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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The National Fire Chiefs Council

1. CORONER

I am Ms N J Mundy for South Yorkshire East District

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 3 March 2025 I commenced an investigation into the death of James William Rownsley. The investigation concluded at the end of the inquest.

My conclusion at inquest was:

Cause of Death: 1a Severe Burns

Conclusion: Accidental death .

Circumstances: James William Rownsley died on 20 February 2025 from severe burns at his home address after his clothing ignited following contact with a gas fire in his home. The presence of emollient cream on his clothing was a significant factor in his death

4. CIRCUMSTANCES OF THE DEATH

Mr Rownsley was a gentleman born in 1935 with limited mobility, who used emollient creams for his skin condition. On the 20th February 2025 he had got up early and was in the habit of lighting his calor gas fire to warm the sitting room whilst the central heating heated up the house. On this date he switched the fire on and then sat close by on his sofa. Mr Rownsley had residue of emollient creams both on the clothing he was wearing and on the throw over his sofa. When Mr Rownsley lit the gas fire a flame caught his clothing and ignited the clothes he was wearing. Mr Rownsley did not realise this had occurred until he sat down on his sofa. When he realised he managed to get to his feet, but was unable to extinguish the flames and fell to the floor where he passed away from severe burns.

I heard evidence from [redacted] the fire investigator that the emollients present on his clothing were responsible for the clothing catching fire and also responsible for the intensity of the fire that would have very rapidly developed once fabric had been ignited.

[redacted] also informed me that despite the efforts of his local Fire Service, South Yorkshire Fire & Rescue, to educate their partners about the dangers associated with the of use of emollients and them becoming absorbed in clothing and bedding (which cannot be removed by washing) and risk of ignition appear not to be fully appreciated by the partners with whom they deal such as General Practitioners, nurses and many others. The family also made it clear that members of the public are unaware of the dangers posed and have made their own efforts to educate the public.

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.

1. The need for effective communication to partners and stakeholders responsible for either prescribing such emollients, or indeed caring for people in the community, of the dangers of using such creams particularly when in close proximity to flames or heat.

2. An apparent lack of awareness of the both professionals and the public regarding the extent of that risk.

3. I was also told that since 2020 there have been 50 deaths in England involving emollient creams but there was a significant discrepancy between the data held by fire services in terms of there being 50 deaths, and the data held by Medicines and Healthcare Products Regulatory agency only had a record of 15. Accordingly, the current system of reporting such data to this regulatory authority should be reviewed with consideration to making this more robust or if there is an absence of such a referral process, for one to be introduced and communicating any such reporting requirements to all fire services.

5. The risk seems to be heightened in situations where elderly persons or persons of lower income are using such methods to heat their homes to avoid the cost of putting central heating on of the entire property.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the National Fire Chief Council 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 the 8th October 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 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.

12 August 2025

Ms N J Mundy, Senior Coroner for South Yorkshire East District