

Karen Dilks Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
1	THIS REPORT IS BEING SENT TO: Indesit Company, Morley Way, Peterbrough, PE2 9JB CORONER
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	I am Karen Dilks, Senior Coroner for the City of Newcastle Upon Tyne
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 29/08/2013 I commenced an investigation into the death of Anthony Lapping aged 48 years. The investigation concluded at the end of the inquest on 24 March 2014. The conclusion of the inquest was Accidental Death.
4	CIRCUMSTANCES OF THE DEATH
	On the 24 th August 2013 Mr Lapping consumed approx. 7-8 pints of beer. He returned to his home of 47 spoor Street, Dunston. A report of a fire at the premises was made by a third party. Fire and Rescue Services found Mr Lapping on the settee in the living room. Although Mr Lapping was successfully rescued and provided with emergency medical treatment he died to the effects of Carboxyhaemoglobin which caused Cardio Respiratory arrest and his death. The evidence of the Fire Investigation Officer was that his investigation led him to the conclusion that a cooker in the kitchen of the premises was switched on and that either a pan or the pans
	contents had ignited spreading to a Hotpoint Fridge Freezer adjacent to the cooker. Insulation material within the fridge freezer caused an extremely rapid development of the fire. This substantially reduced Mr Lapping's prospects of (a) escaping the fire or (b) avoiding the effects of Carboxyhaemoglobin.
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. –
	[BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Opportunities for escape from the fire and from the effects of Carboxyhaemoglobin were significantly reduced due to the rapid spread of the fire. (2) The rapidity of the spread was attributed to the insulation material used in a Hotpoint fridge freezer. (3) There is a clearly identified risk of further deaths if manufacturers do not address the risks posed by the highly flammable nature of the insulation material used in the manufacture of kitchen equipment (fridge freezers) in common use by the public at large. (4) Urgent review of the manufacturing process and the use of appropriate insulation materials in fridge freezers is required.

6	ACTION SHOULD BE TAKEN
	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
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 June 2014. 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: (a) Tyne and Wear Fire and Rescue Service and (b) Environmental Services at Newcastle City Council 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	Dated 8 th May 2014
	SignatureSenior Coroner for the City of Newcastle Upon Tyne