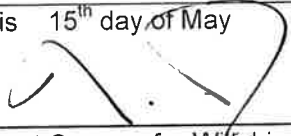




**NICHOLAS LESLIE RHEINBERG**  
**Assistant Coroner for Wiltshire and Swindon**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>The Chief Fire Officers' Association</b> <b>9-11 Pebble Close</b> <b>Amington</b> <b>Tamworth</b> <b>Staffordshire</b> <b>B77 4RD</b></p>
1	<p><b>CORONER</b></p> <p>I am Nicholas Leslie Rheinberg, Assistant Coroner for Wiltshire and Swindon</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 11<sup>th</sup> November 2016 an investigation into the death of Sharon Ann Soares was commenced and on 5<sup>th</sup> January 2017 an investigation into the death of Blaise Sanito Alvares was commenced. Sharon Soares who was aged 30 died on 9<sup>th</sup> November and her husband Blaise Alvares who was 33, died on 23<sup>rd</sup> December 2016. Although their deaths occurred more than a month apart, both died as a result of injuries sustained during a fire at their home at 141 Manchester Road, Swindon on 6<sup>th</sup> November 2016. At the inquest hearing today I concluded that both individuals had died as a result of an accident.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>At some time after 11 pm on Sunday 6<sup>th</sup> November 2016 a fire broke out in the downstairs living room of 141 Manchester Road, Swindon. At the time there were 7 individuals in the house, a three bedroomed terraced property. The fire was intense and produced thick choking smoke, substantially reducing visibility, a problem which was exacerbated by the fact that the electricity supply tripped out eliminating artificial lighting. The conclusion of a thorough fire investigation report was that the probable cause of the fire was the ignition of combustible materials including curtain, clothing and bedding materials by exposure to naked flame from a bio ethanol heater. One of the seven individuals within the house managed to escape through an upstairs window. However, the remaining six were trapped within the property and had it not been for the prompt actions of members of the public and the attending fire brigade, all six would have perished. As it was Mrs Soares and Mr Alvares, although rescued died subsequently from their injuries.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>Evidence was heard at the inquest to the effect that this was at least the second occasion of</p>

	fatalities attributable to a Bio Ethanol burner with a previous death reported in Uttoxeter, together with a substantial number of previous accidental injuries, including a series of events in Staffordshire.
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action to address the concern highlighted above by publishing safety warnings in relation to the use of bio ethanol heaters indoors.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12<sup>th</sup> July 2017. I, the Assistant Coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I am sending a copy of my report to the Chief Coroner and to the following Interested Persons namely the family of the deceased and also to Station Officer Bagnall who was the officer who investigated the fire in question.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>Dated this 15<sup>th</sup> day of May 2017</p> <p>Signature </p> <p>HM Assistant Coroner for Wiltshire and Swindon</p>