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.** The Rt Hon Theresa May MP, Home Secretary **2.** The Rt Hon Greg Clark MP, Secretary of State for Communities & Local Government
1	**CORONER** I am Professor M Jennifer Leeming H M Senior Coroner, for the Coroner Area of Manchester West
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 25th March 2015 I commenced an investigation into the death of Steven Thomas Billington, aged 49 years. The investigation concluded at the end of the inquest on 4th July 2016. The conclusion of the jury following inquest was 'an accident from a deliberate act of putting his clothing on a maiden and placing the maiden in front of the unprotected gas fire resulting in the unintentional ignition of the clothing.'
4	**CIRCUMSTANCES OF THE DEATH** Steven Thomas Billington died on 25th March 2015 as a consequence of inhaling products of combustion arising from a fire at his home address Flat 3, 12 Bradford Avenue, Bolton. The jury concluded, as can be seen above, that the fire occurred when clothing that had been placed on a maiden in front of a gas fire to dry ignited. Mr Billington's flat was one of a number of flats within a premise that had been converted into separate units of living accommodation. As the relevant Fire Safety Orders require, the premises were fitted with a mains powered alarm system. However the on/off control-switch for the system was unprotected and was situated in an accessible communal part of the premises. At some stage the system had been turned off at that switch with the result that the alarm could not and did not give warning of the fire.
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 on/off control-switch for the mains powered alarm system was not protected and was therefore able to be switched off. Evidence was given that the relevant regulations do not require the on/off control for such a system to be rendered inaccessible to all but authorised persons. Further evidence revealed that it would be a simple matter to protect the control by it being placed, for example, in a locked cupboard and this would have no detrimental effect as the control panel for the system that allows it to be reset in the event of false alarm is separately situated from the on/off control-switch.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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 6th September 2016. 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: [redacted] Daughter I have also sent it to the following who may find it useful or of interest: Peter O'Reilly, County Fire Officer & Chief Executive, Greater Manchester fire Service. [redacted] Landlord of premises. 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	**Dated** **12th July 2016**
	Signed **Professor M Jennifer Leeming**