ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Care Quality Commission** **2. South East England Fire and Rescue Service**
1	**CORONER** I am Michael BURGESS assistant coroner, for the coroner area of Surrey
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 29 March 2012, an inquest (under Coroners Act 1988) was opened into the death of Vera Lillian STEEL, aged 81 years. The investigation concluded at the end of the inquest on 13 August 2013.. The conclusion of the inquest was that she died from Multiple Burn Injuries (with Oesophageal Cancer) *Conclusion: Accident*
4	**CIRCUMSTANCES OF THE DEATH** *The deceased was a heavy smoker. On Saturday 24 March 2012, she was taken onto the garden terrace of Glebe Nursing Home where she resided in order to smoke. She had refused to dress and was still in her night attire with a blanket over her legs. She asked her carer to fetch a glass of brandy and whilst the carer was gone, the deceased attempted to light a cigarette using a match. She apparently dropped the lit match into her lap causing a fire and resulting in severe burns. Despite treatment by attending paramedics and the specialist burns unit at King's College Hospital she died later that evening.*
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. – The deceased who had full testamentary capacity, was either bedbound or in a wheel chair. She insisted on smoking. She was extremely frail and tried to light a cigarette using a match. She apparently managed to strike one but she then dropped it (the lit match) into her lap. Her cotton night dress caught fire and she received burns. In the course of evidence we received evidence how it is now possible to obtain a fire protective apron or smock that could be worn or draped over the smoker so that any such incident would result in the match (or a lit cigarette) burning out without any damage to the clothing or smoker.. With many fatal domestic fires being caused by the

	"incautious disposal of smoking products" this sort of pro-active clothing could be more widely available and those places (such as care homes) whose residents may include smokers should be encouraged to provide access to these protective.measures.
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 8th October 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 Persons – [redacted] and Glebe House Nursing Home, Church Lane, Chaldon, Surrey. 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	**13 August 2013**