REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **The Secretary of State:** Department of Communities and Local Government, 2 Marsham Street, Westminster, London, SW1P 4DF. **The Secretary of State:** Department of Business, Energy and Industrial Strategy, 1 Victoria Street, Westminster, London, SW1H 0ET.
1.	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire.
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** I was informed of the death of 6 year old Isabella Pritchard who died at Wexham Park Hospital, Slough, Berkshire on the 7th July 2012 from catastrophic head injuries suffered when the marble mantelpiece in the lounge of her home at [redacted] fell and struck her. Following a lengthy investigation involving the Health & Safety Executive and Thames Valley Police, a conviction was secured against the contractor who originally installed the mantelpiece. Having opened and adjourned my Inquest Investigation into this young lady's death under Schedule 1 of the Coroner's and Justice Act 2009, as a result of the prosecution I was not required to resume the Inquest as the criminal proceedings stood in its stead. However, it is clear that a Coroner's powers under Regulation 28 to issue a Report to Prevent Future Deaths are not restricted to matters revealed in evidence at an Inquest. The matter giving rise to concern may be something revealed at any stage of a Coroner's Investigation.

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4. **CIRCUMSTANCES OF THE DEATH**

Isabella Pritchard was found in the lounge with fatal head injuries and with three pieces of a marble mantelpiece lying around her. The incident was not witnessed but it is clearly understood that the mantelpiece had come away from the wall and struck her. A forensic post mortem examination revealed the cause of death of "severe head injury."

Despite lengthy and detailed Investigations, only the contractor who installed the mantelpiece could be prosecuted under the existing regulations and legislation. The information supplied to me raises concerns with regard to a potential faulty design of the fireplace that was not required to be mechanically fixed to either the wall or some other part of the fire surround and also the apparent situation whereby installation of fireplaces are completely unregulated.

5. **CORONER'S CONCERNS**

During the course of gathering evidence following this tragic death, 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 appears to me that both the manufacturer and installation of stone fireplaces are an unregulated industry.

(2) There appears to be no quality/safety standard that applies to fireplaces. The British Standards (BS1251) appears to relate purely to flues and combustible properties of the chimney itself. I am aware of no BSI kite mark applicable to fireplaces. It therefore seems possible to design and manufacture a product with dangerous design features that are cosmetically attractive but inherently dangerous. The fireplace that struck and killed Isabella Pritchard incorporated a stone mantle weighing 86kg with a design relying on gravity and adhesive to keep it in place. In addition, the installation instructions provided by the manufacturer by their own installer were vague in detail, generic and covered their whole range of products. I understand that most high street DIY warehouses sell fireplaces, some weighing as much as 125kg where the design, if untested, could have the same design faults.

(3) I understand that there is no regulation or building control around the installation of fireplaces. I believe building regulations do not cover this area as they are deemed to be a decorative item. While I understand that

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	the NHBC now mandatorily require the use of mechanical fixings, this does not cover every instance. Also, that the Stone Federation issued guidelines but are guidelines only. Further, they are a non-regulatory trade body where membership is optional and adherence to their guidelines is entirely voluntary. (4) I understand that building regulations are the responsibility of the Department of Communities and Local Government. I would invite consideration of an amendment to building regulations that might not only ensure safe installation at new builds but could also encompass installations where a fireplace is retrofitted, for example, in the course of the renovation. Might it also be possible to include installation of fire surrounds into the GasSafe or HETAS Scheme? (5) I understand that general product safety, including safe design and products requiring to be marked as compliant, fall under the Department for Business Energy and Industrial Strategy. I ask if powers under that sphere of responsibility could be considered in the context of the circumstances of Isabella Pritchard's death with a view to taking steps to prevent the risk of a repeat tragedy in the future.
6.	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your departments 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 **MONDAY 16th 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 also to the family of Isabella Pritchard. You are also under a duty to send the Chief Coroner a copy of your response.

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	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.	**16th August 2017** **Peter J. Bedford** **Senior Coroner for Berkshire**