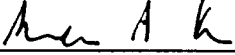




**Andrew A Haigh**  
**Senior Coroner for Staffordshire (South)**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO: [REDACTED] REGULATORY LAWYER, MARKS &amp; SPENCER, 10<sup>th</sup> FLOOR EAST, WATERSIDE HOUSE, 35 NORTH WHARF ROAD, LONDON W2 1NW</b></p>
1	<p><b>CORONER</b></p> <p>I am Andrew A Haigh, Senior Coroner for Staffordshire (South)</p>
2	<p><b>CORONER'S LEGAL POWERS</b></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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On the 6th September 2016 I commenced an Investigation into the death of Roy Frederick Lawton, aged 85. The Investigation concluded at the end of the Inquest on 22nd November 2016. The conclusion of the Inquest was accidental death - the death resulting from burns.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Early on 23rd July 2016 Mr Lawton was sitting on a settee at his home in Gentleshaw having a cup of coffee and smoking a cigar. He dozed off and dropped the cigar which ignited the dressing gown and pyjamas that he was wearing. He put the fire out but had sustained serious burns. He was taken to the burns unit at the Queen Elizabeth Hospital where, despite treatment, he died on 31st August 2016.</p>
5	<p><b>CORONER'S CONCERNS</b></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 <b>MATTER OF CONCERN</b> is as follows: Enquiries into this death included a fire investigation report. The Fire Investigator informed me that the dressing gown that Mr Lawton had been wearing was highly inflammable. He told me that this appears to be the case whether clothing is 100% cotton or a mixture of cotton and polyester. A short while has elapsed since the conclusion of the Inquest as you have been kindly checking the production details. I now understand these are T07/5288 manufactured by Quantum in Vietnam. I wonder if anything can be done either in the production, importing or retail of this clothing either to reduce its inflammability or to warn customers as to the danger .</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 February 2017. I, the coroner, may extend the period.</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.
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [REDACTED] I have also sent it to the Staffordshire Fire and Rescue Service who may find it useful or of interest.</p> <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>Dated 9 December 2016</p> <p>Signature <u></u> Senior Coroner for Staffordshire (South)</p>