REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Pembrokeshire County Council County Hall Haverfordwest Pembrokeshire SA61 1TP** **2. Chief Executive Carmarthenshire County Council County Hall Carmarthen Carmarthenshire SA31 1JP**
1	**CORONER** I am Jonathan Mark Layton senior coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 22nd July 2013 I opened an inquest into the death of Betty Grace Payne then aged 84. The investigation concluded at the end of the inquest on 26th September 2013. The determination of the inquest was one of accidental death The medical cause of death was: 1(a) heat injury 1(b) house fire 2 Ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** (1) Miss Betty Grace Payne was 84 years of age. She never married and had no children. (2) She lived alone at [redacted] Munro Court Pembroke Dock. (3) She was known to smoke and drink heavily and neglected herself. (4) There were past concerns that she had refused personal care, had set her hair alight and drank heavily. Cigarette burns to her clothing had been observed previously. (5) On the 16th July 2013 a call was made to the emergency services from the property. That call is believed to have been made by the deceased. There was no conversation but a smoke detector could be heard in the background. The emergency services duly attended to find that the property was ablaze. (6) The body of the deceased was recovered from within.
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 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) That the deceased was elderly and vulnerable. (2) The improved sharing of information about vulnerable people with the Fire Service could identify those at risk. (3) It is acknowledged that the sharing of information of this kind may for legal reasons not always be possible. (4) Where this information cannot be disclosed then Local Authority staff could receive training from the Fire Service. This will enable Local Authority staff to undertake Home Fire Safety Checks and implement measures to reduce the risk of fire. This training is available from the Fire Service.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. This can be achieved by the sharing of information or training as outlined in paragraph 5 above.
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 21st November 2013. 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 Person: [redacted] nephew of the deceased. 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.
9	**26t September 2013** **Signed:**