REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner *must* make a report to the person the s/he believes may have the power to take such action. These prevention of future deaths reports are known as PFDs.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Cabinet Secretary for Housing and Local Government Welsh Government 5th Floor Tŷ Hywel Cardiff Bay CF99 1SN Email: [redacted] [redacted] Head of Mid and West Wales Fire and Rescue Service Service Headquarters, Lime Grove Avenue, Carmarthen, SA31 1SP Email: [redacted]
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the coroner area of SWANSEA & NEATH PORT TALBOT
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	On 1 July 2023 a fire started in an upstairs bedroom of [redacted]. When the fire started the door to the bedroom was shut and inside the bedroom was Muhammad Esmael, who was three years of age.

	Muhammad's father, Naemat Esmael, was in the adjacent bathroom having a shower. Muhammed's mother, Sharmeen Ahmed, had left Muhammad with his father in the parents' bedroom and had gone downstairs. After being downstairs for a very short period of time, Mrs Ahmed heard what sounded like a ball being kicked on a wall and she went to look up the stairs. Mrs Ahmed also heard a couple of beeps from the fire- alarm. On looking up the stairs Mrs. Ahmed saw in the upstairs hall mirror a fire on the ceiling of the bedroom in which Muhammed was located (although she did not know that he was in there). The door to the room was closed. Mrs. Ahmed shouted to alert Naemat and her daughter and her daughter ran out of the property. Naemat came straight out of the shower and ran into the bedroom where Muhammad was located, and the door banged shut behind him. Mrs Ahmed went to ring for help. Naemat was unable to save Muhammad and was forced to jump out of the bedroom window. Tragically both Naemat and Muhammad died because of the fire. The property was leased to the family by Swansea Council. Swansea Council carried out all the appropriate inspections, including electrical inspections, prior to leasing the property to the family. The property contained two smoke alarms, one in the downstairs hallway and one in the upstairs hallways, as required by Welsh Government legislation. The smoke alarms had been replaced in 2020 and were not due to be replaced until 2025. Swansea Council had tested the smoke alarms, and I am satisfied that the smoke alarms were in good working order when the property was leased. The smoke alarms were appropriately hard wired into the mains electricity and the lighting circuit. I therefore find that the smoke alarms were working at the time of the fire but that they did not sound either because the fire had started in a sealed room behind a door closed which meant that no smoke could get to and activate the upstairs fire alarm or that the electricity circuit had tripped and deactivated the fire alarms where those alarms possibly had insufficient battery power. During the investigation, there were only two possible causes for the fire found at the property and these were smoking and electrical. I find that smoking did not cause the fire as there was no evidence that anyone smoked within the property. There was evidence within the property (including within the bedroom where the fire started) that someone had carried out unauthorised electrical works that fell below the standards of a competent electrician. Some unauthorised electrical alterations had been carried out in the property by Naemat Esmael. Swansea Council did not know about these electrical works and so had not authorised them. In the front bedroom where the fire started a two-way extension lead had been directly wired into a double electrical socket behind a wardrobe. Plugged into this extension lead were a games console and a six-way extender lead. A TV was plugged into the six-way extender lead. The cable of the extension lead was fed into the rear of a console unit through an area that had been cut out. The extension leads were housed within a drawer in the console unit and the TV was sat on the console unit. When the drawer was inspected there was evidence of uneven burn patterns within the drawer. There was also

	evidence of a circular burn pattern that was below the surface where the TV sat and charring to the underside of the console where the TV sat. The console unit and electrics were removed before they could be fully inspected by all the investigators instructed to investigate, including the Chartered Electrical Engineer. The charring and burn pattern around the console unit indicates that something had been on fire within the drawer. The two-way socket, the extension leads, the TV and games console were forensically examined after the fire and there was no evidence of any electrical fault with these electrical items. I therefore find that the fire was not caused by an electrical fault from these items. However, I do find that the fire probably started in or around the console unit. I also find that the fire was probably electrical in origin because there is no other explanation for the fire but also because Mrs Ahmed heard a thud which may have been a switch tripping in the electrical console unit which was downstairs. I am unable to determine the precise electrical fault that caused the fire
4	**CIRCUMSTANCES OF THE DEATH** The deceased died following a house fire in a property leased to them by the Council. The property contained two working smoke alarms but they were not activated by the fire, which started in a bedroom where the door was closed.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to a 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 make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 The first **MATTERS OF CONCERN** is as follows: I heard evidence during the inquest that two working smoke alarms were not activated by this fire which occurred in a residential Council owned property and which led to the deaths of two individuals. I heard that this may have happened because the fire was contained in a bedroom with the door closed. I heard evidence that Welsh Government legislation (Renting Homes (Wales) Act 2016 implemented by The Renting Homes (Fitness for Human Habitation) Wales Regulations 2022) only requires rented properties to be, inter alia, fitted with two hard wired smoke alarms and that separately, sprinkler systems are only mandated in new build properties or properties undergoing alterations (Domestic Fire Safety (Wales) Measure 2011). I heard that smoke alarms in hallways only safeguard communal areas and the means of escape in a fire and that they do not provide adequate protection to mitigate against the risk to life from fires which

	start in individual rooms, including bedrooms. I heard that sprinkler systems are expensive for Councils and landlords to fit but that they are very successful in controlling fires and reducing fatalities from fires in properties. I also heard that hard wired smoke alarms are less expensive to fit but would still be beyond the budget of a local Council with a significant property portfolio, which is the case here. I heard that smoke alarms provide the best protection against the risk to life posed by fire in domestic and other properties. I am concerned that only mandating two smoke alarms in rented accommodation means that there is a continuing risk to life from fire in such accommodation. The second **MATTERS OF CONCERN** is as follows: I heard that certain items within the bedroom where the fire started, including a console unit and electrical items, were removed before they could be fully inspected in situ by the Chartered Electrical Engineer instructed to investigate the cause of the fire. I am told that the items were removed by the Crime Scene Investigators from South Wales Police in circumstances where the Fire Service had exercised its power under section 45 of the Fire and Rescue Services Act 2004 and had commenced an investigation which was aimed at determining the point of origin, cause and behaviour of the fire at [redacted]. The Chartered Electrical Engineer expert told me that he was unable to provide me with any assistance on the cause of the fire because the items had been removed from the scene and because he had only been able to view photographs. It was this Expert's opinion that it would have been preferable if the items had remained in position at the property to enable him to inspect them in situ. I am concerned that items were removed from the scene before all inspections were completed and that this may have prevented me and indeed the Fire Service investigators from determining the cause of this fire. I am concerned either that there may not be a sufficiently robust protocol in place between South Wales Police and the Fire Service on preserving a scene to ensure a full investigation takes place and / or that if there is such a protocol it may not have been followed in this instance. If coroners and investigators are unable to determine the cause of a fire because the scene has not been preserved for as long as required to ensure a full in situ investigation by all instructed investigators, then this prevents lessons from being learnt about the cause of a fire which in turn means there is a continuing risk to life.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 17th January 2025. 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 both Interested Parties, namely, the family of the deceased and the City and County of Swansea. 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	22 November 2024