REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Managing Director, Beko plc, Beko House, Caxton Way, Watford WD18 8UF CORONER 1 Andrew Bridgman, Assistant Coroner, for the coroner area of Manchester South. 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. **INVESTIGATION and INQUEST** 3 On 19th August 2016 an investigation was commenced into the death of John Wilson who died in hospital following a house fire at his home, on 9th August 2016. The investigation concluded with an Inquest held on 11th April 2017. Medical cause of death la Multiple injuries with burns and inhalation of products of combustion II Ischaemic heart disease, lung transplantation for chronic obstructive pulmonary disease, end stage kidney disease and diabetes The conclusion of the Inquest was: Narrative: Mr Wilson died as a result of injuries sustained in a fire at his home, which was caused by a faulty component of a Beko fridge freezer produced in 2005. The said model was subject to a product recall in 2011 following one death in 2010 and a further death in 2014. Mr Wilson was unaware of the product recall and was unable to take any action. CIRCUMSTANCES OF THE DEATH 4 Mr Wilson was born on 5th January 1953. He was 63 years of age at his death. At about 5:00am on 9th August 2016 Mr Wilson and his wife were woken by the alarm connected to his home O2 Equipment alerting him to the fact that the electricity supply had gone off. opened the bedroom door to find the ground floor in flames. Mr Wilson eventually made his escape by rolling from his bedroom window, on the first floor, onto a mattress placed on the ground beneath by a neighbour. Mr Wilson was taken to hospital. He had suffered superficial or partial thickness burns over 25% of body area, predominantly over his back and upper limbs. He had multiple vertebral fractures, and fractures of his pelvis and right thigh. He died that evening.

5 CORONER'S CONCERNS

The cause of the fire was a Beko fridge/freezer purchased by an advantage of the fire was a Beko fridge/freezer purchased by a control of the fire was a Beko fridge/freezer purchased by a Beko fridge/freezer.

Mr Wilson's name was added to the database for product recall in May 2011.

The evidence of were written to on 22nd July 2011 and again on 27th September 2011 to inform them of the product recall. There was no evidence that the letters had been sent or that they had not been delivered as they were sent using standard mail rather than recorded or registered post. The Wilsons did not respond.

It was the evidence of the family that they did not receive any such letters and that they were unaware of the product recall pertaining to the fridge/freezer they had purchased, by now almost 6 years previously. They had a few years previously received notice of recall of a Hotpoint product and had responded to that.

told the Inquest that as the Wilsons had not contacted Beko following the recall letters their details were passed to OnCall to carry out a door knocking campaign. Beko had no record of OnCall attending the Wilsons address. However, Beko produced a record of British Gas attending on 21st June 2012, which stated that a letter was left as there was no answer.

It came to light during the course of the Inquest that there was a second death in 2014 from a house fire attributed to a recalled model of a Beko fridge/freezer.

No further action was taken to make direct face to face contact with a contact wi

evidence was that the rationale of the door knocking campaign was to make direct contact with the occupants at that particular address, and that is what OnCall and/or British Gas were contracted to do. It was surprising therefore that Beko accepted failure to make contact on just one attempt and that no further attendance at the property was expected or required. There are clearly many reasons why a person may not be at home and I would have anticipated a second or even third attendance, at different times of the day and/or day, before it could be said that a reasonable door knocking campaign had been undertaken.

In this particular case the evidence was that because of his poor health Mr Wilson hardly went out and spent most of his day in the downstairs front room of the house. It seems highly likely that on a second visit direct contact would have been made with Mr Wilson.

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.

The MATTER OF CONCERN is -

- 1. that more could have been done to ensure that the product recall came to the attention of and that the additional step required to do so was not an onerous one.
- that no further direct attempts were made either by registered post or recorded delivery or a second door knocking campaign following the second death in 2014

3. the evidence was that as the recalled products get older the risk of each of them catching fire increases **ACTION SHOULD BE TAKEN** In my opinion Beko, following this third death consequent to one its faulty products, should review its position with regard to making further attempts to make contact, preferably direct, with those persons on the product recall database who have not responded to the product recall. It may well be that the person who originally purchased the fridge/freezer no longer lives at that address or has got rid of it but with an estimated 80,000 units still in use it is very likely that many are still in use at the registered property or if not the person living at that property may well be able to provide information as to what has happened to the fridge freezer registered to that property. 7 YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th September 2017. 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. I have also sent it to widow of Mr John Wilson. 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. 12th July 2017 9 Andrew Bridgman

Assistant Coroner