INQUISITION
An Inquisition taken for our Sovereign Lady the Queen

At Southwark on the 15th day of July 2009 and by adjournment on the 28th 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
   Catherine Hickman

2. Injury or disease causing death
   a. Inhalation of fire fumes and burns
   b. 
   c. 
   d. 

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 | 15.07.77  Southampton |
| (b) Name and Surname of deceased | Catherine Hickman |
| (c) Sex | Female |
| (d) Maiden surname of woman who has married | n/a |
| (e) Date and place of death | 03.07.09 Flats 79, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP |
| (f) Occupation and usual address | Fashion designer Flats 79, Lakanal House, Sceaux Gardens, Camberwell SE5 7DP |

Signature of Her Majesty's Coroner

Signature of Jurors (if present)
Catherine Hickman

Catherine Hickman died in the lounge of flat 79 of Lakanal House facing east between 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-loggiong 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 O, 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.