Ms N J Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: James Courtney** Chief Fire Officer and Chief Executive, 197 Eyre Street, Sheffield S1 3FG
1	**CORONER** I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 01/11/2016 I commenced an investigation into the death of Jack Owen Sheldon, 13 . The investigation concluded at the end of the inquest on 14 March 2017. The conclusion of the inquest was Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On the 27th October 2016 Jack Sheldon was stripping paint off a motorbike he had bought in the shed in the garden of his home with the door closed. The shed filled with petrol vapours and petrol leaked onto objects within the shed. At some point after 20.00 hrs on the 27th the petrol vapours reached a flammable level and reached the naked flame of the candle (being used for light) and flashed and thereafter led to an intense shed fire. It was not known that Jack was in the shed until after the fire had been extinguished. Four emergency calls were made to the fire service, the first call led to reservation of an appliance but this was not mobilised as the second call taken had more detailed information leading the operator to mobilise the second allocated appliance, which was in fact the second nearest, leading to a delay of some four minutes in the appliance arriving at the scene. It is unlikely that this would have made a difference to the outcome to Jack.
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) Lack of an effective system for management of multiple calls being received regarding the same incident and prioritisation of appliances. (2) Lack of effective training of staff with regard to the importance of verbal communication (3) Lack of effective protocols for mobilisation of appropriate appliances and associated training of staff (4) Need for training of staff to ensure they have full knowledge of the systems in place to check availability of appliances prior to mobilisation. (5) An overview of the system generally with regard to the practicality of operators switching between screens to check appliances and their availability and location when already dealing with emergency situations.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you James Courtney 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 Monday 08 May 2017. 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] and to the Local Safeguarding Board. 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 14 March 2017 Signature____________________ Senior Coroner for South Yorkshire (East District)