IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Kevin Stephen O'Hara
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Surrey County Council Executive Director of Adults, Wellbeing and Health Partnerships. [redacted] Surrey County Council Chief Fire Officer
2	**CORONER** Ms Susan Ridge, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into the death of Kevin Stephen O'HARA was opened on 7 March 2023, resumed on 2 November 2023 and concluded on 22 November 2023. The medical cause of death was: 1a. Inhalation of fire fumes and burns. With respect to where, when and how Mr O'Hara came by his death it was recorded at Box 3 of the Record of Inquest as follows: Kevin Stephen O'Hara died in a fire in the early morning of 7 February 2023 at his home in Frimley, Camberley. He lived on his own and was

	bedbound in his living room. He was known to smoke in bed and it is more likely than not that the fire started because a lit cigarette fell onto a mattress used as a crash mat next to Mr O'Hara's bed. This resulted in a smouldering fire which created significant amounts of smoke. Mr O'Hara died from inhaling fire fumes and burns. The fire was only detected when a smoke alarm situated in the hallway of the flat detected smoke seeping through the living room door. Mr O'Hara's death was recorded at 0420 hours that morning. The inquest concluded with a short form conclusion of 'Accident'.
5	**CIRCUMSTANCES OF THE DEATH** Mr O'Hara was aged 63 at his death. He lived in a one bedroom flat on the ground floor of a two storey Independent Living Scheme in Frimley, Surrey. He was bedbound in his living room. He lived alone but carers came in four times a day. He misused alcohol and was known to smoke in bed. Concerns about fire risks from his smoking had been reported to both Surrey Fire and Rescue Service (SFRS), Surrey Adult Social Care (ASC) and the landlords. It was known that he could not self-rescue in the event of fire. Mr O'Hara died in a fire on 7 February 2023 which resulted from a lit cigarette igniting debris on a mattress being used as a crash mat next to his bed. The resulting fire created a significant amount of smoke. The smoke detectors (one linked to a careline operator) and the intercom box were in the hallway. The door to the hallway from the living room was shut. As a result the fire was not detected until sufficient smoke had built up to seep through the top of the living room door into the hallway to then trigger the alarm. Once SFRS became aware that the alarm had activated they deployed quickly but Mr O'Hara died from the effects of the fire before they could reach him. It is not known how long the fire had been burning before the smoke activated the alarm.

6	**CORONER'S CONCERNS** During the course of the inquest, the court heard that a SFRS Safe and Well Visit conducted on 17 November 2022 did not identify (and as a result did not action) the correct siting of smoke detection/alarm and careline monitor. In the course of the evidence, it was accepted that a visit by ASC to review Mr O'Hara at his flat on 23 January 2023 following concerns about his health and fire risk from smoking should have resulted in a risk assessment. The Inquest heard that SFRS and ASC have undertaken work to mitigate the risks of a recurrence. That work has included, a Serious Incident report, increased training and greater coordination across ASC and SFRS and care providers, updated policy, briefings and the adoption by SFRS and ASC of a new Person at Risk Referral Form to better identify fire risks to individuals. However, 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: Evidence was given that the Safe and Well Visit in November 2022 was conducted by an inexperienced officer. The results of that visit did not seem to be subject to any scrutiny. SFRS do not appear to have in place a system of review or audit by line managers or more experienced staff of completed Safe and Well Visits, with the risk, as in this case, that errors or issues requiring action are not identified. That SFRS reviews of individuals deemed high risk, are usually undertaken by the officer who conducted the initial Safe and Well Visit with the risk that opportunities for oversight and reassessment are missed. Evidence was given that the visit to Mr O'Hara by ASC on 23 January 2023 should have resulted in a risk assessment. Although ASC has policy (some of which predated Mr O'Hara's death) about when to conduct a

	risk assessment it does not appear to have in place a system of oversight to ensure that where appropriate, risk assessments follow a visit.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr O'Hara's family

10	**Signed:** **Susan Ridge** **H.M Assistant Coroner for Surrey** **Dated this 23rd day of November 2023**