REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Fire Officer, Greater Manchester Fire and Rescue Service**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 27th March 2015 I commenced an investigation into the death of **Kenneth George Bailey** dob 11th December 1950. The investigation concluded on the 9th July 2015 and the conclusion was one of **Accidental death**. The medical cause of death was 1a Smoke Inhalation 11. Lung cancer, cerebrovascular disease, fibrotic lung disease (on home oxygen).
4	**CIRCUMSTANCES OF THE DEATH** **The deceased had been diagnosed with lung cancer and was in a very debilitated condition. He required oxygen at his home to allow daily living. On the 25th March 2015 he was at home smoking a cigarette when he dropped it or the ash from it, on to a kitchen roll which then ignited leading to a significant house fire. He died as a result of inhaling significant quantities of acrid smoke.**
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. – **During the course of the evidence I was told of the efforts of neighbours and others to attempt a rescue, which to some extent they were able to do. One reason for this attempted rescue was because of the time lapse in getting fire appliances to the scene. I was informed that there is a Fire Station in Mossley, Aston u Lyne, but this is only manned during very limited opening hours.** **I was also informed that there is a significant body of volunteers prepared to act as local volunteer fire officers.** **Because the fire station was not manned, it took approximately 10 minutes for the fire service to arrive, and whilst this is of course reasonably fast, the local people felt the response time used to be quicker when the local "station" was open.** **If there is a delay in the arrival of the emergency services, there is always the danger that unqualified people will try to perform a rescue thus placing themselves in danger of injury or even death.**

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 9th September 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 namely [redacted] (partner 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	**14.7.15** [redacted] **John Pollard, HM Senior Coroner**