REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Chief Executive, Stockport Metropolitan Borough Council**
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 23rd September 2020 I commenced an investigation into the death of Darrell Spear. The investigation concluded on the 25th May 2021 and the conclusion was one of accidental death. The medical cause of death was 1a Inhalation of products of combustion and thermal injury 1b 1c II Left ventricular hypertrophy and hypertension
4	CIRCUMSTANCES OF THE DEATH On 22nd September 2020 there was a fire at [redacted] Windermere Road where Darrell Leonard Spear lived. He died from the fire. Police and fire service investigations found that the fire had probably started accidentally and accelerated rapidly due to the extensive hoarding within the address and the outside door of the conservatory was open increasing the flow of oxygen to the fire.

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 MATTERS OF CONCERN are as follows. – 1. The inquest heard that Mr Spear and his wife were known to agencies and that it was recognised that self-neglect and hoarding were significant issues. Their lifestyle meant that there was a significant risk to them both including from fire. Although these issues had been identified in the months preceding Mr Spear's death it was only on 22nd September that steps were taken to arrange to clear the property later that week. 2. The evidence before the inquest suggested that communication between agencies was poor in relation to information sharing and that there was no clear strategy to address the risk presented to both Mr Spear and his wife.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 3rd August 2021. 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] (family of deceased), who may find it useful or of interest. 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	**8th June 2021**  **Alison Mutch HM Senior Coroner Manchester South**