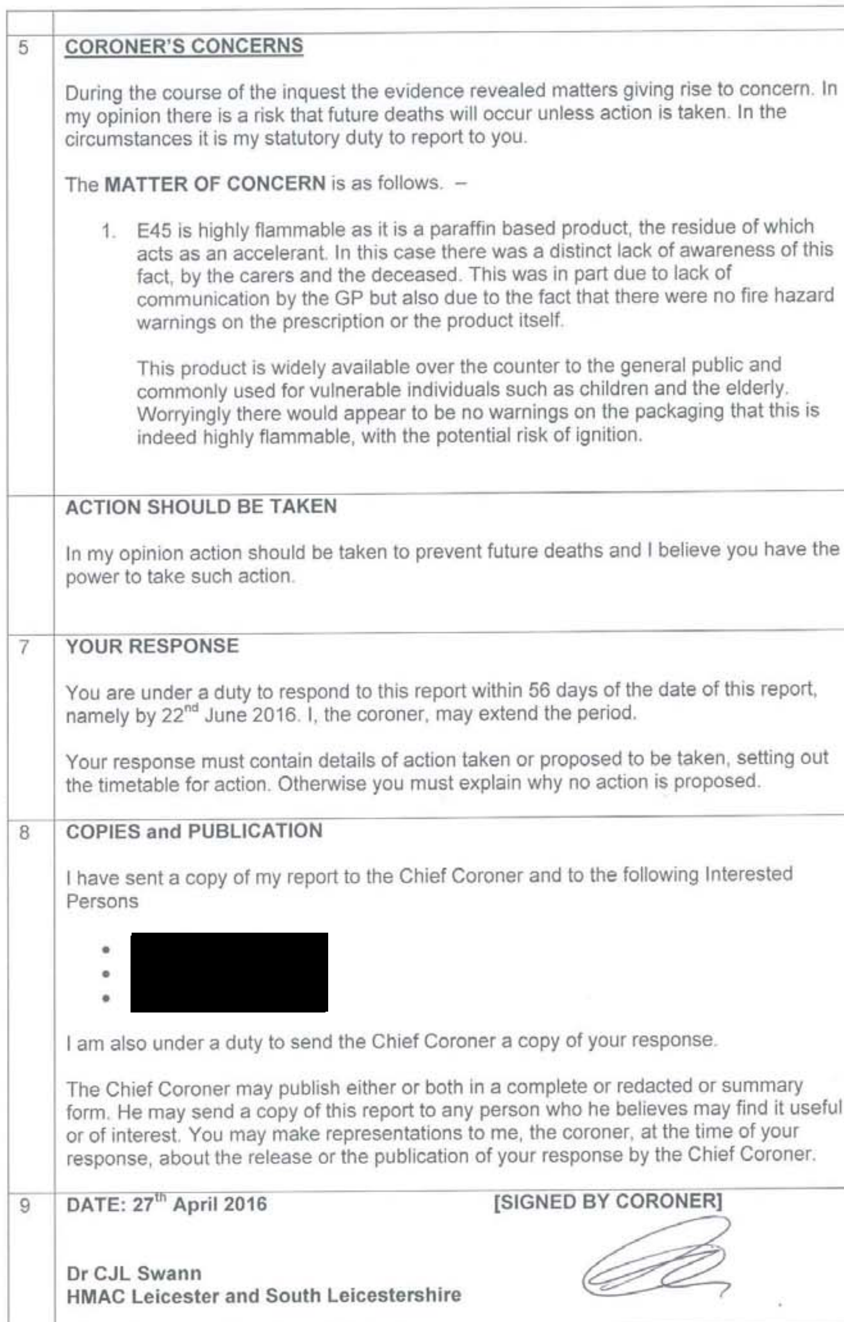
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **Mr Elliott Howard-Jones, Director of Commissioning and Operations, NHS England, Central Midlands.** • **President of the Chief Fire Officers Association.** • **Mr Rakesh Kapoor, Chief Executive, Reckitt Benckisher Healthcare (UK) Ltd. (Manufacturer of E45).**
1	**CORONER** I am Dr Christina JL Swann, Assistant Coroner for the coroner area of Leicester City and Leicestershire South
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 16th September 2015 Mrs Hocking, Assistant Coroner commenced an investigation into the death of Christopher Michael Holyoake. At inquest on 19th February 2016 I heard evidence which culminated in the conclusion of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Holyoake had been diagnosed with a terminal and inoperable brain tumour. He was essentially bed bound, primarily being cared for by his friend and also having carers come in to the home four times a day. The carers were responsible for washing and dressing Mr Holyoake and assisting him with simple activities of daily living. This included applying E45 daily after his wash. They were also responsible for changing his bedding and clothing regularly. Mr Holyoake was deemed to have capacity by the GP who saw him regularly over the last few months of his life, for continuing physical care needs. E45 had been prescribed by his GP however this had been done on request from the District nurses. He had therefore not seen the GP face to face at this time or been issued any warnings regarding it's highly flammable nature. He was known to smoke whilst sat up in his bed and had no intention to stop smoking at any point. On the 7th September Mr Holyoake's friend had momentarily gone into the garden to take out the rubbish, when suddenly he noticed that smoke was billowing out of the door. He realized that there was a fire and he bravely attempted to rescue Mr Holyoake who could not save himself due to being bed bound. Unfortunately not being a well man himself, he was unable to save Mr Holyoake and waited for the fire crew to arrive which they did expediently. Mr Holyoake was taken to the Leicester Royal Infirmary where sadly he was later pronounced deceased. The fire officer felt following his investigation, that the most likely source of the fire would have been Mr Holyoake's lighter, coupled with the fact that he and his bedding and clothing were covered in E45 emollient residue. He described how this would have acted as an accelerant in this situation, increasing the intensity and speed with which the fire took hold and therefore giving the deceased very little opportunity to be rescued.



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 **MATTER OF CONCERN** is as follows. –

1. E45 is highly flammable as it is a paraffin based product, the residue of which acts as an accelerant. In this case there was a distinct lack of awareness of this fact, by the carers and the deceased. This was in part due to lack of communication by the GP but also due to the fact that there were no fire hazard warnings on the prescription or the product itself.

   This product is widely available over the counter to the general public and commonly used for vulnerable individuals such as children and the elderly. Worryingly there would appear to be no warnings on the packaging that this is indeed highly flammable, with the potential risk of ignition.

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 22nd June 2016. 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

- [redacted]
- [redacted]
- [redacted]

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 **DATE: 27th April 2016** **[SIGNED BY CORONER]**

Dr CJL Swann
HMAC Leicester and South Leicestershire