	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. RT HON MATT HANCOCK MP SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE** **2. THE CHIEF EXECUTIVE – NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE** **3. DUNCAN SELBIE, CHIEF EXECUTIVE PUBLIC HEALTH ENGLAND** **4. THE CHIEF EXECUTIVE, BRITISH MEDICAL ASSOCIATION** **5. THE CHIEF EXECUTIVE, CARE QUALITY COMMISION** **6. THE MANAGER TRENT AND DOVE SOCIAL HOUSING**
1	**CORONER** I am Mrs Margaret Joy Jones assistant coroner for the coroner area of Staffordshire South.
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 22.08.2019 I commenced an investigation into the death of MAUREEN MILTON AGED 74. The investigation concluded at the end of the inquest on 20.11.2019. The conclusion of the inquest was ACCIDENTAL DEATH, with the medical cause of death recorded as "1a Burns".
4	**CIRCUMSTANCES OF THE DEATH** The deceased was 74 years of age, she had poor mobility and was something of a recluse. She was known to be a very heavy smoker. Carers had identified that she was at risk of fire and consequently a safeguarding referral had been made in July 2019. On the 25th July 2019 she refused to have her smoke alarm linked to her first call alarm. At 0911 hours on the 18th August 2019 Staffordshire Fire and Rescue were called to her flat in Burton upon Trent by neighbours. On arrival they were confronted with a smoke-filled property. The deceased was recovered from the lounge and pronounced dead at the scene. Fire investigations identified the source of the fire to be a cooks (long) match used to attempt to light a cigarette coming into contact with clothing (probably a nightdress) worn by the deceased whilst she sat in an armchair in the lounge of the property. There was evidence of petrol based emollient cream which she was likely to have used and which probably soaked her clothing. This would have acted as an accelerant to the fire. Toxicology identified a low level of carboxyhaemoglobin and the cause of death was burns.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows. – Evidence given by fire investigators was that they are increasingly attending fires involving (mostly) the elderly where there is evidence of petrol based emollient cream in use. The petrol base is found in a significant number of prescribed creams and creams (such as moisturisers) which are readily available over the counter. This cream impregnates clothing and is not washed away during a normal washing programme. In the event of a fire the victim is rapidly engulfed by flames with little chance of survival. The cause of death is generally burns, not inhalation of smoke. The concern is the lack of awareness of this problem by medical professionals, carers, victims and their families. It is felt appropriate heighten awareness of this growing problem amongst health professionals and others who work in the field of prescribing such creams and those caring for patients using petrol based emollients.
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 17.01.2020 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 to the following Interested Persons: [redacted] (family member), [redacted] – West Midland Fire Service, and [redacted] Staffordshire Fire Service 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	**22.11.2019** **SIGNED BY CORONER** Margaret J Jones HM Senior Coroner

Staffordshire (South)

Coroner's Office
No 1 Staffordshire Place
Stafford
ST16 2LP
Tel No: 01785 276127
Fax No: 01785 276128

www.staffordshire.gov.uk
sscor@staffordshire.gov.uk