REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Mr Matt Harrison, Chief Executive, Great Places Housing Association • [redacted], Director of Housing - MCC • [redacted] Executive Director Strategic Commissioning & Department for Adult Social Services – MCC • NHS Manchester Clinical Commissioning Group Copied for interest to: • Chief Coroner • Family of Deceased • Manchester Local Medial Committee • The Mayor of Greater Manchester, Mr Andy Burnham • GM Fire and Rescue Service
1	**CORONER** I am Nigel Meadows, H.M. Senior Coroner for the area of Manchester City.
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	**INQUEST** I resumed and concluded the inquest into the death of **Mr Brian MaClean on 6 September 2017** and recorded that he died from: 1a Smoke inhalation II Alcohol toxicity Somewhat unusually I recorded a conclusion of – Alcohol related
4	**CIRCUMSTANCES OF THE DEATH** The deceased was born on 20 December 1957 and had developed over a number of years a significant alcohol consumption problem. He was also a regular smoker of cigarettes. He had lost touch largely with his family and had spent periods of time in private rented accommodation and more recently at a Salvation Army Hostel.

	He took up occupation of Flat 35 George Thomas Court, Harpurhey, Manchester, on 26 November 2012 and lived on his own. This accommodation is owned by Great Places Housing Association (GPHA). He was allocated a support worker who discovered that he had no telephone or access to email and was only ever intermittently available to see his support worker. The deceased was not in employment and was in receipt of state benefits. It seems that a referral was made to the Manchester City Council Adult Social Services Department on 26 January 2016. His support worker had discovered that he had no household appliances other than a microwave in which he cooked all of his meals and had little in the way of possessions. He claimed to have a nursing background and a long term chronic bowel condition. This apparently resulted in the local authority writing a letter to the deceased asking if he required any help or support and when they received no reply the case was closed. Greater Manchester Fire and Rescue Service (GMFRS) regularly work with housing providers to facilitate the referral of persons at increased risk of suffering a fire. No such referral was made in respect of the deceased. The deceased was registered with a GP at the Singh Medical Practice but was an infrequent attender, but with a diagnosis of Chrohn's Disease and a long term alcohol problem. The fire had self-extinguished. On 19 March 2016 the deceased had consumed a very excessive amount of alcohol and had been smoking whilst sitting in his sofa. A fire started on the sofa which created a great deal of noxious smoke. It also caused him to suffer a burnt leg. When the alarm was raised and GMRFS attended he was found in the hall way having apparently made attempts to remove his trousers. He died as a result of smoke inhalation contributed to by alcohol toxicity. All other sources of ignition for the fire apart from a discarded cigarette were ruled out. The premises did not have an automatic water sprinkler system. Statistically a significant proportion of fatal fires involve single males living on their own having drink, drugs or mental health problems. Since the incident GMFRS have worked with GPHA to deliver fire prevention staff awareness training and to introduce them to the new 'Safe and Well Visits' that GMFRS are now offering. A copy of the record of inquest and the evidence accompanies this report. This report is being distributed to MCC Housing Department with a request that they consider it internally but also that they distribute it to all other Housing Associations within Greater Manchester. In addition to the NHS and the GP MPC.

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. That Social Services did not take a more proactive role in pursuing any referral and understanding the risks presented by the deceased. This requires joined up thinking and working with GPs, the NHS locally, the housing provider and finally GMFRS. 2. There was no identification of the deceased as being potentially at risk of a fire in his premises and no referral to GMFRS. 3. There was no process for GPHA to automatically consider fire risks and prevention and make referrals to GMFRS for safe and well visits. 4. It is clear that GPHA did not have an automatic water suppression system (sprinklers) that could be fitted to properties which comprise blocks of flats and or for individuals at high risk. In addition appropriate smoke alarms and other assistive technology could have been installed. 5. The recipients of this report would be well advised to read and digest the detailed GMFRS Fire Investigation Report and its recommendations which are wholly endorsed by the court.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Wednesday 8th October 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 Interested Persons. I have also sent it to organisations who may find it useful or of interest.

	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	Signed:  Nigel Meadows HM Senior Coroner Monday 11th September 2017