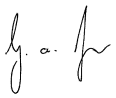
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Mr. Michael GOVE MP Secretary of State for Housing** **2 [redacted] Chief Executive Care Quality Commission**
1	**CORONER** I am Gareth JONES, Assistant Coroner for the coroner area of West Sussex, Brighton and Hove
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 04 January 2023 I commenced an investigation into the death of Jill BRICE aged 93. The investigation concluded at the end of the inquest on 18 October 2023. The conclusion of the inquest was that:
4	**CIRCUMSTANCES OF THE DEATH** **Jill Brice died on the 23rd of December 2022 at Royal Sussex County Hospital in Brighton. She was in sheltered housing in the Dene (Housing Association property). The extractor fan in her residence [redacted], Brighton caught fire causing her to suffer burn injuries and smoke inhalation from which she died. Mrs. Brice was not wearing her emergency pendant when she died. The Fire Safety Report (attached) recommended that care residents be reminded to have their pendant close to them at all times. I would like reassurance that this be actioned.**
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) **The Fire Safety Report recommended that care residents be reminded to have their pendant close to them at all times. I would like reassurance that this be actioned.**
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 December 15, 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 the Chief Coroner and to the following Interested Persons **1. [redacted]** **2. East Sussex Fire & Rescue** **3. Secretary of State for Health** **4. Chief Executive NHS England** **5. Teacher Housing Association** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 20/10/2023**  **Gareth JONES** **Assistant Coroner for** **West Sussex, Brighton and Hove**