

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. First Class Care 83-85 Derby Rd, Nottingham NG1 5BB</p>
1	<p>CORONER</p> <p>Tanyka Rawden, Assistant Coroner for Nottingham and Nottinghamshire</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</p> <p>On 19 July 2018 an investigation was commenced into the death of Simon Paul Barber aged 49 years. The investigation concluded with an inquest on 17 January 2019.</p> <p>The conclusion of the inquest was:</p> <p>"Simon Paul Barber died on 18.07.18 at [REDACTED].</p> <p>The medical cause of death is:</p> <p>1a. Hypoxia due to smoke inhalation 2. Multiple sclerosis</p> <p>Simon Paul Barber died as a result of a fire started by a naked flame coming into contact with his clothing. It is likely that naked flame was being used to light a cigarette and it is likely that the paraffin based cream used on Simon Paul Barber led to the fire growing quicker and burning more intensely.</p> <p>The risk assessments that were carried out by care providers were inadequate, and there were missed opportunities to refer to Simon Paul Barber for a further home safety check.</p> <p>An assessment of the bungalow for fire risks had not taken place"</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Simon Paul Barber was a gentleman who was wheelchair bound due to multiple sclerosis.</p> <p>He moved from a flat to a bungalow on 11 July 2018.</p> <p>He received care four times a day from First Class Care.</p>

	<p>The inquest was assisted with evidence from the manager of First Class Care, Ms Mandy Leverton who said that during the assessment of needs performed by First Class Care, consideration was not given to how Simon Paul Barber would exit the property in an emergency.</p> <p>The Court heard evidence that there was one ramp to the property, placed at the front door. At the side door into the kitchen were steps that Simon Paul Barber was unable to negotiate in his wheelchair.</p> <p>The front door was locked with the key being in the key safe outside the address. The side door was open during the day and locked at night.</p> <p>The risk to Simon Paul Barber of his continued use of cigarettes was not considered. In 2012 a home safety assessment was carried out by the fire service and this found Simon Paul Barber was high risk due to his smoking habits. No further assessment was carried out despite his reduction in manual dexterity when handling cigarettes. Carers were using a paraffin based cream on Simon Paul Barber and were not using the flame retardant blanket provided by the Fire Service in 2012.</p> <p>In the days before he died, Simon Paul Barber dropped a lit cigarette in his lap causing a burn mark in his blanket. This incident was not reported by staff.</p> <p>It was accepted by First Class Care their assessment had been inadequate</p>
5	<p><u>CORONER'S CONCERN</u></p> <p>During the course of the investigation my inquiries 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 MATTER OF CONCERN is as follows. –</p> <p>Evidence was given before the Court that the risk assessment carried out First Class Care was inadequate.</p> <p>In my opinion there is a risk that future deaths may occur unless adequate risk assessments are carried out by First Class Care and staff are made aware of the importance of reporting all incidents that endanger the safety of service users</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion urgent 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 25 March 2019. I may extend this period upon your application.</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>

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COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Sally Fenn

Others sent copies for information:

1. CQC via email
2. [REDACTED], Director for Adult Social Care, Loxley House, Station Street, Nottingham, NG2 3NG
3. [REDACTED], Nottingham City Council, Loxley House, Station Street, Nottingham, NG2 3NG

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.

Mrs Tanyka Rawden

28 January 2019