

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

- 1 BMA House, Tavistock Square, London, WC1H 9JP
- 2 CEO for Sussex Clinical Commissioning Groups (NHS Brighton & Hove CCG, NHS East Sussex CCG, NHS West Sussex CCG)

 NHS West Sussex CCG, Wicker House, High Street, Worthing, BN11 1DJ

1 CORONER

I am Robert SIMPSON, Assistant Coroner for the coroner area of West Sussex Coroners Service

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 01 April 2021 I commenced an investigation into the death of Pauline McInroy ALLISON aged 78. The investigation concluded at the end of the inquest on 27 July 2021. The conclusion of the inquest was that:

On the 26/03/2021 Pauline Mcinroy Allison died at the Royal Sussex County Hospital, Brighton as a result of significant burns sustained in a fire at her house. Mrs Allison caused the fire by smoking in bed and as she was immobile she was unable to escape.

4 CIRCUMSTANCES OF THE DEATH

On the 26/03/2021 the Fire & Rescue Service were called to Mrs Allison's home address by her husband following discovery of a fire. Mrs Allison had been largely bedbound since 2017 and the source of the fire was on, or down the side of, her bed. Mr Allison was unable to move his wife away from the fire and he was discovered unconscious in the same room when the Fire & Rescue Service arrived.

A West Sussex Fire & Rescue investigation and a forensic fire investigator both concluded that the cause of the fire had been smoking materials coming into contact with flammable materials on the bed. Mrs Allison was known to smoke in bed despite having been warned of the dangers of this.

5 CORONER'S CONCERNS

During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) Mrs Allison used emollient creams containing flammable ingredients. I heard evidence that these ingredients can build up on clothing and bedding. The effect of this build up is to make material ignite more easily and burn more quickly.



In addition to this the presence of an air mattress (often used by those with limited mobility) can further facilitate the ignition and spread of a fire by introducing additional air to the fire if it melts or punctures.

The West Sussex Fire & Rescue Service informed me that they are trying 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.

I am concerned 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.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 September 29, 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 and to the following Interested Persons

The Family of Mrs Allison
West Sussex Fire & Rescue Service

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

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: 03/08/2021

Robert SIMPSON Assistant Coroner for

West Sussex Coroners Service