## **ANNEX** A

# **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	The Rt. Hon Kwasi Kwarteng MP Secretary of State Dept. for Business, Energy and Industrial Strategy
1	CORONER
	I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 29 December 2017 I commenced an investigation into the death of Richard John Dyson aged 38 and Simon Brian Midgley aged 36. The investigation concluded at the end of the Inquest on 14 April 2021. The conclusion of the Inquests was that both men were unlawfully killed as a result of:
	1(a) Inhalation of smoke and fire gases 1(b) Hotel Fire
4	CIRCUMSTANCES OF THE DEATH
	Mr Dyson and Mr Midgley were guests staying at the Cameron House Hotel, Loch Lomond on the weekend of 16-18 December 2017. Around 6.30 am on Monday 18 December 2017 a fire broke out in the hotel. The two men were found in an unresponsive condition after 8 am by firefighters wearing breathing apparatus. They were pronounced dead later that morning.
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. –
	(1) Every hotel should have a readily accessible and accurate list of the guests and staff members in the establishment on a particular night. In an emergency situation it is imperative that the Fire and Rescue Service are provided with accurate information speedily in case anyone remains trapped in the building. It is a situation where every second counts.
	(2) It is foreseeable that in the stressful atmosphere of an emergency, people may hesitate or make mistakes. In this case, forgetting to take the guest list as the building was evacuated. In consequence, although the Fire and Rescue Service had arrived at the hotel by 6.51 am, it was not until sometime after 8am that it was established two

guests were missing. Critical time was lost before rescue efforts began to find them. The precise times cannot be provided as the Procurator Fiscal was not willing to disclose copies of witness statements or reports on the ground they were confidential.

(3) To avoid needless impediments to rescue efforts, it would be prudent for hotels to have an electronic system such as SharePoint which would enable the emergency services to gain prompt access to such vital information.

#### 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 14 June 2021. 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.

I have also sent it to the following who may find it useful or of interest:

- 1)
- 2)
- 3) UK Hospitality Association
- Health and Safety/Local Authority Enforcement Liaison Committee
- 5) Local Authorities Health and Safety Practitioners Forum
- 6) National Fire Chiefs Council
- 7) Crown Office and Procurator Fiscal Service
- 8) Cameron House Resort (Loch Lomond) Limited
- 9) Media representatives

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 Dated: 14th April 2021

Signed:

KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E)