	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, East End Homes** **2. Chief Executive, East London NHS Foundation Trust** **3. [redacted] St Paul's Way Medical Centre**
1	**CORONER** I am JONATHAN STEVENS, assistant coroner, for the coroner area of Inner North London
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 7th April 2020 Assistant Bourke commenced an investigation into the death of PAULINE VIOLET OAKLEY [age 75]. The investigation concluded at the end of the inquest on 10th September 2020. The conclusion of the inquest was that the deceased died on 3rd April 2020 at the Royal London Hospital of burns suffered after an accident at her home when she fell on an electric heater.
4	**CIRCUMSTANCES OF THE DEATH** Pauline Oakley lived alone in a flat at 29 Southern Grove London. The building is a 7 floor block of flats owned and managed by East End Homes. Pauline Oakley had limited mobility and required carers three times per day. She had been discharged from hospital on 1st April 2020 with a hospital discharge plan that included support from the Occupational Therapy Reablement Team. Her GP had also written her Co-ordinate My Care Plan. On 3rd April 2020 Pauline Oakley fell at her home onto a two bar electric heater. A fire started around her and she was unable to move. The electric heater was old and did not have the safety mechanism found in modern electric heaters which automatically turn the heater off in the event it is knocked over. The fall took place between approximately 05.00 – 05.15 and the fire alarm was activated by the smoke at about 05.30. Residents in neighbouring flats heard but ignored the fire alarm. At 08.50 a friend of Pauline Oakley arrived at the block of flats and realised there had been a fire and called the emergency services. The police arrived at 09.01 and London Fire Brigade arrived at 09.02. Between 09.03 – 09.13 Pauline Oakley was rescued from the scene of the fire by the London Fire Brigade. Pauline Oakley was attended to by a doctor from the Helicopter Emergency Medical Service and taken to the Royal London Hospital. She had sustained full thickness burns to her thorax, abdomen, back, face away and bilateral arms. The burns covered 60% of her body. The injuries were assessed as un-survivable and she died late the same day in hospital.

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) There was no assessment of the safety or suitability of Pauline Oakley's flat, or the appliances within the flat arranged by the NHS Trust Foundation responsible for her discharge home as part of the hospital discharge plan. The evidence was that had she had fallen on a modern electric heater, with a built in safety mechanism, there would have been no fire. (2) There was no assessment of the safety or suitability of Pauline Oakley's flat, or the appliances within the flat arranged by as part of the Co-ordinate My Care Plan. (3) The fire alarm in the flats was apparently not monitored by East End Homes, the police or the London Fire Brigade. When an alarm was activated it was dependent upon a resident in the flats or a member of the public to call the emergency services. Residents of the flats may have thought that the alarm was monitored and therefore there was no need for any resident to call the emergency services.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 13th November 2020. 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] sister of the deceased 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	**18th September 2020** **SIGNED**