### ANNEX A

## **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

NOTE: This form is to be used after an inquest.

# **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** THIS REPORT IS BEING SENT TO: The Housing Manager, Leeds City Council, Kirkstall Area Housing Office, 45 Kirkstall Lane, Leeds, LS5 3BE CORONER I am David Hinchliff, senior coroner/area coroner/assistant coroner, for the coroner area of West Yorkshire (Eastern) CORONER'S LEGAL POWERS 2 I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. 3 INVESTIGATION and INQUEST Julie Ann CAMM, aged 49 years, born 10 February 1963. The investigation concluded at the end of the inquest on 18 December 2013. The conclusions of the inquest were by Narrative, which was: "Julie Ann Camm was a single lady aged 49, who suffered with schizophrenia causing her to have frequent auditory hallucinations. There was no reference in her history to self-harm or suicide. On Tuesday 13 November 2012 at approximately 03:45 hours Julie was found in her smoke logged flat, 121 Latchmere Drive, Leeds 16. She had deliberately started a fire in the bedroom of her home and had also inflicted life threatening incised wounds upon herself with an electric knife. Her death was confirmed there by Paramedics at 04:20 hours on 13 November 2013. The evidence does not support a view that Julie has deliberately taken her own life and nor was her death an accident. It is more likely that at the time her mental health had declined and she was responding to auditory hallucinations arising from her condition." 1(a) Carbon monoxide poisoning Multiple incised wounds CIRCUMSTANCES OF THE DEATH Julie Ann Camm was a single lady aged 49 who was not in employment and who was late of 121 Latchmere Drive, Leeds 16. Miss Camm suffered from mental health issues and was diagnosed with schizophrenia. She has previously been the subject of Sections pursuant to the Mental Health Act and there is reference in her history to her setting fires in the street but no previous mention of self-harm. Miss Camm was last seen alive by her family on 11 November 2012 and efforts to contact her thereafter proved futile but this was not unusual.

At 04:10 hours on Tuesday 13 November 2012 the Emergency Services were contacted to the report of a fire at her address. On arrival of the Fire and Ambulance Service, it

was discovered that Miss Camm was dead on the landing of the property. She was found with deep cuts to her wrist, calf and throat. The fire had been started by a naked flame in the bedroom that had been left smouldering.

The house was secured from within.

Miss Camm's death was confirmed by Paramedics at that location at 04:20 hours on 13 November 2012. There was a detailed Police enquiry revealing there to be no suspicious circumstances. A Fire Service investigation concluded that the fire was started deliberately by the application of a naked flame to bed linen in the bedroom.

### 5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. -

The Fire Service Report revealed that there were no smoke alarms fitted to the property. This property was originally in the ownership of a Housing Association and it was established that there had been a partial re-wire, kitchen sockets only in 2008. Had it been due for a full re-wire then hard-wired smoke detectors would have been installed. The Housing Association's procedure at the time was to encourage their tenants to refer to the West Yorkshire Fire and Rescue Service to have a home fire safety check, but this was not in place when Miss Camm took out this tenancy. I am aware that the Fire Service provide fire safety advice to all members of the community and will provide and fix smoke detectors free of charge where necessary. A considerable amount of work has been carried out to forge links with other agencies and provide them with education in risk identification with regard to fire safety. The Fire and Rescue Service would encourage individuals or agencies to refer any member of the community to them. particularly those most vulnerable in the first instance through their local Fire Service. This property is now within the ownership of Leeds City council. Originally it was owned by a Housing Association - Leeds West North West Homes. The Council took over on 1 October 2013.

It is a matter of grave concern to me that there were no smoke detectors in the property, notwithstanding the vulnerability of Miss Camm as a tenant. I, therefore, recommend that the owner of this property inspect all their housing stock and arrange for either hardwired detectors to be fitted at the earliest opportunity. Until this can be achieved I further recommend that the landlord contact the West Yorkshire Fire and Rescue Service for home assessment teams to carry out the necessary assessment and, where appropriate, fit battery operated smoke detectors until such time as permanent hardwired detectors can be installed.

Had a smoke detector been in place, it is likely that neighbours and members of the public in the vicinity would have been alerted to the fire in sufficient time for Miss Camm to be rescued and her death could have been avoided.

### 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

### 7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 March 2014. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

# 8 COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: West Yorkshire Fire Service, Family of the deceased and Derek Winter, (Coroner's Society) I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. 9 David Hinchliff Senior Coroner