# IN THE SURREY CORONER'S COURT IN THE MATTER OF:

# The Inquest Touching the Death of Zane Ilorie Christopher Yusuf GBANGBOLA A Regulation 28 Report – Action to Prevent Future Deaths

#### THIS REPORT IS BEING SENT TO:

- The Rt Hon Penny Mordaunt MP, Minister of State for Department for Work and Pensions.
- Mr Martin Temple, the Chair of the HSE Board.
- Mr Graham Arundell, the MD of HAE Ltd.

#### 1 CORONER

Richard Travers HM Senior Coroner for Surrey

## 2 | CORONER'S LEGAL POWERS

I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

# 3 | INVESTIGATION and INQUEST

The inquest into the death of **Zane Gbangbola** was opened on the 13<sup>th</sup> February 2014 and was resumed on the 13<sup>th</sup> June 2016. It was concluded on the 7<sup>th</sup> September 2016.

I found the medical cause of death to have been: 1a. Carbon Monoxide Toxicity.

I concluded with a short form conclusion of: 'Accidental Death'.

## 4 | CIRCUMSTANCES OF THE DEATH

At the date of his death on the 7th February 2014, Zane was seven years old and was living with his parents, and at the family's home address at Thameside, Chertsey, Surrey. At that time, that area of Surrey had suffered severe flooding and as a result Zane's parents had bought a number of electric pumps to pump out water from the property's flood basement.

On the 6th February 2014, having been told to expect a further rise in the

level of the flood water, Zane's parents decided to hire a non-electric and more powerful pump. In consequence, on the 6th February 2014 attended Surrey Hire and Sales Ltd ('SHS') where she hired a centrifugal petrol driven pump. There was a dispute in the evidence as to what was said in the hire shop, but I found that she could use the pump inside the house provided it was ventilated. That advice was in line with advice given in a Safety Guidance document relating to petrol driven centrifugal pumps prepared by Hire Association Europe Ltd ('HAE') for use by their members. It contained the words, "To reduce the risk of serious or fatal injury from breathing toxic fumes, do not run the pump indoors unless you have good ventilation. Ensure that you have proper ventilation when working in other confined areas such as trenches." HAE is a trade body representing plant, tool and equipment hire companies. SHS were members of HAE and had access to that Safety Guidance document. The Safety Guidance document had on it an oblong box containing the HSE's logo, although this was described to me by Deputy Director in the HSE's Field Operations Division, as a "banner" as opposed to the HSE logo itself. He explained to me that the HSE had not approved the contents of the Safety Guidance document and the banner was there simply to provide details of how to find the HSE's website, where further safety information would be available. Mr Galloway stated that the inclusion of the HSE's oblong shaped banner, rather than the HSE's logo in a square box, was intended to convey that this did not represent the HSE's endorsement of the document. However, he accepted that, whilst this might have been the intention, there was a real risk that members of the public would not understand the niceties of the notice and would take it as an endorsement by the HSE of the document and its contents. The Safety Guidance document presents a potential danger. During the course of the evidence I heard from experienced Gas Incident Investigation Officer who has been employed by the Health and Safety Laboratory, which is an agency of the HSE, since 1991. He told me that, when in use, this pump created very large volumes of Carbon Monoxide and that "it would never be safe to have the pump inside the premises if there was any chance that a person might be there'. could not accept the finality of that statement as the Whilst level of danger would, he said, depend upon the size and nature of the premises and the means of ventilation available, he did agree that, as a general statement, it had force, especially in relation to use for domestic purposes. He further agreed that this advice would apply to any piece of equipment that was driven by an internal combustion engine.

the Managing Director of HAE, took a very similar stance and said that HAE intended to review their Safety Guidance documents, although they remain in use pending that review.

#### 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.

I am concerned that the Safety Guidance documents currently prepared by HAE in relation to equipment that is driven by an internal combustion engine, where there is a realistic risk that that equipment might be used in confined areas, are inadequate and potentially misleading. Further, that the use of the HSE logo, in whatever form it might appear, runs the risk of being interpreted by someone reading the document as being an endorsement by the HSE of the document and its contents, thereby exacerbating the potential risk of harm by increasing that person's confidence in the guidance albeit that the guidance may be poor.

#### The MATTERS OF CONCERN are:

- a. The adequacy and accuracy of the Safety Guidance documents prepared by HAE for their members, not only in relation to this centrifugal pump, but in relation to any piece of equipment that is powered by an internal combustion engine where there is a realistic prospect that that piece of equipment might be used in an enclosed area.
- b. The use of the HSE logo on documents that are prepared for general use by trades people and members of the public alike, whether that be the official HSE logo or whether it be in the form of an HSE banner Consideration should be given to taking steps to ensure that the use of any such logo, banner or equivalent representation of the HSE emblem does not give the appearance of the guidance within that document having been endorsed by the HSE when in fact it has not been.

#### 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that you, the persons listed in paragraph one above, have the power to take such action.

#### 7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

#### 8 | COPIES and PUBLICATION

I have sent a copy of this report to the following:

- 1. The Rt Hon Penny Mordaunt MP, Minister of State for Department for Work and Pensions.
- 2. the Chair of the HSE Board.
- the MD of HAE Ltd.
- 4. Leigh Day Solicitors (on behalf of the family)
- 5. BLM (on behalf of Surrey Hire and Sales Ltd)
- 6. DWF (on behalf of the Spellthorne Borough Council)
- 7. The Environment Agency
- 8. CMS Cameron McKenna LLB (on behalf of Brett Aggregates)
- 9. Ashford and St Peter's Hospitals NHS Foundation Trust
- 10. Chief Fire officer Surrey Fire and Rescue Service
- 11. The Chief Coroner

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.

#### Signed:

Richard Travers

DATED this 13th September 2016