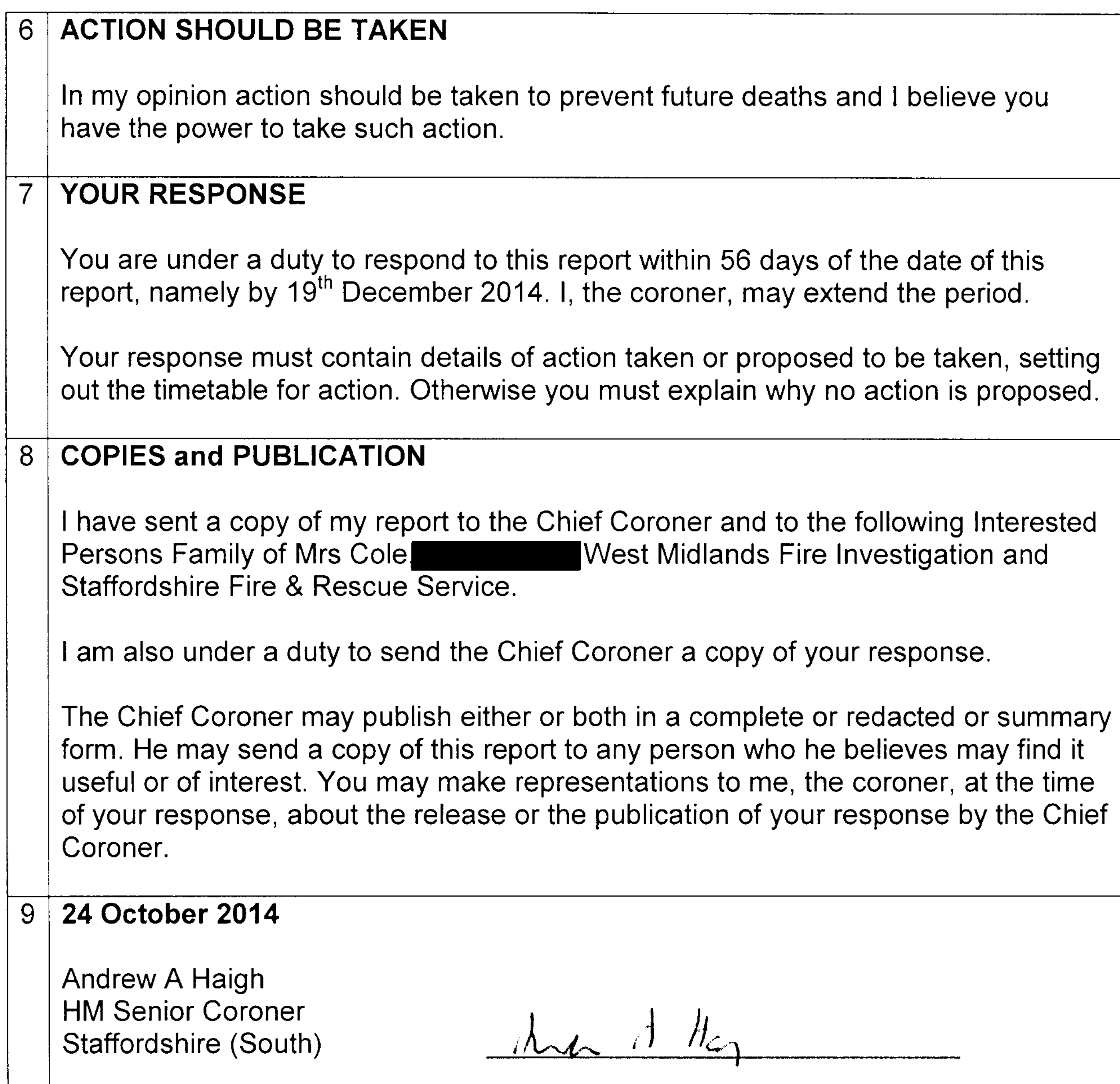
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Welbeing, Greencoat House, 32 St Leonards Road, Eastbourne, E Sussex BN21 3UT
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
2	**CORONER'S LEGAL POWERS** I make this report under 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 16th July 2014 I commenced an investigation into the death of Hilda May Cole, Aged 86 years. The investigation concluded at the end of the inquest on 21st October 2014. The conclusion of the inquest was Accidental death with Mrs Cole having died from extensive 3rd degree burns to the whole body.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Cole was found dead in her home on the morning of 7th July 2014 by firemen who had been called to the property. She had died from burning. It is likely that she had been smoking while sitting on a sofa in her lounge and had dropped a lit cigarette onto the seat or other material on it.
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. Mrs Cole had one of the pendant alarms supplied by you. She was a smoker with reduced mobility and there was a risk of fires. At the inquest I heard that family members were not aware that the system that you provide can be linked into other alarms such as fire alarms and burglar alarms. If they had been aware they would have subscribed to the fire alarm system for Mrs Cole. The family have told me that they have subsequently seen literature on which these others services do appear. However they wonder if you should be taking more steps to advise existing service users of the additional facilities you provide and if new customers are aware of these facilities. I wonder if this something that you should be pursuing?



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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th December 2014. 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 Family of Mrs Cole West Midlands Fire Investigation and Staffordshire Fire & Rescue Service. 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	**24 October 2014** Andrew A Haigh HM Senior Coroner Staffordshire (South)