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 Gas Safety Register**
1	**CORONER** I am Jason PEGG, HM Acting Senior Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 11th November 2015 I commenced an investigation into the death of Thomas Oliver HILL aged 18. The investigation concluded at the end of the inquest on 2nd June 2025.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 28th October 2015 in the rear of an ambulance on a road between Brechin and Dundee, Scotland. The deceased inhaled a fatal quantity of carbon monoxide whilst in the bathroom of Glenmark Cottage, Glenesk, Angus, Scotland whilst preparing for a bath. The carbon monoxide had been expelled from a lit liquified petroleum gas cabinet heater. The bathroom was of insufficient size for the flue-less liquified petroleum gas cabinet heater to be safely used without causing a build-up of carbon monoxide. The liquified petroleum gas cabinet heater burner plaques were cracked which contributed to the death by exacerbating the build-up of carbon monoxide.
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: The flue-less liquified petroleum gas cabinet heater was operated in a room which was too small dimension so to safely use the heater without causing a build-up of carbon monoxide. A warning label was affixed inside the cabinet heater in the space occupied by the liquified petroleum gas bottle. There was an absence of a visible warning label on the outside of the heater. It was not obvious to all potential users of the heater that the heater could only be used safely in a room of sufficient dimension. The risk applies particularly so in the case of rented cottages and similar premises such as Glenmark Cottage.
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 05, 2025. 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 [redacted] I have also sent it to National Residential Landlords 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: 10/06/2025**  **Jason PEGG** **HM Acting Senior Coroner for** **Hampshire, Portsmouth and Southampton**