

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am M D FLEMING, HM Senior Coroner, for the coroner area of West Yorkshire Western Coroner Area.
2.	DATE OF REPORT 11 August 2026
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. Haier Smart Home UK & I Limited ("Haier UK") 2. Office for Product Safety & Standards (OPSS) You are under a duty to respond to this report within 56 days of the date of this report, namely by October 05, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .

6.	SUMMARY OF CORONER'S CONCERN The above raises concerns that unless the model (DX C10DCER-80 Hoover branded condenser tumble dryer) and any wider product safety implications are further examined, circumstances creating a risk of future deaths may continue. It is my understanding that the Office for Product & Safety Standards (OPSS) has received a significant number of product fire notifications from the fire services across the UK involving this model. Of concern is that 1.6 million of current Hoover & Candy branded condenser or vented tumble dryers may share this model's characteristics.
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 19 May 2025 the inquests into the deaths of Sohaib AHMED who at the date of his death was aged 38 years and his daughter Manahal Nazir AHMED who, at the date of her death was 9 years, were opened. Their joinder inquests were resumed and concluded on 24 July 2026. I found that the cause of death with respect to Sohaib Ahmed to be:- 1a. Inhalation of Fire Gases I found the cause of death with respect to Manahal Nazir Ahmed to be:- 1a Hypoxic-ischaemic Encephalopathy 1b Cardiac Arrest 1c Inhalation of Fire Gases I arrived at narrative conclusions:- In respect of Sohaib Ahmed: On 08 June, 2025, Sohaib Ahmed was found to have died in a house fire at his home address at 34 Russell Close, Heckmondwike, West Yorkshire, with smoke inhalation. It is found more likely than not that the source of the fire was a tumble condensing dryer in the kitchen, although the circumstances of the ignition remain unclear. In respect of Manahal Nazir Ahmed: On 08 June, 2025, Manahal Nazir Ahmed was found unresponsive at her home address of 34 Russell Close, Heckmondwike, West Yorkshire. She was immediately taken to hospital, where notwithstanding treatment she succumbed and died as a consequence of smoke inhalation. It is found more likely than not that the source of the fire was a tumble condensing dryer in the kitchen, although the circumstances of the ignition remain unclear.

9.

CIRCUMSTANCES OF DEATH

On the 08 June 2025 at approximately 6.06 a.m., a neighbour became aware of smoke coming from the home address of Sohaib and his daughter Manahal at 34 Russell Close, Heckmondwike, West Yorkshire. Upon the attendance of the fire service at 6.19 a.m., upon entering the property, Sohaib was immediately found unresponsive behind the front door along with his daughter [REDACTED], when they were both administered CPR.

The fire fighters extinguished the fire in the kitchen at the rear of the property on the ground floor.

Manahal was found laid on the floor in a rear first floor bedroom and also removed from the premises and CPR administered.

Upon the attendance of the paramedics, Sohaib, despite resuscitation attempts at the scene succumbed and passed away at the scene at approximately 7.02 a.m.

Manahal and her sister [REDACTED] were rushed to Hospital, where Manahal, notwithstanding prolonged resuscitation efforts, succumbed and died.

Her sister [REDACTED] survived the incident but only after extensive hospital treatment.

During the inquest it was found more likely than not that the source of the fire in the kitchen was a DX C10DCER-80 Hoover branded condenser tumble dryer, albeit that the specific mechanism and circumstances of the ignition within the dryer remain undetermined and unclear.

10.

CORONER'S CONCERNS

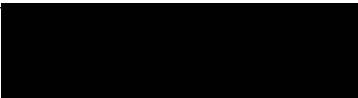
During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The above raises concerns that unless the model (DX C10DCER-80 Hoover branded condenser tumble dryer) and any wider product safety implications are further examined, circumstances creating a risk of future deaths may continue.

It is my understanding that the Office for Product & Safety Standards (OPSS) has received a significant number of product fire notifications from the fire services across the UK involving this model. Of concern is that 1.6 million of current Hoover & Candy branded condenser or vented tumble dryers may share this model's characteristics.

I also heard that two experts have described how this particular type of tumble dryer may burn almost completely once the fire becomes established, making later identification of the initiating defect extremely difficult.

	I found that the evidence cannot determine whether the ignition resulted from tracking, defective solder joint, heater relay failure or another internal electrical failure, such that my concerns are that this may indicate a potentially serious mechanism failure that cannot be identified from available evidence, and therefore cannot be readily prevented. The MATTERS OF CONCERN are as follows: • To consider the appropriateness of a root case analysis being undertaken into this model (DX C10DCER-80 Hoover branded condenser tumble dryer), and examining similar incidents involving this model of dryer with a view to identifying any recurrent failure modes, alteration to the design, issue of technical service bulletins or a recall or safety campaign. • To consider the appropriateness of a similar root case analysis being undertaken in similar branded condenser or vented tumble dryers which may share this model's characteristics in order to determine whether such products present a risk which requires corrective actions. • To consider whether it is appropriate that the sales of the model are halted pending the root cause analysis and any approval or assessment by the Office for Product & Safety Standards (OPSS) and any further necessary review of the root cause analysis and any remedial action.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • Spouse of the deceased • West Yorkshire Fire Service • London Fire Brigade • Office for Product Safety & Standards (OPSS) • West Yorkshire Police - [REDACTED] • Simmons & Simmons I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE



M D FLEMING
HM Senior Coroner for
West Yorkshire Western Coroner Area