9th October 2023

Plumis
Intelligent Fire Suppression

Analysis of 10 years of Prevention of Death reports following fire deaths in domestic and care homes

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Analysis of 10 years of Prevention of Death reports following fire deaths

Whilst certain types of buildings present unique fire challenges, and recent failures in building and fire safety practices have been brought centre stage, fire safety is not just about the construction and fabric of a building.

At Plumis, we're committed to improving fire safety and reducing the number of fire-related fatalities and injuries across the UK and have been advocating for the last decade for greater measures to be taken to protect those not able to easily escape from fire.

In 2021, we launched an initiative setting out some of the key fire safety challenges highlighted by research undertaken by the BRE to create seven risk profiles to demonstrate the personas of vulnerable individuals who may need further preventative solutions in place.

Risk profiles

Electra

Electra buys electrical goods from online marketplaces, not realising that the selling of these products is unregulated. According to Electric Safety First, faulty electrical goods account for 25% of electrical fires.

Sous

Sous enjoys cooking but doesn't always keep their eyes on the stove. Cooking appliances are the ignition source for almost half of all accidental fires and casualties.

Bones

Bones has a medical condition, illness, temporary or lack of physical mobility that prevents them from responding appropriately or being able to escape easily from a fire.

Indie

Indie lives alone with no one observing behaviour changes such as waking up in the middle of the night to cook, which could signify the onset of dementia.

Snooze

Snooze is likely to not hear a smoke alarm when they are asleep because of their lifestyle habits. In the event of a fire, this means they could inhale damaging or lethal amounts of toxic smoke and gases whilst asleep.

Vapor

Vapor uses smoking materials in the home in rooms like the bedroom or living room, where careless disposal of the smoking materials can result in upholstered furniture, bedding or rubbish catching fire

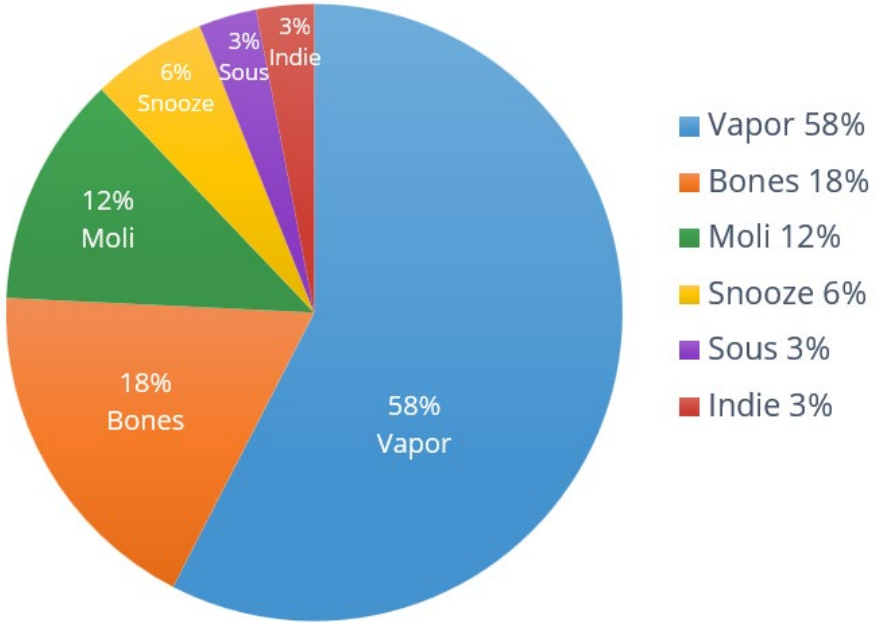
Moli

Moli is bedbound, lives alone and is visited three times a day by carers. To reduce the likelihood of bed sores, emollient creams are applied to Moli's skin. The residue – from both paraffin and paraffin-free emollients – have been found to soak into clothing, dressings and bedding leaving a flammable residue.

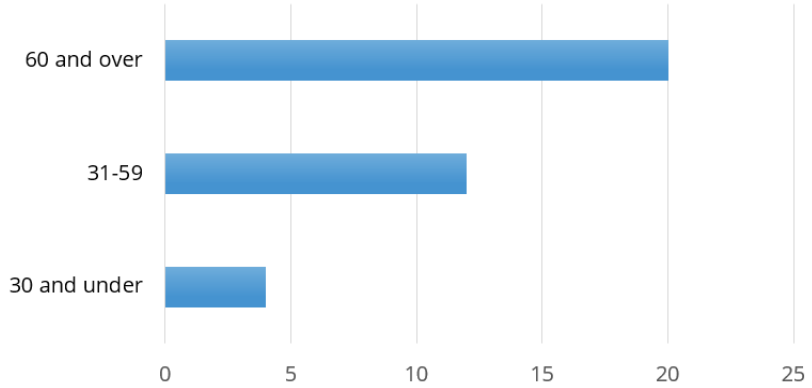
Alongside this work, we have collated a summary from analysing the Prevention of Future Death reports (following fires in domestic settings or care homes) in accordance with paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 to demonstrate how each case aligns with our personas.

Data Summary

Chart showing % deaths represented by Plumis persona:



Age groups of deceased:



Percentage who were receiving care at the time of death:

37%

Data and analysis: Prevention of Future Deaths reports

This chart summarises our findings up to 30 September 2023.

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
1	13/8/13	24/3/12	https://www.judiciary.uk/wp-content/uploads/2014/05/Steel-2013-01851.pdf	Vera Steel, 81, was a heavy smoker and insisted on lighting up with matches. She was either bed bound or in a wheelchair. She asked her carer to fetch a glass of Brandy and whilst the carer was gone she attempted to light a cigarette using a match. She apparently dropped the lit match into her lap causing a fire and resulting in severe burns.	81	Care Home	Vapor	Surrey	Surrey
2	17/1/14	13/1/12	https://www.judiciary.uk/wp-content/uploads/2014/06/Camm-2014-0023.pdf	Julie Ann Camm was a single woman aged 49, who suffered from schizophrenia. On 13 November 2012 at 3.45am she was found in her smoke logged flat. The fire had been started deliberately by the application of a naked flame to bed linen in the bedroom. There were no smoke alarms in the property.	49	Social Housing	Bones	W Yorkshire	W Yorkshire
3	8/5/14	24/8/13	https://www.judiciary.gov.uk/publicati	Mr Lapping, 48, had consumed 7-8 pints of beer. He was found on the settee in the living room, although he	48		Sous	Newcastle	Tyne & Wear

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			ons/anthony-lapping/	was rescued, he subsequently died. The cooker in the kitchen was switched on and a pan/pans had ignited, spreading to a Fridge/Freezer adjacent to the cooker. Insulation in the fridge-freezer caused an extremely rapid development of the fire					
4	12/5/14	3/12/13	https://www.judiciary.gov.uk/publications/amanda-richards/	Amanda Richards was a wheelchair user. She had live-in carers 22 hours a day. On 3 December 2013 she dropped a cigarette when she was alone and died in the subsequent fire	NR	Social housing	Vapor	Coventry	West Mids
5	24/10/14	7/7/14	https://www.judiciary.uk/wp-content/uploads/2014/11/Cole-2014-0460.pdf	Hilda Cole, 88, died after dropping a lit cigarette onto her sofa. She was a smoker with reduced mobility. Family members had not been aware that the system provided for the pendant could be linked to other alarms. Her pendant was not linked to a smoke alarm.	88		Vapor	Staffordshire south	Staffs
6	5/11/14	10/11/10	https://www.judiciary.gov.uk/publications/santosh-muthiah/	Mr and Mrs Mutiah, were both taken to hospital but Muthiah, 36, died as a result of smoke fumes from a fire caused by a fault in a fridge freezer	36			Gr London Northern	LFB

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
7	24/2/15	5/9/14	https://www.judiciary.gov.uk/publications/christopher-butler/	On 5 September 2014 Mr Butler aged 55 died from a combination of smoke inhalation and alcohol intoxication. The fire was caused by an electrical malfunction in cabling behind the cavity wall. The property had an old style fuse box and it was considered that a more modern one would have prevented the cable from overheating	55		Snooze	Oxfordshire	Oxfordshire
8	30/4/15	Nov14?	https://www.judiciary.uk/prevention-of-future-death-reports/william-thompson/	William Thompson, 72 died in a fire caused by a discarded cigarette. His bedding caught fire and he was killed by smoke inhalation. There were smoke and heat detectors in kitchen and living room, but nothing in the bedroom. He was known to be at significantly raised fire risk because of his smoking drinking and immobility. He used a zimmer frame	72		Vapor	Inner London St Pancras	LFB
9	14/7/15	25/3/15	https://www.judiciary.uk/prevention-of-future-death-reports/kenneth-bailey/	On 25 March 2015 Kenneth Bailey was smoking a cigarette when he dropped it onto a kitchen roll which ignited. He was suffering from lung cancer and was using oxygen at home.	65		Vapor		
10	22/9/15	7/3/15	https://www.judiciary.gov	Emma Waring was 23 years old at the time of her death. She was working	23	Social housing	Vapor	Manchester North	GMFRS

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			.uk/publications/emma-waring/	with a family support worker as a result of her 2 year-old son having been taken into care 8 months previously. She was known to be a heavy drinker and cigarette smoker and was by all accounts a vulnerable individual. The evidence at inquest indicated that the fire had started at some time after 01:50 hours on 7 March 2015; the smoke alarm activated and would have been audible to neighbours. However,r the initial call to the emergency services was not made until 02.40 hours. It was more likely than not that a cigarette had come into contact with bedding materials and that whilst the deceased was asleep the fire had developed filling the bedroom with toxic smoke. At some point the deceased had become aware of the fire, possibly due to the smoke detectors operating, and had attempted to escape but had been quickly overcome by the toxic products of combustion					

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11	12/2/16	30/8/15	https://www.judiciary.uk/prevention-of-future-death-reports/joseph-sarkozi/	Joseph Sarkozi, 66. An investigation concluded that the most likely cause of the fire was discarded smoking materials having ignited bedding materials in the first floor rear bedroom	66		Vapor	Avon	
12	27/4/16	7/9/15	https://www.judiciary.uk/prevention-of-future-death-reports/christopher-holyoake/	Mr Hollyoake was bedbound. He was being cared for by his friend, assisted by carers 4 times a day His friend had gone into the garden to take out rubbish. The most likely source of the fire was his lighter, coupled with the fact that he and his bedding and clothing was covered with E45 emollient residue.	NR		Moli	Leicester City	
13	23/5/16	30/12/14	https://www.judiciary.uk/prevention-of-future-death-reports/sadie-peters/	The inquest into the deaths of Sadie PETERS, Joseph PETERS and George PETERS was opened on the 8th January 2015 and was resumed on the 17th May 2016 and concluded that same day. In the case of each death, the cause of death was Inhalation of fire fumes. The fire started in a small extension to the caravan that housed a solid fuel	NR		3 deaths	Surrey	Surrey

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				burner and that this burner was the most likely cause of the fire. There was no smoke detector fitted inside the caravan.					
14	12/12/16	16/7/16	https://www.judiciary.gov.uk/publications/ellen-kelly/	On the 7th July, 2016 Ellen Kelly had a cigarette at her home address which she did not fully extinguish. She placed it into a carrier bag containing other cigarette butts and this caught fire. An extensive fire then occurred at the flat and she suffered smoke inhalation injuries and died on the 16th July, 2016 at St Marys Hospital. The Coroner was concerned that the doors in the block did not have self closers and were not fire doors	86	Social housing	Vapor	St Pancras	LFB
15	10/5/17	13/3/16	https://www.judiciary.uk/wp-content/uploads/2022/10/Cedric-Skyers-Prevention-of-future-deaths-report-2022-	Mr Skyers was a hemiplegic resident of Manley Court Nursing Home, who could not stand or reposition himself on his own, nor propel his wheelchair. He was wheeled into the garden to smoke, a regular routine, on the morning of 13th March 2016. He was assessed as safe to smoke on his own, but the staff were unaware that some of his laundered clothes had burn marks. At about midday, he	69 Age in press report not PDR		Moli	Inner London South	LFB

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			0305_Published.pdf	was seen to be on fire and immediate attempts were made to extinguish the fire by smothering and water, which was effective. It lasted less than five minutes. It had been caused by the breeze fanning his smouldering clothes, burnt by his lit cigarette. He died in hospital of extensive burning.					
16	15/5/17	9/11/16	https://www.judiciary.uk/prevention-of-future-death-reports/sharon-soares/	Cause of the fire was the ignition of combustible materials by exposure to the naked flame of a bio ethanol heater. Sharon Soares, 30, died on 9 November 2016 and her husband Blaise Alvares, 33, died on 23 December 2016. At the time of the fire in the 3 bedroom house there were 7 people	30 and 33		2 deaths	Wiltshire and Swindon	
17	14/6/17	27/12/16	https://www.judiciary.uk/prevention-of-future-death-reports/rasikaben-chauhan/	Mrs Chauhan, 84, lived in a block of flats specialising in sheltered accommodation for elderly people of south east Asian/Indian origin. On the 27 December 2016, Mrs Chauhan was in a chair facing her Hindu shrine when one of two oil burning candles became dislodged from the shrine falling onto her clothes and fully	84	Social housing	Bones	Northampton	

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				engulfing her in fire. The oil burner contained ghee (clarified butter).					
18	27/7/17	20/3/17	https://www.judiciary.uk/prevention-of-future-death-reports/sheila-gaskin/	Sheila Gaskin died on 20 March 2017. She was bedbound and visited by carers 4 times a day. She smoked in bed. The Fire service had provided flame retardant bedding.	NR		Vapor	S Wales Central	
19	15/8/17	5/3/17	https://www.judiciary.uk/?s=Ian+Leak&pfd_report_type=&post_type=pfd&after=&before=&order=relevance	Ian Leak, 59, died after a fire began caused by a lit cigarette coming into contact with combustible material. After a a number of strokes, he had significant disabilities and serious mobility problems.	59	Social housing	Vapor	S Manchester	GMFRS
20	11/11/17	19/3/16	https://www.judiciary.uk/prevention-of-future-death-reports/brian-maclean/	Brian MacLean, 60, consumed an excessive amount of alcohol and had been smoking whilst sitting on his sofa. The deceased was not in employment and was in receipt of state benefits. It seems that a referral was made to the Manchester City Council Adult	60	Social Housing	Vapor	Manchester City	GMFRS

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
				Social Services Department on 26 January 2016. His support worker had discovered that he had no household appliances other than a microwave in which he cooked all of his meals and had little in the way of possessions. The local authority wrote a letter to the deceased asking if he required any help or support and when they received no reply the case was closed.					
21	7/3/18	21/8/17	https://www.judiciary.uk/prevention-of-future-death-reports/elizabeth-griffin/	Elizabeth Griffin, 71, was wheelchair bound. On 14/7/17 she was alone at home in bed when a fire started in the dishwasher in the kitchen. She attempted to call for help at 8.11 via her pendant alarm. The call responder did not recognise the sound of the activated smoke alarm and was unable to communicate effectively with Mrs Griffin. LFB found her unresponsive at 8.30.	71			Inner W London	LFB
22	7/6/18	12/10/16	https://www.judiciary.uk/prevention-of-future-death-	Kevin Freely, 61, was bedbound and immobile following a previous stroke. He was known to smoke hand rolled cigarettes and cannabis in bed. Whilst his carer was on a break a fire started	61		Moli	W London	LFB

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			reports/kevin-freely/	in his bed area, probably because he suffered a seizure and dropped the cigarette. He was unable to move away from his bed to escape. He was on an airflow mattress and emollient cream was being used as part of his care. He died the following day					
23	6/7/18	8/12/17	https://www.judiciary.uk/prevention-of-future-death-reports/jacob-sulaiman/	Jacob Sulaiman, 61, died as a result of a flame being applied to combustible material in his bedroom. It was unclear whether the fire was started deliberately, or as a result of an attempt to light a cigarette. The remote monitoring in the property was activated, but he was found, unresponsive when the LFB arrived	61	Social housing	Vapor	Inner N London	LFB
24	14/12/18	4/9/17	https://www.judiciary.uk/prevention-of-future-death-reports/barnaby-aylward/	Mr Aylward, 49, was a heavy smoker and was overcome by smoke from a fire more than likely caused by his failure to safely handle a lit cigarette when he was using an armchair in his home. He was known to have mental health issues.	49	Social housing	Vapor	W Yorkshire	W Yorkshire
25	21/12/18	25/1/17	https://www.judiciary.uk/prevention-of-future-	A fire occurred at the home address of the deceased (Ms Mihaela Lazar and Ms Dorina Zangari) on 25th January 2017. The fire probably	NR			Eastern Greater London	LFB

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			death-reports/dorina-zangari/	started from clothing overlying a heater on the lower level of the premises. This caused dense smoke to spread through the maisonette and the 2 deceased were unable to escape to safety before being overcome with fire fumes			2 deaths		
26	28/1/19	18/7/18	https://www.judiciary.uk/prevention-of-future-death-reports/simon-barber/	Simon Barber, 49, died as the result of a naked flame coming in contact with his clothing. It is likely that the flame was being used to light a cigarette, but that the paraffin-based cream used on him led to the fire growing quicker and more intensely. He lived in a bungalow, was wheelchair bound with carers 4 times a day.	49	Social housing	Moli	Nottingham	
27	30/5/19	18/8/17	https://www.judiciary.uk/prevention-of-future-death-reports/peter-moran/	Peter Moran, 89, had a history of chronic obstructive pulmonary disease, diabetes, irregular heartbeat, dementia and limited mobility. He lived alone and had a care plan in place. Precautions had been taken to reduce the fire risks in the property. The carers had been instructed to remove knobs from the cooker after use and place them out of reach of	89		Bones	Stoke and North Staffs	

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
				the deceased. On 8th August 2017 a carer visited the deceased and cooked breakfast. The gas cooker grill element had not been fully turned off, leaving an almost invisible flame still burning when the carer left. The cooker knobs and lighter had been placed on top of a cupboard out of reach of the deceased. Other visitors during the evening did not notice the lighted grill. At around 3.00am on 9th August 2017 the deceased got out of bed. He noticed the grill was still ignited and used a taper to take a flame from the grill and attempted to light the gas fire in the lounge causing the plastic log effect to smoulder. The Fire and Rescue Service attended and found the deceased inside the property. The grill was alight and the cooker knobs and lighter were still on top of the cupboard. He was taken to the Royal Stoke University Hospital, Stoke-on Trent where he died at 2.30 am on 19th August 2017. The medical evidence was that the cause of death was hospital acquired respiratory infection due to smoke inhalation					

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				with underlying chronic obstructive pulmonary disease and ischaemic heart disease.					
28	19/9/20	3/4/20	https://www.judiciary.uk/prevention-of-future-death-reports/pauline-oakley/	Pauline Oakley, 75, lived alone in a flat. She had limited mobility and required carers three times a day. She had been discharged from hospital on the 1st of April 2020. On the 3rd of April she fell onto a 2-bar electric fire. A fire started around her and she was unable to move. The electric heater was old and did not have the safety mechanism found in modern electric heaters which automatically turned the heat off in the event it is knocked over. The fire took place between 5:00 and 5:15 AM the smoke alarm was activated at about 5:30 residents in neighbouring flats heard the noise but ignored the alarm. When the London Fire Brigade attended at 9:02 she had sustained considerable burns.	75	Social housing	Bones	Inner North London	LFB
29	17/11/20	27/10/19	https://www.judiciary.uk/wp-content/uplo	Sylvia Griffiths, suffered from dementia and was found dead in her home on the morning of 27 October 2019. She had been overcome by	NR		Snooze	Staffordshire	Staffs

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			ads/2022/06/Sylvia-Griffiths-2020-0238_Redacted.pdf	fumes from a fire which had been caused by inappropriate use of an electric kettle. It was noted as she was known to wander from her home, she was locked in with a window left unsecured so she could get out if necessary.					
30	17/11/20	11/9/20	https://www.judiciary.uk/wp-content/uploads/2020/12/Neil-Barre-2020-0237_Redacted.pdf	Mr Barre died from burns sustained in a fire in his home. Earlier that day he had dropped a cigarette while smoking in bed. There is no other information in the report	30		Vapor	Staffordshire	Staffs
31	26/11/20	18/10/19	https://www.judiciary.uk/prevention-of-future-death-reports/john-jennings/	On the 18th of October 2019 at 1:04 AM a line was opened to Mr Jennings from an alarm monitoring company to his home following the activation of a smoke alarm this call did not result in the LFB being called until 1. 21am. The coroner's report does not indicate the circumstances that caused the fire, nor Mr Jennings age,	NR			North London	LFB
32	28/6/21	1/10/17	https://www.judiciary.uk/	On the 1 October 2017 Zainab left her home address home address of	36/6	Social housing		Stoke & N Staffordshire	

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			prevention-of-future-death-reports/zainab-hashim-and-tafaoul-abdulkarim/	Ringland Close, because a fire had started in the same block. To leave the block she had to go into the communal area of the block of flats which had become filled with smoke and fire fumes. The fumes caused Zainab, and her children, to collapse, and become unconscious. All were rescued by the Fire Service and taken to the Royal Stoke University Hospital where Zainab and Tafaoul passed away. Evidence at the Inquest: It became apparent during the course of the inquest that no resident at the Ringland Close block of flats knew of the existence of the Stay Put policy. Stoke-on-Trent City Council gave evidence to the effect that to communicate this policy to their residents they do so in exactly the same way that they had before the fire at Ringland Close. There are fire notices in the communal areas of the flats and in September 2017, a tenant newsletter was posted through all letterboxes at relevant blocks of flats.			2 deaths		

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
				This newsletter reiterated the "Stay Put" policy. During this particular incident no residents had stayed within their property. No residents were aware of the "Stay Put" policy. Evidence was heard that, had Zainab and Tafaoul, stayed within their home the two deaths would not have occurred.					
33	2/7/21	4/11/20	https://www.judiciary.uk/wp-content/uploads/2021/07/Henry-Boddy-2021-0227.pdf	Mr Boddy was found collapsed on 4 November 2020 in his own property, at which there was a significant fire ongoing. He was rescued by London Fire Brigade, resuscitated by London Ambulance Service and treated in hospital. However, he died later the same day from the consequences of this fire, which was later found to have been caused by either unsafe use of candles for lighting or unsafe use/disposal of smoking materials. Mr Boddy was a hoarder.	NR		Vapor	Inner London North	LFB
34	26/8/21	28/9/20	https://www.judiciary.uk/prevention-of-future-death-	James Frederick Golds lived in a flat. He was vulnerable and had become increasingly confused prior to 28th September 2020. He was a known smoker and there had been concerns	NR	Social housing	Vapor	Greater Manchester sth	GMFRS

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			reports/james-golds-prevention-of-future-deaths-report/	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. He lived in accommodation occupied by vulnerable members of the community who need some support.					
35	12/10/21	4/4/21	https://www.judiciary.uk/prevention-of-future-death-reports/helena-opuku-prevention-of-future-	Mrs Helena Opoku, 67, died on 4th April 2021 at her home address, she died as the result of carbon monoxide toxicity. Mrs Opoku had used charcoal braziers in her home to cook and provide heat. Both gas and electricity had been disconnected in her home. On 7th January 2021 a safeguarding alert, regarding the risk to Mrs Opoku	67		Bones	E London	LFB

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			deaths-report/	of self-neglect, was raised whilst she was an inpatient receiving treatment for injuries sustained in a road traffic collision. Following discharge from hospital on 14th January 2021 social services neither assessed Mrs Opoku, nor her home. Social services did not allocate Mrs Opoku a social worker until 1 April 2021, at the time of her death that social worker had not made contact with Mrs Opoku					
36	14/2/22	8/4/17	https://www.judiciary.uk/prevention-of-future-death-reports/daphne-holloway-and-ivy-spriggs-prevention-of-future-deaths-report/	8 April 2017 a fire started in the Newgrange Residential Home, Cheshunt. The fire was caused by resistive heating in the electrical wiring in or around the ceiling level of the linen cupboard, the fire spread because of inadequate compartmentation in the roof space- this led to the collapse of the roof. Daphne Holloway, 88, and Ivy Spriggs, 91, were found dead in their rooms. Neither appeared to have attempted to leave their rooms.	88/91			Herts	

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37	21/2/22	19/4/21	https://www.judiciary.uk/prevention-of-future-death-reports/sean-ennis-prevention-of-future-deaths-report/	Mr Ennis,79, died from the consequences of smoke inhalation from the fire. It is likely that the fire had started when a match dropped into refuse at the side of an armchair. There was no smoke alarm in the bedroom and the Telecare alarm centre did not know he was a smoker and after the alarm activated the centre was unable to contact him.	79	Social housing	Vapor	N Greater London	LFB
38	26/4/2022	20/4/18	https://www.judiciary.uk/wp-content/uploads/2022/04/Ashleigh-Timms-Prevention-of-future-deaths-report-2022-0123_Published.pdf	Ashlie Timms (46) lived in a self-contained flat in a supported accommodation unit. Ms Timms suffered from, physical disabilities, a moderate learning disability, and a borderline personality disorder. On 20th April 2018, a fire broke out in Ashlie's bedroom at a time between 01 30 and 02.00 hrs. The most likely cause of the fire was combustible material coming into contact with a portable electric fan heater located near the foot of Ashlie's bed.	46		Bones	E London	LFB
39	4/10/22	21/2/22	https://www.judiciary.uk/prevention-	Mr Cauthery, 82, was identified as having an increased fire risk due to smoking. As he was frail, his ability to	82		Vapor?	N London	LFB

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			of-future-death-reports/reginald-cauthery-prevention-of-future-deaths-report/	react to and escape a fire was significantly reduced. Smoke alarms were fitted at his home, but these were not connected to the telecare monitoring system in his home. A smouldering fire started in the electrical motor of his bed on 21 February 2022. The smoke alarms activated but the Fire Brigade was not contacted for at least 10 minutes after the alarm first went off. Mr Cauthery sustained extensive burns and died in hospital the following day. NOTE! I've spoken to the manufacturer of the bed motor who hadn't seen the Reg 28 report! Their view is that the voltage in the motor is so small, a cigarette is the most likely cause of the fire – but am awaiting further information.					
40	16/3/23	3/5/22	https://www.judiciary.uk/wp-content/uploads/2023/03/Brian-Harfield-Prevention-of-future-deaths-	On 3rd May 2022 a fire started in the living room of Mr Harfield's flat in the proximity of his recliner chair. It is unclear how the fire started but it was more likely than not caused by the wiring of a lamp which was located close by. Sadly Mr Harfield (85) was	85		Indie?	W Sussex	W Sussex

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			report-2023-0092_Published.pdf	overcome by the smoke and was found unconscious in his kitchen. Despite medical intervention by the Fire Brigade, he sadly did not recover and was pronounced deceased at the scene.					
41	25/7/23	15/4/23	https://www.judiciary.uk/wp-content/uploads/2023/08/Paul-Keating-Prevention-of-future-deaths-report-2023-0279_Published.pdf	Paul Keating died on 15th April 2023 from the combined effects of carbon monoxide toxicity and pre-existing heart disease in a fire at the flat where he lived alone. The likely cause of the fire was the careless discarding of smoking materials in his bedroom. As he was entitled to, he had declined to allow contractors to install a sprinkler system in his flat when his local authority landlord was seeking to install such systems in all of their high-rise properties following the Grenfell Tower disaster.	NR	Social Housing	Vapor	W Yorkshire	W Yorkshire
42	29/8/23	9/3/23	https://www.judiciary.uk/wp-content/uploads/2023/09/Mizanur-Rahman-	Mr Rahman died on 9 March 2023 at the Royal London Hospital from the effects of smoke inhalation during a fire which took place in the early hours of 5 March 2023 at the 4th floor multi-occupancy flat where he resided. The fire was found to have	41	Social Housing (not from report)		N London St Pancras	LFB

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
			Prevention-of-future-deaths-report-2023-0306_Published.pdf	been caused by a faulty lithium-ion e-bike battery which was charging at the time. The e-bike from which the battery came, which was owned by another occupant of the flat, had been heavily modified, notably including a retro-fitted additional battery cage and motor. The coroner found on the evidence, which included that of a London Fire Brigade Fire Investigation Officer (whose evidence was in turn informed by input from the Chief Scientific Adviser at the Fire Science Department, who had examined the e-bike and remains of the charger\battery), that the fire started with a faulty lithium ion battery, probably a battery and charger which did not match and carried different voltage ratings, leading to thermal runaway and catastrophic failure of the lithium ion battery. Despite attempts by occupants of the flat to prevent the fire's escalation, this was not possible and the flat					

	Date of report	Date of death	Coroner's report	Circumstances	Age	Tenure	Plumis Persona	Coroner	FRS
				quickly filled with toxic smoke necessitating its evacuation. Sadly, Mr Rahman did not successfully evacuate before he was overcome by the smoke, causing his death.					
43	8/9/23	16/5/21		On the 8th April 2021, Lynsey Sarah Smalley deliberately set fire to her bed at her home address during an acute psychotic episode. The smoke from the fire caused inhalation injury which led to her admission to the Intensive Care Unit at Ysbyty Gwynedd, Bangor. Lynsey Sarah Smalley remained in the intensive care unit for several weeks with poor respiratory progress. She did not recover from her injuries and died at Ysbyty Gwynedd, Bangor on 16th May 2021. Given her psychotic episode it cannot be said that she intended to end her life by causing the fire.	44			NW Wales	N Wales

Plumis
Intelligent Fire Suppression

About Plumis

Plumis is an innovative British engineering company whose Automist® fire suppression misting technology has saved lives in homes across the UK. Trusted in both the UK and US, Plumis has completed over 12,000 Automist® installations and been honoured as Innovation Category winner in the Queen's Award for Enterprise.

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