Her Majesty's Coroner Staffordshire (South) Coroner's Jurisdiction

Date: 17.11. 2020

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:
Staffordshire Fire and Rescue Service HQ
Pirehill Stone Staffordshire ST15 0BS

CORONER
I am Mr Andrew A Haigh HM Senior Coroner for Staffordshire (South)

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST
On 16 September 2020 I commenced an investigation into the death of **Neil BARRE**. The investigation concluded at the end of the inquest on 12 November 2020. The conclusion of the inquest was '**Accident**' with the death having resulted from burns sustained during a house fire.

CIRCUMSTANCES OF THE DEATH:
Mr Barre died at the Queen Elizabeth Hospital in Birmingham on 11th September 2020 from burns sustained in a fire at his home in Cannock. Earlier that day he had dropped a cigarette while smoking in bed despite having been warned about the dangers of this activity.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows:

During the course of the inquest a suggestion was made that it may be helpful for Staffordshire Fire and Rescue Service to be aware of when those receiving domiciliary

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care are not using special equipment (such as fire retardant blankets) that are provided to them. Staffordshire FARS may well have links with groups providing care and there could be greater use of communications with such groups.

<u>ACTION SHOULD BE TAKEN</u>

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

<u>YOUR RESPONSE</u>

You are under a duty to respond to this report within 56 days of the date of this report, namely by 12.1.2021. 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.

<u>COPIES and PUBLICATION</u>

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

Family
Care Quality Commission
West Midlands Fire Service

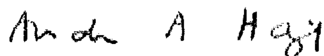
I have also sent it to other interested persons who may find it useful or of interest:

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.

Dated : 17.11.2020
Signature



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