

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none"> Chairman of the National Patient Safety Agency ██████████ Chief Fire Officer, Staffordshire Fire & Rescue Service, President of the Chief Fire Officers Association.
1	<p>CORONER</p> <p>I am Christopher Wilkinson, Assistant Coroner, for the coroner area of West Sussex</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 16th February 2015 the Senior Coroner commenced an investigation into the death of John Hills born 29 September 1931, being age 84 at the date of his death. An inquest was subsequently opened and adjourned on 17th February 2015 and a Pre-Inquest review held by me on 29 April 2015. The investigation concluded at the end of the inquest on 23 June 2015. The conclusion of the inquest was that Mr Hills died as a result of 40% burns to his face, trunk and limbs, suffering also from COPD and Hypertensive Heart Disease. My conclusion was that Mr Hills had died accidentally.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <ol style="list-style-type: none"> Mr Hills had been resident in a nursing home in Worthing since 2003. He had no family and had been taken into care following incidences of self-neglect at home. He was registered blind and suffered from paranoid schizophrenia. He had mobility issues and at the time of the incident used a wheelchair. He was doubly incontinent (requiring pads) and had a dry skin condition which required a regime of 4-6 x daily full body appliances of Cetraben emollient cream (500 gram). The exact extent of Mr Hills' capacity was unascertained but it was considered more likely than not that he would have found it difficult to understand complex information about his overall welfare, long term care needs, risk and safety issues. Mr Hills had few interests, but loved to smoke his pipe. It was described as his 'only pleasure'. For a number of years the home had facilitated this, with a dedicated area for him to smoke. No formal risk assessment or smoking policy was however in place until 22 November 2014 (although this was a property risk assessment rather than a personal one for Mr Hills). On 24 November 2014, Mr Hills had been responsible for a small fire in the conservatory of the care home, where he had been allowed to smoke. It was established that he had flicked a lit match. No personal injury was caused but the small fire required to be extinguished, resulting in property damage. A further risk assessment was subsequently undertaken and measures put in place to reduce the risk of fire in the conservatory (the designated smoking area). This focused on introducing non-combustible materials and furniture as well as fire-fighting equipment. Fire prevention procedures were instigated but no personal risk assessment was undertaken. A fire assessment advisor subsequently attended the home. A new 'smoking care plan' was put in place on 8 December 2014. This required Mr Hills (amongst other measures) to wear a fire retardant apron when smoking and to be monitored every 30 mins. The application of Cetraben cream was not noted

	<ol style="list-style-type: none"> 7. Mr Hills was a creature of habit and had a number of favourite items of clothing. These included a favourite old cardigan and scarf, both of which he refused to have removed. He would wear both items constantly and sometimes he slept in them. They were rarely washed. He had a habit of wrapping himself in many layers of clothing, with a minimum of 2 blankets wrapped round him. He insisted on wearing his scarf on the outside of his fire apron and it was often a battle to get him to do otherwise. He did not like wearing the fire apron, but would do so if he was told. 8. On 6 February 2015 at approx. 7.40pm, Mr Hills was brought to the conservatory to smoke. He was collected from his room and deposited by a new nurse who had only been with the home for two days. The care home manager took over. He was settled into position by the home manager, and set up with all of his smoking paraphernalia. His pipe was lit for him and his matches were removed. He was left to smoke alone. 9. The evidence established a tragic chain of events. The new nurse believed Mr Hills would be dressed with his apron in the conservatory before smoking and after she had left him – the apron was usually kept on a hook in the conservatory. The manager had assumed that he had it on when he had arrived at the conservatory (it was not on its designated hook and he appeared to be wearing something similar in colour). Sadly, the presence of the apron was not physically checked and consequently Mr Hills was not wearing his fire apron on the evening of 6 February. The apron was subsequently found in a laundry basket, having been washed. The fact not communicated to other staff. 10. At approx. 8pm the fire alarm sounded. Mr Hills was discovered in flames in his chair. The fire was extinguished and emergency services called. He was transferred to hospital but died the following day as a result of his injuries. 11. The fire investigation evidence concluded that Mr Hills had either dropped or placed his lit pipe in his lap. The insulating quality of his incontinence pad had likely precluded his ability to sense the smouldering heat from the tobacco in the pipe which built to a point of ignition where a flame developed. His clothing and blankets were ignited and the flames accelerated by the multiple layers of clothing he wore, including his shirt (which, it was subsequently established, contained a fire hazard warning label). 12. The evidence established that the accelerant quality of the paraffin based emollient cream was, more likely than not, a considerable contributory factor. It was clear that it had been absorbed by his unwashed clothing over a period of time. Although not scientifically proven by the fire officer (his evidence was not based on controlled or laboratory based results), tests undertaken on fabric soaked in 'wet' Cetraben and 'dried' Cetraben, showed that the soaked and dried product had a much more flammable characteristic than the 'fresher' wet soaked fabric and that fire developed 4-5 times faster. None of the staff at the home appeared to be aware of this risk and it was clear that nothing had been mentioned to them or brought to their attention concerning any potential risks at the time the cream was prescribed.
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> (1) Cetraben emollient cream is a paraffin-based product. It contains 23-24% paraffin content (13.2% white soft paraffin and 10.5% light liquid paraffin). Neither the prescription label (nor prescription guidance) nor the bottle contain

	<p>(2) Diprobase emollient cream (the next 'greasy' preparation product and next step up from Cetraben) contains 21% paraffin content (15% white soft paraffin and 6% liquid paraffin) but 7.2% alcohol, and carries a fire hazard warning on prescription: "Dressings and clothing in contact with this product are easily ignited by a naked flame – Keep away" (the product bottle itself has not been examined for warnings during the course of my enquiries).</p> <p>(3) The British National Formulary does not list either product specifically as being flammable, but does contain a general warning for paraffin based emollients that reads: "Fire hazard with paraffin-based emollients: Emulsifying ointment or 50% liquid paraffin and 50% white soft paraffin ointment in contact with dressings and clothing is easily ignited by a naked flame. The risk is greater when these preparations are applied to large areas of the body, and clothing or dressings become soaked with the ointment. Patients should be kept away from fire or flames and not to smoke when using these preparations. The risk of fire should be considered when using large quantities of any paraffin-based emollient"</p> <p>(4) Mr Hills was clearly recorded (in his medical notes) as being a chronic smoker with acute bronchitis. He was also recorded as being a pipe smoker (in his medical records on 13/10/14) yet had a repeat prescription for Cetraben 500 gram being recorded on 11/09/14. There is nothing to evidence that any risk was considered or communicated by either the GP surgery or the prescribing pharmacy.</p> <p>(5) The NPSA carried a Rapid Response Warning (and report) on 26 November 2007 providing background and recommendations on the use of paraffin based products, but focused (as does the BNF) on (non-proprietary emollient preparations, specifically) emulsifying ointments or 50% plus paraffin content emollients. It is not clear whether this has been recently reviewed or whether the potential risk of lower % paraffin content creams has been considered and addressed.</p> <p>(6) Rapid Response (and report) 4 of 26/11/07 cites a reported death occurring in similar circumstances and a similar incident is reported in the British Journal of Dermatology in 2001. The NPSA commissioned the HSE to undertake fire hazard testing with White Soft Paraffin as a result, but it is not clear if subsequent cases have occurred or have been highlighted or whether any other cases have involved lower % content emollient creams.</p> <p>(7) Cetraben and Diprobase are proprietary emollient preparations in wide application in non-hospital environments, notably care homes, but also in private nursing and home care. It appears that there is little information conveyed or publicised about the potential risk of ignition/fire outside of hospitals or other clinical treatment areas, particularly where the cream is in frequent application and clothing (or bedding) has a high risk of becoming soaked or soiled by repeated application and contact.</p> <p>(8) I am concerned about the potential risks associated with Cetraben (and associated lower % creams) and the level of awareness, communication and prevention of such risks in the community. I believe this should be considered, the risks assessed and action taken, as appropriate.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you or your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th October 2015. I, the coroner, may extend the period.</p> <p>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.</p>

8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;</p> <ul style="list-style-type: none"> • [REDACTED], Manager, St Michaels Nursing Home, Worthing <p>I have also sent it to the following persons who may find it useful or of interest;</p> <ul style="list-style-type: none"> • [REDACTED] Shelley Surgery, Worthing • [REDACTED], Investigating Officer, West Sussex Adult Safeguarding Team • [REDACTED] Station Manager (Fire Investigator) WSFRS • [REDACTED] Chief Fire Officer, West Sussex Fire & Rescue Service • Care Quality Commission <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>DATE: 11/08/2015</p> <p style="text-align: right;">Christopher Wilkinson. Assistant Coroner, West Sussex</p>