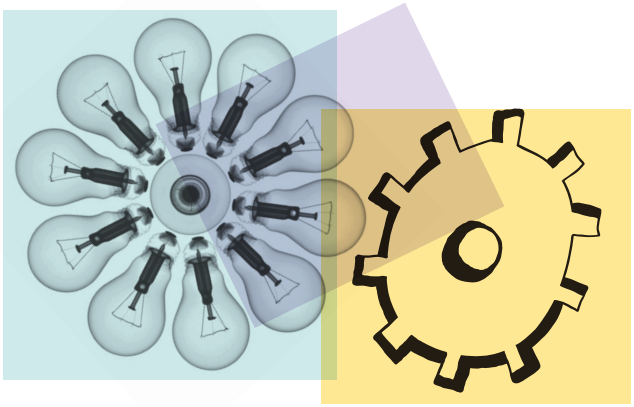

Inquests: safety and learning for the housing sector

Last year the Grenfell Tower tragedy put safety in social housing back in the news. Whilst attending an inquest will be a rare occurrence for a housing manager, some deaths in private or social housing may lead to an inquest, not only those relating to house fires. Inquests have been held in respect of deaths from carbon monoxide poisoning from faulty boilers; a child trapping its head in a faulty lift and suicide following harassment by a neighbour.

When is an inquest needed?

An inquest is needed if:

- a death is violent or unnatural;
- the cause of death is unknown; or
- if the person died in custody or state detention.

The purpose of an inquest is to establish:

- who the deceased was; and
- how, where and when they died.

In addition to answering these four questions, at the end of an inquest the Coroner gives either a short-form or narrative 'conclusion' (formerly known as the verdict). Common short-form conclusions in housing inquests are accident/misadventure; natural causes; and suicide. A 'narrative' conclusion is a brief, neutral, factual statement e.g. Mr Smith died on 5 April 2018 as a result of injuries caused by a fire in his home and is commonly used in complex inquests where a short-form conclusion does not adequately reflect what happened to the deceased.

The Coroner as risk manager: Prevention of Future Death Reports ('PFD reports')

Distinct to the Coroner's duty to determine who, how, where and when the deceased died, the Coroner has a separate duty to write a PFD report if anything revealed by the investigation raises concerns that there is an ongoing risk of death to the public. The Coroner must issue the PFD report to the organisation with the power to remedy the problem the Coroner has identified and to prevent future deaths. A response must be provided in 56 days covering:

- what has been done to consider the Coroner's recommendation(s);
- whether any changes will be made; and
- if the recommendation is not going to be adopted, why?

PFD reports are published on the Chief Coroner's website. They can seriously damage reputations and can be seized on by the media, bereaved families and regulators.

High profile cases

In recent years, there have been a number of high profile housing inquests. Lakanal House, Shirley Heights and the Derby hoarder – all of which yielded a PFD report from the Coroner. Lakanal and Shirley Heights involved fires in high-rise blocks and many similar issues feature in the Grenfell Tower Inquiry. The PFD reports contained some common themes:

- building design and cladding;
- appropriateness of advice from emergency services;
- adequacy of signage;
- failure to complete or adequately complete fire risk assessments;
- staff training on fire-resistance of materials; and retro fitting of sprinklers.

It has become apparent in the wake of Grenfell that many of the PFD recommendations arising from these high profile inquests were considered by the relevant organisations to be unnecessary, inappropriate or already in place to protect the public and therefore were not implemented.

The Derby hoarder was a vulnerable adult who had refused treatment for mental health issues. Paper had caught fire near a gas ring in the kitchen used to heat the house, which had been piled floor to ceiling with rubbish. The PFD report recommended a new targeted power to enable authorities to step in when hoarding creates a fire risk.

Safety and learning

Early identification of risk and learning from near-misses and deaths is a vital part of keeping tenants safe. If a death occurs, justifying risk management decisions will become a vital part of the inquest process, especially if the Coroner is considering a PFD report. Evidence that landlords have implemented actions to keep their buildings safe in future will be required in advance of the inquest and a senior manager many need to give oral evidence at the inquest itself. What steps can be taken to minimise risk and demonstrate learning to the Coroner?

- ensure a robust approach to governance at all times;
- review and amend relevant policies to align with current guidance and to minimise the risk of a similar incident recurring;
- ensure risk assessments are comprehensive, timely and well-documented;
- implement 'joined-up' thinking throughout the procurement / design and build process (an issue identified following Grenfell);
- pay particular attention to risks involving vulnerable tenants;
- review staff training in all aspects of safety management; and
- disclose internal investigation and action plan to the Coroner showing what recommendations have been made and when these will implemented.

How Capsticks can help

Capsticks is a market leader in inquests and housing law and is ranked in the top tier for both by the Chambers Guide to the legal profession. If you require inquest representation or would like to discuss any inquest or safety related housing issues, please contact:

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