Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** • **Tesco Stores Limited** **Copied for interest to:** • **Chief Coroner** • **Sainsbury's Supermarkets Limited** • **ASDA Stores Limited** • **WM Morrison Supermarkets Limited** • [redacted] • **Greater Manchester Fire and Rescue Service**
1	**CORONER** I am Zak GOLOMBECK, HM Area Coroner for the coroner area of Manchester City
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** On 05 September 2023 I commenced an investigation into the death of Afolabi Oluwafemi OJERINDE aged 48. The Inquest was opened on 26th September 2023. The final hearing has not yet taken place. However, following investigations by my office and Greater Manchester Fire and Rescue Service, there is concern that future deaths will occur, and I am of the opinion that action should be taken to reduce the risk of death. I have been made aware of a Section 21 Improvement Notice pursuant to Health and Safety at Work Act 1974 from Greater Manchester Fire and Rescue Service.
4	**CIRCUMSTANCES OF THE DEATH** Mr Afolabi Oluwafemi Ojerinde ("the Deceased") died on 5th September 2023 at Wythenshawe Hospital. The medical cause of his death has been offered as 1a. Major Burns. The circumstances of his death relate to him attending an unmanned Tesco petrol station and using of the petrol pumps to then douse himself in petrol, and thereafter set himself alight. The Deceased was able to pay for the petrol using the 'pay at pump' function, and without having a motor vehicle or an authorised plastic or metal container. The Deceased was allowed to proceed once payment had been made, and seemingly without any additional checks through CCTV/security cameras.
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) 1. The Deceased was able to use the petrol pump without the required motor vehicle or authorised plastic or metal container; 2. There was no member of staff present at the petrol station to approve or deny the Deceased access to the petrol pump, and his approval was automatic following payment made at the pump.
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 August 20, 2024. 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 Interested Persons. I have also sent it to organisations 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.
9	**Dated: 25/06/2024** **Zak GOLOMBECK** **HM Area Coroner for** **Manchester City**