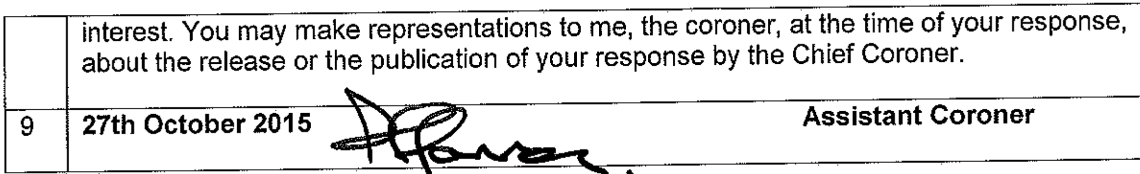
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Bristol City Council** 2. [redacted] **daughter of the Deceased** 3. [redacted], **son of the Deceased** 4. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon
2	**CORONER'S LEGAL POWERS** 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** On 7th November 2014 I commenced an investigation into the death of Mr. George Hines age 79 years. The investigation concluded at the end of the inquest on 3rd September 2015. The conclusion of the inquest was that the medical cause of death was I(a) Carbon monoxide toxicity, and the narrative conclusion as to the death was that: "The Deceased died from carbon monoxide toxicity following a fire at his home address".
4	**CIRCUMSTANCES OF THE DEATH** Mr. Hines lived in one of a group of low rise flats designated by the Bristol City Council as 'elderly preferred (50+)' accommodation. This was a sheltered housing facility which was monitored from an emergency control room (ECR) and Mr. Hines also received weekly visits from a housing support advisor from the Council as well as a weekly intercom check. The Council also provided a 24-hour emergency call-out facility for each resident. Mr. Hines' flat was provided with a telephone as well as pull-cords in each room which enabled him to contact the ECR in an emergency. Once the cord was pulled the system was designed to enable the Emergency Control Officer to speak to Mr. Hines via the intercom system and for him to respond without the need of using the telephone manually. During the early hours of 23rd October 2014 the ECR received a 'manual trigger' indicating a pull cord had pulled. Just over one minute later a second 'manual trigger' was received. However, the ECO's who received these calls were unable to connect with Mr. Hines' flat via the intercom and could not speak to him. One minute later a call was placed by the ECO to Mr. Hines' landline telephone number but it was not answered. The call was designated by the ECO as a 'no speech' alarm call (i.e. where a resident activates the alarm but there is no voice contact) and the on-call Housing Support Advisor (HSA) was requested to attend the address. Given the call was in the early hours a security officer was also requested to attend the address with the HSA. The HSA arrived at the address around 20 minutes after being requested to attend and the security officer arrived a few minutes later. Together they went to Mr. Hines' flat and gained entry using a master key. Upon opening the front door the flat was seen to be full of thick black smoke. The emergency services were called by 999, this call being made 42 minutes after the first 'manual trigger' by the pull cord. Fire officers attended quickly and entered the flat where they found the body of Mr. Hines in the lounge. He was removed and resuscitation was attempted by paramedics but to no avail. The Fire Investigation Officer determined that the most likely cause of the fire was a smouldering cigarette on some clothing on a chair in the deceased's 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. – (1) The pull-cord in the bedroom of the deceased was found by the Fire Investigation Officer not to be connected to the ceiling switch. Notwithstanding the regular visits by the HSA this defect was not noted and no corrective action had been taken. No evidence of a regular planned preventative maintenance programme was given to the Inquest with regard to ensuring all pull-cords were working and in good order. The Council should implement a regular inspection and maintenance programme for the alarm system if not already in place. (2) There was a recently installed smoke detector system with battery back up. The Fire Investigation Officer confirmed the smoke detector was probably functioning correctly at the time of the fire. The previous stand alone battery smoke detector was also in place. The evidence given to the Inquest was that it was the responsibility of the resident to regularly test the smoke detector and replace the battery as necessary, notwithstanding the flat was sheltered accommodation and the deceased was elderly. The Council should implement a regular programme of its own of inspection, testing and maintenance of the smoke detector. (3) The flat has a pull-cord alarm system which is connected 24 hours a day to an Emergency Control Room. The recently installed smoke detector alarms only in the individual resident's flat and not elsewhere in the building and does not alarm automatically in the ECR. The smoke detector did not alert other residents to the fire. The Council should consider connecting the smoke detector to the alarm system installed in each flat as well as ensuring it also alarms in the communal area. The current advice to residents on discovering a fire is to leave their flat and alert the emergency services by pulling the emergency cord in the communal area or in a neighbour's flat. The Inquest heard evidence there was no pull-cord in the communal area of this building. The residents are also instructed that the alternative to pulling the cord was that they should dial 999. Instructions to residents to pull the cord first may give a false sense of security that the emergency services have been alerted even if they receive no audible response from the ECR. The Council should revise its instructions to residents in the event of fire generally and specifically that they are instructed to dial 999 first before taking any other action.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 22nd December 2015. 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 [redacted] daughter of the deceased and [redacted] son of the deceased. I shall send a copy of your response to [redacted], daughter of the deceased. I have sent a copy of my report to the Chief Coroner. 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	**27th October 2015** **Assistant Coroner**