IN THE WEST YORKSHIRE WESTERN CORONER'S COURT IN THE MATTER OF:

The Inquests Touching the Death of Christine Dryden A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Incommunities
1	CORONER Martin Fleming, HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	INVESTIGATION and INQUEST On 28 April 2016 I opened an inquest into the death of Christine Dryden who, at the date of his death, was aged 40 years old. The inquest was resumed and concluded on 2nd August 2016 I found that the cause of death to be: - 1a. Hypoxic Brain Injury and Pulmonary Oedema 1b Inhalation of Fire Gases I arrived at a conclusion of Accident
4	CIRCUMSTANCES OF THE DEATH On 20 April 2016 Christine Dryden was found unresponsive in a house fire at When taken to Bradford Royal Infirmary, although attempts were made to resuscitate her, she succumbed and died on 23 April 2016. It is found more likely than not that she inadvertently turned on the hob of her cooker under a plastic deep fat fryer, causing it to ignite. There is no evidence of third party involvement.

RT3589

5 CORONER'S CONCERNS

During the course of the inquest I heard that although Mrs Dryden's installed smoke and heat detectors were in working order at the time of the fire, there were no regular checks made on them.

The MATTER OF CONCERN is as follows. -

 To review the effectiveness of existing office arrangements for maintaining and carrying out period checks on smoke and heat detectors in your properties.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that Incommunities has the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8 COPIES

I have sent a copy of this report to:

- daughter
 Appello
 Fire Investigator
- Chief Coroner

9 DATED this 17 August 2016

M.D. Fleule 7
M.D. Fleming

M.D. Fleming Senior Coroner