	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Asra Housing Group – Nazarana Court** **Chief Fire and Rescue Officer** **Indian Hindu Welfare Organisation**
1	**CORONER** I am Hassan Shah, Assistant Coroner for the coroner area of Northampton.
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 the 30th December 2016 an investigation was commenced into the death of Rasikaben Lallubhai CHAUHAN (84). The investigation concluded by way of inquest on 17th May 2017. The medical cause of death was 1a) Multiple burn injuries
4	**CIRCUMSTANCES OF THE DEATH** Mrs Chauhan was an 84 year old lady living in a block of flats specialising in sheltered accommodation for elderly people of south east Asian/Indian origin. On the 27th December 2016, Mrs Chauhan was in a chair facing her Hindu shrine when one of two oil burning candles became dislodged from the shrine falling onto her clothes and fully engulfing her in fire. The oil burner contained ghee (clarified butter). Mrs Chauhan was wearing a sari type robe dress. The ghee and the sari were both factors which would have caused Mrs Chauhan to become engulfed in flames very quickly. The Northamptonshire fire and rescue station manager revealed in evidence that he does have knowledge of several other incidents and that in some areas advice is being given in relation to the use of battery powered candles.
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 could 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) It is not clear if any awareness about this specific risk has been raised at a local or national level, with relevant community and religious organisations.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation, 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 August 2017. 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:-. **Son of deceased** **Care Quality Commission** **Northamptonshire Fire Station** Similarly, you are 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.
9	**[DATE]** **14th June 2017** **[SIGNED BY CORONER]**