

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Ms Bronwen Rapley, Chief Executive, Peak Valley Housing Association, The Hub, Stockport Road, Mottram, Hyde SK14 6AF.</p>
1	<p>CORONER</p> <p>I am, Chris Morris, Area Coroner, for the coroner area of South Manchester</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 25th April 2017, Alison Mutch OBE, Senior Coroner for Manchester South, commenced an investigation into the death of Ian Leak who was aged 59 when he died at his home address on 5th March 2017. The investigation concluded on the 10th August 2017.</p> <p>The conclusion of the inquest was that Mr Leak died as a consequence of a fire in his flat, which was likely to have been started by a lit cigarette coming into contact with combustible material. At the end of the inquest, I recorded a conclusion of Accident. The medical cause of death was 1a) Fire Related Death II) Ischaemic Heart Disease.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Leak had suffered from very poor health for a number of years. Having been diagnosed with a brain tumour, he endured some 15 brain operations, and experienced a number of strokes.</p> <p>As a result, Mr Leak was left with significant disabilities. He had serious mobility problems, and his memory was affected. He could also become confused. Mr Leak was a tenant at Peak Housing's Honiton Oaks property, where he had his own flat.</p> <p>On 5th March 2017, the fire service was alerted to a fire at Mr Leak's flat. The flat was entered and Mr Leak was tragically found to have died.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>I heard evidence that Honiton Oaks was, at all material times, equipped with two fire alarm systems, both of which appear to have operated as intended in this case.</p> <p>The first fire alarm system detects heat and / or smoke in communal areas and, if triggered, opens glass smoke vents and deactivates the lift having returned it to the</p>

	<p>ground floor. In accordance with the 'Stay Put' policy currently in operation of Honiton Oaks, whilst this system creates a visual alert on a fire control panel within the building, it does not trigger an audible fire alarm which other residents can hear.</p> <p>The second system consists of combined heat and smoke detectors fitted in tenants' individual flats. These generate an audible warning within the individual flat where the detectors have been triggered, but operates independently of the system covering the communal areas.</p> <p>In the course of the inquest, I heard that as a result of planned upgrades to the Honiton Oaks alarm systems, from the end of this month, the communal system will be linked to an external monitoring service in addition to the internal panel.</p> <p>I also heard evidence to the effect that Mr Leak was not the only tenant with mobility problems who resided at Honiton Oaks.</p> <p>In such circumstance, the matter of concern is that in the light of the building's 'Stay Put' policy, consideration should be given in the case of tenants who have particular mobility problems or are otherwise likely to have difficulty in escaping from a fire within the confines of their own flat, to arranging for external monitoring of the individual fire alert systems within those tenants' flats.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th October 2017. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) [REDACTED] partner of the deceased. 2) [REDACTED] sister of the deceased, who may find it useful or of interest.</p> <p>I have also sent it to Greater Manchester Fire and Rescue Service who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Christopher Morris Area Coroner Manchester South</p> <p>15/08/2017</p> 