WEST YORKSHIRE WESTERN DISTRICT

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Rob Webster, Chief Executive, SW Yorks Partnership NHS Foundation Trust.** [redacted] 2. **HHJ Lucraft , Chief Coroner** [redacted] 3. **Steve Close, Chief Executive, Together Housing.** [redacted] 4. **John Roberts, Chief Fire Officer, West Yorkshire Fire and Rescue Service.** [redacted]
1	**CORONER** I am JOHN NIGEL BROADBRIDGE, Assistant Coroner, for the Western coroner area of West Yorkshire
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 8th September 2017 the Senior Coroner, Mr Martin Fleming, commenced an investigation into the death of BARNABY LUKE AYLWARD ("Mr Aylward") aged 49 years. The investigation concluded at the end of the inquest held over 3rd and 4th December 2018. The (narrative) conclusion of the inquest was that: "The deceased died as a result of an accidental fire in the early hours of Monday 4 September 2017. The deceased, a heavy smoker, was overcome by smoke from a house fire more likely than not caused by his failure to handle safely a lit cigarette when he was using an armchair in the living area of his home at [redacted] Huddersfield. After smouldering, combustible materials in or around the armchair affected by the lit cigarette ignited. The ensuing fire took hold quickly from which the deceased did not escape despite the operation of fitted smoke alarms. He was found only a short distance in front of the armchair and was pronounced deceased there at 03.55 hours that same morning. The deceased suffered from long standing serious mental disorders which required anti-psychotic medication treatment. He lived alone. His home regularly contained accumulations over time of the deceased's clutter, including waste, which restricted where he could properly rest and care for himself fully and safely. It also increased the risk of fire and smoke in the dwelling and it contributed to the fire intensity that morning. His ability and willingness to manage his own safety completely was inadequate including because of persistent restlessness. He remained vulnerable to the circumstances in which he died which whilst identifiable were not identified in any concerted plan and not promptly and thoroughly remedied for his long term benefit. He was not assessed to require compulsory detention under the Mental Health Act 1983, s2 on 1 September 2017 and remained in community mental health care at the date of his death" The medical cause of death was determined as 1a) asphyxia due to 1b) smoke inhalation due to the house fire.

4	**CIRCUMSTANCES OF THE DEATH** Mr Aylward was a heavy smoker, and was overcome by smoke from a house fire more likely than not caused by his failure to handle safely a lit cigarette. The precise reason for the cigarette to come into contact with combustible material was not able to be established. After smouldering, combustible materials in or around the armchair (in which he was likely to have been seated) affected by the lit cigarette ignited; the fire intensity was increased because of combustible material discarded or stored by Mr Aylward in his living area space which usable area had been reduced by that clutter, which was evident on any inspection, around his home. The ensuing fire took hold quickly from which the deceased did not escape despite the operation of fitted smoke alarms. It was more likely than not that Mr Aylward had died from smoke inhalation before firefighters were able to extinguish the fire. If he tried to escape he did not get far. He had been observed to have been agitated and restless for some hours the evening and night before. He had undergone formal assessment for detention under the MHA 1983 on 1 September 2017 but only one independent Doctor's recommendation to detain was given and the detention did not proceed. He remained at home.
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 could 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) Mr Aylward was a social housing tenant. He exhibited certain behaviours that were in part linked to his serious mental illness. Those presented risk of death in a fire at home including heavy smoking and allowing clutter and waste to accumulate there. Those behaviours and thus risks were known to certain individuals, including his family, and agencies but they did not except in time of crisis or emergency: a) review those potential risks with a multi agency preventative approach and re assess those risks regularly over time; b) take any collective responsibility nor for any one person or agency to take responsibility to reduce or eliminate risk by action eg clearing clutter and fire risk; and education about risk and reluctance to compel Mr Aylward to improve his environment regularly if needed; c) did not feel empowered to make property inspections regularly or at all and advise Mr Aylward and other agencies, or have sufficient resources at the right level to inspect and assist; d) may have been hampered by issues of confidentiality in communications between agencies. If all agencies had shared the particulars of his behaviours the burden of risk might be shared and understood and potential to reduce or eliminate the risk attempted, reviewed and managed. (2) The mental health care delivered to Mr Aylward was within a Care Planning Approach. The Care Plan documentation did not identify his above behaviours in writing and thus potential risks, nor indicate review and solutions including with housing provision (3) The presence of clutter and thus risk was not always evidenced in other clinical notes as a symptom of Mr Aylward's illness of significance as were other presentations of his illness. (4) There was some but not much evidence of seeking to extend support to Mr Aylward through his family members including practical and financial help.

	(5) The appropriateness for a risk management meeting and also MHA assessment in part to be held away from the patient to enable frank discussions to take place between mental health professionals rather than in front of the patient when perhaps more robust views may not have been enabled.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 11th February 2019 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 namely [redacted] 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	**14th December 2018** JNBroadbridge ..... **John Broadbridge** **Assistant Coroner for Western area West Yorkshire**