



West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA

Date: 19 April 2026

Case: [REDACTED]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Local Government Association ([REDACTED], Interim Chief Executive)

[REDACTED], Minister of Housing, Communities and Local Government

[REDACTED], Chair, National Fire Chiefs Council

[REDACTED], Interim Chief Executive, Care Quality Commission

CORONER

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I am **Richard Furniss**, HM Assistant Coroner for **West London**

CORONER'S LEGAL POWERS

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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>

INVESTIGATION and INQUEST

On 23 January 2025 I commenced an investigation into the death of Paul HUTCHINSON. The investigation concluded at the end of the inquest on 20 April 2026. The conclusion of the inquest was Accidental Death

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The medical cause of death was

1a Burns

CIRCUMSTANCES OF THE DEATH

The Deceased died of burns in a fire in his Extra Care Sheltered Accommodation ('ECSA') on 21 January 2025.

The building comprised 36 one- and two-bedroomed flats. The Deceased lived in a one-bedroom flat. He had suffered a stroke in 2016 which caused him to have limited mobility and speech, incontinence and cognitive difficulties. ECSA means that he lived independently in self-contained accommodation but with managed on-site care and support on a 24-hour basis.

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In August 2024, a Person Centred Fire Risk Assessment ('PCFRA') determined the risk as 'high'. There were multiple burn marks on clothing, carpet and furnishings as a result of the Deceased smoking, but no adequate control measures or mitigating measures were recorded or taken, and there was no action to notify a local Fire Officer.

The Deceased set himself alight by smoking. His smoke detector activated at 1435 hours on 21 January 2025, but was silenced by a member of staff, as were multiple other detectors. The first call to London Fire Brigade was 8 minutes after 1435 and the manager of the accommodation did not contact LFB until 1450 hours.

The inquest heard evidence and submissions from London Fire Brigade.

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 Regulatory Reform (Fire Safety) Order 2005 and the Fire Safety (Residential Evacuation Plans) Regulations 2025 do not appear to apply to the individual flats in ECSA because they are private dwellings. The concern is that there is no specific requirement for a PCFRA (or a personal emergency evacuation through the PCFRA) with an agreed format and risk factors, a

requirement for emergency equipment and staff training and a timescale for regular reviews (including where the individual circumstances of a person in care change). This concern may apply to others in formal residential care.

2. Staff training is not standardised for ECSA (or sheltered accommodation more generally) and may not include, for example, evacuation strategy, emergency evacuation plans, the use of telecare/fire alarm system and fire suppression systems.

3. Fire Risk Assessments for premises providing ECSA and sheltered accommodation more generally may not contemplate vulnerable residents as forming 'any group of persons identified...as being especially at risk' (see article 9(7)(b) of the 2005 Regulations). Vulnerable residents may be at special risk because of (for example) smoking or cooking practices and may have a compromised ability to self-evacuate. The concern is that Fire Risk Assessments do not take this into account.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you, the four organisations listed above to whom this report is directed, have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 June 2026. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

8  Chief Executive, Housing 21

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.

20 April 2026

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Signature

Richard Furniss HM Assistant Coroner for West London