Regulation 28: Prevention of Future Deaths report

William THOMPSON (died 07.11.14)

	THIS REPORT IS BEING SENT TO: **1. Mr Tim Shields** **Chief Executive** **London Borough of Hackney** **Hackney Town Hall** **Mare Street** **London E8 1EA**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 10 November 2014, I commenced an investigation into the death of William Thompson, aged 72 years. The investigation concluded at the end of the inquest earlier today. I made a determination of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Thompson died in a fire at his home caused by a discarded cigarette. His bedding caught light and he was killed by smoke inhalation. Mr Thompson lived in supported housing.

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 evidence I heard at inquest was that, whilst smoke and heat detectors were installed in Mr Thompson's hall and kitchen, there was no smoke detection system in his bedroom. He was known to be at significantly raised fire risk because of his smoking, drinking and immobility (he used a Zimmer frame). London Fire Brigade had been called to his home more than once in the past. However, his social workers never addressed their minds to the question of whether there was a smoke detector in his bedroom and, if not, whether that might be useful. This seems to be an area that would benefit from exploration for particularly high risk service users.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 3 July 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 the following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] Group Manager, London Fire Brigade • [redacted] daughter 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 30.04.15