## **ANNEX A**

# **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. The Chief Executive of the Royal Society for the Prevention of Accidents
1	CORONER
'	CONONER
	I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 16 <sup>th</sup> January 2024, I commenced an investigation into the death of Raymond Brattley, aged 71 years. The investigation concluded at the end of the inquest on 13 <sup>th</sup> June 2024. The conclusion of the inquest was: <b>ACCIDENT</b>
4	CIRCUMSTANCES OF THE DEATH
	These are set out in my summary and findings of facts which are attached.
	Raymond BRATTLEY was a heavy cigarette smoker, who on a number of previous occasions placed partly extinguished cigarette ends into a wastepaper bin in his flat, which subsequently caught fire, but these were successfully extinguished. On 8th January 2024, a fire resulted in his flat from careless smoking, which engulfed Mr Brattley resulting in him developing widespread full thickness burns to his entire body from which he rapidly died at the scene.

### 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. -

It was known to the staff at Portland Mews that this gentleman was a heavy smoker and that on a number of previous occasions, he set fire to waste paper bins in his flat as well as burning himself, carpets and soft furnishings due to careless smoking. On all previous occasions, the fires were contained or extinguished. Appropriate action was taken by the staff in respect of this issue. However, in the most general of terms, evidence was heard from a fire investigator, that if issues of this nature arise in other organisations or care settings, they should be brought to the attention of the Fire Service, who would freely provide advice about ways in which to mitigate the ongoing and foreseeable risk of cigarette related fires occurring in other vulnerable individuals. Such measures might include the provision of metal wastepaper bins and the use of fire-retardant materials. It is recognised that in similar institutions, tenants are permitted to smoke on such premises, but there is a tension between allowing smoking on the premises and risk of fires occurring, particularly in vulnerable individuals who may have similar mobility problems to Mr Brattley.

## 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action by highlighting to the widest audience, the risks of careless smoking in vulnerable individuals and indicating that the Fire Services would willingly provide assessment and advice for them.

### 7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 27<sup>th</sup> September 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 the following Interested Persons: the family of Raymond BRATTLEY, the CQC, the Station Manager and Fire Investigator at Humberside Fire and Rescue Service, Humber Mental Health,

Of Howes Percival Solicitors and the Chief Inspector for the Crown Premises Fire Safety Inspectorate.

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.

NM

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2nd August 2024