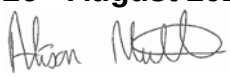
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Secretary of State for Department of Communities, Housing and Local Government**
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater **Manchester 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 1st October 2020 I commenced an investigation into the death of James Golds. The investigation concluded on the 21st July 2021 and the conclusion was one of accident. The medical cause of death was 1a Respiratory failure secondary to smoke inhalation; II 17% total body surface area burns, chronic obstructive pulmonary disease
4	CIRCUMSTANCES OF THE DEATH James Frederick Golds lived at Flat [redacted] Millom Court. He was vulnerable and had become increasingly confused prior to 28th September 2020. He was a known smoker and there had been concerns relating to how he managed the risks of smoking. On 28th September 2020 emergency services were called to the address for a reported fire. James Golds was rescued from his flat by the fire service. He was taken to Wythenshawe Hospital with significant fire related injuries. He deteriorated and died at Wythenshawe hospital from the complications of smoke inhalation. The cause of the fire was identified as an accident caused by a cigarette discarded whilst he was confused.
5	<u>CORONER'S CONCERNS</u> 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. From the evidence before the court it was clear that Mr Golds presented a significant risk of accidentally starting a fire. He resided in accommodation occupied by vulnerable members of the community who needed some support to live independently. The Court heard that there was little guidance for facilities such as his about how the risk of fire should be managed and escalation of such risk. 2. In addition in relation to the design and fire prevention features for such accommodation the inquest heard that there was no statutory requirement for sprinkler systems. Smoke detectors were in the hallway areas of each flat but because of the way in which a cigarette related fire developed the detector would not be triggered until the fire was well established. This made it difficult to escape and increase the risk of the fire spreading further.
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 21st October 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 namely, [redacted] (family of the deceased), 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.

9	**26th August 2021**  **Alison Mutch** **HM Senior Coroner Greater Manchester South**