



Her Majesty's Coroner Staffordshire (South) Coroner's Jurisdiction

Date: 17.11.2020

Case: [REDACTED]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Staffordshire Fire and Rescue Service HQ
Pirehill Stone Staffordshire ST15 0BS

CORONER

I am Mr Andrew A Haigh HM Senior Coroner for Staffordshire (South)

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>

INVESTIGATION and INQUEST

On **28 October 2019** I commenced an investigation into the death of **Sylvia Ruth GRIFFITHS**. The investigation concluded at the end of the inquest on 12 November 2020. The conclusion of the inquest was 'Accident' with the death having resulted from 'inhalation of fumes' following a house fire.

CIRCUMSTANCES OF THE DEATH:

Sylvia Griffiths suffered from dementia and she was known to wander from her home. She would therefore be locked in her home at night with a window left unsecured so that she could get out if necessary. She was found dead in her home on the morning of 27th October 2019. She had been overcome by fumes from a fire which had been caused by inappropriate use of an electric kettle.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed a matter 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:

During the course of the inquest a suggestion was made that there can be fire/smoke alarms that are particularly directed at people suffering with dementia. It was

mentioned that **Staffordshire Fire and Rescue Service** may well have links with groups helping the demented and that there could be greater communication about and use of such alarms.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 12.1.2021. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

Family

West Midlands Fire Service

I have also sent it to other interested persons 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.

Dated : 17.11. 2020

Signature



Andrew Haigh Senior Coroner for Staffordshire South