REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Leeds City Council Civil Litigation and Housing Section, [redacted], Principal Legal Officer [redacted] **2.** Deputy Director, Fire Safety, Home Office, [redacted]
1	**CORONER** I am Oliver Longstaff, Area Coroner for the Coroner Area of West Yorkshire (Eastern)
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 28/04/2023 I commenced an investigation into the death of Paul Keating, aged 59 (17/12/1963). The investigation concluded at the end of the Inquest on 20/07/2023. The conclusion of the Inquest was that Mr Keating's death was accidental, caused by the combined effects of Carbon Monoxide toxicity and Ischaemic Heart Disease.
4	**CIRCUMSTANCES OF THE DEATH** Paul Keating died on 15th April 2023 from the combined effects of carbon monoxide toxicity and pre-existing heart disease in a fire at the flat where he lived alone. The likely cause of the fire was the careless discarding of smoking materials in his bedroom. As he was entitled to, he had declined to allow contractors to install a sprinkler system in his flat when his local authority landlord was seeking to install such systems in all of their high rise properties following the Grenfell Tower disaster.
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) Mr Keating lived on the eleventh floor of a 17-storey tower block. His landlord was the local authority. In 2017, following the Grenfell Tower disaster, the local authority undertook a programme of installing sprinkler systems in all the residential tower blocks for which they were responsible, including Mr Keating's. (2) Being a single private dwelling, albeit in a tower block, Mr Keating's flat was not covered by the provisions of The Regulatory Reform (Fire Safety) Order 2005. The

	local authority had no statutory power to enter Mr Keating's flat for the purposes of installing a sprinkler system without his consent. (3) Over a period of six months during which the sprinkler system was installed in the tower block where Mr Keating lived, he did not respond to letters informing him of the planned installation of the sprinkler system and inviting his agreement to contractors entering his flat as part of that work. He additionally refused to open his door to the tenant liaison officer. (Further, it was discovered after his death that Mr Keating had disabled the hard-wired smoke detector and a battery-operated smoke detector within his flat.) (4) The necessary work was done in the common parts of the building to connect Mr Keating's flat to the sprinkler system, but the work done could not cross the threshold of his flat without his consent. Of the 98 flats in the building, Mr Keating's was the only flat not connected to the sprinkler system. (5) If the local authority had had the statutory power to enter Mr Keating's flat for the purposes of installing the sprinkler system, it would have exercised that power and Mr Keating's flat would have been connected to that system. (6) Had Mr Keating's flat been connected to the sprinkler system, it is likely that the system would have been activated by the smouldering soft furnishings in his bedroom and the fire would have been extinguished before he was overwhelmed by carbon monoxide.
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 20/09/2023. 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 West Yorkshire Fire & Rescue Service Fire Investigation Team (an interested person for the purposes of the Inquest). 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	25th July 2023