REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr David Etheridge OBE, Chief Fire Officer, Fire and Rescue Service Headquarters, Sterling Road, Kidlington, Oxfordshire, OX5 2DU.**
1	**CORONER** I am Peter G Clark, Assistant Coroner, for the coroner area of Oxfordshire
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 17 September 2014, an investigation into the death of Christopher John Butler, aged 55, was commenced. The investigation concluded at the end of the inquest on 21 January 2015. The conclusion of the inquest was a narrative verdict. The deceased died from a combination of smoke inhalation and alcohol intoxication following a fire at his home. The cause of the fire was an overheated electrical cable serving the cooker and single 13amp plug socket. The medical opinion on the cause of death was: 1a) Smoke inhalation and alcohol intoxication. Other significant conditions contributing to the death but not related to the death or conditions causing it was: ii) Asthma
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a previous medical history of alcohol intake above recommended sensible limits, suspected epilepsy and asthma. On Friday 5 September 2014, Oxfordshire Fire and Rescue Service were called to a house at his home address, being 85 Wilsdon Way, Kidlington. The fire was believed to have started between 11am and 12pm on that day. The body of the deceased was removed from the premises and death was confirmed by Paramedics at the scene. The degree of intoxication of the deceased at the time would have impaired his ability to recognise the danger of smoke and his ability to escape the fire. Fire investigation was undertaken and formal evidence provided indicates the cause of the fire appears to be due to an electrical malfunction in relation to the electrical cabling behind the cavity wall and an examination of the inner core of the cable indicated that the cabling through a wooden joist caused the additional insulation of the cable and possible damage due to the acute bend in the wire. This defect in the insulation of the cabling could have been present from the date of construction over 25 years ago. The property had an old style fuse box and evidence was received that a more modern trip fuse would have more likely prevented the cable overheating to the extent where a fire occurred.

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 fault in the wiring that resulted in this fire may be present in other similar properties within the estate built at the same time. Electric testing will not necessarily reveal this fault. Consideration as to what information and action can be undertaken by the Fire and Rescue Service to alert the local community on this matter. This issue is brought to your attention for solution.
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 21 April 2015. I, the coroner, may extend the period but a formal application for this will need to be made in time. 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 who may find it useful or of interest. The family of Christopher John Butler. 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 February 2015** [redacted] **Peter G Clark** **Assistant Coroner**