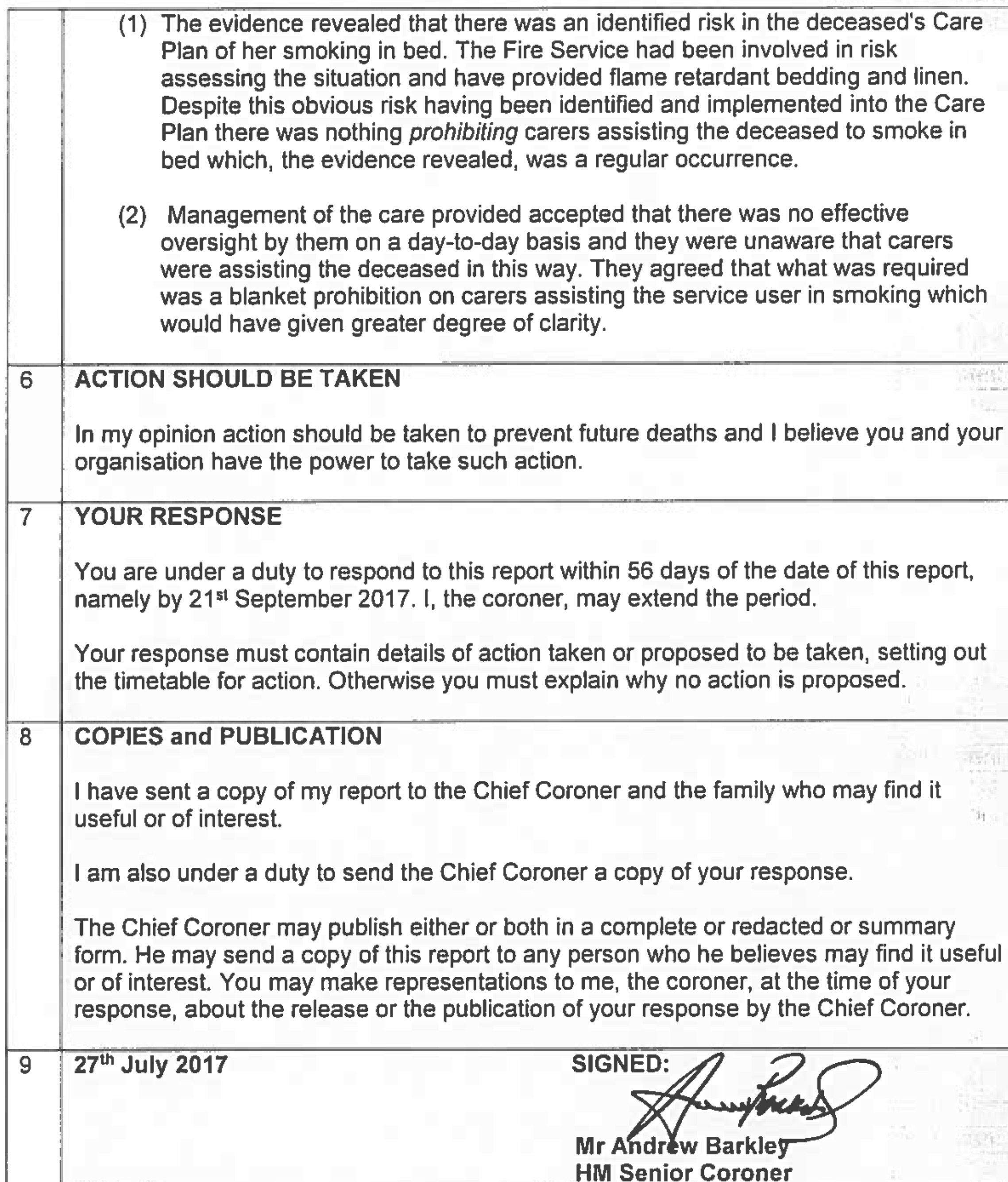
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms Gillian Baranksi, Chief Executive, Welsh Government Office, Rhydycar Business Park, Merthyr Tydfil, CF48 1UZ** **2. Sir David Beehan, Chief Executive, Care & Quality Commission, National Customer Service Centre, Citygate, Gallowgate, Newcastle-Upon-Tyne, NE1 7PA**
1	**CORONER** I am Andrew Barkley, Senior Coroner, for the coroner area of South Wales Central.
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 29th March 2017 I commenced an investigation into the death of Sheila Margaret Gaskin. The investigation concluded at the end of an inquest held at the Welshpool Town Hall on 7th July 2017. The conclusion of the inquest was "Accidental Death".
4	**CIRCUMSTANCES OF THE DEATH** The deceased was bedbound and assisted in living at her home address by carers who visited four times a day. She was known to have issues with alcohol and smoked a large number of cigarettes, often in her bed. On the evening of the 20th March 2017 she was visited by her carers at 9 o'clock in the evening. The evidence showed that she asked for assistance in lighting a cigarette which was done for her by one of her carers and they left her property at about 9:30pm. The following morning on 21st March 2017 on attending the property it became apparent that there had been a fire and upon entering the property the deceased was found in her bed with obvious burns and soot markings.
5	**CORONER'S CONCERNS** During the course of the inquest, and the investigation leading up to it, 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN]



	(1) The evidence revealed that there was an identified risk in the deceased's Care Plan of her smoking in bed. The Fire Service had been involved in risk assessing the situation and have provided flame retardant bedding and linen. Despite this obvious risk having been identified and implemented into the Care Plan there was nothing *prohibiting* carers assisting the deceased to smoke in bed which, the evidence revealed, was a regular occurrence. (2) Management of the care provided accepted that there was no effective oversight by them on a day-to-day basis and they were unaware that carers were assisting the deceased in this way. They agreed that what was required was a blanket prohibition on carers assisting the service user in smoking which would have given greater degree of clarity.
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 21st September 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 the family 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	**27th July 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**