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 and 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 SE5 7DP
(f) Occupation and usual address	Management consultant Flat 82, Lakanal House, Sceaux Gardens, Camberwell SE5 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;

(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 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.