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CO/4000/2015

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
THE ADMINISTRATIVE COURT

Royal Courts of Justice
Strand
London WC2A 2LL

Thursday, 22 October 2015

B e f o r e:

MR JUSTICE OUSELEY
and
HIS HONOUR JUDGE PETER THORNTON QC

Between:
SMITH Claimant

v

HER MAJESTY'S CORONER FOR CORNWALL
Defendant

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(Official Shorthand Writers to the Court)

MR R HARLAND appeared on behalf of the **Claimant**
The Defendant did not appear and was not represented

J U D G M E N T
(As approved by the Court)

1. **MR JUSTICE OUSELEY:** This is an application made with the consent of the Attorney General under Section 13 of the Coroners Act 1988. The four applicants are Mr and Mrs Smith and Ms Branton and Mr Digby.

2. They are, respectively, the parents of Richard Smith, deceased; and the mother and stepfather of Kevin Branton, deceased.

3. The deceased were two young men in their early 30s who died on 13 November 2010.

4. The applicants seek the quashing of the verdict at an inquest held on 6 December 2012 by the Coroner for Cornwall, Dr Carlyon, recording a verdict of accidental death on both. The applicants seek a further inquest into their deaths, preferably to be linked with an inquest yet to be held into the deaths of three members of the Cooke family, who died in February 2013.

5. Their application is not opposed by the Coroner, nor by a company called Beko PLC.

6. Beko is involved in this case, and in the Cooke's case and others, because in the case of these deceased the cause of death, as found by the Coroner's jury, though accidental, came from carbon monoxide poisoning as a result of the use of the grill of a gas cooker manufactured by Beko and distributed by Beko in the UK. It was used with the grill door closed, allowing a fatal build up of carbon monoxide outside the cooker. The instructions for the use of the cooker did not explain why the grill door should not be closed, nor were there any instructions to that effect on the cooker itself.

7. In the Cooke's case a different but similar model, modified to permit its use with liquified petroleum gas, was involved, also made and distributed by Beko.

8. Richard Smith and Kevin Branton shared a house in Saltash, Cornwall. On 13 November they were found dead there by Richard's father.

9. The Coroner's jury recorded the verdict that they had died as a result of carbon monoxide poisoning arising from the operation of a grill of a Flavel Milano e50 cooker with the grill door shut. The Coroner's record of inquest refers to evidence given by those involved in the immediate discovery of the body and post mortem, but also that of a gas incident investigator who established what the design problem was; a design problem that could be rectified, apparently, in a quite simple manner by reducing the effectiveness of the seal around the grill door by making cuts in it. It also dealt with efforts made by Beko PLC to inform customers and the gas industry of this problem. Mr Smith had not received any such notification.

10. The Coroner's jury also heard evidence from Detective Constable Brimicombe, who carried out an investigation into the history of the cooker and other incidents of carbon monoxide poisoning caused by use of the gas grills. The Flavel Milano had a safety certificate issued in May 2007. Referring to United Kingdom deaths, he said that, in November and December 2008, there were a number of incidents of fatal carbon monoxide poisoning caused by the use of this grill.

11. The cooker in this case was bought by Mr Smith, Richard's father, on 31 December 2008; as Detective Constable Brimicombe said, "before the full extent of the problem was known".

12. The fatalities led to action being taken by Beko and Glen Dimplex. Glen Dimplex was the distributor for Beko in Ireland. This was done, it was said, in conjunction with the local trading standards offices, which appear to include those in the United Kingdom.

13. It was ascertained, said the Detective Constable, that, whilst the products had passed the standard required at the time of manufacture, there was now a weakness in that standard. He explained the press campaign undertaken in the United Kingdom through 2009: a television programme and contact with retailers.

14. Mr Smith had purchased the gas cooker from a Co-op Society in Plymouth which had received eight cookers from the United Co-op, to which Beko had supplied the cookers. In 2009 the Plymouth Society was taken over by another retailer, Vergo, but it had all gone out of business by May 2010. Beko had supplied the United Co-op Group with details of the problem which it had forwarded to Vergo but, said the Detective Constable, it was not possible to confirm what action was taken by Vergo. It is reasonable to assume that the change of ownership and subsequent financial problems had not helped.

15. The Coroner considered whether it was necessary to make a Rule 43 report but she noted the voluntary involvement of the cooker manufacturers in trying to publicise the issue, the evidence of the Detective Constable to which I have referred, health and safety officers and trading standards officers, and could see no further organisations to inform. However, noting that the press were present, both from TV and local newspapers, she hoped that their reporting would enable the public to examine their gas appliances and seek assistance from trading standards or manufacturers in assessing if they had relevant cookers and, if so, what they should do to rectify the problem.

16. The families of the deceased were not represented at the inquest. Beko was not represented and gave no evidence.

17. The power to quash the verdict of the jury arises in Section 13 of the 1988 Act. This enables a verdict to be quashed where the court is satisfied that:

> "1(b) whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence, or otherwise, it is necessary or desirable in the interests of justice that another investigation should be held."

18. Mr Harland, on behalf of the applicants, has pointed, rightly, to the width of the concept of what is necessary or desirable in the interests of justice. This is not a case in which any criticism is made of the Coroner in her approach to the inquest before her. It is not said that she excluded evidence that she ought to have included, or included evidence that she ought to have excluded, or that she made an insufficient inquiry. What is said by Mr Harland is that investigations that have been carried out and new evidence which

has come to light since the verdict means that it is necessary or desirable that another investigation should be held.

19. His helpful grounds have referred the court to a number of decisions. It is not necessary to go through those. We note what was said by the court in **Her Majesty's Attorney General v Her Majesty's Coroner for South Yorkshire West and Others** [2012] EWHC 3783 Admin (the Hillsborough inquest decision), where the Lord Chief Justice, Lord Judge, said:

> "The emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered."

20. It is also, as the Lord Chief Justice pointed out, not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict would be returned. Even when significant fresh evidence serves to confirm the correctness of the earlier verdict, it may sometimes, nevertheless, be desirable for the full extent of evidence to be publicly revealed.

21. In another case, this court has held that the possibility of a narrative verdict and the possibility of evidence raising questions of more general importance, in this case to purchasers or manufacturers of gas appliances, may satisfy the test. It is therefore a very wide power.

22. The application by the families makes a number of points about which it is not necessary to express any concluded view. They are these: although the reference to Glen Dimplex and the statement of DC Brimicombe may suggest that there was more information at the inquest about what happened in Ireland than the claimants are aware of, it seems to me at any event that the activity which occurred in Ireland, which has now been demonstrated by further evidence in 2008, went well beyond what the company did in the United Kingdom. The distribution of the goods in question was stopped and more widespread publicity appears to have been given, although the latter may reflect a smaller local market.

23. The significance of stopping the selling goes beyond that Mr Harland says; it could have meant that the goods were not available for purchase as at the date when Mr Smith purchased it. If not available for purchase, it would not have been purchased and available, therefore, for use fatally by his son and his friend.

24. There is evidence of activity and of knowledge in Ireland before the purchase, and of activity which could have affected availability for sale in this country.

25. Secondly, Mr Harland refers to the involvement of other bodies. In reality, this relates to a point touched upon by DC Brimicombe but goes rather beyond it. There were discussions between Hertfordshire County Council trading standards -- of which, to some extent DC Brimicombe may have been aware, but I do not know -- which showed that the recall had taken place in Ireland. However, recall was not seen as necessary in

the United Kingdom. The position in relation to the goods was that there would be modifications to those that were in stock and production was going to change. What that did not appear to deal with was what was going to happen to those already produced and sold. It is said by Mr Harland, as indeed by Mr Brimicombe, that this may indicate a weakness in regulatory systems.

26. One of the problems which Mr Harland also raises, not ventilated at the inquest, was the extent to which the testing process only looked to test what happened if people using the machine used it in conformity with the instructions. That testing process failed to recognise that even careful, ordinary users, if they were not alerted by notices on the machine as to what to do and its significance, could easily find that they had used the machine in a way which could lead to their deaths without anything abnormal striking them about it. Nor did it deal with the nature of an accidental event causing the grill door to close.

27. So there may have been errors or deficiencies and weaknesses in the testing system, and there may have been deficiencies and weaknesses in the way in which Hertfordshire County Council trading standards approached what it knew in 2009.

28. I make no comment about whether that is in fact right but that is a point which appears to be new and appears to merit investigation.

29. Mr Harland tells me that, because Beko is headquartered in Watford, Hertfordshire, Hertfordshire trading standards have a wider responsibility than purely for products sold in Hertfordshire.

30. The last point made by Mr Harland is that there is a potential ongoing problem. That may be so. What troubled me in particular -- and I speak for myself here -- was the relationship between this inquest and the inquest into the deaths of three members of the Cooke family and their dog. This is also thought perhaps to have arisen from carbon monoxide poisoning from a different, but not wholly different, form of gas cooker manufactured by Beko. I was concerned that the wider issues that this case is said to raise could be adequately ventilated within the course of that inquest, which would limit the need or desirability of a further inquest in this case. However, I am persuaded, for my part, that, without the events concerning the deaths of these applicants' children being formally before the Coroner, the full investigation that would be given to the Cookes' death would never have applied to the deaths of these young men. The product is a different product, even if the seal is the same.

31. More importantly, the issue in that inquest may well be the adequacy of the recall notices and the recall efforts, whereas the way in which Beko and others dealt with their knowledge of the problem will apply to this product rather than to the modified LPG cooker and the issues will look at knowledge in particular both before purchase and just before death. The period before death in this case is the period before November 2010. The Cookes did not die until February 2013. The question of what was known at February 2013 will not be material to what happened and what was known as at November 2010, whereas that is crucial to the investigation of the deaths of the young men here.

32. Accordingly, there are sufficient differences to persuade me that the investigation into what happened in relation to these cookers may not, although possibly it could, take place during the course of the Cooke family inquest unless it is linked to the deaths of the sons of the applicants.

33. The circumstances, therefore, that I have referred to, have persuaded me that there is a proper case in the interests of justice which make it at least desirable that the verdict should be quashed and a further inquest ordered.

34. I am also persuaded that, although there will be a lengthening of the Cooke inquest because it will be conjoined, there will be a significant degree of overlap. There is the one firm of solicitors, which will be a help in that respect. I have also seen nothing to lead me to suppose that there is any loss of relevant witnesses, which is an important consideration, or that the recollection of significant witnesses would have been dimmed by the passage of time so as adversely to affect the ability of the Coroner to hold a proper inquest in relation to these deaths.

35. Accordingly, I, for my part, will grant the application, quash the verdict and order a fresh inquest to be held, subject to any directions which the Coroner may give in conjunction with the Cooke inquest.

36. HHJ PETER THORNTON: I agree.

37. MR HARLAND: My Lord, there was the application for costs on the papers. I understand what the case law says, and neither the Coroner nor any other party has objected to this application.

38. MR JUSTICE OUSELEY: I don't see how we can make an order costs. There will be no order for costs.

39. You had an application in relation to a representation order, does that need to be dealt with?

40. MR HARLAND: My Lord, I don't think it does.

41. MR JUSTICE OUSELEY: No. Thank you very much.