IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Brian Leonard Bicat
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: 1. **Mr Matt Hancock – Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall London SW1A 2NS** 2. **Dr Ian Hudson, Chief Executive, Medicines and Healthcare Products Regulatory Agency (I would request separate responses from Medicines and Medical Devices Division) 151 Buckingham Palace Road, London SW1W 9Sz** 3. **Mr Mike Durkin, Director of Patient Safety, NHS Improvement, 133-155 Waterloo Road London SE1 8UG** 4. **Chief Executive of the Proprietary Association of Great Britain, Vernon House, Sicilian Avenue London WC1A 2QS** 5. **Chief Executive of Alliance Pharmaceutical** 6. **Chief Executive – Diprobase – Bayer Public Ltd, 400 South Oak Way, Green Park, Reading, Berkshire, RG2 6AD** 7. **NHS England** 8. **Bradford District Care Foundation Trust**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 3/10/17 I opened an inquest into the death of **Brian Leonard Bicat** who, at the date of his death was aged 82 years old. The inquest was resumed and concluded on 18/7/18. I found that the cause of death to be: - 1a. Multi Organ Failure 1b Extensive Cutaneous Burns After consideration of the evidence I arrived at a conclusion of Accident

4	**CIRCUMSTANCES OF THE DEATH** Mr Bicat lived with his wife at [redacted] He had a longstanding history of skin allergies and at the time of his death was suffering with leg ulcer's for which he was under the care of district nurses and was treated with daily applications of paraffin based Diprobase emollient cream and Hydromol ointment. On 22/9/17 Mr Bicat sustained severe burns at his home address, which he inadvertently caused as he smoked a cigarette, when a naked flame from his lighter came into the proximity of his dressing gown. Although he was immediately taken to hospital he succumbed and died from his extensive cutaneous burns later the same day. It was found more likely than not, that the speed and intensity of the fire was increased by the presence of paraffin based emollient ointment and cream present on his dressing gown and pyjamas. Fire Officers from West Yorkshire Fire and Rescue service undertook a number of controlled fire tests using similar night clothes worn by Mr Bicat and in some of the tests Diprobase emollient cream and Hydromol ointment were impregnated into the samples. The results revealed that the presence of the cream and ointment caused the fires to develop with much greater speed and intensity as compared to those tests where the cream and ointment was not present. The tests showed that the diprobase cream containing the least amount of paraffin had the fastest fire development of all the tests. West Yorkshire Fire and Rescue Service gave evidence at the inquest that the speed and the intensity of the fire was increased by the presence of the paraffin based emollient ointment and cream present on Mr Bicat's dressing gown and pyjamas. Evidence presented at the inquest suggested that although fire risk of high content paraffin emollient creams was contained on alerts and guidance, this did not extend to lower emollient creams containing lower levels of paraffin. Evidence was heard at the inquest to suggest that the GP was not regularly updated with respect to the specific fire risks of paraffin based ointments.
5	**<u>CORONER'S CONCERNS</u>** 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 **MATTER OF CONCERN** is as follows. – • Paraffin based ointments and emollient creams which contain a low level of paraffin pose a potential fire hazard risk • Warnings of such risks are not displayed on all product packaging • Consider more prominent labels and alerts re fire hazard on product containers • Health care professionals in both hospital and community setting may not be aware of the potential fire hazard poised by emollient creams which contain a low level of paraffin • To consider fire warning labelling on all emollients including those below 50% content, making clear the mechanisms of the risk • Health care professionals including pharmacists to verbalize product warnings at the point of prescription, dispensing or point of sale. • Members of the public are able to purchase such products in retail outlets and online where verbal warnings from healthcare professionals are not given • Review patients with repeat prescriptions for emollients and cross reference those that smoke. Give safety advice retrospectively and review prescriptions. • Raise awareness with health care professionals and include paraffin based skin products in annual continuing fire safety training • Review information sharing of burns data between hospitals, YAS and fire service so that incidents that didn't receive a fire service attendance can be investigated fully. • The NHS prescribing systems (system One and Optimise) appear to be updated by individual CCG's resulting inconsistent alerts and warnings. • Consider a review of the current effectiveness of obtaining fire incident reports involving paraffin based skin products since there is currently a lack of accurate national data involving paraffin based skin products
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the recipients of this report have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] – wife • [redacted] – GP • [redacted] – West Yorkshire Fire and Rescue Service • [redacted] – Service Manager – Adult Physical Health Bradford District Care Foundation • Chief Coroner
9	**DATED this 29/5/18** M D Peel **Senior Coroner – West Yorkshire - Western**