Case
Study

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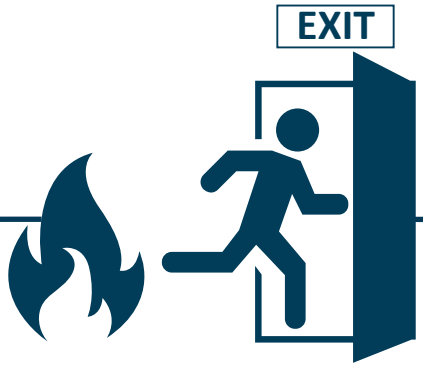

Case Study – A catalogue of failures led to death

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Ashlie Timms, aged 46, died in supported living accommodation in April 2018 after staff failed to call 999 promptly and evacuate her during a fire. The jury concluded that the actions of Sequence Care Group (SCG), Ramsay Safety Solutions and the London Fire Brigade all contributed to her death, following an inquest before Area Coroner Graeme Irvine at Walthamstow Coroners Court.

The inquest today found the death of Ashlie Timms was caused by the following:

- A fire detection and fire alarm system which did not have an a connection to an Alarm Receiving Centre (ARC) to automatically alert the emergency services
- An incorrect text address location on the alarm display, that Sequence Care knew to be incorrect
- Staff departed from basic fire evacuation procedures
- Up to a 45 minute delay to summon emergency services, demonstrating a significant lack of urgency to do so
- The resetting of the fire alarm on at least two occasions
- Ashlie was not evacuated, despite her Personal Emergency Evacuation Plan (PEEP) requiring staff to do so
- The presence of an electronic keypad lock at the main point of escape presenting an obstacle in a highly stressful situation
- Absence of an effective fire safety audit in 2017
- Departures from British fire standards and recommendations, conflicting organisational fire policies and fire risk assessments that went unchallenged
- Lack of a bespoke fire related policy and fire risk assessments

At the time of her death, Ashlie Timms was living at Connington Court in Waltham Forest, a residential care home run by Sequence Care Group (SCG). Timms suffered from a personality disorder as well as restricted mobility and had a care package and Personal Emergency Evacuation Plan (PEEP) which required staff to approach her immediately and instruct her regarding evacuation in the event of a fire.

The fire alarm sounded at a time between 1:30 am and 2 am on 20th April 2018, but staff did not immediately evacuate Timms due to ignorance of the fire procedures as well as the fire alarm being mislabelled which led some staff to check the wrong side of the building first. By the time staff reached the correct side of the building, they claim they were unable to enter Ashlie's flat from the corridor due to being overwhelmed by smoke.

The fire brigade were not called until 2:13 am, up to 45 minutes after the fire alarm sounded. The jury heard that a staff member knocked at a neighbour's door to inquire about the number to call for the emergency services. The jury also heard from support workers on shift that night who said that they had never seen Ashlie's PEEP.

In a report conducted by the London Fire Brigade (LFB), Watch Manager Drummond concluded that if a staff member had implemented the PEEP properly, "it is likely that in the initial stages of the fire, the staff member would have been able to assist Ms Timms away from danger into an area of safety". This is consistent with his conclusion that at the time the alarm first went off, the fire was still quite small, readily survivable and that the conditions were tenable for evacuation. Fire safety expert Colin Todd (FIA Board Member and FIA Fire Risk Assessment Council Chair) who acted as an expert witness also described the delay in staff calling the LFB as 'totally unacceptable'.

Furthermore, in recent changes made to the premises, SCG had installed a combination lock on the inside of Ashlie's flat door that required her to enter a four digit number to exit the flat. Without having a form of manual override, this was described by Colin Todd as 'dangerous' and a practice that he had never seen before. During the fire, Ashlie was able to exit her bedroom and reach this flat door unassisted but she did not manage to escape from the flat.

Mr Todd also points towards the failures of Ramsay Safety Solutions (RSS), who were responsible for advising SCG about their fire procedures and conducting fire risk assessments. The representative of RSS accepted in the inquest that they were not qualified to conduct these risk assessments and draft these procedures for supported living accommodation. Todd described the last risk assessment in 2017 as 'absurd' and deficient in a number of respects, including the failure to highlight the absence of automatic transmission of alarm signals. The same fire risk assessment, as well as an audit carried out by London Fire Brigade (LFB) in October 2017, also failed to identify the fact that the fire safety procedures were not fit for purpose. The LFB audit in October 2017 was described by LFB Deputy Assistant Commissioner Stephen Norman as 'flawed'.

Aston Luff, Solicitor at Hodge Jones & Allen, representing the family of Ashlie Timms, said: "The circumstances of Ashlie Timms' death are shocking. Her family were entitled to trust that she was safe in the care of experienced staff, who would be competent enough to know how to call the fire brigade in the event of an emergency. Instead, Ashlie died from a fire that would have been readily survivable if Sequence Care Group had implemented the correct evacuation procedures and dialled 999 sooner. When the staff employed are unable to take such basic steps to protect the residents in their care, it raises wider questions of the value placed on the care of vulnerable people such as Ashlie."

Source: **https://www.hja.net/news-and-insights/press-releases/civil-liberties-human-rights/care-home-providers-actions-caused-vulnerable-residents-death-after-tragic-fire-in-supported-living-accommodation-inquest-finds/**

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