	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS Re Cedrick Skyers 00725-16, died 13.03.16 (JB) THIS REPORT IS BEING SENT TO: 1. [redacted], Chief Executive, BUPA, 15-19 Bloomsbury Way, Bloomsbury WC1A 2BA 2. [redacted], Chair, Lewisham Adult Safeguarding Board, 2nd Floor Laurence House, Catford, London, SE6 4RU 3. [redacted], Chief Executive, Care Quality Commission, Care Quality Commission (CQC), 151 Buckingham Palace Road, London, SW1 9SZ
	CORONER I am Andrew Harris, Senior Coroner, London Inner South
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners & Justice Act 2009 and regulations 28 and 29, the Coroners (Investigations) Regulations 2013.
3	INVESTIGATION I opened an investigation into this death on 31.03.16. The London Fire Brigade, Care Quality Commission and Metropolitan Police and Adult Safeguarding Board began investigations into this unnatural death in a nursing home. Delay to the coronial investigation was occasioned by the need for these authorities and the coroner to agree that there was no legal reason that the inquest could not be heard prior to any prosecution. I concluded an inquest on 16.10.17 with a narrative.
4	CIRCUMSTANCES OF THE DEATH Mr Skyers was a hemiplegic resident of Manley Court Nursing Home, who could not stand or reposition himself on his own, nor propel his wheelchair. He was wheeled into the garden to smoke, a regular routine, on the morning of 13th March 2016. He was assessed as safe to smoke on his own, but the staff were unaware that some of his laundered clothes had burn marks. He was known not to like supervision. He was unusually left alone in the garden and it was not evident how he could summon help. At about midday, he was seen to be on fire and immediate attempts were made to extinguish the fire by smothering and water, which was effective. It lasted less than five minutes. It had been caused by the breeze fanning his smouldering clothes, burnt by his lit cigarette. Emergency services attended promptly and despite full resuscitation he died at 13.05 in hospital of extensive burning. Had he been supervised or had means of alarm call, he would likely have survived.

	Although not recorded, as evidence from the nursing home on the wearing of smoke aprons was not heard, Fire expert advice was accepted that had he been wearing a smoking apron, he would also have survived.
5	CORONER'S CONCERNS The **MATTER OF CONCERN** is as follows. – The management of the Care Home and its owners, BUPA, have undertaken a through investigation and implemented a detailed Action Plan which has reduced many of the risks to life of accidental fires from resident's smoking identified in the inquest. But one area remains a concern. BUPA corporate guidance indicated, at the time of Mr Skyer's death and now, that residents who wish to smoke must have risk assessments with their abilities, dependencies and special requirements taken into account. The concern relates to the process of mitigating the risks from personal risk assessment of immobile patients. A new safe smoking risk assessment form has been introduced, which requires assessment of safely lighting and smoking a cigarette now to be recorded. The only new question to be asked which would score a concern for a resident such as Mr Skyers, in a wheelchair, is one as to whether the resident has any difficulty in balance. If that is recorded as *yes*, the process requires the documentation of the steps to be taken to limit associated risks. Nowhere is the risk associated with immobility specifically recognised, yet patients who are immobile and smoke in bed are required to be supervised. A BUPA Fire Risk Advisor told the court that he would recommend the same requirement should be made for those who are immobile but smoking elsewhere. The present policy appears to leave the nurse with the discretion as to what may be inserted into the plan. A BUPA manager informed the court that residents would be offered an apron and alarm pendant. This was not apparent in the documentation. It was not documented that a person who declined these would be expected to accept supervision, nor the importance of these for someone who is completely immobile. If this too was declined, it would seem that if the resident insisted in continuing to smoke without supervision or apron, consideration should be given as to whether this should be recorded as being a choice against professional advice. Reviewing all the evidence, including the variation in skills of nurses in smoking risk assessment and particularly noting the fire investigator's evidence that the resident's clothes can be completely consumed by fire in two minutes, the mitigation of risks of death to those who smoke outside in BUPA homes and are immobile and cannot summon help seem to have not been sufficiently recognised.
6	ACTION SHOULD BE TAKEN I consider the evidence given at this inquest gives rise to a concern that circumstances creating a risk of other deaths will occur and in my opinion, action should be taken to prevent the occurrence or continuation of such circumstances,

	or to eliminate or reduce the risk of death created by such circumstances. I am therefore reporting this matter to those who manage and regulate such nursing homes and to those who are investigating the circumstances of this death from the viewpoint of the needs of vulnerable adults. .
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 3rd July 2017. 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. If you require any further information about the case, please contact the case officer, [redacted]) If you require further information about the process of responding to this report please contact my clerk, [redacted] to whom your response should be sent.
8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: [redacted] solicitors for family and [redacted] solicitors for BUPA. I am also sending a copy to [redacted] Care Quality Commission investigator, [redacted], London Fire Brigade and Detective Sergeant [redacted], the Metropolitan Police and the Secretary of State for Health and Social Services. 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	[DATE] 10 May 2017 [SIGNED BY CORONER]