The
Coroner's
Service

North London Coroner's Service,
Barnet, Brent, Enfield, Haringey and Harrow,
Barnet Coroner's Court,
29 Wood Street, London, EN5 4BE
E-mail: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE

DEATHS

THIS REPORT IS BEING SENT TO:

[redacted], Chief Executive
Office of Product Safety Standards
4th Floor Cannon House
18 The Priory Queensway
Birmingham
B4 6BS
C/O: [redacted]

[redacted], Chief Executive
British Standards Institute
389 Chiswick High Road
London
W4 4AL
C/O: [redacted] & [redacted] &
[redacted]

The Home Office Fire Policy Team
Direct Communications Unit
2 Marsham Street
London
SW1P 4DF
C/O: [redacted]

National Fire Chief's Council
71-75 Shelton Street
Covent Garden
London
WC2H 9JQ
C/O: [redacted]

[redacted], Chief Executive
Association of Manufacturers of Domestic Electrical Appliances
Vintage House
36-37 Albert Embankment
London
SE1 7TL
Email: [redacted]
C/O: [redacted]

[redacted], Chief Executive
Chartered Trading Standards Institute
1 Sylvan Court Sylvan Way
Southfields Business Park
Basildon
Essex
SS15 6TH

C/O: [redacted] & [redacted]

[redacted], Managing Director
Hotpoint UK Appliances Limited
Morley Way
Peterborough
PE2 9JB
C/O: [redacted]

[redacted], Chief Executive North
Yorkshire Council
County Hall
Northallerton DL7
8AD
C/O: [redacted] &
[redacted]

1	**CORONER** I am Mr P. Straker, Assistant Coroner for the coroner area of the Northern District of Greater London
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 the 17th of May 2023 I commenced investigations into the deaths of Champagauri and Dipak Bhatt. The investigations concluded on the 15th of November 2024 after inquests held over the 6th, 7th and 8th of November 2024. The inquests had the following short narrative conclusions: (a) Following a fire caused by an electrical fault in the tumble dryer, Champagauri Bhatt died from the resulting inhalation injury. (b) Following a fire caused by an electrical fault in the tumble dryer, Dipak Bhatt died from the resulting inhalation injury.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of 29th of March 2023 a fire caused by an electrical fault in the tumble dryer at [redacted] Edgware caused Champagauri and Dipak Bhatt to die from inhalation injuries. There was a 10% chance the EMI filter caused the fire and a 90% chance the condensate pump caused the fire.
5	**CORONER'S CONCERNS** During the inquest a London Fire Brigade witness made suggestions for more effective data sharing and use and It was apparent future deaths may 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) That ingress of moisture into condensate pumps may result in tracking faults causing resistive heating and fire. (2) That changes in information management would result in better analysis of, and learning from, white goods fires. (3) Manufacturers to give the and Office of Product Safety Standards (OPSS) as the regulator and London Fire Brigade (LFB) to support their fire prevention work data on parts replaced on warrantyee for condensate pumps and RFI filters. (4) Working group CPL / 61 look at standards of manufacture of mains and sub mains operated condensate pumps and RFI filters, to improve standards. (5) Manufacturers to share data on decisions and rationale behind recall / replacement of condense pumps and RFI filters Office of Product Safety Standards (OPSS) as the regulator and London Fire Brigade to support their fire prevention work. (6) Companies investigating fires to notify Trading Standards and the Office of Product Safety Standards (OPSS) of the outcome of those investigations. (7) Manufacturers to be required to use the OPSS risk assessment methodology, PRISM, when conducting risk assessments to account for persons in a property and their actions, i.e. sleeping whilst a product is taking advantage of lower electricity rates. (8) Identification plates on appliances that will not be destroyed by fire akin to those on vehicles.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Friday 31 January 2024, 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. The family of Ms Champaguri and Mr Dipak Bhatt 2. London Fire Brigade 3. Hotpoint
9	**Date:** 06/12/2024 Peter H. Straker