## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Avon Fire and Rescue Services**<br>**2. [redacted] brother of the Deceased**<br>**3. [redacted] Chief Fire & Rescue Adviser**<br>**4. Chief Coroner** |
| 1 | **CORONER**<br><br>I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 23rd September 2015 I commenced an investigation into the death of Mr. Joseph Sarkozi age 66 years. The investigation concluded at the end of the inquest on 28th January 2016. The conclusion was that the medical cause of death was I(a) Exposure to heat and fire and the conclusion as to the death was that of Accidental Death. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Shortly after midnight on 30th August 2015 a 999 call was placed by the next door neighbour of the deceased who lived in a terraced house. The report was of a smell of burning and smoke. Three appliances from the Avon Fire and Rescue Services (the 'fire service') attended promptly and proceeded to try and identify the source of the small and smoke. There was no external evidence of any fire when they arrived on scene. On entering the premises of the caller the fire officers and fire fighters reported only slight smoke and smoky smell in the premises. The front door of the caller's premises was left open and the windows were later opened to ventilate any smoke. One the windows had been opened no more smoke was evident.<br><br>A search of the house was made using a thermal imaging camera to try and identify any hot spots within the premises. The fire fighters could only find hot spots associated with four down lighters in the kitchen ceiling which had tungsten bulbs. On the kitchen ceiling around the light fittings the fire officers noted there were sooty deposits. Examination of the light fittings through the floorboards of the room above did not reveal any smell or smoke coming from those light fittings.<br><br>A Watch Manager inspected the roof of the caller's property as well as those of the neighbouring properties at the front and rear from ground level using a torch and no signs of fire were detected.<br><br>The Watch Manager knocked on the door of the adjoining property, where the deceased resided, and could not obtain any response. However, dogs could be heard barking in the premises. There was no letterbox in the front door through which the Watch Manager could look into the premises. No alarms or smoke detectors could be heard in the deceased's premises. It was determined that there were no grounds at that time to force entry to the premises of the deceased.<br><br>During the time the fire officers were at the caller's premises the caller made known to them that during that day some cardboard boxes had been knocked over in the room above the kitchen which had no floor covering over the floorboards. It was thought that this might have disturbed some dust which had since come into contact with the hot surfaces of the tungsten bulbs causing the smoke and smell that had been detected. |

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| | Having not found any source of the smoke and smell the Watch Manager (B), who was the officer in charge, concluded that the source of the smoke and smell was due to dust on the tungsten bulbs. Fire fighters proceeded to remove the tungsten bulbs an also gave the caller general fire safety advice at the scene. The officer in charge advised Fire Control that this had been a false alarm with good intent.<br><br>The appliances left the scene and the last one left approximately 25 minutes after arrival.<br><br>Approximately 10 minutes after the last appliance left the scene the original caller made a further 999 call and reported that she could see flames and smoke coming out of the rear first floor window of the adjoining property. She also reported hearing a man screaming in the premises but this had stopped.<br><br>Five minutes later the first appliance was on scene. Forced entry was made to the premises of the deceased and fire fighters wearing breathing apparatus went into the building. They found little evidence of fire or smoke on the ground floor. The deceased was found in his bedroom on the first floor at the rear of the premises. The fire fighters found significant smoke damage but only glowing embers in this bedroom which were extinguished. The deceased was pronounced dead at the scene.<br><br>An investigation was carried out by the fire services which concluded that the most likely cause of the fire was discarded smoking materials having ignited bedding materials in the first floor rear bedroom. During the investigation a hole was found in a wall of the bathroom on the first floor of the deceased's premises which was directly adjacent to the property of the caller. It was concluded that this hole was the most likely means by which smoke and smell entered the adjoining property. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The fire officers who attended the premises concluded that the ceiling lights in the kitchen were the most likely source of the smoke and smell which had been detected.<br>(2) This conclusion was reached as no other source of the smoke and smell was found.<br>(3) This conclusion was reached notwithstanding there had been no report of any previous problems with the light fittings; no smoke or smell could be detected coming from the light fittings when inspected; the boxes in the room above the light fittings had been dislodged some time before the smoke and smell was detected; and no obvious layer of dust was observed in the room above the light fittings.<br>(4) The fire service should disseminate nationally the learning from this incident to ensure that other fire officers and fire fighters are aware of the risk of concluding that dust on light fittings can be the cause of smoke and burning smell in the absence of any positive evidence. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th April 2016. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to [redacted] brother of the deceased and [redacted] Chief Fire & Rescue Adviser |

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| | I shall send a copy of your response to [redacted]<br><br>I have sent a copy of my report to the Chief Coroner.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **12th February 2016** **Assistant Coroner** |