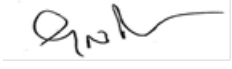
MISS N PERSAUD
HIS MAJESTY'S AREA CORONER
EAST LONDON
124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], Commissioner, London Fire Brigade** **Sent via email: [redacted]** **[redacted], Chief Executive Officer, London Borough of Newham.** **Sent via email: [redacted]**
1	**CORONER** I am Nadia Persaud area coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 6 November 2023 I commenced an investigation into the death of Mrs Gabrielle Sarah Anne Steel (aged 76 years). The investigation concluded at the end of the inquest on the 2 October 2024. The conclusion of the inquest was that Mrs Steel died as a result of an accident.

4	**CIRCUMSTANCES OF THE DEATH** Gabrielle Steel suffered a decline in her overall health from January 2023, following the death of her husband. She was admitted to hospital in March 2023 with weakness, malnutrition, and deranged electrolytes. She required admission to hospital for around 3 weeks, following which she was deconditioned, and her mobility was much reduced. On discharge from hospital in April 2023 she was bed bound. Mrs. Steel was known by the multi-agencies supporting her, to be bed bound; to smoke in her bed and to drink alcohol. The risk of fire was recognised, and the local authority occupational therapist requested a fire home safety visit from the London Fire Brigade. A fire home safety visit took place by the London Fire Brigade at her home address on the 3 August 2023. The London Fire Brigade assessor recommended flame retardant bedding. They also recommended to Mrs. Steel that her non-flame-retardant bedding should be disposed of. The flame-retardant bedding was provided promptly, but there was poor communication of the wider fire risk management plan. The outcome of the fire assessment was not shared with Mrs. Steel's daughter, the care agency or the referring occupational therapist. A copy of the fire risk assessment document and management plan was not left within the premises to inform those caring for Mrs. Steel. The local authority care and support plan was updated by a social worker on the 29 September 2023. The fire risk was again recognised, but there is no evidence that any attempt was made to seek the outcome of the fire safety visit or to devise a fire risk management plan. On the late evening of 17 October 2023 the emergency services were called, due to a fire in Mrs. Steel's home address. The fire service attended promptly. A fire was discovered on Mrs. Steel's bed. Mrs. Steel was removed from the address and resuscitation was provided. Sadly, she did not respond to resuscitation and her life was pronounced extinct on scene. A fire investigation determined that the likely cause of the fire was the unsafe disposal of smoking materials on the bed area. The flame-retardant duvet cover was not on the bed at the time of the fire.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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: 1. The risk of fire, due to smoking in bed was recognised by a local authority occupational therapist. A request was made to the London Fire Brigade for a home fire safety visit. The assessment took place promptly, but neither the occupational therapist, nor the social worker enquired into the outcome of the home fire safety visit, so that a risk management plan could be put in place. 2. The findings of the home fire safety visit were shared only with Mrs Steel – a vulnerable, elderly lady. The findings were not conveyed to those with responsibility for caring for her. 3. A written risk assessment/risk management plan was completed by the London Fire Brigade. This was not left in the property or shared with Mrs Steel, her family, her carers or the agency who requested the fire safety

	check. 4. As a result of the poor communication from the LFB, there was no risk management plan in place to reduce the risk of fire harm to Mrs Steel. Had the findings of the fire assessor been communicated, carers would have been aware of the need to re-iterate the importance of stubbing out cigarettes in an ashtray and not leaving cigarettes to burn out; the need to dispose of all non-flame retardant bedding, to ensure that the safe bedding was in place at all times; the importance of keeping extraneous flammable materials away from the bed, as much as possible.
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. London Borough of Newham – concern (1) London Fire Brigade – concerns (2) to (4)
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **29 November 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 family of Gabrielle Steel, to Highland Care UK Ltd and to the local Director of Public Health 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 other 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.
q	**3 October 2024**  Ms G N Persaud