HM CORONER
Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **United Lincolnshire Hospitals NHS Trust** 2. **Air Liquide** 3. **Lincolnshire County Council** 4. **NHS Lincolnshire West Clinical Commissioning Group**
1.	**CORONER** I am Paul Duncan Smith Assistant Coroner for the coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincolnshire, PE23 5JE.
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 4th April 2014, an investigation was commenced into the death of Robert Spring, aged 65 years. The investigation concluded at the end of the inquest on 6 March 2015. The conclusion of the inquest was that Mr Spring died as a result of an accident, the medical cause of death being: 1a. Severe degree of burns 2 Excess of alcohol consumption.
4.	**CIRCUMSTANCES OF THE DEATH** 1. Mr Spring had a long history of Chronic Obstructive Pulmonary Disease. He was a smoker. In February 2013 he was treated within the Emergency Department of Lincoln County Hospital for a head injury sustained after drinking alcohol. 2. On 3rd March 2013 he was admitted as an inpatient to Lincoln County Hospital where he received treatment for bronchopneumonia. 3. On 25 March 2013, prior to discharge from hospital, he was assessed as meeting the criteria for the provision of Home Oxygen. He was discharged from hospital on March 28th. He remained in receipt of Home Oxygen up until his death. 4. On 14 March 2014 Mr Spring died in a fire at his home, a flat forming part of a complex providing independent sheltered living. 5. An investigation by Lincolnshire Fire and Rescue Service (LFRS) concluded that the cause of the fire was either the use of a cigarette lighter, or a dropped cigarette. Mr Spring died in his armchair. At the time of his death he was smoking whilst using an oxygen concentrator.

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. – (I) Mr Spring was identified at the initial hospital assessment as being at high risk by virtue of his use of Home Oxygen and also by virtue of his smoking habit. There was no mechanism in place whereby such risk could be notified directly to LFRS notwithstanding that Mr Spring had expressly consented to his personal information being shared with them. Such reporting was deferred to Air Liquide. (II) The fact that Mr Spring, as a smoker, was considered to be high risk was confirmed by risk assessments undertaken by representatives of Air Liquide, the Home Oxygen supplier, upon the installation of the Home Oxygen on 27 March 2013 and upon subsequent service visits undertaken on 19 June 2013 and 8 January 2014. (III) Although a mechanism existed for the communication of that increased risk to LFRS by Air Liquide, a facet of their system, designed to prevent duplicate notifications being delivered, operated to prevent notification of his status as a smoker and LFRS were notified only that Mr Spring was a user of Home Oxygen. (IV) Evidence was given at Inquest that LFRS have available, free of charge, a variety of safety equipment for those most at risk of such incidents. Such equipment comprises both smoke and carbon monoxide alarms, flame retardant bedding and portable "misting systems". (V) The absence of full notification to LFRS meant that the extent of the risk to which Mr Spring was exposed was not identified. As a consequence, he was not assessed by LFRS for the provision of the safety equipment described above. (VI) Whilst a number of Properly Interested Persons have already met to discuss the concerns raised by this death, and whilst Air Liquide have already taken steps to ensure that their internal systems are more robust, there remains a need to put in place more extensive lines of communication between all relevant agencies, to ensure that the heightened risks posed by such patients are drawn to the attention of LFRS at the earliest opportunity. (VII) Evidence was also given at Inquest that the availability of such safety equipment is not well known, and that by increased publicity to the relevant agencies in relation to their availability, there may be a wider distribution of such material with a consequential saving of lives.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has 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 18 May 2015. 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

	(a) [redacted] (b) [redacted] (c) Lincolnshire Fire and 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.
	23rd March 2015 .... **P D Smith** **Assistant Coroner**