REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Whirlpool (UK) Appliances Ltd c/o Plexus Law, Joseph's Well, Hanover Walk, Leeds**
1	**CORONER** I am David Lewis, Assistant Coroner, for the coroner area of North Wales (East and Central)
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 20 October 2014 HM Senior Coroner commenced an investigation into the deaths of Bernard Hender and Douglas McTavish. The investigation concluded at the end of the inquest on 1 September 2017, when I announced my findings and conclusion following evidence I heard on 19-21 April and 16-17 August 2017. The conclusion of the inquest was a narrative in the following terms: Shortly after 06.15 on the 10th October 2014 the deceased and a friend were each retrieved by officers from North Wales Fire and Rescue Services from their home address at The Star, Llanwrst, which had been the subject of a major accidental fire. The deceased died later the same day due to smoke inhalation and carbon monoxide poisoning due to the effects of the fire. On the balance of probabilities the fire was caused by an electrical fault in a tumble dryer in the laundry room at the flat In the case of each of the deceased the medical cause of death was: 1 (a) Smoke inhalation with Carbon Monoxide Poisoning 1 (b) Dwelling fire.
4	**CIRCUMSTANCES OF THE DEATH** The deceased and [redacted] were all present in the flat which they shared at the Star at Llanrwst on 10 October when a fire took place. The fire, which originated in the laundry room, was discovered at about 06:00. Within minutes the alarm was raised by [redacted] who attempted to rouse both of the deceased before making good his escape. The Fire and Rescue Service responded promptly and appropriately. Although they were able to retrieve both of the deceased within minutes of their arrival, both succumbed the same day to the effects of smoke from the fire. The inquest heard a number of possible theories as to the cause of the fire. Some were easily discounted but four received lengthy and detailed attention from witnesses who were either experts in their field or possessed of such experience that their evidence amounted to quasi-expert testimony. Having considered the entirety of the evidence I found that whilst it remained a possibility that the fire had started as a result of one of four possible causes (a problem with the light fitting, a problem with the iron, a problem with the tumble dryer or spontaneous combustion of recently dried material) on the balance of probabilities the fire could be attributed to a problem with the tumble dryer; more specifically an electrical fault associated with the door switch assembly. I heard evidence confirming that the manufacturers of the dryer were aware of a significant number of others fires associated with similar appliances and door switch assemblies in

	which a problem with the door switch had either been identified or not ruled out as cause of the fire.
5	**CORONER'S CONCERNS** 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) The door switch assembly of interest in this case is used in literally hundreds of thousands of appliances manufactured by Whirlpool. I did not emerge from the hearing confident that Whirlpool's risk assessment processed have fully identified or appreciated the extent of the risk of fire (and its potential consequences). My impression was that at least some of the evidence from those called at the request of Whirlpool was defensive and dismissive in nature. The description by the company's former Global Product Safety Director of the company's approach to what he described as 'soft data' from the field (meaning, amongst other things, reported instances of fires) was of considerable concern to me. I am concerned that the company's reluctance to place due reliance on information coming forward in this way, and instead to prefer to take advice from itself, represents an obstacle to timely learning and a likely inhibitor to progressive steps which might prevent fires and save lives. (2) In the course of evidence [redacted] spoke about his belief that the most likely cause of the fire being spontaneous combustion, and explained that he was aware of hundreds of fires of that origin. I was not sure that public awareness of the magnitude of the risk and of the circumstances in which it might materialise reflects the picture painted by [redacted]. I am concerned that not enough has been done historically to raise awareness of this risk.
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 26th December 2017. 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 Families of Mr Hender and Mr McTavish c/o Leigh Day Solicitors, [redacted] and Peterborough Trading Standards in their capacity of Primary Authority 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	**[DATE] 31.10.17** **[SIGNED BY CORONER]**