REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care** 2. **[redacted], brother of the Deceased** 3. **Care Quality Commission** 4. **Supported Independence Limited** 5. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Area Coroner, for the coroner Area of Avon
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 9th December 2020 I commenced an investigation into the death of Mr. Christopher Evans age 56 years. The investigation concluded at the end of the inquest on 1st March 2023. The conclusion was that the medical cause of death was I(a) Acute myocardial ischaemia; 1(b) Coronary Artery Atheroma and immersion in hot water and the conclusion as to the death was that 'The Deceased died of an acute cardiac event following immersion in very hot water'

4	**CIRCUMSTANCES OF THE DEATH** The Deceased had a long history of alcohol misuse, although he had a very low level of alcohol in his blood at the time of his death, and poorly controlled diabetes mellitus. As a result he was vulnerable and his physical health was deteriorating. Following a Care Act assessment on 7th September 2020 social services determined that the Deceased required placement with 24-hour care appropriate to meet his care and support needs. A referral was made to the Extra Care Housing team in order that a suitable placement be found. In the meantime the Deceased was placed in supported accommodation provided by Supported Independence Limited. The services provided Supported Independence Limited were registered with the Care Quality Commission (CQC). However, the Deceased's accommodation was a small flat within a single building comprising a number of similar flats. The building was licensed with the local authority as a house in multiple occupation (HMO) and therefore was not within the remit of the CQC. On moving to his supported accommodation on 6th February 2019 a support plan and risk assessment were prepared. One of the risks identified was that he was at risk when bathing independently due to his mobility issues, his heavy drinking and his diabetes. The risk was to be managed by the Deceased telling the staff when he was going to have a bath and the staff would then monitor him regularly so that they could attend to any problems he may have. On the morning of 28th September 2020 the Deceased was found by a member of staff unresponsive in his bath. He had not informed staff of his intention to take a bath. The bath was full of water and the Deceased was almost completely submerged. A member of staff described the water as 'boiling' meaning it was very hot and not literally. A paramedic who attended was unable to put his gloved hand into the water because it was so hot. The Deceased was pronounced dead at the scene. The post-mortem examination confirmed the Deceased had suffered with injuries in keeping with scalding. The degree of burns / scalding was not sufficient to cause death on their own but the pain and trauma likely precipitated acute myocardial ischaemia. Death by drowning was considered unlikely.

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 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) Mr. Evans resided in supported accommodation which was appropriately licensed as an HMO. The provision and maintenance of services, including electricity, gas and water was the responsibility of Supported Independence Limited. However, the HMO licence did not require there be thermostatic control valves fitted to the hot water taps in the Deceased's flat. (2) Since the Deceased resided in his own accommodation and was not provided with a regulated activity. the accommodation was not regulated nor subject to inspection by the CQC. (3) Similarly the HSE had no authority to inspect premises under the Health and Safety at Work Act 1974 as the Deceased resided in his own home. (4) If the Deceased, who was vulnerable, had resided in health and social care premises then there would have been a requirement to assess the risk of scalding and burning in the context of his vulnerability. (5) Engineering controls could then have been provided to minimise the risk of scalding particularly where there is whole body immersion. (6) In accommodating vulnerable persons in such an HMO there appears to be a deficiency in the regulatory framework in that there is no requirement to assess and manage the risk of scalding and no overview by any regulatory body.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 19th June 2023. 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 [redacted], brother of the deceased, Supported Independence Limited and the Care Quality Commission. I shall send a copy of your response to [redacted], brother of the deceased, Supported Independence Limited and the Care Quality Commission. I have sent a copy of my report to the Chief Coroner. 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	**24th April 2023** **Area Coroner**