NHS

NHS Brighton & Hove CCG, NHS East Sussex CCG, NHS West Sussex CCG:

Response to the Assistant Coroner for West Sussex Coroners Service Regulation 28 report to prevent future deaths

27 September 2021

1. Introduction

1.1 This report provides a response to the West Sussex Coroners, in respect of the Regulation 28 report issued to NHS Brighton & Hove CCG, NHS East Sussex CCG and NHS West Sussex CCG (the CCGs). This report relate to the death of Pauline McInroy ALLISON on 26/03/2021 as a result of significant burns sustained in a fire at her home.

1.2 The CCGs have taken the opportunity, as part of this investigation, to review its broader preventable deaths messaging relating to inflammable products and identify any learning outside the scope of the Regulation 28 report. The CCGs are aware of the risks from emollient creams containing flammable ingredients and have published warnings on this in the past as will be referred to later in this report.

2. Background and context

2.1 On 12 August 2021 the CCGs received a Regulation 28 Report to Prevent Future Deaths from the West Sussex Coroner's office. This related to the tragic case of an immobile West Sussex resident who suffered burns at her home and died at the Royal Sussex County Hospital, Brighton in March 2021.

2.2 The cause of the fire had been smoking materials coming into contact with flammable materials on the bed- the deceased used emollient creams containing flammable ingredients. The Regulation 28 report states that the deceased had been largely bedbound since 2017 and was known to smoke in bed despite having been warned of the dangers of this.

2.3 The Regulation 28 report cited West Sussex Fire & Rescue Service attempts to improve awareness amongst families, care providers and GPs of the increased risk of fire posed by the use of these types of emollient creams especially by immobile persons who smoke. The report expressed concern that not enough is being done to ensure that these patients, their families, and carers are aware of the risks and to ensure that they are referred to their local Fire & Rescue Service for advice and assistance and that more action should be taken to prevent future deaths by the CCGs.

3. Sussex CCGs work around emollient use risks

3.1 Sussex CCGs take very seriously the increased risk of fire posed by the use of these types of emollient creams and have disseminated warnings about this in the past. In August 2019, for example, the then Coastal West Sussex CCG, which covered parts of West Sussex issued a warning to primary care via a newsletter on the risks of emollients and fire. This included that they advise "*patients who use these products not to smoke or go near naked flames, and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them".* The same article also recommended health care staff "*must ensure patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk".*

3.2 In 2016 an MHRA Drug Safety Update was issued on *Paraffin-based skin emollients on dressings or clothing: fire risk.* This is summarised in appendix 2 at the end of this document. The MHRA Drug Safety Updates are sent to all practices/GPs on a subscription basis. All practices should be receiving these reports as they are a focus for questions by the Care Quality Commission on inspection on how practices deal with these reports when they come in and keep a log of any actions undertaken. In West Sussex there would always be a section on the quarterly locality prescribing group meetings for the drug safety updates and also would be included in the newsletter if relevant to general practice. Sussex CCG leads will be looking in to how we ensure locums are covered also and communicate with them both the emollient newsletter article but also in the future, how we enable them to access future prescribing newsletters and register for the MHRA Drug Safety Updates.

3.3 Following a death related to the use of emollient creams in 2019 an updated safety notice was circulated across both health and social care sector. This remains current advice and has been included in training resources for staff and the public. The East Sussex Coroner issued a Regulation 28 notice which was shared appropriately also across East and West Sussex and both health and social care with the fire service delivering bespoke training to their staff. The Coroner also forwarded the response from the MRHA and the NHS National Director for Patient Safety, (referenced above). In addition the Institute of Fire Engineers wrote an article relating to the impact of emollient creams on fire – this has been shared widely across both sectors and the county.

4. New plans to address emollient use risks

4.1 CCGs leads from Safeguarding have recently spoken to their equivalents in the fire service across Sussex and a great deal of information shared again with professionals and the public regarding the risks of emollient creams.

4.2 Sussex CCGs will be re issuing in this September's newsletter to primary care a warning around the use of emollients and fire risk. This will be highlighted as 'message of the

month'. Anonymised reference to this incident will be made to emphasise it was a local case and primary care to be reminded to advise patients who use these products not to smoke or go near naked flames, and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them . In addition, within the newsletter, primary care will be encouraged to ask any at risk patients (i.e. known smokers or those on home oxygen) to talk to their local Fire and Rescue Service and seek advice and guidance to help minimise the risk when using emollients.

4.3 Warnings for patients and carers will be reinforced including through a visual patient information leaflet produced jointly by the MHRA and the National Fire Chiefs Council. The newsletter will also be sent to the Local Pharmaceutical Committee representative on the Sussex Health and Care Partnership APC for dissemination out to community pharmacy highlighting the patient information leaflet that can be given to relevant patients when emollients are dispensed

4.4 CCG Safeguarding and Communication leads will agree a timetable for the reiteration of this message with primary care and patients so it is highlighted and visible on a regular basis. This will also include sharing information on the risks of emollient creams with public health colleagues working in smoking cessation programmes.

4.5 Appendix 1 below is a short timeline and list of planned actions Sussex CCGs will progress to help mitigate further fire risks linked to usage of emollient products.

5. Summary

5.1 In response to the request for information and assurance from Sussex CCGs around providing mitigation on the causes leading to the tragic death of Mrs Allison, the above report outlines how seriously Sussex NHS commissioners and primary care have taken the fire hazard risk to users of emollient products and especially smokers. The report outlines work undertaken prior to this particular incident occurring to reduce the risk posed to users of emollient products and involved collaborative working with primary care and the fire brigade.

5.2 The report also sets out what actions we have taken or plan to take in light of the death of Mrs Allison including communication work with our primary care teams and also linking emollient users with their local fire brigade for further support and advice. We are confident these will help raise better awareness of the dangers of smoking and fire risks associated with emollient products with both users of these products as well as their carers. We will ensure this message is repeated in a timely way within primary care.

Appendix 1

Actions planned /timeline

Task	Timeline for completion	Identified CCG Lead Team
Remind GPs and pharmacies to refer patients identified at increased risk to the fire service via the GP bulletin as well as the prescribing updates	**30 September 2021**	**Comms and Medicine management**
To review if searches and/or alerts can be put on the prescribing system to alert GPs when they prescribe emollients where the patient is known to be a smoker.	**31 October 2021**	**Medicine Management and Digital Team**
For the CCG to work with the local authority to share the updates and latest communication with care homes and carers and with domiciliary care agencies to reinforce the message	**31 October 2021**	**Via Care Home cell – Comms team**
To look in to how locums are given access to the prescribing newsletters and register for the MHRA Drug Safety Updates.	**31 October 2021**	**Medicine management**

Appendix 2

[1]Drug Safety Update Latest advice for medicines users. The monthly newsletter from the Medicines and Healthcare products Regulatory Agency and its independent advisor the Commission on Human Medicines ***Volume 9, Issue 9, April 2016***

Paraffin-based skin emollients on dressings or clothing: fire risk

Smoking or a naked flame could cause patients' dressings or clothing to catch fire when being treated with paraffin-based emollient that is in contact with the dressing or clothing.

Reminder for healthcare professionals:

• Advise patients not to: smoke; use naked flames (or be near people who are smoking or using naked flames); or go near anything that may cause a fire while emollients are in contact with their medical dressings or clothing

• Change patient clothing and bedding regularly—preferably daily—because emollients soak into fabric and can become a fire hazard

• Incidents should be reported to NHS England's Serious Incident Framework (includes Wales), Healthcare Improvement Scotland, or to the Health and Social Care Boards in Northern Ireland
When patients are being treated with a paraffin-based emollient product that is covered by a dressing or clothing, there is a danger that smoking or using a naked flame could cause dressings or clothing to catch fire. We informed healthcare professionals of this risk in January 2008.

Examples of paraffin-based emollients include:

• white soft paraffin

• white soft paraffin plus 50% liquid paraffin

• emulsifying ointment

The risk is greater when these preparations are applied to large areas of the body, or when dressings or clothing become soaked with emollient.

We are aware of a recent fatal incident reported to the NHS England National Reporting and Learning System, in which a naked flame ignited emollient in contact with a patient's dressings and clothing.

Posters have previously been available from the National Patient Safety Agency, and may be a useful source of information for local use.

[1] Article citation: Drug Safety Update volume 9 issue 9 April 2016: 9