	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: David Behan, CEO, Care Quality Commission, 151 Buckingham Palace Rd, Victoria, London, SW1 9SZ [redacted] Sharon Allen OBE, CEO, Skillsforcare, West Gate, 6 Grace St, Leeds, LS1 2RP [redacted] Peter Holland CBE, Chief Fire and Rescue Advisor, The Home Office, Fire and Resilience Directorate, Home Office, 2 Marsham Street, London, SW1P 4DF cfra@homeoffice.gsi.gov.uk
1	CORONER I am Sarah Ormond-Walshe, Assistant Coroner, West London jurisdiction
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 On 3rd July 2017 the court opened an investigation into the death of Kevin Freely. He had died on 12th October 2016. **The inquest was concluded on 7th June 2018.** The record of Inquest stated the following: The medical cause of death found for the deceased was: 1a Cardiorespiratory arrest 1b Injuries sustained in a fire II. Previous Stroke Where, when and how, by what means and in what did he die:

	The deceased was bedbound and immobile following a previous stroke. He had previously had a traumatic head injury in the past and a history of seizures had since been controlled with medication. At the time he died he had carers and lived at his home at [redacted] He was known to smoke hand-rolled cigarettes and cannabis in bed. On 12th October 2016 his carer left him with a rolled-up cigarette and went on a two hour break away from the house. The deceased either suffered a seizure causing his cigarette, once lighted, to make contact with his bedclothes or otherwise he dropped his cigarette on his bedclothes. Whichever it was, a fire started in his bed area and it sadly caused his death on the same day, the deceased being unable to move from his bed to escape. The Conclusion given was: The deceased died in a fire at his home when his lighted cigarette came into contact with his bedclothes either due to an accident or a seizure.
4	CIRCUMSTANCES OF THE DEATH The deceased was aged 61 when he died. He died at his home at [redacted] The deceased had a history of heart disease, physical disability and drug and alcohol dependence with some mental health concerns. He was being cared for in a bed with an airflow mattress at his home. He had had a stroke many years previously and was paralysed down his left side. He was doubly incontinent, bedbound and needed 24 hour care. He was known to be a cigarette smoker and he used to smoke in bed. Despite his immobility and disabilities, he would have been able to light his own cigarette. He was on regular Morphine tablets and also smoked cannabis for pain relief. I have heard that having an airflow mattress is essentially like kindling a fire, especially when used in conjunction with paraffin based emollient creams on a user's skin. Such creams can accumulate and make the immediate environment to the patient more flammable. The deceased had been having paraffin based emollient cream applied to his skin as part of his care. He had been alone when he set alight a cigarette and either had sustained a seizure or had otherwise just accidentally dropped the cigarette, but the cigarette caused his bed clothes to set alight. Sadly, the deceased died still lying in his bed. The fire that occurred in this case was almost totally isolated to the first floor and particularly, the deceased's bed and bedroom.

5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still 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. – The NHS National Patient Safety Agency brought out a Rapid Response Report 4 on 26th November 2007 entitled "*Fire hazard with paraffin based skin products on dressings and clothing*". I am concerned that the message within the 2007 Safety Report is not being heeded by patients and Care Organisations responsible for caring for patients in their own homes.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. 1. Whilst I acknowledge that everything has to viewed proportionately, and further, it is a human right of a person to choose to smoke in their bed, I am concerned that all patients in such circumstances as the deceased (that is: immobile in a bed with an airflow mattress, having regular paraffin based emollient cream applied to his skin and smoking cigarettes whilst in bed), are made aware of the risks. Further, it is important that the carers take advice from the Fire Services in respect of regular washing (in a biological detergent) the linen and bed-clothes of a patient where paraffin emollient creams are being used to avoid the build-up of paraffin based emollients. 2. Care organisations must at the very least remind themselves about this Report. If there are any that are not following its advice, they should take heed immediately as patients are being put at risk. 3. The London Fire Brigade witnesses remind us all that risk assessments and smoke detectors also play a very important role. Here, no risk assessment was done and one smoke detector in this house was missing an essential part and one did not operate when checked after the fire. 4. I am sending this report to the Home Officer Fire Safety Office too. This is to lodge my support for more promotion/advertisement of the facts in this Safety Report. Patients themselves may not be aware of the risks posed with combining cigarette smoking in bed, air flow mattresses and the use of paraffin based emollient creams. The three together create a specific and very real risk of injury in a fire and, with this invariably disabled/debilitated group of patients, death. Therefore, any resources spent on broadcasting these risks to patients is encouraged. 5. Further, to assist in the education of patients and Care Organisations, I am told that the use of fire retardant aprons and fire retardant bedding may reduce the risk of a death by fire with this group of patients who choose to continue to smoke in such an environment.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th July 2018. 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. If you require any further information or assistance about the case, please contact the Coroner's Officer, [redacted] and [redacted]
8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: The deceased's family Caremark, Kingston London Fire Brigade. 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	DATE 7th June 2018 SIGNED BY CORONER