REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Department for Communities and Local Government **2.** **3.**
1	**CORONER** I am Simon Nelson, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 12th of March 2015 I commenced an investigation into the death of **Emma Waring** for whom the cause of death was given as being that of 1a inhalation of the products of combustion. At the inquest on 17 September 2015 the conclusion was one of an 'accidental death'.
4	**CIRCUMSTANCES OF DEATH** Emma Waring was 23 years old at the time of her death. She was working with a family support worker as a result of her 2 year-old son having been taken into care 8 months previously. She was known to be a heavy drinker and cigarette smoker and was by all accounts a vulnerable individual.. She moved into her rented accommodation in July 2014 and as with similar dwellings in the immediate vacinity it had been fitted with 'hard wired' smoke alarms by Rochdale Boroughwide Housing. The evidence at inquest indicated that the fire had started at some time after 01:50 hours on 7 March 2015; the smoke alarm activated and would have been audible to neighbours. However the initial call to the emergency services was not made until 02.40 hours. It was more likely than not that a cigarette had come into contact with bedding materials and that whilst the deceased was asleep the fire had developed filling the bedroom with toxic smoke. At some point the deceased had became aware of the fire, possibly due to the smoke detectors operating, and had attempted to escape but had been quickly overcome by the toxic products of combustion [redacted]designated Community Safety Manager with the Greater Manchester Fire and Rescue Service confirmed in evidence that the Service 'strongly advocated the installation of domestic automatic water suppression systems (sprinkler systems) and that had such a system been installed in the deceased's home then the chances of her surviving this fire would have been significantly increased
5	**<u>CORONER'S CONCERNS</u>** 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:- Immediate and positive consideration of the compulsory inclusion in the design, planning and building phases for residential properties (especially for those properties housing vulnerable

	individuals) of Automatic Water Suppression Systems more commonly known as 'domestic sprinklers' so as to provide further safeguards in the event of accidental or indeed deliberate fires in such premises.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 21st 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 Interested Persons namely:- 1. Family of the deceased 2. Greater Manchester Fire and Rescue Service 3. Rochdale Boroughwide Housing 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 from. 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	Date: 22nd September 2015 Signed: Simon Nelson