: n/a Flat 81, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP	

Signature of Her Majesty's Coroner

Signature of Jurors (if present)

Felipe Francisquini Cervi

Felipe Francisquini Cervi died in the bathroom of flat 81 of Lakanal House on 03/07/09 between 1745 and 1800 hours. Fatal injuries were sustained by the inhalation of fire fumes generated from the initial fire in flat 65 and subsequent fires in flats 79, 37 and 53.

After the fire started in Flat 65, the flames spread through the composite panels of Flat 79.

Whilst sheltering in Flat 81 Felipe Francisquini Cervi was overcome by smoke from the numerous fires in Lakanal House.

Smoke entered Flat 81 from the 11th floor corridor, as well as from the bathroom ventilation duct. This duct was directly connected to secondary fires lower down the building.

Evidence suggests these fires were caused by flaming debris falling from Flats 65 and 79.

When the front door of Flat 79 collapsed into the 11th floor corridor, smoke and fire were able to spread along the corridor and enter Flat 81 because:

(a) The 'boxing in' under the stairs of Flat 81 failed to provide the required 60 minutes fire resistance;

(b) There were no fire seals on the front door of Flat 81;

(c) There was a lack of fire-stopping on internal pipework from previous renovations;

(d) The panel above the door of Flat 81 failed to provide adequate resistance.

All of these factors, in addition to the interconnected bathroom ducts contributed to a serious failure of compartmentation.

Had a fire risk assessment been carried out at Lakanal House, it is possible that these features may have been highlighted for further investigation.

The installation of a new heating system in the 1980s would have been an opportunity to ensure that the fire-stopping around pipes leading into Flat 81, and segmentation within the suspended ceiling, offered adequate protection from fire.

The 2006/7 refurbishment provided numerous opportunities to consider whether the level of fire protection of the building was adequate.

If the panel above the door of Flat 79, and the boxing in of both Flats 79 & 81 had been fire resistant to 60 minutes, the spread of fire and smoke into the roof cavity of the 11th floor

corridor would have been greatly limited.

If the roof cavity had been adequately protected, the occupants of the bathroom in Flat 81, including Felipe Francisquini Cervi, would in turn have had significantly less exposure to smoke.

In addition, fire fighters could have channelled resources more heavily towards search and rescue rather than active fire fighting.

Finally, it would have extended the period in which Felipe Francisquini Cervi could have escaped to the east balcony via the internal stairs of Flat 81.

With regard to firefighting operations, the initial attack on Flat 65 was both adequate and timely.

The extensive smoke logging in the communal corridors led to the bridgehead being moved, and firefighters becoming involved in rescuing residents from flats other than Flat 81.

Rescue attempts to Flat 81 were significantly hampered by the effects of smoke logging.

By moving the bridgehead further down the building on account of secondary fires in Flats 37and 53, the firefighters had further to go to reach Flat 81 on the 11th floor, and used more oxygen from their BA due to the efforts involved in doing so.

The unprecedented move of the bridgehead placed demands on time, resources, and manpower, which hampered rescue attempts.

If firefighters had been aware of the precise location of Flat 81 a rescue may have been effected before Felipe Francisquini Cervi sustained fatal injuries.

When speaking with the adults in Flat 81, it would have been appropriate for London Fire Brigade personnel to follow standard guidance advising persons to 'stay put', had they not been affected by smoke or fire. Given the worsening smoke, it would have been appropriate for the LFB to have used such a call to explore potential routes and means of escape.

There was a clear expectation by Brigade Control that trapped persons would be rescued by firefighters.

Their advice to the caller relied heavily on this assumption.

The training of brigade control officers failed to promote active listening or encourage operators to react to dynamic or unique situations.

Between 16.36 and 17.32 there were numerous calls made between Brigade Control and members of the public concerning families trapped in Flat 81.

Although Brigade Control informed firefighters of Flat 81, insufficient efforts were made to prioritise the flat and to deploy BA wearers specifically to this location in time to save the occupants.

Several of Felipe Francisquini Cervi's family members also spoke in person to members of the London Ambulance Service and the London Fire Brigade, communicating the whereabouts of Felipe Francisquini Cervi and his family members.

As was the case with other flats in the building, the firefighters had little knowledge of the layout and numbering system of Lakanal House. Thus, Flat 81 was not reached in time to save the occupants.

Consideration was given to the safety of those in flats above the fire in Flat 65.

However, confusion about the layout and the rescuing of residents elsewhere meant that flats directly above the fire were not actually reached in time.

Given the young age of Felipe, it would be unrealistic to assume he could have escaped unassisted. It would have been possible for Felipe Francisquini Cervi, accompanied by an adult, to have left the bathroom of flat 81 without assistance from the fire brigade up until approximately 17.15 using the escape balcony on the east side of the building.

Unfortunately, evidence suggests that the adults with Felipe Francisquini Cervi were unaware of escape routes such as this, and where they led to.