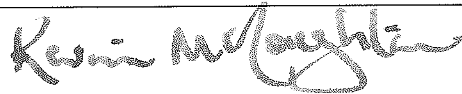
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **2.** [redacted] **3. The Secretary of State for Housing, Communities and Local Government, 2 Marsham Street, London, SW1P 4DF**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (E).
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 16th August 2019 I commenced an investigation into the death of Philip Noel Sheridan, aged 32. The investigation concluded at the end of the Inquest on 5th January 2021. The Inquest concluded with a Narrative Conclusion recording that his death on 6th July 2019 was attributable to the complications of smoke inhalation arising from a fire on 26th June 2019 in the cellar flat where he lived alone.
4	**CIRCUMSTANCES OF THE DEATH** Philip Noel Sheridan had begun cooking in his cellar flat around midnight on 25/26 June 2019, but had then probably fallen asleep. Around 0300 on Wednesday 26th June 2019 a fire was discovered. He managed to get out of the flat and up to street level but then collapsed. Despite treatment in a specialist burns intensive care unit he continued to deteriorate and died on Saturday 6th July 2019 at Pinderfields Hospital, Wakefield. At the time of the fire there was no smoke detector fitted in his cellar flat. There was only one exit door which had no handle fitted to it and was situated next to the seat of the fire on the hob, thus necessitating him being in close proximity to the fire and smoke when trying to escape. The cellar flat conversion had taken place without: (a) Planning consent; (b) Building Regulation approval; (c) Leeds City Council Housing Department being informed of the existence of the cellar flat as a separate dwelling. In consequence no regulatory authority had inspected the cellar flat. Had they done so it is likely an Emergency Prohibition Order would have been served in view of the hazards present.
5	<u>**CORONER'S CONCERNS**</u> 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) [redacted] entered an Assured Shorthold Tenancy Agreement with the deceased on 14th August 2013. He was a 'person in control' of the cellar flat within the meaning defined in the Housing Act 2004. He and/or [redacted] were involved in the management of other properties in the Leeds area in the period 2013-2019. He or they should have been aware that the cellar flat did not have planning consent, Building Regulation Approval and had not been inspected by Leeds City Council Housing Officers. The evidence taken at the Inquest gave rise to a concern on the balance of probability that the hazards identified in the cellar flat may be replicated in other properties managed by them, particularly in relation to the provision of smoke detection equipment or emergency escape routes in the event of fire. 2) Leeds City Council made payments relating to Local Housing Allowance direct to [redacted] totalling £9462.05 in respect of the cellar flat which had taken the address of [redacted] Leeds. This was done without ascertaining whether the cellar flat had planning consent, Building Regulation Approval or had been inspected by Leeds City Council Housing Officers to establish whether it was safe for human habitation. Evidence taken at the Inquest indicated there were many other comparable properties in Leeds. This situation gives rise to a concern that fire hazards may be present in respect of properties which may have the appearance of being approved by virtue of the award of Local Housing Allowance. 3) Evidence taken at the Inquest indicated that whilst a Landlord has an obligation to provide smoke detection devices at the inception of a tenancy, there was no ongoing duty to ensure they continued to be effective or replace them if found to be faulty. In this case the tenant had resided in a cellar flat for nearly six years, before he sustained injuries in a fire which proved fatal. There was no smoke alarm in the cellar flat at the time of the fire on 26th June 2019. I am concerned that the laudable statutory objective enshrined in The Smoke and Carbon Monoxide Alarm (England) Regulations 2015 is undermined if a landlord is not required to check periodically such devises are still effective.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your respective 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 March 2021. 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: 1) [redacted] Sister of the deceased on behalf of his family. 2) West Yorkshire Police, FAO D/S [redacted] 3) West Yorkshire Fire and Rescue Service, FAO [redacted] 4) Leeds City Council, Housing Department FAO: [redacted] (Principal Housing Officer).

	I have also sent it to the following who may find it useful or of interest: 1) E (Gas and Electricity) Ltd. 2) Leeds City Council, Council Tax Section, FAO 3) Sunday Mirror Newspapers 4) Yorkshire Post Newspapers 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	**Signed:**  **Kevin McLoughlin** **Senior Coroner** **West Yorkshire (E)** **Dated: 20th January 2021**