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. **HEAD OF ADULT SOCIAL SERVICES, LONDON BOROUGH OF HOUNSLOW** 2. **[redacted] CARE SERVICES MANAGER AT GREENROD PLACE**
1	**CORONER** I am Chinyere Inyama, senior coroner for the coroner area of West London
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 6th August 2014 I commenced an investigation into the death of [Ian David Morley age 57. The investigation concluded at the end of the inquest on 14th May 2015. The conclusion of the inquest was in narrative form including the following words "...His death was clearly the result of an accident but the risk of the accident occurring was not adequately managed at the time".
4	**CIRCUMSTANCES OF THE DEATH** The deceased was wheelchair bound and resident in supported accommodation with a history of multiple sclerosis. His carers found him alight after, it is presumed, he dropped a cigarette onto the seat of his wheelchair which was covered by a towel rather than a fire retardant seat cover. His condition had deteriorated prior to his death.
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.The multiple sclerosis nurse who had been working with the deceased noted that his condition had deteriorated shortly before his death. This should have prompted a fresh risk assessment but it was not evident that it did, in fact, do so. 2. There was inadequate fire risk management at Greenrod Place
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. The action for the Adult Social Care Service should be to either review the existing or develop a new protocol for sharing of information between specialist nurses, GPs, care homes and Adult Social Services such that risk management of people being looked after is kept current and optimal. The action from Greenrod Place is to organise a 'Home Fire Safety Visit' in accordance with the advice in the attached letter from [redacted], Group Manager, NE Area Fire

	Safety Regulation, East Ham Offices of the LFB. For both recipients of this PFD, they must adopt the use of the attached LFB Home Fire Safety Risk Referral Matrix in all their residential premises
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th October 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 persons: [REDACTED] (daughter of the deceased), Telecare Services Association, UK Telehealthcare, National Security Inspectorate, British Standards Institute, Health & Wellbeing Boards, CQC, Fire & Security Association, Fire Industry Association, NICEIC, Electrical Contractors Association and [REDACTED] (LFB). 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	**17th August 2015** **SIGNED BY CORONER** [REDACTED]