REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Re: Kevin David John BRANTON, Richard Lee SMITH, Audrey COOK, Alfred Henry COOK and Maureen Henrietta COOK, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Parliamentary Under Secretary of State, Department of Business Energy and Industrial Strategy** **2. [redacted], Office for Product Safety and Standards**
1	**CORONER** I am Geraint Urias Williams assistant coroner, for the coroner area of Cornwall and the Isles of Scilly.
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 17/11/2010 an investigation was commenced into the deaths of Kevin David John Branton, 32 and Richard Lee Smith, 32. On the 01/03/2013 an investigation was commenced into the deaths of Maureen Henrietta Cook, 47, Alfred Henry Cook, 90 and Audrey Cook, 86. The investigations concluded at the end of the inquest on 23/11/2020. The conclusion of the inquest was accidental death as a result of carbon monoxide poisoning.
4	**CIRCUMSTANCES OF THE DEATH** The 5 deceased died in 2 separate incidents with a common feature namely that a gas cooker at their homes had an inherent defect which meant that if the grill was used with the door closed fatal levels of carbon monoxide were produced.
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 could 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 there is no national or central database which contains details of gas appliances manufactured, supplied or fitted to homes in the UK which would

	allow rapid identification and tracing of potentially dangerous items. (2) That communication between manufacturers, suppliers, wholesalers, fitters and householders in connection with the supply etc of gas appliances is hindered by the lack of mandatory recording of the said manufacture, supply and fitting of such appliances. (3) That the lack of a mandatory scheme for recording the supply etc of such items means that it is difficult and time consuming to trace potentially dangerous items when urgency is of the utmost importance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 Monday 1st February 2021. 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: The next of kin of the deceased, Beko Plc, Hertfordshire County Council Trading Standards, Intertek, Arcelik. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE]** **[SIGNED BY CORONER]** **07/12/2020** **Mr G. U. Williams, Assistant Coroner**