SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FORFAR

[2023] FAI 37

FFR-B14-22

DETERMINATION

BY

SHERIFF PAUL BROWN

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

THOMAS OLIVER HILL

FORFAR, 18 September 2023

Determination

The Sheriff, having considered the information presented at the inquiry, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 ("the Act"), Determines that:

F1. In terms of section 26(2)(a) of the Act, Thomas Oliver Hill, born 5 March 1997, died at 1737 hours on 28 October 2015 in an ambulance travelling from Glenmark Cottage near Tarfside in Angus ("the cottage") towards Ninewells Hospital, Dundee.

F2. In terms of section 26(2)(b) of the Act, the accident which resulted in Mr Hill's death occurred during the afternoon of 28 October 2015 sometime before 1520 hours within a bathroom ("the bathroom") at the cottage.

F3. In terms of section 26(2)(c) of the Act, the cause of Mr Hill's death was carbon monoxide poisoning from a mobile gas cabinet heater ("the heater") within the bathroom.

F4. In terms of section 26(2)(d) of the Act, the cause of the accident resulting in the death was a crack in the heater's ceramic plaque which resulted in a malfunction in combustion.

F5. In terms of section 26(2)(e) of the Act, there were precautions which could reasonably have been taken and, had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided. These were:

[1] Burghill Farms ("the landlords") and/or Piers Le Cheminant ("the tenant") could have removed the heater from the bathroom and removed all mobile gas cabinet heaters from the cottage.

[2] The landlords and/or the tenant could have put in place a gas safety system to ensure annual inspection as well as maintenance, repair and renewal of all gas appliances and installations at the cottage by a suitably qualified gas engineer.

[3] Scott Murray, a gas engineer, could have ensured he fully understood his own qualifications and thereafter he could have made the landlords and/or the tenant aware of the fact that he was not qualified to carry out gas work on domestic premises or on mobile gas cabinet heaters.

[4] Written gas safety advice and guidance could have been made available to guests at the cottage on what to do in the event of the carbon monoxide alarm being activated.

F6. In terms of section 26(2)(f) of the Act, the following were defects in the system of working at the cottage which contributed to the accident resulting in the death;

[1] There was absent a landlord and/or tenant gas safety system of work that ensured annual inspection as well as the maintenance, repair and renewal of all gas appliances and installations at the cottage by a suitably qualified gas engineer.

[2] There was absent an effective system of work for Scott Murray, a gas engineer, to ensure he understood his own qualifications and to ensure he informed the landlord and/or tenant that he was not qualified to carry out gas work on domestic premises or mobile gas cabinet heaters.

[3] There was no written gas safety advice and guidance available to guests at the cottage on what to do in the event of a carbon monoxide alarm being activated.

F7. In terms of section 26(2)(g) of the Act, other facts relevant to the circumstances of the death are**:**

[1] The malfunction in the heater's combustion was exacerbated by the presence of water vapour and/or steam in the bathroom as well as insufficient room volume and the absence of purpose provided ventilation. In this regard, a number of facts emerged about the nature of mobile or portable gas cabinet heaters during the course of the inquiry which are relevant to the circumstances of the death, as follows:

(a) These are appliances which are "flueless" meaning they take the air for combustion from the room in which they are situated and they expel the products of combustion back into the room.

(b) The manufacturer's instruction manual should always be consulted as the rooms in which these appliances are used must have sufficient volume and purpose provided ventilation. In the absence of the manufacturer's instructions, users should consult the relevant British Standard.

(c) If these appliances malfunction, they can pose a grave risk to the health and even the life of their users. They are often used in small unventilated spaces for the purposes of emergency heating. There was an apparently widespread lack of awareness about these dangers.

(d) Regulation 30 of the Gas Safety (Installation and Use) Regulations 1998 ("GSIUR") prohibits flueless appliances in bathrooms and shower rooms. Regulation 2 of GSIUR excludes these heaters from that prohibition. However, this is not because they do not pose the same dangers as fixed flueless appliances but rather due to issues of enforceability and a delineation between health and safety regulations and consumer safety.

(e) These heaters should never be used in bathrooms due to the presence of water vapour and/or steam which can compromise the combustion process leading to unsafe carbon monoxide emissions.

[2] There was an apparent widespread lack of awareness with the witnesses in the inquiry about what to do in the event of a carbon monoxide alarm being activated despite a substantial amount of published government advice and guidance. For example, the Health and Safety Executive's website has a page setting out what to do if it is suspected that an appliance is "spilling carbon monoxide." The advice is to call the

National Gas Emergency Service on 0800 111 9999, switch off the appliance and shut off the gas supply at the meter control valve, open all doors and windows to ventilate the room and visit your GP and tell him/her that you believe you may have been exposed to carbon monoxide.

[3] At the time of Mr Hill's death there were only 8 out of 11,600 gas engineers in Scotland qualified to carry out gas work on mobile gas cabinet heaters. It is unknown how many of these would have only held the qualification to give training. The course for obtaining this qualification is short but there is a lack of demand for gas work on these heaters since it is often cheaper to replace them than pay for inspection or repair.

[4] A carbon monoxide alarm at the cottage was not properly installed. It is important to follow the manufacturer's instructions when installing carbon monoxide alarms.

Recommendations

The Sheriff, in terms of section 26(1)(b) of the Act, and having regard to the matters mentioned in section 26(4) of the Act, Recommends that:

[1] Local authorities in Scotland should consider making it a condition of any licence issued in terms of The Civic Government (Scotland) Act 1982 (Licensing of Short-term Lets) Order 2022 that licence holders provide specific gas safety information to guests, namely;

1. Written advice and guidance on what to do in the event of a carbon monoxide alarm sounding.

2. If there is a mobile gas cabinet heater in the accommodation, the manufacturer's instruction manual should be provided along with a warning that any such appliance should not be moved.

NOTE

Introduction and contents

[1] On 28 October 2015, Mr Hill was on holiday with his partner Charlotte Beard and her family at a remote Highland Cottage with no mains gas or electricity supply. In the afternoon, he went into the small unventilated bathroom in the cottage to take a bath. There was a crack in the ceramic plaque burner of the heater in the bathroom which compromised combustion leading to the emission of carbon monoxide which in turn caused Mr Hill's death.

[2] This determination follows an inquiry into the circumstances of his death held under the provisions of the Act. It is made up of nine parts, namely:

The legal framework

[3] Fatal accident inquiries are now governed by the terms of (a) the Act; and (b) the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the Rules"). In this determination, unless otherwise stated, references to sections are to sections of the Act; and references to rules are to rules within the Rules.

[4] The purpose of a fatal accident inquiry is set out in section 1(3). It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (see section 1(4)). A fatal accident inquiry is inquisitorial, not adversarial (see rule 2.2.(1)).

[5] Section 1(2) provides that an inquiry is to be conducted by a sheriff. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1).

[6] The present inquiry was a discretionary one in terms of section 4 of the Act; the Lord Advocate, having considered that the death occurred in circumstances giving rise to serious public concern, decided that it was in the public interest for an inquiry to be held into the circumstances of the death.

[7] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate. A determination under section 26 is to be in Form 6.1 (see rule 6.1)

[8] The findings the sheriff is required to make are set out in section 26(2), namely, (a) when and where the deaths occurred; (b) when and where any accident resulting in the deaths occurred; (c) the cause or causes of the deaths; (d) the cause or causes of any accident resulting in the deaths; (e) any precautions which (i) could reasonably have been taken; and (ii) had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided; (f) any defects in any system of working which contributed to the deaths or any accident resulting in the deaths; and (g) any other facts which are relevant to the circumstances of the deaths.

[9] The making of recommendations is discretionary. The recommendations which the sheriff is entitled to make are set out in section 26(4). The recommendations must be directed towards (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances. Recommendations may (but need not) be addressed to (i) a participant in the inquiry; or (ii) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

[10] In order to identify precautions which, had they been taken, might realistically have avoided the death, or to identify defects in the system of working which

contributed to the death it is necessary that the sheriff is satisfied on the balance of probabilities that those precautions or the defects in the system of working contributed to the death. Likewise, in order to make recommendations the sheriff has to be satisfied that there is a reasonable possibility that the recommendations may prevent deaths in similar circumstances. The 2016 Act does not contain a definition of the term "accident" for these purposes. However it is clear that the accident which resulted in the death of Mr Hill was the malfunctioning of the heater exacerbated by its location in a small unventilated bathroom.

[11] The Procurator Fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which information is presented is not restricted. The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability (section 1(4)).

[12] The scope of the inquiry extends beyond mere fact finding. It looks to the future and seeks to prevent deaths occurring in similar circumstances. Where the circumstances have given cause for serious public concern an inquiry may serve to restore public confidence and allay public anxiety.

Participants and representation

[13] The Crown was represented by Mr Gavin Callaghan, Procurator Fiscal Depute.

[14] Other participants and representation were as follows:

Burghill Farms: Ms Bone, Solicitor Advocate.

Piers Le Cheminant: Mr Logue, Solicitor.

Scott Murray: Mr Hennessy, Solicitor Advocate.

The Health and Safety Executive: Ms McCabe, Solicitor Advocate.

[15] I am grateful to all of those appearing for their assistance in the inquiry and for entering into a joint minute of agreement which substantially reduced the length of the inquiry.

The inquiry process

[16] A First Notice was lodged by the Crown dated 14 January 2022 and a First Order was made with a preliminary hearing fixed at Forfar Sheriff Court on 8 March 2022. The First order having been made, the inquiry was intimated upon Mr Hill's parents. Intimation was also made upon the HSE, the Secretary of State for Work and Pensions (the DWP being the UK government department responsible for gas safety), Burghill Farms, Piers Le Cheminant and Scott Murray. The HSE, Burghill Farms, and Messrs Le Cheminant and Murray entered the inquiry as participants. Subsequent preliminary hearings took place on 29 March 2022 and 17 May 2022 at which an inquiry was fixed for 7 November 2022. In order to ensure outstanding matters were resolved and parties

were prepared for the inquiry further hearings took place on 19 July 2022, 4 October 2022 and 1 November 2022.

[17] At the inquiry on 7 November 2022, the Crown indicated they had received new information. As a result, Mark Beard became a potentially interested party and the inquiry was discharged for him to be given the opportunity to seek legal advice. A preliminary hearing was fixed for 28 November 2022. Mark Beard was represented at that hearing by Mr Jim Laverty, solicitor, who asked for further time to consider matters. The case called again on 6 January 2023 at which stage it was intimated that Mark Beard did not wish to participate in the inquiry other than as a witness and new dates were fixed with evidence heard on 27 and 28 February and 1, 2 and 3 March 2023. Thereafter written submissions were lodged by parties and a hearing on submissions took place on 23 March 2023. Parole evidence was led by the Procurator Fiscal Depute in accordance with the duty under section 20(1)(a) of the Act. No witnesses were called by any other participant. The witnesses called by the Crown were:

1. Jeremy Hill, the deceased's father.
2. Charlotte Beard, the deceased's partner.
3. Alita Beard, the mother of Charlotte Beard.
4. Jensen Beard, the brother of Charlotte Beard.
5. Mark Beard, the father of Charlotte Beard.
6. Richard Cooke, former factor and estate manager for Burghill Farms.
7. Scott Murray, former gas engineer.
8. Piers Le Cheminant, former tenant of Glenmark Cottage.

9. Steven Critchelow, HSE Inspector.

10. Barry Baker, HSE Head of Operations (Field Operations Division, Scotland).

Thomas Hill

[18] Thomas Hill was clearly an admirable and talented young man. His death had a devastating effect on his family and on his partner, Charlotte Beard. Evidence from Jeremy Hill provided the inquiry with some background information on his life as did the joint minute of agreement and the evidence of Charlotte Beard. He was born on 5 March 1997. At the time of his death he was ordinarily resident at an address in Hampshire. He was a student of the University of Stirling. During term time he resided in the Halls of Residence there. He was studying aquaculture at the University of Stirling and had a great interest in wildlife and the environment. Jeremy Hill described the harrowing experience of being informed of Mr Hill's death and travelling to Scotland to identify his body.

[19] When asked if there was anything he wished to raise with the inquiry, Jeremy Hill said in his experience people were not aware of what to do when a carbon monoxide alarm sounded. Similarly, he questioned the level of public awareness and information available in relation to mobile gas cabinet heaters and the dangers they can pose. He had one himself when young and was not aware of the size of room required.

[20] Charlotte Barbara Louise Beard gave evidence and said she was Mr Hill's partner at the time of his death. They had met in college. She described a very happy

relationship and said they had plans for the future together. She said she was traumatised by his death.

The facts and circumstances of Mr Hill's death

[21] I was satisfied on the evidence before the inquiry that the following facts and circumstances were proved.

Glenmark Cottage

[22] The cottage is an old and remote Highland cottage at the foot of Mount Keen in the Angus Glens. Stone-built and over 150 years old. It is accessed by a rough access road and not connected to any mains energy supply. It is two miles away from the end of the publically maintained road at Invermark Lodge near Tarfside, Edzell in the county of Angus. There were two bedrooms upstairs and downstairs there was a living room, kitchen and bathroom. The bathroom had a sink, toilet and bath in it. The living room was heated by a wood burning stove. The bedrooms, living room and the bathroom were each heated by what is commonly referred to as a portable or mobile gas cabinet heater (sometimes referred to in this case by the brand name "Superser"). In the kitchen there were additional gas appliances. A water heater and a gas cooker (as well as gas mantle lights in the kitchen and living room) were powered by external high pressure vessels. There was a gas powered fridge that was designed for a caravan. The heaters and fridge were powered by butane gas cylinders.

Lease and lets

[23] There were some business structuring complexities but Burghill Farms were effectively the landlords and Richard Cooke was the Factor and Estate Manager for Burghill Farms. The cottage was let out to holidaymakers. Most of these were regular visitors. One of these regular visitors, Piers Le Cheminant, took over the operation of this holiday letting business in 2008 when Richard Cooke arranged to lease the cottage to him in exchange for rent as well as a share of the letting income. The lease between Burghill Farms and Piers Le Cheminant was silent on the question of gas safety arrangements although covering documentation and conversations between Richard Cooke and Piers Le Cheminant at the time made it clear that Burghill farms were taking an "arm's length" approach to the cottage. Piers Le Cheminant was expected to take over all internal issues in relation to the cottage (including arranging gas safety checks). The details of what these checks should be and the legal requirements were never discussed. Whilst there was obviously some vague awareness of the requirements for gas safety checks, both Richard Cooke and Piers Le Cheminant were ignorant of the duties in terms of the GSIUR.

Gas safety checks

[24] Richard Cooke referred Piers Le Cheminant to Scott Murray. Scott Murray lived nearby where he helped run his family caravan site and garden centre business. Scott Murray had acquired qualifications from the Gas Safe Register in order to carry out gas work at the family business. This meant he was on a publically available register

which led to requests to carry out other work. He could not recall how he came to do work at the cottage but there were records of him carrying out work there in 2007.

[25] Piers Le Cheminant asked Scott Murray to carry out checks at the cottage. He asked him to check the external vessels, the water heater and the cooker and Scott Murray issued certificates in relation to these appliances and installations. Piers Le Cheminant also asked him to check the mobile gas cabinet heaters and make sure they were "functioning" properly. Scott Murray did this at the beginning of every season.

[26] Regulation 3 of GSIUR places a duty upon a self-employed gas engineer to be qualified for the gas work (as defined in Regulation 2) they undertake. Carrying out an annual inspection itself may not be gas work, but many activities involved in doing the necessary tasks to complete it may be gas work. If, during an annual safety check, one can satisfy all of the requirements of Regulation 26(9) of the GSIUR without breaking into the gas supply or altering an appliance's gas supply, its ventilation or the integrity of its flue or altering an appliances safety features, then it may be that gas work as defined by Regulation 2 of the GSIUR has not been performed. However, maintenance of gas appliances is generally considered to be gas work. In the case of the cottage there was no gas meter and therefore it was not possible to measure the appliance heat input and a burner pressure must be measured to satisfy Regulation 26(9) of the GSIUR. Taking a burner pressure would generally require gas work to be performed. Scott Murray's checks on the heaters at the cottage consisted of a visual inspection. The status of these checks was never clarified by Scott Murray, Piers Le Cheminant or Richard Cooke.

[27] Scott Murray's qualifications in relation to domestic premises lapsed in 2008 when he failed to complete the Gas Safe Register renewal course. Scott Murray never held the Gas Safe Register qualification required to carry out gas work on gas cabinet heaters. Scott Murray never told Piers Le Cheminant or Richard Cooke that he did not hold these qualifications. Both Richard Cooke and Piers Le Cheminant were content that checks were being carried out at the cottage by a gas engineer and were unaware of the fact that there were different categories of gas qualification. They made no enquiry with Scott Murray about the detail of his qualifications or the exact nature of the checks he was carrying out.

Mobile gas cabinet heaters

[28] Mobile gas cabinet heaters are what is known as "flueless" appliances. That means they are not sealed from the room in which they are situated. They take the oxygen for combustion from the room and they discharge the products of combustion back into the room. This means they can be dangerous in certain circumstances. These heaters should not be used in bathrooms or shower rooms since water vapour and steam can compromise combustion. There is a prohibition on "fixed" flueless appliances in bathrooms for this reason under Regulation 30 of the GSIUR. Mobile gas cabinet heaters are excluded from this prohibition by virtue of Regulation 2 of the GSIUR. This is not because they do not pose the same danger. The reason for this could not be definitively confirmed and government records relating to this decision have since been destroyed. The HSE view is that extending the prohibition to mobile gas cabinet heaters might have

the "unintended consequence" of criminalising members of the public under Health and Safety provisions and there would be "enforceability" issues. This would be moving from health and safety issues into the sphere of consumer safety which was the responsibility of a different government body.

[29] These heaters also have a brittle ceramic burning plaque which can degrade or be relatively easily broken. This can lead to compromised combustion and the production of carbon monoxide. Additionally, they have manufacturer specified conditions for operating relating to a minimum room volume and the need for purpose provided ventilation. The instruction manual for the heater was never found and it proved impossible to source. In the absence of a manual, users should consult the relevant British Standard. The bathroom was less than one quarter of the size of minimum room volume required and there was no purpose provided ventilation.

Unsafe situations

[30] Gas engineers are trained on what to do when they encounter unsafe situations. They are trained to follow the Gas Industry Unsafe Situations Procedure ("GIUSP") published by the Institution of Gas Engineers and Managers. There are two relevant categories, namely, "Immediately Dangerous (ID)" and "At Risk (AR)." Mr Critchlow referred to a third category of "Not Current Standards (NCS)." If a gas engineer "encounters" an unsafe situation that can be categorised as being "Immediately Dangerous" or "At Risk" he has a duty to enact GIUSP. He has to inform the

responsible person and affix a label to the appliance indicating that it should not be used (although he has no power to put an appliance beyond use).

[31] The word "encounter" applies to the work an engineer is engaged in but also recognises the engineer has knowledge and skills and if an engineer encounters something that is visually dangerous there is a duty to enact GIUSP. It does not create a duty to investigate or work further but if an engineer was, for example, working on a boiler and saw a nearby cooker that had clear visual defects, he would be expected to enact the procedures. Most gas engineers know that by not following this procedure they can be removed from the register. They are trained and examined on this and following it is a key part of their duties. GIUSP stipulates that a flueless appliance in a bathroom should be treated as "Immediately Dangerous." GIUSP is freely available as a technical bulletin published by the Institution of Gas Engineers and Managers.

[32] Following Mr Hill's death, Steve Critchlow, an inspector from HSE, carried out an examination of the gas appliances and installations at the cottage. He identified a number of gas safety issues which he identified in terms of the GIUSP categorisation. The external propane gas cylinders had a pressure drop that was "Immediately Dangerous." Pigtail hoses on the auto-changeover device were too old and "Not Current Standards." A length of external rigid copper pipework was not sleeved and "Not Current Standards." The heater being in the bathroom was "Immediately Dangerous." The heater's hose was too old and "Not Current Standards." The bathroom's volume was "At Risk." The bathroom's lack of ventilation was "At Risk." The crack on the ceramic plaques was "At risk" deemed to be "Immediately Dangerous"

following testing. The bedroom volume was "At Risk" and the lack of ventilation was "At Risk" with another old hose being "Not Current Standards." Similarly, the second bedroom's volume was "At Risk," lack of ventilation "At Risk" and an old hose "Not Current Standards." The kitchen's volume was also "At Risk," there was some ventilation but it was insufficient and "Not Current Standards" and the hose was damaged by worm drive clips and was "At Risk." The carbon monoxide alarm was not properly installed and positioned close to a vent discharging combustion products from the fridge. The gas cooker had no restraining chain and no anti-tipping device which was deemed "Not Current Standards" and the hose connecting the cooker was continually under strain and deemed "At Risk." The hose was not the correct material as it required a flexible metallic core due to LPG attacking natural rubbers. A plain rubber hose was used and this was "At Risk." The cooker was positioned too close to a wooden cupboard which was "Not Current Standards." The refrigerator was designed for a domestic caravan. It discharged its combustion products into the room. The permanent installation of such a device in a domestic residence was "Immediately Dangerous." Again a rubber hose was used which was "At Risk." The hose outlet was connected to an unrestrained copper pipe which was very vulnerable to damage.

[33] In total there were three "Immediately Dangerous" situations (rising to four when the plaque fault was tested) and twelve "At Risk" situations. In addition to this there were five butane cylinders in use inside the property, consisting of two 15kg size and three 7kg size. The butane cylinder for the fridge was not kept in a suitable fire resistant store. Gas industry practice is to adhere to the UK LPG code of practice which

states "appliances may be supplied from butane cylinders located inside the premises subject to a maximum of 15kg in not more than two cylinders per dwelling." This is also "Not Current Standards" but it increased the likelihood of a small fire turning into a major fire or explosion. At the conclusion of the HSE investigation, the gas supply into the property was capped and a warning notice was attached to the gas supply. Gas warning notices were also attached to the relevant appliances. Scott Murray did not enact the GIUSP and did not advise Piers Le Cheminant of any gas safety concerns at the cottage. In particular, Scott Murray did not raise any concerns about the heater in the bathroom. Scott Murray had a poor grasp of gas safety issues and procedures and did not know what a technical bulletin was.

Previous carbon monoxide alarm activations

[34] There was one carbon monoxide alarm at the cottage. It was not properly installed in accordance with the manufacturer's instructions. It was not fixed to the wall near the ceiling as it should have been. It was placed on a worktop in the kitchen near a vent cut into the worktop. This vent was apparently designed to allow for the discharge of the combustion products from the gas powered fridge into the kitchen.

[35] The carbon monoxide alarm sounded whilst Piers Le Cheminant was staying at the cottage. This was possibly in 2014. Piers Le Cheminant took no action in relation to this. The carbon monoxide alarm sounded again when two holidaymakers, Nick and Pamela Hancock, were staying at the cottage on 18 October 2015. Nick Hancock lit the heater in the bathroom. Soon after the carbon monoxide alarm sounded. He checked

the heater and noted that one of the burners was flickering and the heater was making "put-put" sounds. Pamela Hancock experienced stinging or nipping eyes at the time.

[36] Nick Hancock sent an email to Piers Le Cheminant at 1749 on 18 October 2015 saying,

> "The superser in the bathroom was not burning properly and making a noise, and the CO detector went off whilst we were using it. However, the gas in it is really low so that might be why."

Piers Le Cheminant responded at 0955 hours on 19 October 2015 saying,

> "I'll warn Mark that he will need to change the bathroom cylinder, and keep an eye on any smell (if you see what I mean!). I'll probably buy another new heater before next season."

Scott Murray checks the heater

[37] Piers Le Cheminant contacted Scott Murray either directly by telephone or by leaving a message for him at Scott Murray's family business. Scott Murray was advised that the heater was making a "popping" sound and was asked to check that it was "functioning correctly." Scott Murray attended the cottage on 22 October 2015. He removed the mobile gas cabinet heater from the bathroom and changed the cylinder. He turned the heater on and watched it for two or three minutes from a standing position with the grill partially obscuring his view of the ceramic plaque.

[38] Piers Le Cheminant emailed Mark Beard on 22 October 2015 at 1803 hours saying,

> "Scott delivered more coal and gas today and there is plenty of wood. He checked the heater in the bathroom because Nick Hancock reported it was making a noise. Bill (who was up there when Scott arrived) tells me that it was just because it was almost empty but I'm not sure if Scott changed the cylinder or

> not so perhaps you could have a quick look: there are spares in the barn if necessary."

[38] Piers Le Cheminant then spoke to Scott Murray on the telephone who told him he had replaced the cylinder and the heater was functioning properly. Piers Le Cheminant sent a further email to Mark Beard on 23 October 2015 at 1015 hours saying,

> "I spoke to Scott this morning and he delivered the gas and coal yesterday; there is one half-full big red cylinder in the little hit (switched on) and one full in reserve. He did change the cylinder in the bathroom heater and says it's OK now."

Mark Beard did not inform the other members of his group about the emails.

27 October 201 – The alarm sounds

[39] The Beard family (Mark, Alita, Jensen and Charlotte) and Mr Hill arrived at the cottage. At some point after their arrival, Mark Beard looked at the heater in the bathroom and disconnected the gas cylinder which was something that was often done when the group was visiting to check whether there was a loose connection or if a new cylinder had to be fitted. He did not carry out any more invasive work on the heater and did not attempt to fix it.

[40] On the evening of 27 October 2015 the carbon monoxide alarm sounded again. The heater in the bathroom was on with the door open at the time. Mark Beard noted that the alarm was on the worktop near the vent above the gas powered fridge. He assumed that the alarm had been triggered by combustion products from the fridge. He did not consider the heater in the bathroom as a potential source although his son Jensen had brought it to his attention that the heater was on. Mark Beard took the alarm

outside and put it back down at a different location on the kitchen worktop. He did not tamper with the alarm. He told the group he had "reset" it and it was "OK" as it had "gone off because of the vent from the fridge which was gas powered so the vent lets off small amounts of CO." This was in response to the other members of the group expressing concern at the alarm being activated.

[41] Other members of the group made suggestions that the heaters should not be used, that Piers Le Cheminant should be contacted or that help should be sought. Mr Hill voiced his concerns about the dangers of carbon monoxide. Mark Beard said it was too dark and too remote to go for help at that stage, that he had "applied the scientific method to the alarm going off" and he wanted to "move the alarm to a different location in the kitchen" to see if it activated again and if it did then they would go for help. The other members of the group were reassured by this. There was no information, advice or guidance available within the cottage on gas safety and no instructions on what to do in the event of a carbon monoxide alarm sounding.

The events of 28 October 2015

[42] Thomas Hill went for a bath on the afternoon of 28 October 2015 sometime around 1430 hours. At around 1520 hours, Charlotte Beard became concerned and knocked on the bathroom door. There was no response. After banging and shouting she was joined by the other members of the Beard family. They tried to force the door open but it was solid wood. Jensen Beard got an axe from an outbuilding and it was used to break open the door. When the door was broken open, Jensen Beard noted the

presence of steam. Thomas Hill was found unconscious on the floor within. The bath was almost full with the tap running and the flame on the heater was burning unevenly. Thomas Hill was removed from the bathroom and lain at the threshold of the cottage door where Alita Beard and Charlotte Beard carried out CPR as Mark Beard went for help.

[43] Mark Beard drove to Invermark Lodge and raised the alarm. A gamekeeper made his way to the cottage and assisted with CPR. He noticed "chirping" sounds coming from within that sounded like an alarm. An air ambulance was called but could not land due to poor weather. An ambulance arrived at 1652 hours and paramedics took over the care of Mr Hill. A "Special Operations Response Team" ambulance crew arrived around 20 minutes later and began to transport Mr Hill to Ninewells Hospital in Dundee. It was noted there were no signs of life and attempts at resuscitation were unsuccessful. Life was pronounced extinct at 1737 hours in the course of the journey to Ninewells Hospital whilst the ambulance was still making its way down the Glen. A post mortem was carried out on 2 November 2015 and the cause of death was determined to be "I(a) Carbon Monoxide Poisoning (Domestic Gas Heater)."

HSE investigation

[44] Steve Critchlow, HSE Inspector, attended at the cottage on 30 October 2015. He immediately noted a crack on the ceramic plaques of the heater in the bathroom. He carried out a test with the heater in the bathroom but no unusual readings were obtained. The heater was transported to the Health and Safety Laboratory in Buxton

where further tests were carried out and it was discovered that the crack would intermittently cause the flame to go behind the ceramic plaques and compromise combustion thereby producing high levels of carbon monoxide. In his opinion, the cause of death was carbon monoxide poisoning due to the crack in the ceramic plaques compromising combustion which in turn was exacerbated by the presence of water vapour and/or steam in the bathroom as well as the restricted room size and absence of purpose provided ventilation. He was of the opinion that any competent qualified gas engineer would have identified the gas safety issues at the cottage including the dangers posed by the heater in the bathroom and should have followed the unsafe situations procedure.

[45] Steve Critchlow made investigations regarding training for mobile gas cabinet heaters. He discovered there were only 8 out of 11,600 gas engineers in Scotland in 2015 who had the necessary qualification to work on gas cabinet heaters. At least a substantial portion if not all may simply have held the qualification in order to give the training itself. The training could quite easily be accommodated in the core gas training course. There was low demand for this qualification as it was often cheaper to replace a heater than engage a gas engineer. Mr Critchlow was of the view that sole practitioners and small business owners do not necessarily have the same support as professionals working for bigger organisations and it might be worthwhile exploring whether more frequent training or continuing professional development might assist them.

Indictment proceedings

[46] On 8 October 2021, Burghill Farms and Piers Le Cheminant pled guilty, on indictment in terms of section 76 of the Criminal Procedure (Scotland) Act 1995, to breaches of Regulations 36(2)(a) and 35 of the GSIUR and section 33(1)(c) of the Health and Safety at Work etc. Act 1974. Both were prosecuted on a "non-causal" basis in respect of the death of Mr Hill. On 28 October 2021 fines were imposed of £120,000 on Burghill Farms and £2,000 on Piers Le Cheminant.

HSE policy

[47] Barry Baker, the head of operations in the field operations division in Scotland for HSE, reviewed HSE policy in relation to Mr Hill's death. HSE were aware that there was ambiguity in relation to the applicability of Regulation 36 GSIUR to holiday lets in Scotland. There was a review of GSIUR scheduled for 2026 at which time it was intended to address this issue. A review was carried out to establish why mobile gas cabinet heaters were excluded from the GISUR Regulation 30 prohibition on flueless appliances in bathrooms. No records were available on why this policy decision was taken at the time but it was HSE's position that the inclusion of mobile gas cabinet heaters in the Regulation 30 prohibition carried potential "unintended consequences." These heaters were available to members of the public and were "positioned" rather than fixed. It would not be feasible to enforce against the positioning of all such appliances in a bathroom or room used as sleeping accommodation as this may place duties on those not intended to be captured by GSIUR such as domestic householders.

However, mobile gas heaters still require to be maintained in a safe condition and be subject to an annual gas safety check if they are supplied by a landlord for use in rented domestic premises. Anyone working on such an appliance still requires to be competent. The wider duties of the Health and Safety at Work etc Act 1974 apply to employers and the self-employed. This would include taking all reasonable steps to ensure that the mobile cabinet heaters were used and maintained in accordance with any safety instructions and their operations manual.

[48] In terms of the number of incidents involving cabinet heaters, an interrogation of the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) 11(1) gas fatal data from 2013/14 to 2020/21 in relation to mobile space heaters has revealed the following three fatalities; 21 November 2015, deceased person was in his holiday home in the South of Scotland and succumbed to CO poisoning due to a 3kw cabinet heater with propane cylinder; 28 October 2015, Thomas Hill; 13 April 2014, deceased person succumbed to CO poisoning from a flueless water heater fitted in a bathroom believed to be connected to a shower and connected to LPG labelled as a "natural gas appliance." This information was UK wide. RIDDOR data is publically available.

[49] HSE published "Safety in the installation and use of gas systems and appliances" (L56), the Approved Code of Practice (ACOP) and guidance which accompanied GSIUR first published in 1984. L56 is currently in its fifth edition published in 2018. It is free to download from the HSE website. L56 1998 (2nd Edition) references mobile and portable appliances (specifically LPG cabinet heaters) and

required landlords to ensure they were maintained and checked for safety annually by a registered gas engineer. This guidance remains part of L56 (5th Edition). There is freely available guidance for landlords covering their general duties and portable mobile space heaters that has been in place for many years within L56. Examples of other guidance include, (a) HSE publication INDG285 Landlords – A guide to landlord's duties, (b) Guidance on HSE's website covering landlord's duties, (c) HSE also runs a free Gas Safety Advice Line offering information on gas safety that is open between 9.00am and 5.30pm Monday to Thursday and 9.00am to 5.00pm on Friday (excluding bank holidays).

[50] Gas Safe Register (GSR) guidance specifically aimed at gas engineers was first issued in a 2009 Technical Bulletin (TB065 – current edition issued 19 August 2010) which covers LPG cabinet space heaters and the requirements of gas safety legislation. Guidance on non-room sealed appliances located in sleeping accommodation is included in another Technical Bulletin (TB105 – current edition 4 March 2020). GSR provide free gas safety advice on LPG gas fires on their website and they run an annual gas safety week in September every year. It is aimed at everyone who has gas appliances in their homes or businesses and encourages them (if not required by law) to get their appliances checked once a year for safety. GSR have a free reminder service which anyone can sign up for and which will remind you when checks need to be undertaken. GSR have been producing TV advertisements, radio advertisements and have a YouTube channel containing videos about gas safety. There is guidance covering carbon monoxide risks which has been in place for many years including HSE

publications going back to 2001 on HSE's website archive. There is guidance covering gas safety for short term lets with the focus on longer rental properties. There is a 2018 GSR publication on short term lets and private guidance for short term landlords "Responsible hosting in the United Kingdom – Airbnb Help Centre." The National Landlords Association (NLA) provide a video on their website regarding general gas safety, landlord's duties and CO poisoning. The Carbon monoxide and Gas Safety Society is a charity that provides free guidance and offers support to those who have been directly or indirectly affected by a carbon monoxide incident. The UK Government takes the risk of carbon monoxide poisoning seriously and is taking steps to raise awareness of and tackle these risks. A summary of government activities can be accessed on the HSE website.

[51] In terms of any further steps that could be taken to raise awareness, HSE is not complacent about the risks of carbon monoxide and the dangers that poorly installed or maintained gas appliances pose to the safety and health of householders and tenants. There is a dedicated operational policy team that works with stakeholders to develop standards and raise awareness of the importance of all aspects of gas safety. HSE consider that the current suite of guidance that is available from HSE, GSR and other bodies is suitable to highlight the risks that exist from the use of portable/mobile cabinet heaters and provides clear guidance on practical steps that can be taken to control the risks. HSE believe there is suitable legislation in place that when followed would remove risk of carbon monoxide from portable or mobile appliances in premises within the scope of GSIUR. HSE believes that Regulations 3, 35 and 36 are enforceable with

clearly identifiable duty holders that HSE can enforce against. In the case of the death of Mr Hill, a report was submitted by HSE to COPFS and a prosecution was taken for breaches of Regulations 35 and 36.

[52] In reference to the use of CO monitors as a safety precaution in relation to mobile cabinet heaters, HSE supported this as a useful back-up precaution but they were not to be regarded as a substitute for proper installation and maintenance of gas equipment by a Gas Safe registered engineer. Such alarms should comply with BS EN 50291 and carry the appropriate conformity marking. CO alarms should be installed, checked, maintained and serviced in accordance with the manufacturer's instructions. The regulation of the provision and use of CO alarms do not fall within HSE's remit and CO alarms are not covered by GSIUR or L56. Paragraph 21 of L56 states that "CO alarms are not covered by GSIUR or this ACOP." HSE was aware that the Scottish Government provided statutory guidance for the provision of carbon monoxide alarms in private rented housing in June 2015 (subsequently revised in November 2016 and February 2021). The Housing (Scotland) Act 1987 (Tolerable Standard)(Extension of Criteria) Order 2019 inserted a criterion to require private landlords to have "satisfactory equipment installed for detecting and for giving warning of carbon monoxide present in a concentration that is hazardous to health"

Scottish Government and local authority

[53] A note was submitted to the inquiry by Dr Steven Garvin, Head of Building Standards Division at the Scottish Government setting out building standards on carbon

monoxide alarms as well as the requirements upon landlords in terms of gas safety and the extension of this to holiday lets in terms of The Civic Government (Scotland) Act 1982 (Licensing of Short-term Lets) Order 2022 ("the 2022 Order). A letter was also submitted by Steven Thomson, Team Leader, Environmental Protection for Angus Council on "the Licensing of Short Term Lets and Carbon Monoxide Poisoning Observations by Angus Council." One of the purposes of the 2022 Order is to "ensure all short-term lets are safe." The 2022 Order provides that the use of accommodation for a short term let is an activity for which a licence is required under the Civic Government (Scotland) Act 1982. The 2022 Order also brings short term lets into the Repairing Standard regime. Section 12(f) of the Housing (Scotland) Act 2006 has been amended to reflect this. The Repairing Standard includes an obligation to carry out gas servicing and the provision of carbon monoxide detection. The 2022 Order provides for mandatory licence conditions which focus on the health and safety of occupiers. These include as a condition of licence that the licence holder must arrange for an annual gas safety inspection of, *inter alia*, all gas appliances in the property. If, after an annual inspection, any appliance does not meet the required safety standard, the licence must not grant a short term let until the works necessary to bring the appliance to the required safety standard have been carried out.

[54] Where there is a lack of detailed guidance on a subject there is scope for individuals and local authorities to interpret requirements. It would be open to local authorities to require license holders to prepare and make available to guests an emergency plan which could include information on what the symptoms of carbon

monoxide poisoning are and what to do if the alarm goes off. Currently this is not a specific requirement of the mandatory conditions or included in the relevant guidance. There was no evidence of there being any specific requirement in terms of information on mobile gas cabinet heaters.

Assessment of evidence

General

[55] I found most of the information and evidence at the inquiry to be credible and reliable. The HSE witnesses were credible and reliable and clearly had sufficient qualifications and experience to give their opinion to the court. In relation to the witnesses to the events leading up to Mr Hill's death, the passage of time had an impact on the memory of some. I found Jeremy Hill, Alita Beard, Jensen Beard and Richard Cooke to be credible and reliable witnesses and was content to accept their evidence. There were particular and discrete issues of reliability in relation to aspects of the evidence of Charlotte Beard, Mark Beard and Piers Le Cheminant but I otherwise found all three to be generally credible and reliable. I had more significant concerns about the evidence of Scott Murray. I would also mention here that the Crown submitted material to the inquiry about witnesses suffering ill-effects, possibly from carbon monoxide, whilst staying at the cottage and a noise heard after Mr Hill entered the bathroom. An issue arose about whether I should place any weight on this material since it was not given under oath and had been brought to the Crown's attention after the witnesses involved had watched other evidence in the inquiry. Ultimately, the

information was not determinative of any issue before me. On the face of it, it appeared as though the information might support the view that there was a fault with the heater on 27 October 2015 and when Mr Hill entered the bathroom. This would not have made a material difference to my findings. I was satisfied (in the absence of this information) that there was clear evidence that the crack in the plaque was present on 18 October 2015 and subsequent dates as I explore more fully below. It therefore seemed to me unnecessary to invite further evidence or submissions in relation to this information.

[56] There were essentially two areas where inconsistencies or disputes about what had happened arose. The issues were:

a. Mark Beard's involvement with the heater and alarm.

b. Scott Murray's checks and the crack on the ceramic plaques.

Charlotte Beard

[57] Just prior to the inquiry commencing on 7 November 2023, Charlotte Beard, in speaking with the Crown about arrangements for giving evidence, provided new information about Mark Beard that raised questions about his interaction with the heater and the carbon monoxide alarm prior to Mr Hill's death. The inquiry was postponed as a result for Mark Beard to take legal advice on this. Ultimately, Mark Beard intimated that he did not wish to be a participant in the inquiry other than as a witness.

[58] What she said under oath in evidence about this was that after they arrived at the cottage there had been problems getting the heater to switch on and Mark Beard looked at the "settings it was on." He checked if the gas bottle was empty, he looked at some of

the connections made sure there were no leaks on the valve and took the front or top cover off of the heater. Looking at a photograph of the heater she believed it was the "top part" that had been removed. She could not recall whether this had been on the "Sunday or the Monday." She explained that she had not told the police about this when giving her statement because she was in a "state of trauma" and "it didn't seem relevant." Her recollection was hazy but she could remember her father looking for something in his car like "a screwdriver or something." She said her father was always doing work at the cottage.

[59] She said when the alarm sounded on 27 October 2015 her father "took the batteries out and took the alarm outside." She said when he returned he told them he had "taken it apart and was checking for any dust, looking at the inside" and he explained it "went off because there was dust inside." She said this "fits the behaviour and routine" she had seen with her father previously at home when he had taken apart a fire alarm or smoke alarm that had sounded. She did not see what Mark Beard did outside with the alarm.

[60] Mark Beard was adamant that he did not in any way interfere or tamper with the heater or the carbon monoxide alarm and he would not have considered that to be a safe thing to do. Jensen Beard also said he saw Mark Beard remove the connector on the cylinder for the heater which was something routinely done to check if it needed to be changed before replacing it and he had not carried out any more "invasive" work and he had not seen him try to fix the heater. There were no signs arising from Steve Critchlow's investigation that either the heater or alarm had been tampered or

interfered with. I was therefore satisfied that Mark Beard did not tamper, interfere with, take apart or try to fix either the heater or the alarm.

Mark Beard

[61] I found Mark Beard to be generally credible and reliable. However, there were two issues in relation to which I found him to be unreliable. These were the question of whether the bathroom heater was on when the CO alarm sounded on 27 October 2015 and the nature of the discussions after the alarm sounded.

[62] He could not recall the bathroom heater being on when the CO alarm sounded. He suggested he did not consider the bathroom heater as a potential source of carbon monoxide because it was "two rooms away." Jensen Beard was clear in his evidence that the bathroom heater was on. Jensen Beard also said he brought it to his father's attention that the heater was on and asked him whether he should switch it off and Mark Beard told him to do so. I accepted Jensen Beard's evidence as credible in this regard.

[63] Mark Beard also said there was no disagreement between the group on what to do and he could not recall any discussions about going to get help. The other members of the Beard family were all clear in their evidence that they were expressing concerns about the alarm going off and suggesting that they should go for help. They were clear that Mark Beard had told them he had assessed the fridge as the source of carbon monoxide, he had replaced the alarm and that if it went off again they could go for help.

I accepted the evidence of the other members of the Beard family to be credible and reliable in this regard.

[64] To be fair to Mark Beard, on both of these issues, he accepted that if others had given evidence to that effect then he would not dispute it. He was clear there had been no "disagreement" but this was the Procurator Fiscal Depute's characterisation of the discussions which could easily be a matter of perception.

[65] On the point of the investigations that Mark Beard carried out, I had an additional concern about his reliability. He basically assumed that the source of carbon monoxide was the fridge because the alarm was next to the vent. As Steve Critchlow pointed out, laying aside the benefit of hindsight, this was not an unreasonable assumption to make. However, as I have set out, Mark Beard described this assumption as a conclusion drawn from applying "the scientific method." The use of this phrase and a generally authoritative tone, which was also seen in his evidence, gave a false impression of special skill in relation to assessing the reason for the alarm sounding. All of the members of the group were reassured by this. The significance of this in the present case was in relation to the question of written information and advice on what to do when a carbon monoxide alarm sounds. Although Mark Beard, perhaps surprisingly, said that written advice and guidance may not have changed his approach, Alita and Charlotte Beard were clear it would have changed their response. I was satisfied that it would have put them on a surer footing to challenge Mark Beard's suggested approach.

Piers Le Cheminant

[66] Piers Le Cheminant's memory of the agreement between himself and Richard Cooke was not entirely clear. At first, he said that there was no discussion about him taking over gas safety in the cottage. Richard Cooke said this was part of the discussions and that Piers Le Cheminant was to be responsible for all "internal matters" including gas safety. The lease itself was indeed silent on these matters. However, emails and "covering documentation" showed that Richard Cooke had made reference to gas checks and directed Piers Le Cheminant to a "clerk of works" as well as to Scott Murray. To be fair to Piers Le Cheminant, when shown this, he accepted there must have been discussions in this regard. He said that, even so, it did not "clarify it was a legal requirement." It was accepted on behalf of Burghill Farms that such a delegation could not take place in any event and there was clearly ambiguity about the arrangements which is dealt with more fully below.

[67] I mention this to deal with one particular area where Piers Le Cheminant's reliability was undermined. However, he was quick to make concessions and I otherwise found his evidence to be credible and reliable. In particular, I accepted his evidence about his dealings with Scott Murray. I accepted his evidence that he instructed Scott Murray to "check" that the heaters were "functioning properly" at the beginning of every season. I accepted his evidence that he promptly instructed Scott Murray to "check" the heater was "functioning properly" upon receiving the email from Nick Hancock. There were contemporaneous emails from Piers Le Cheminant to Mark Beard that supported his evidence in this regard. It was suggested it would have

been a reasonable assumption for Scott Murray to make that he was only being asked to check whether the gas cylinder in the bathroom heater was low. Piers Le Cheminant disagreed with this and was clear that he asked Scott Murray to check the functioning of the heater as well and Scott Murray had told him it was "functioning fine."

[68] I accepted his evidence that Scott Murray had never given him any advice that would have caused him concern. Scott Murray never told him about his lack of qualifications. Scott Murray had never advised him of any gas safety issues at the cottage. Scott Murray never advised him of the dangers posed by the heater in the bathroom and if he had been told he would have removed them (I also accepted Richard Cooke when he said the same thing). Scott Murray never told him that the fridge had to be "vented" outside and he was, in fact, "particularly unaware" of this. Scott Murray never advised him about the dangers posed by the number of gas cylinders in the premises or the requirement to secure the cooker.

[69] I accepted that he was reassured that Scott Murray had checked the heater since he understood him to be a gas engineer (both Richard Cooke and Mark Beard were also reassured by Scott Murray's attendance due to his status as a gas engineer). I accepted his evidence that he was not aware of the different categories of qualifications for gas engineers (neither was Richard Cooke and Steve Critchlow opined that he would not expect a lay person to know about this). Crucially, I accepted his evidence that if he had known Scott Murray did not possess qualifications in relation to domestic premises or gas cabinet heaters then he would have instructed someone else to carry out these tasks.

[70] Similarly, it was put to Richard Cooke that a *"clerk of works never instructed* [Scott Murray] to annually service the cabinet heaters." Richard Cooke was not in a position to refute this but said Scott Murray was instructed to service the gas appliances in the cottage and in having that instruction Richard Cooke believed neither party would have distinguished between the different types of gas appliance. He was not aware that a cabinet heater in a bathroom was unsafe and if he had been aware of this he would have had it removed.

Scott Murray

[71] I did not find Scott Murray to be credible or reliable on a number of aspects of his evidence. The Crown submitted that he was a "poor historian" and that his evidence was "confusing" and "unclear." Mr Hennessy took issue with this and invited the court to take account of the context of his evidence, the passage of time and the fact that after giving initial statements he had received no further contact until just before the inquiry proceedings.

[72] I did make some allowance for the submissions made by Mr Hennessy and I accepted that it was not always possible to distinguish between issues of credibility and reliability given the passage of time. Nonetheless, there were a number of difficulties with Scott Murray's evidence. He made claims which I did not accept, namely, that he advised Piers Le Cheminant about the requirement to vent the fridge, chain the cooker and had expressed concerns about the number of bottles in the cottage. There was also a tendency to minimise his involvement. For example, when asked why his qualifications

lapsed there was no sense that he took responsibility for this, he simply assumed all of his qualifications had been renewed. When asked about a strained hose to the cooker he suggested the cleaner might have moved it remarking, "I don't know what the cleaner does." When asked about dangerously low pressure in the external vessels he said it was not like that when he tested it. When asked about the requirement to annually service the mobile gas cabinet heaters, he claimed to be aware of this but did not say anything to Piers Le Cheminant because he was not "the owner of the gas fires." When it was being put to him that he should have known the heater in the bathroom posed a particular difficulty, he said he did not know the heater was there the full time as it was a mobile heater (despite the fact that he attended the cottage every year and would have seen the heater there and when he attended the cottage on 22 October 2015 he removed the heater from the bathroom to change a cylinder). The cumulative effect of all of this was the clear impression that Scott Murray was seeking to distance himself from his involvement with the gas appliances and installations at the cottage and I did not find any of his evidence in this regard to be credible or reliable.

[73] Furthermore, it was clear that his knowledge of gas safety issues was extremely poor. He had no knowledge of any of the three to four "Immediately Dangerous" situations, the twelve "At Risk" situations or any of the "Not Current Standards" situations. In evidence he claimed to have given advice to Piers Le Cheminant on venting the fridge, securing the cooker and the number of bottles in the cottage. Steve Critchlow said this demonstrated knowledge of unsafe situations in circumstances where the GIUSP had not been enacted by him. However, as I have said, I did not

accept this. I believed Piers Le Cheminant when he said he received no advice from Scott Murray. The result was that I could not place any reliance on Scott Murray's claims to have had any of this gas safety knowledge at the material time. He had received Gas Safe Register training but it could not be said that he had retained everything he had been taught. I could therefore place no reliance on Scott Murray having the ability to identify any gas safety issues at the cottage including the crack on the heater. The starkest example of his lack of knowledge was his evidence that he did not know what a Technical Bulletin was. Steve Critchlow described himself as being "open mouthed with shock and disappointment" to hear a former gas engineer say this.

[74] He wished to give the impression that he attended at the cottage on 22 October 2015 as part of a gas delivery service. He tried to present his "checking" of the heater that day as being a "favour" for Piers Le Cheminant. I did not find this evidence to be credible or reliable. I accepted Piers Le Cheminant's evidence that he asked him to check if the heater was functioning properly. It was therefore impossible to place any reliance on the effectiveness of his "check" on the heater on 22 October 2015 (or indeed that he carried out any of the other "checks" he claimed he did). He claimed to have some experience with mobile gas cabinet heaters, which made sense given his involvement with a caravan park. He also said he knew a crack on the plaque would be a "good indication" that a heater was faulty but I could place no reliance on his ability to properly check for this. I accepted his evidence that he attended the cottage that day, removed the heater, changed the cylinder and carried out a cursory visual inspection

from a standing position for two to three minutes. I did not accept that in any way could be taken as reliable evidence that the crack was not present.

Analysis and determination

Section 26(2)(a) When and where the death occurred

[75] I agreed with the submission that the point at which life was pronounced extinct was the correct basis for this determination.

Section 26(2)(b) When and where any accident resulting in the death occurred

[76] The alarm was raised when Charlotte Beard went to check on Mr Hill in the bathroom on the afternoon of 28 October 2015 at 1520 hours. I agreed with the submission that this should be the basis for my finding on when the accident resulting in death occurred.

Section 26(2)(c) The cause or causes of death

[77] It was a matter of agreement that the cause of death, based on toxicological analysis and Steve Critchlow's evidence, was "I.(a) Carbon Monoxide Poisoning (Domestic Gas Heater)."

26(2)(d) The cause or causes of any accident resulting in the death

Crown submissions

[78] The Crown submitted the cause of the accident resulting in the death was exposure of Mr Hill to dangerous levels of carbon monoxide attributable to the crack in the ceramic plaques of the heater within the bathroom of the cottage. The Crown went on to submit that, "Such occurred in the context of the improper presence of said heater in the bathroom, and other heaters there also, in circumstances where no such heater of that type could be safely used there due to the size of the rooms, and absence of ventilation."

Burghill Farms submissions

[79] Ms Bone adopted the Crown' submissions so far as relating to the heater within the bathroom. It was said there was no evidence that the other heaters caused or contributed to the accident involving Mr Hill. Mr Critchlow's evidence was that none of the rooms in the cottage were of sufficient size or ventilation to allow for the use of such heaters. Further, in relation to the bathroom, a flueless appliance, such as the cabinet heater, would create an immediately dangerous situation. What emerged during the Inquiry is that the dangers of placing a mobile cabinet heater in a small room, particularly a bathroom, were largely unknown to many witnesses before the accident.

Piers Le Cheminant submissions

[80] Mr Logue submitted the cause of the accident was exposure to fatal levels of carbon monoxide by a portable gas heater. The Crown submissions regarding other heaters were criticised as on the evidence no other gas appliance contributed to the death of Mr Hill. Separately, it was not known when the crack in the plaque occurred. Mr Critchlow's evidence was that the Heater must have had a defect for the death to have occurred. The crack could have occurred before or after Mr Hill entered the bathroom on the day of the accident. Mr Critchlow's evidence was that ceramic plaque is brittle, it could break if dropped. The Crown accepted that the crack may not have been visible when Mr Murray attended the premises on 22 October 2015. In relation to the Crown's submissions on other heaters in the cottage, Mr Critchlow's evidence was that no other gas appliance contributed to the death of Mr Hill.

Scott Murray submissions

[81] Mr Hennessy generally took no issue with the proposed finding in terms of Sections 26(2)(d) but did take issue with the Crown's reference to "other heaters there also." It was submitted that setting out context was not appropriate.

HSE submissions

[82] Ms McCabe submitted that cause of the accident was the exposure to dangerous levels of carbon monoxide attributable to the heater.

Analysis and determination on section 26(2)(d)

[83] With regard to the cause or causes of any accident resulting in the death in terms of section 26(2)(d) of the Act, it seemed to me that there were four key points:

1. The crack in the plaque.
2. Water vapour or steam in the Bathroom.
3. Limited room volume.
4. No purpose provided ventilation.

[84] Put short, the crack in the plaque compromised combustion leading to the production of large quantities of carbon monoxide. The water vapour or steam in the room is likely to have exacerbated that compromised combustion and led to greater levels of oxygen depletion. The limited room volume and lack of purpose provided ventilation would have prevented the dilution of carbon monoxide in the room.

[85] Taking each of these issues in turn. The events of 28 October 2015, the post mortem examination and the HSL testing of the heater demonstrate overwhelmingly in my view that the crack in the plaque was the fault that compromised the heater's combustion leading to the emission of carbon monoxide. The activation of the carbon monoxide alarm on 18 October 2015 and 27 October 2015 combined with the effects on Mrs Hancock's eyes and Mr Hancock's observations of the flame also lead me to the conclusion that the crack was present at these times as well.

[86] There was agreement that it was "not known when the crack developed" and "it was not possible to establish how the crack had been caused." It was plain to me that this was merely an agreement that the point in time (and event) when the crack was

caused could not be identified. It was still open to me to conclude that the crack was present on the key dates of 18 October 2015, 22 October 2015, 27 October 2015 and 28 October 2015. The evidence clearly indicated that it was.

[87] The only evidence which suggested the crack may not have been present at these times, at least on 22 October 2015 and before, was the evidence of Scott Murray that he "checked" the heater on the 22 October 2015 and he did not see a crack. For the reasons already set out, I had concerns about Scott Murray's evidence in this regard. His "check" of the heater consisted of what at best could be described as a cursory visual inspection. Mr Critchlow explained that the crack could have started as a hairline crack and progressed over time. Mr Critchlow also said the fault caused by the crack was intermittent and he had operated the heater without it taking place during his testing. When the fault first manifested during testing at the HSL it was after five minutes of operation. When it was taken back to the bathroom for further testing again it manifested after five minutes. Mr Murray claimed he watched the heater operate for "two or three minutes" from a standing position through the grill. These are circumstances in which the crack could easily have been missed or have been at a stage in its development that it was not immediately visually apparent (especially given the restricted view he had). There were numerous examples of gas safety issues in the cottage that Scott Murray had missed or had done nothing about and it seemed to me he could easily have missed this issue as well. Accordingly, the accident resulting in Mr Hill's death was the excessive production of carbon monoxide by the heater. The cause of that accident was the crack in the plaque.

[88] I rejected the Crown's suggestions on "context." That does not strike me as the appropriate finding here. For one thing, particularly in the circumstances of this case, it would be difficult to see where the line should be drawn on any "context" of a cause. I agreed with the submissions that the other heaters in the cottage were not relevant to a determination under this head. In my view, the other factors referred to as "context" were "exacerbating" factors that should more appropriately be characterised as other facts relevant to the circumstances of the death in terms of section 26(2)(g) of the Act.

[89] In that regard, flueless appliances should not be operated in bathrooms due to the presence of water vapour and/or steam which has the ability to affect combustion and deplete the amount of available oxygen. Mr Hill was running a bath at the time of the accident and Jensen Beard referred to the presence of steam on breaking open the door. Mr Critchlow made it clear in his evidence that this would exacerbate the compromised combustion caused by the crack. The heater required volume and ventilation for safe use. The bathroom was approximately one quarter of the size it needed to be to safely house the heater and there was no purpose provided ventilation. Even the window in the bathroom could not be opened. A sufficient room size and purpose provided ventilation would have diluted the build-up of carbon monoxide.

Section 26(2)(e) – Any precautions which could reasonably have been taken, and, had they been taken, might reasonably have resulted in the death or any accident resulting in the death being avoided

Crown submissions

[90] The Crown submitted:

a. There could have been a system of maintenance in place conform to the requirements of Regulations 35 and 36 of the 1998 Regulations and the Approved Codes of Practice in force. Such a system of maintenance, carried out by a person with appropriate qualifications and skills, would have created the opportunity for the heater to be removed from the cottage. Servicing should not have been less frequently than annual. There should also have been reactive maintenance, taking the carbon monoxide alarm seriously and making proper investigations.

b. The gas cabinet heaters could "not to have been used as a means of providing heat at the Cottage at all." A competent gas engineer would have recognised the lack of volume and ventilation and steps could have been taken to remove the heaters from service. It was said that "because of the mobile nature of such heaters, the Inquiry's interest can be properly directed at the other heaters in the building."

c. Scott Murray could have provided advice that the heaters were not suitable for use in the Cottage or at least to have provided advice in respect of the issue of minimum room sizes and the fact such heaters

posed a risk in bathrooms. Although he said he was ignorant of these issues (and did not have the requisite qualifications), Mr Critchlow said he should have known of these issues.

d. "Residents" could have been provided information on what to do in the event of a carbon monoxide alarm activating. There were discussion amongst the Beard family and Mr Hill about what to do following the sounding of the carbon monoxide alarm on 27 October 2015. Options appear to have included seeking external help or shutting off heaters. While the latter aspect may very well have reduced the risks, it should not be left to holiday makers to make safety critical judgements on such matters. While Mr Beard was equivocal in respect of whether he would have followed instructions had they been visible on a notice board, Mrs Beard was not.

Burghill Farm submissions

[91] Ms Bone submitted a more robust system of annual inspection could have been in place to ensure all gas appliances were checked annually by a properly qualified Gas Safe registered engineer. Whilst Burghill Farms had delegated responsibility for gas safety and annual gas safety checks to Mr Le Cheminant and were aware a gas engineer was attending the cottage, it is accepted that they did not have a robust system in place for ensuring such checks were indeed being carried out such as requesting copy certificates which would evidence such checks being properly carried out by properly

qualified gas engineers. Had they such a system in place, it would have become apparent the cabinet heaters were not subject to an annual check. If a competent gas engineer had then been engaged to carry out such a check, the heaters would have been identified by that engineer as not suitable for use and removed from the bathroom (and cottage). Mr Cooke said in evidence more should have been done by them to satisfy themselves that annual gas checks were being carried out. It was not possible to delegate all responsibility to Mr Le Cheminant. Burghill farms were not aware a specific qualification was required for cabinet heaters and that Mr Murray did not possess this. A more formal system of requesting copies of the annual gas safety checks may have identified issues with gas safety. A more formal agreement with Mr Le Cheminant may have avoided any misunderstanding. Mr Cooke and Burghill Farms were not aware of the issues raised by Mr Hancock and would not require to be told of that nor the reactive maintenance following thereafter. However, it was inappropriate for the Crown to suggest a finding that Burghill Farms did not comply with its Regulation 36 duties as that would amount to a finding of criminal liability. Criminal responsibility was dealt with when Burghill Farms pled guilty to a "non-causative breach" (as agreed).

[92] Another reasonable precaution would have been not to use the cabinet heaters in the cottage as a means of heating. What emerged during the Inquiry is that the dangers of placing a mobile cabinet heater in a small room, particularly a bathroom, were largely unknown to many witnesses before the accident. Mr Critchlow observed that such heaters need to be in a large room, with adequate ventilation but that, in his experience, people put them in a small room and closed the windows. The issues at Glenmark

Cottage, in terms of knowledge of limitations, are not therefore unique but perhaps reflective of a wider public ignorance.

Piers Le Cheminant submissions

[93] It was submitted that when a specific issue with the bathroom heater arose (the popping sounds reported), Mr Le Cheminant gave prompt instruction to a gas engineer to investigate. The gas engineer visited the Cottage and no adverse finding was reported back to Mr Le Cheminant. It was not known to Mr Le Cheminant that the engineer was not qualified to inspect the Heater. No one stayed at the property overnight before it was checked by a Gas Safe registered engineer. Mr Le Cheminant has not paid rent on the Cottage since 2016. Mr Le Cheminant's lease of the Cottage ended before the start of the inquiry. It was submitted that an FAI is an exercise in applying the wisdom of hindsight. The inquiry has no power to apportion blame amongst persons or organisations that might have contributed to the accident. The aim is to prevent further accidents or deaths occurring in similar circumstances. It was hoped the inquiry would further emphasise the need for the general public, landlords and gas engineers to be aware of the dangers mobile gas heaters pose when used in (i) bathrooms, (ii) rooms of insufficient volume or (iii) rooms of insufficient ventilation and the requirement to have an annual safety check mobile gas heaters.

[94] Mr Logue said the court was aware that criminal proceedings were brought against Mr Le Cheminant and Burghill Farms in respect of respective failures under regulations 35 and 36 of the Gas Safety (Installation and Use) Regulations 1998 and

section 33(1)(c) of the Health & Safety at Work Act 1974. The proceedings were disposed of by way of an agreed crown narrative and pleas in mitigation at Dundee Sheriff Court on the 8th and 27th October 2021 and fines were imposed. As was outlined in the crown narrative for the prosecution the admitted breaches of both accused were expressly non-causative in the death of Mr Hill. Taking into account what has already been covered in the prosecution, it was respectfully suggested that the inquiry should focus on what has not yet been explored. In relation to the Crown's submissions in relation to the system of maintenance, the court may consider that this has already been dealt with by the court by way of a criminal prosecution. Instead, precautions which could have reasonably been taken were (i) to remove the portable gas heater from the bathroom and (ii) attach a warning sticker to the portable gas heater informing users that it must not be used in a bathroom.

Scott Murray submissions

[95] It was submitted by Mr Hennessy that there was clear evidence before the Inquiry that apart from the stove, mobile cabinet heaters were the only source of heat for the Cottage and there was no viable alternative. Mr Murray had provided some advice relative to the heaters by expressing concerns about the number of gas bottles in the cottage and his concerns were not acted upon. He was told there was no prospect of an alternative power source. Had he provided more specific advice about the unsuitability of the heaters, Mr Le Cheminant was not obliged to follow it and it was not likely he would have done so. Mr Murray was not trained or qualified to work on mobile cabinet

heaters and did not know the room volume and ventilation requirements. It was not a breach of the 1998 Regulations to use a mobile cabinet heater in a bathroom.

[96] Accordingly, it was submitted that it would not have been a reasonable precaution for Scott Murray to give advice as suggested by the Crown. It was submitted that a FAI is not a forum for determining an individual to be at fault on the basis of an alleged failure to take reasonable steps in the face of risks which they ought to have foreseen at the time.

HSE

[97] Under this heading, Ms McCabe invited the court to bear in mind that the purpose of an FAI is not to determine any question of civil or criminal liability and the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one … the phrase "might have been avoided" is a wide one … It means less than "would on the balance of probabilities have been avoided" and rather directs one's mind in the direction of lively possibilities. Reference was made to a number of authorities in relation to these propositions which were not controversial. The court must be satisfied:

a. that the precaution might (in the sense of a "lively possibility") have prevented the death; and

b. that the precaution was a reasonable one.

[98] Ms McCabe, on behalf of the HSE, invited the court to make no finding in terms of section 26(2)(e).

Analysis and determination in terms of section 26(2)(e)

[99] Breaking down the Crown's submissions, I am essentially invited by them to make a finding that four "reasonable precautions" could have been taken in terms of section 26(2)(e) of the Act. These were:

1. A system of maintenance could have been in place conform to the requirements of Regulations 35 and 36 of the 1998 Regulations and the Approved Codes of Practice in force.
2. All gas cabinet heaters could have been removed from the cottage.
3. Scott Murray could have advised Piers Le Cheminant of the dangers associated with the gas cabinet heater being located in the bathroom.
4. Advice and guidance could have been made available to "residents" on what to do in the event of a carbon monoxide alarm sounding.

[100] It seems to me that the key to understanding the issue of "reasonable precautions" in this case is the simple observation that the mobile gas cabinet heater should not have been in the bathroom (or the cottage for that matter). If the heater was not there, Thomas Hill's death would have been avoided. The removal of the heater from the bathroom would have created more than a "lively possibility" of preventing the death. The task then is to consider reasonable precautions which could have resulted in that happening. With this in mind, it makes sense to deal with each in a slightly different order than the Crown did.

Removal of the heaters

[101] The simplest precaution that could reasonably have been taken, therefore, was to just remove the heater from the bathroom. Since all of the gas cabinet heaters in the cottage were portable and none of the rooms in the cottage were sufficient in volume or ventilation to house any one of them, I agreed that the interest of the inquiry could be extended to other heaters and throughout the cottage. Therefore the first reasonable precaution that could have been taken would have been to remove the heater from the bathroom and thereafter all of the mobile gas cabinet heaters from the cottage.

Gas safety system

[102] There could reasonably have been a system of maintenance, repair and renewal of all gas appliances and installations at the cottage by a suitably qualified gas engineer. Steve Critchlow's evidence demonstrated that there would have been a high degree of likelihood that any competent and qualified engineer would have advised the removal of the heater from the bathroom and the cottage due to the lack of room size and ventilation. I was satisfied from Richard Cooke and Piers Le Cheminant's evidence that they would have acted on any such advice and removed the heaters.

[103] I rejected Mr Logue's suggestion that the issue had been dealt with in the criminal proceedings and the court should move onto issues "not yet explored." This would be to avoid a crucial chapter at the heart of the inquiry's function in this case. I also found it difficult to understand the submissions made by Ms Bone that the court should avoid saying any such system of maintenance should be conform to

Regulations 35 and 36 of GSIUR because that would be tantamount to the court finding "fault." This was a case where it was agreed before me that Burghill Farms had tendered a plea of guilty to a criminal charge on indictment in this regard although I noted Ms Bone wished to emphasise that these pleas were on a "non-causative basis."

[104] However, as it happens, in the context of this case, I do not feel I have to form a concluded view on this point. It seems to me preferable, from the point of view of clarity, to make a determination that stands alone and can easily be understood without making reference to other regulations or codes of practice as a short hand means of articulating the precaution. I agree with Ms Bone's submissions on why a robust system of maintenance could be a reasonable precaution under this section.

Scott Murray advice

[105] If advice from a gas engineer could have resulted in the heaters being removed, it is understandable why the Crown then say Scott Murray could have given that advice. The difficulty is that Scott Murray could not have given that advice because there was no reliable evidence that he had the ability to give that advice. His position was not quite as clear cut as the Crown suggested. He alluded to some knowledge about the dangers of flueless appliances in bathrooms and accepted he may have had some knowledge about room size and ventilation at the time. But it was impossible to place any reliance on Scott Murray's evidence when it came to his knowledge of gas safety matters.

[106] A precaution that could reasonably have been taken, though, was for Scott Murray to properly understand his own qualifications and properly communicate them to his customers. It seems to me clear from the evidence that Piers Le Cheminant and Richard Cooke took a false reassurance from the fact that Scott Murray was a Gas Safe registered gas engineer (as did Mark Beard). If Scott Murray told Richard Cooke or Piers Le Cheminant he was not qualified to work on mobile gas cabinet heaters or domestic premises, that would have alerted both men to the "nuances" of gas work qualifications and I am satisfied on their evidence that this could have led to them instructing a suitably qualified gas engineer to carry out the checks on the heaters.

Advice and guidance

[107] It is only the final precaution that does not deal with removal of the heater. There was evidence of three instances when the carbon monoxide alarm in the cottage had sounded. The first was when Piers Le Cheminant himself was staying at the cottage the previous season. This could have prompted him to make further investigations at that time and to consider an appropriate response. The fact that the cottage was in a remote location made the issue of considering safety responses more acute in my view. I agreed that it was not appropriate that holiday makers be left to make safety critical decisions under pressurised situations.

[108] It was also clear that there was a general lack of awareness about what to do in the event of a carbon monoxide alarm sounding. Mark Beard, having some technical skill, gave all of those at the cottage on 27 October 2015 the false impression that he had

the situation under control as I have set out more fully above. Alita Beard said it absolutely would have impacted on the way she reacted to the situation. It would also have put Alita Beard, Charlotte Beard and Mr Hill on a sounder footing to challenge Mark Beard's misplaced attempts to address the issue by his own methods. I make my findings here accordingly.

Section 26(2)(f) – Any defects in any system of working which contributed to the death or any accident resulting in the death

Crown submissions

[109] The Crown proceeded on the understanding that a clear causal connection is required for such a finding to be made. The Crown invited the court to find that there were a number of defects in the system of work which contributed to Mr Hill's death. These were:

1. The absence of a system of proactive and reactive maintenance conform to the requirements of Regulations 35 and 36 of the 1998 Regulations, and associated guidance, which system would have resulted in the removal of the heaters from the cottage.
2. Allied to the foregoing, the presence of the heater within the bathroom of the cottage there.
3. Further, the failure by Mr Le Cheminant to take appropriate steps in light of the carbon monoxide alarm sounding during the Hancock's visit.

4. The failure of Mr Murray to provide advice re the siting of such a heater in the bathroom, and the implications of minimum room volumes.
5. The absence of guidance as to the steps to be taken by holidaymakers at the cottage should a carbon monoxide alarm sound.

Burghill Farm submissions

[110] Ms Bone acknowledged, as with the above submission, the failure on the part of Burghill Farms to have a more robust system of annual inspection in place to ensure all gas appliances were checked annually by a properly qualified Gas Safe registered engineer. It was acknowledged that if this had been in place the heaters ought to have been removed from the cottage due to limitations in the size of its rooms and the ventilation offered. The same point was reiterated with regards the Crown referencing compliance or otherwise with Regulation 36 duties.

Piers Le Cheminant submissions

[111] Mr Logue said his submissions on precautions might equally be identified as defects in the system of working.

Scott Murray submissions

[112] Mr Hennessy simply said he reiterated the same submissions as under the previous heading.

HSE submissions

[113] Ms McCabe pointed out that the same considerations arise here as in relation to the previous heading and invited the court to make no finding.

Analysis and determination 26(2)(f)

[114] Similar considerations arise in relation to this question as arose in relation to my finding under section 26(1)(e) of the Act. It seemed to me:

1. The system Burghill Farms and Piers Le Cheminant had for gas safety at the cottage was deficient and there was absent an effective system of maintenance, repair and renewal of gas applications and installations at the cottage by a suitably qualified gas engineer and the system which they did have in relation to gas safety, in failing to achieve such a system, was deficient.
2. Scott Murray did not have an effective system for understanding his own qualifications and ensuring that Piers Le Cheminant and Richard Cooke understood that he was not qualified to carry out gas work on domestic premises or mobile gas cabinet heaters.
3. There was no written advice and guidance available to guests at the cottage on what to do in the event of a carbon monoxide alarm.

[115] I am satisfied that each of these defects in a system of working contributed to the death or the accident resulting in the death of Mr Hill. As discussed above, if Burghill Farms and Piers Le Cheminant had a robust gas safety system in place this could have

ensured a suitably qualified engineer inspected the heaters at the cottage and would have resulted in advice being given to have the heater removed from the cottage. If Scott Murray advised Piers Le Cheminant of his lack of qualifications this could have led to the employment of a suitably qualified gas engineer with the same result. If advice and guidance had been available to guests this could have resulted in an appropriate response giving rise to a proper inspection of the property to identify the source of carbon monoxide.

Section 26(2)(g) – Any other facts which are relevant to the circumstances of the death

Crown Submissions

[116] Mr Critchlow's evidence referred to the training and competence requirements for persons in Mr Murray's position. The Crown noted that for 'sole operators' there might be an argument that more frequent refresher training may be helpful. Mr Critchlow was careful to categorise that as being his personal opinion. The Crown did not make a formal recommendation and suggested

> "if the court was amenable to this it may be indicated under this head that the Health and Safety Executive and Gas Safe Register may wish to give some consideration to that question."

[117] The Inquiry revealed a general lack of awareness of carbon monoxide issues. It might be hoped that it would raise awareness of the gas emergency line which Mr Critchlow referred to. This is a free service, and as he said, can be used without judgement and should be used without hesitation. The Crown would urge people so to do if they suspect carbon monoxide could be present.

Burghill Farms submissions

[118] Mr Murray did not have the appropriate qualifications to carry out gas work nor to perform an annual inspection on the mobile cabinet heaters within the cottage albeit this was unknown to Richard Cooke. Mr Critchlow advised that enquiries he made with Gas Safe Register in 2015 revealed that of 11,600 registered gas engineers in Scotland only 8 were qualified to work on cabinet heaters. Even then some of those engineers may be trainers and thus not commercially available. It would therefore seem difficult for landlords with such cabinet heaters in their premises to meet their gas safety requirements it being hard to identify a suitably qualified engineer and one within a reasonable distance of their property. Mr Critchlow acknowledged that cabinet heaters are simple devices and accepted that 7-8 questions on cabinet heaters could be incorporated into general gas safety training quite easily allowing for more competent engineers to work on such heaters at a landlord's request. It was suggested that this may be something, in addition to comments made by the Crown in respect of refresher training for Gas Safe registration, the court would wish to consider as part of the determination.

Piers Le Cheminant submissions

[119] No submissions were made in this regard

Scott Murray submissions

[120] Mr Hennessy made a number of submissions under this head. It was submitted that the vast majority of the Gas Safety (Installation and Use) Regulations 1998 do not apply to mobile cabinet heaters. In particular, Regulation 30 does not apply. GIUSP provides best practice guidance. The law prevails over such guidance. The bathroom heater was fitted with an Atmospheric Sending Device (ASD) which is designed to shut the appliance off in the event of oxygen levels depleting below a safe limit.
Mr Critchlow did not take the ASD test on 3 November 2015 to fruition. No obvious defect was found with the ASD. However, in the circumstances of Mr Hill's death, "it has not afforded the level of protection one would hope." Had the bathroom heater not been in a defective condition, Mr Hill's "death would not have occurred or was unlikely." Any qualified gas engineer would have identified the presence of the heater in the bathroom as being At Risk and ought to have applied a warning notice. No gas engineer has the ability to prohibit use of an appliance completely. There were as many as three other gas safe registered and qualified engineers carrying out work at the Cottage in the period since Mr Murray began his annual work in around 2007. Unnamed engineers were involved in fitting (i) a new wall mounted water heater and (ii) in carrying out work to fit a flue to the gas powered fridge. Mr Hennessy named two others that attended the cottage in different capacities. They did not affix warning notices to any gas appliances in the Cottage, including the heaters.

Analysis and determination in terms of section 26(2)(g)

[121] Again, I accepted the general premise of the Crown's submissions if not the detail. It seemed to me Mr Critchlow's opinion on training and a lack of awareness of what to do when a carbon monoxide alarm sounds were relevant. With regards to submissions made by other parties my view is as follows. Mr Murray's lack of qualifications have been dealt with elsewhere. Training on gas cabinet heaters fell to be incorporated into the wider issue of training. The relevance of the ASD was not established on the evidence (a simple device designed as a secondary safety feature which by its nature has limited capacity to sense the room atmosphere as it is near ground level). The fact the bathroom heater was in a defective condition is clearly dealt with under other headings. Mr Henessey's submissions about other gas engineers has no relevance, there was no evidence that any other gas engineer had the level of contact and involvement with the gas appliances at the cottage (and the heaters in particular) that Scott Murray did nor were they directly instructed to check the gas appliances in the context he was. A gas engineer being unable to prohibit use of an appliance could possibly be relevant in circumstances where advice was tendered and ignored but I was not satisfied that Scott Murray did not give any advice or warnings to Piers Le Cheminant and/or Richard Cooke regarding the gas appliances at the cottage.

[122] I was satisfied the general nature of mobile gas cabinet heaters and their requirements for safe use and the lack of awareness as to how to respond to carbon monoxide alarms were relevant to the circumstances of the death. The training issues mentioned are dealt with below. One issue not mentioned by parties was the issue of

the carbon monoxide alarm. It was not properly installed and was sitting on a worktop near a vent for the gas fridge. That was part of the picture in terms of Mark Beard's mistaken assumption that the alarm was triggered by the fridge. Mr Critchlow also gave evidence about why there are instructions on how to install these alarms. Proper installation of carbon monoxide alarms is therefore also relevant in my view.

[123] Finally, I was satisfied that the exclusion of mobile gas cabinet heaters from the prohibition on flueless appliances in bathrooms in terms of Regulation 30 GSIUR was a relevant fact. The HSE take the view that the inclusion of mobile gas cabinet heaters in this prohibition would lead to enforceability issues and members of the public being caught by Health and Safety legislation. This means this particular issue crosses into the realms of consumer safety and no evidence was led in that regard before this inquiry. Nonetheless, it is relevant to the circumstances of the death.

Section 26(1)(b) and (4)(a) – The taking of reasonable precautions which might realistically prevent other deaths in similar circumstances

[124] The Crown submitted holiday let operators should consider the risks and duties associated with the use of gas appliances including mobile gas appliances and, in particular, consider providing specific advice on (i) steps to be taken if a carbon monoxide alarm sounds, and (ii) in relation to the use and location of such heaters. There is guidance available online. It may be appropriate for information on not removing them from the room they are in and not placing them in a bedroom or bathroom.

[125] The Department of Work and Pensions and the UK government could consider whether all forms of holiday let arrangements should be captured under the current Regulation 36 duties, whether Regulations (in particular Regulations 30 and 34) should apply to mobile cabinet gas heaters and if the review can take place ahead of the current planned schedule.

[126] The applicability of Regulation 36 of the 1998 Regulations differs in Scotland from that in England and Wales. Put shortly, in England and Wales these duties broadly apply to landlords in a lease situation, but also (generally) in a license (Regulation 36(1)(a)(i) and (ii)) situation. In Scotland, there is no corresponding applicability to licenses (Regulation 36(1)(b)). One issue which arises is whether all holiday let situations in Scotland amount to tenancies, such as to always take a person providing short term holiday lets within the ambit of Regulation 36. The situation is not as clear as may be desirable. Mr Baker acknowledged that issue. There was authority for the proposition that holiday lets are a form of tenancy for the purposes of Regulation 36 (Paragraph 8 of Schedule 4 to the Housing (Scotland) Act 1988); Schedule 1 to the Private Housing (Tenancies) (Scotland) Act 2016; *St Andrews Forest Lodges Ltd* v *Jeremy Grieve and Iona Grieve* [2017] SC DUN 25). If holiday lets were tenancies, the Regulation 36 duties would apply. If not, section 3 of the Health and Safety at Work Etc. Act 1974, Regulation 3 of the Management of Health and Safety at Work Regulations 1999, and Regulation 35 of the 1998 Regulations should provide a basis for holding to account operators under license (though in the context of Regulation 35, that would be conditional on there being evidence that the locus was a

place of work). On safety critical matters such as gas safety, ambiguity as to the applicability of safety responsibilities should be avoided.

[127] The issue relating to Regulation 30 and the evolution of the definition of gas appliances through various sets of Regulations in the 1980s and 1990s was explored by Mr Baker. The upshot of HSE's research, however, was that it has not been possible to ascertain why a decision has been taken to exclude mobile gas heaters from the definition, save for the purposes of Regulations 3, 35 and 36 of the 1998 Regulations. Possible reasons are postulated dealing with potential unintended consequences of such a measure. Mr Baker recognises that the formulation of the 1998 Regulations means that such heaters are not captured by the "ban" in terms of Regulation 30. Given the risks posed by the presence of such heaters in bathrooms, the non-application of Regulation 30 to mobile cabinet heaters was worthy of some consideration. Absent compelling reasons to the contrary, consideration should be given to extending the application of more of the regulations to cover such heaters. Indeed, it might be that some of those unintended consequences could be avoided if such application was restricted to rented properties or similar. Regulation 34, which places duties on gas engineers to provide information about dangers posed by gas appliances to persons responsible for premises, should similarly apply to mobile gas cabinet heaters.

[128] The 1998 Regulations are due to be reviewed in 2026 and the applicability of Regulation 36 to short term holiday lets in Scotland would be considered at that time. Such a review should take place as soon as possible, to enhance clarity of understanding of those involved in this market in Scotland of what their responsibilities are.

[129] The new licensing regime of short term lets was explored in evidence, it requires an annual gas safety inspection and requires that if the requisite safety standard is not met the property cannot be let until any remedial works have been carried out. There is a requirement to display fire, gas and electrical safety information. The court might consider that local authorities, as issuers of licenses under the new regime, might have a part to play in encouraging the provision of such information. This point was considered by Steven Thomson (Team Leader, Environmental Protection from Angus Council) who explained;

> "Where there is a lack of detailed guidance on a subject there is scope for individuals and Local Authorities to interpret requirements differently … although there is a requirement to have a CO alarm it would be prudent to require hosts to prepare and make available to guests, an emergency plan which could include what the symptoms of CO poisoning are and what to do if the alarm goes off. Currently this is not a specific requirement of the mandatory conditions or included in the relevant guidance."

[130] The Crown "endorsed" these comments. Local authorities in Scotland could consider making it a condition of short term let licenses that license holders provide specific information to persons using said properties as to what to do in the event of a carbon monoxide alarm sounding.

Burghill Farms submissions

[131] No submissions were made

Piers Le Cheminant submissions

[132] In relation to the Crown's submissions on extending Regulation 30 to mobile gas heaters it was suggested that the inquiry had not heard sufficient evidence in relation to the wider implications that extending the Regulations may have. Reference was made to Mr Baker's evidence in which he set out a number of practical difficulties HSE would have in enforcing Regulation 30 if it were to be extended to mobile gas heaters.

Scott Murray submissions

[133] No submissions were made.

HSE submissions

[134] Evidence was heard from Barry Baker that the 1998 Regulations will be reviewed in 2026 by HSE colleagues in policy and legal services. Insofar as short term lets were concerned, Mr Baker advised that application of the Regulations to short term lets will feature in that review process. In any event, the Civic Government (Scotland) Act 1982 (Licensing of Short-term Lets) Order 2022 ("the 2022 Order") (which came into force on 1 March 2022) provides that the use of accommodation for a short term let is an activity for which a licence is required under the Civic Government (Scotland) Act 1982. The 2022 Order also brings short term lets into the Repairing Standard regime. Section 12(f) of the Housing (Scotland) Act 2006 has been amended to reflect this. The Repairing Standard includes an obligation to carry out gas servicing and the provision of carbon monoxide detection. The 2022 Order provides for mandatory licence conditions which

focus on the health and safety of occupiers. These include as a condition of licence that the licence holder must arrange for an annual gas safety inspection of, *inter alia*, all gas appliances in the property. If, after an annual inspection, any appliance does not meet the required safety standard, the licence must not grant a short term let until the works necessary to bring the appliance to the required safety standard have been carried out.

[135] Insofar as mobile cabinet heaters were concerned, Mr Baker explained that there is a difference between health and safety legislation around occupational risk management (which is within the remit of the HSE) and consumer legislative issues. He further explained that if additional regulatory duties applied to mobile cabinet heaters (as suggested by the Crown) then an ordinary member of the public could put such a heater somewhere inappropriate and commit an offence (under occupational health and safety legislation). There are obvious difficulties surrounding the enforceability of such an offence and, in any event, would not be a matter for the HSE. Mr Baker's clear view was that "widening it to consumer risk wouldn't be helpful". The Inquiry heard no competing evidence that widening the Regulations would, conversely, be helpful.

[136] Finally, as far as bringing the review forward is concerned, it is submitted that no such recommendation ought to be made as there is no scope for the review to be undertaken more quickly. Mr Baker gave evidence that it has been planned for 2026 due to developments with housing and net zero considerations and there is a demand on the HSE in terms of EU retained legislation and the requirement to work with the government legal department.

[137] The Crown also made reference to training and competence requirements for persons in Scott Murray's position. Whilst no formal recommendation was sought, the HSE's position was that, in any event, this is a question for Gas Safe Register whom it is noted did not receive intimation of this Inquiry. Indeed, Mr Baker gave evidence that the HSE does not get involved in training given to gas engineers as Gas Safe Register are "very much in control of the registration regime".

Analysis and determination in terms of section 26(1)(b) and (4)(a)

Regulation 36

[138] It was recognised by HSE that there was ambiguity in terms of the applicability of Regulation 36 to holiday lets in Scotland. Barry Baker, on behalf of the HSE indicated that there is a forthcoming review of the Regulations scheduled for 2026. The issue regarding the applicability of Regulation 36 to holiday lets in Scotland is to be addressed at that review. On this basis, and in light of the new licensing regime, Ms McCabe for the HSE submits that any recommendation to that effect is not necessary. There was no suggestion in this case that ambiguity in Regulation 36 of the GSIUR played any part in the death of Mr Hill. Matters have moved on significantly since 2015 as set out in Ms McCabe's submissions and HSE clearly indicated their intention to address this issue. The invitation of the Crown does not, in my view, meet the statutory test.

Public awareness

[139] The carbon monoxide alarm sounded three times. Once the previous season when Piers Le Cheminant was staying at the cottage himself. Once when the Hancocks were staying at the cottage on 18 October 2015 and finally on 27 October 2015 when the four members of the Beard family and Mr Hill were present. Eight people therefore heard the carbon monoxide alarm sound in the cottage. They all seemed to be unaware of the official guidance on what to do.

[140] In addition to this there was widespread lack of awareness about the potential dangers posed by mobile gas cabinet heaters in the event of a malfunction. A number of witnesses had anecdotes of their experience with these heaters and expressed surprise at the consequences of malfunction. There was apparent widespread lack of awareness about the volume and ventilation requirements. Mr Critchlow described the "paradoxical" nature of these heaters. They were often used for back up or emergency heating. In those circumstances, people wanted to be warm and were therefore not minded to have them in large rooms with a "hole in the wall" or a window open.

[141] The Crown invite the court to make recommendations to operators of holiday letting accommodation as a group but it seems to me the Crown's submissions in this regard are too wide and vague. The introduction of a licensing regime for holiday lets administered by Local Authorities seems to me to offer an opportunity to make a more effective and practical recommendation. The appropriate location of mobile gas cabinet heaters and their safety will be dealt with by the requirement for inspections and the repairing standard. However, I am persuaded by the Crown's submission that a

recommendation should be made here that Local Authorities in Scotland consider making it a condition of granting a licence in terms of this order that specific gas safety information be provided to guests, namely:

1. Written advice and guidance on the symptoms of carbon monoxide poisoning and what to do in the event of a carbon monoxide alarm sounding.
2. If there is a mobile gas cabinet heater in the accommodation, the manufacturer's instruction manual should be provided and guests should be advised that it should not be moved.

Training

[142] Mr Critchlow in his evidence said that it may be worth considering more frequent training or continuing professional development for small business owners and sole practitioners. There were very few gas engineers in Scotland qualified to work on mobile gas cabinet heaters (in 2015 there were 8 out of 11,600 engineers) and that the length of the course relating to these heaters was relatively short, the Gas Safe Register should consider making mobile gas cabinet heaters part of the core course that all gas engineers must complete.

[143] The Gas Safe Register were not participants in the Inquiry and no service had been made on them. Ultimately, there was no requirement for this court to look at the training of gas engineers. In terms of training, Scott Murray did not have the necessary qualifications to carry out work on domestic premises or mobile gas cabinet heaters.

There were also clear gaps in his own knowledge (bearing in mind the passage of time since 2015 and the fact that he no longer worked as a gas engineer at all). There was no evidence to suggest that the issues seen here were anything other than personal to Scott Murray and there was no evidence to suggest these were due to issues with the Gas Safe Register training arrangements.

[144] Mr Critchlow was careful to point out in this particular case he had dealt with one specific gas engineer so it was difficult to draw conclusions about training in general. There is therefore no basis for me to make specific recommendations to the Gas Safe Register in this regard.

Mobile gas cabinet heater exclusions from Regulation 30

[145] The Crown invited me to recommend that DWP and HSE consider reviewing the exceptions to the prohibition on flueless appliances in bathrooms and shower rooms that apply to mobile gas cabinet heaters in terms of the regulations. Mr Baker gave a clear indication as to the HSE view on this matter and the rationale behind the exclusion. The Crown make suggestions as to how "unintended consequences" might be addressed without having explored this with Mr Baker and having brought forth no other evidence in this regard. As Mr Baker has pointed out, this is a matter for those responsible for consumer safety and fell outside the scope of this inquiry which was concerned with the leasing and holiday letting context. Again, there was no evidence that this issue with the Regulations played any part in the death of Mr Hill. It was clear to me that this was not a case where no mention was made of the presence of the heater in the bathroom

because it was not fixed and therefore excluded from Regulation 30. The guiding document for gas engineers in these circumstances is GIUSP which makes the position clear.

[146] Neither was the exclusion in relation to Regulation 34 relevant in the context of this case since Scott Murray did not have the requisite qualifications to carry out the work he was carrying out and no reliance could be placed on him having the knowledge to raise any issues regarding the heater. Again, GIUSP applied and was not enacted. The issue was not sufficiently explored in evidence or in submissions by the Crown to give a basis for this recommendation.

Review schedule

[147] Finally, the Crown invite me to recommend that DWP and HSE carry out their review of GSIUR currently scheduled for 2026 at an earlier date. I am surprised at this invitation. Mr Baker gave an explanation of the scheduling of this review and the Crown did not question this during his evidence. There was no basis for the Crown to invite such a recommendation in my view.

The time taken to hold this inquiry

[148] A substantial period of time elapsed between the death of Mr Hill and this matter being brought to an inquiry. Charlotte Beard commented on the fact that this period of waiting for answers had been very difficult for her. Mr Hennessy raised the

point that the Inquiry took place 7 years and 4 months after Mr Hill's death and he submitted this had an impact on the ability of witnesses to recall details.

[149] Mr Hill's death did raise a number of complex issues and a number of reports had to be obtained. There was also an intervening solemn criminal prosecution. Efforts were made to expedite the inquiry once the matter was brought into court. A number of preliminary hearings called to ensure dates were fixed as soon as possible. Even with an unexpected and unavoidable last minute delay to the dates originally fixed, parties cooperated to ensure everything was in place and appropriate fresh dates could be scheduled for evidence to be heard. Parties agreed a Joint Minute which reduced the length of the inquiry. I am grateful to all involved for their efforts in this regard.

[150] Nonetheless, concerns will remain at the time taken to hold this inquiry. To that end, I asked the Crown to provide me with a detailed breakdown of the timeline. In the circumstances of this case, I feel it is appropriate to reproduce their response here:

> "It is acknowledged that a significant period of time has passed since Mr Hill's death. This period of time and other matters have been the subject of detailed correspondence between the parents of Mr Hill and COPFS. An initial Death Report was submitted to the Procurator Fiscal on 30 October 2015. This prompted a joint Police/HSE investigation, under the direction of COPFS. Personnel from the Health and Safety Investigation Unity (HSIU) attended various meetings in relation to this investigation as it progressed. Primacy was handed over to the HSE (from the Police) in December 2016. HSIU maintained contact with the HSE during the period prior to submission of the HSE report and had anticipated receipt of it in the autumn of 2017. The report from the HSE was ultimately received on 20.02.18. HSIU submitted a report for Crown Counsel's instructions within 9 months of receipt of that report on 29.11.18. Crown Counsel considered this matter and issued certain instructions on 19.12.18 and a specialist inspector's report was requested from HSE at that time.
>
> A draft of the report was provided to HSIU in July 2019, and the Depute preparing the case met within HSE to discuss the report on 30.09.2019.

[Explanation given on unavailability of Crown personnel - Crown made contact with HSE on 10.01.2020]. Further information was sought from HSIU by the Specialist Inspector on 04.02.2020, and this was provided the next day. It was understood that on receipt of comments from HSIU, the awaited report would be available shortly thereafter. This was later clarified to be an expectation that the report would be available in May. HSIU thereafter liaised with the HSE on a monthly basis until the report was available.

The specialist report was received and disclosed on 28.06.2020. The case was re-reported for Crown Counsel's Instructions within 3 months of receipt of the specialist report on 11.09.2020 and discussions between Crown Counsel and the Depute took place. Crown Counsel's instructions to prosecute on a non-causal basis were later received on 24.12.2020 and a draft charge and proposed agreed Crown narrative was sent to parties for consideration on 14.01.2021. A defence expert report was instructed, and the Crown enquired about the availability of that report bi-monthly until a copy was received on 28.05.2021. Proposals in respect of the charge and narrative were received from parties on 04.06.21 and a Crown revision was sent to parties on 23.06.21. The Crown enquired about this with parties on [throughout August and September]. Further proposals were received from parties on 15.09.21 and a meeting took place on 23.09.21. After further discussion between parties, Crown Counsel's Instructions were sought and obtained on 29.09.21 and parties confirmed the pleas that were later entered at court on 08.10.21. The deferred sentence in relation to the section 76 indictment called on 28.10.21.

…

The Depute was asked by the Head of HSIU on 23.12.2021 to make contact direct with the Sheriffdom Business Manager. [description of liaison with courts leading to First Notice lodged on 14 January 2022].

As stated, it is accepted that a significant period has passed between the commission of the offences and the pleas and FAI coming before the court. This was a complex matter which required careful investigation and legal consideration. A considerable amount of time in this case has been spent awaiting submission of various reports. HSIU management and HSE management were in communication regarding the reports and this case was monitored throughout. When the Crown had the various reports which were required to progress this case, steps were taken to ensure progression as soon as possible."

Conclusion

[151] Thomas Oliver Hill's death resulted from a concatenation of missed opportunities. The gas cabinet heater which caused his death passed the landlords, the tenant who was a holiday letting operator and a gas engineer. The carbon monoxide alarm sounded three times and a total of eight holidaymakers heard it. Each moment represented a step in the chain when Mr Hill's death might have been averted.

[152] Mr Hill's death was a tragic example of the dangers of carbon monoxide in general and the dangers of mobile gas cabinet heaters in particular. There is a suite of advice and guidance publically available in this regard. Mobile gas cabinet heaters have ceramic plaques which are brittle. When these plaques are compromised, the heaters can malfunction and produce dangerous levels of carbon monoxide. These heaters should never be placed in bathrooms or shower rooms where the water vapour and steam can compromise combustion. They should be placed in rooms of sufficient volume with purpose provided ventilation.

[153] At the time of Mr Hill's death a fairly robust system was already in place. The regulations placed duties on landlords and holiday letting operators. The Gas Safe Register provided a training course on mobile gas cabinet heaters and how engineers should respond when encountering safety issues whilst carrying out their duties. Guidance was publically available on how to respond to carbon monoxide alarms. And the carbon monoxide alarm, the last line of defence, did its job three times (even though it was not properly installed).

[154] Since the death of Mr Hill in 2015 the legal framework for gas safety in holiday letting accommodation has moved on substantially. The Civic Government (Scotland) Act 1982 (Licensing of Short-term Lets) Order 2022 will bolster gas safety in holiday letting accommodation. The DWP and HSE plan a review of gas regulations in 2026. It is to be hoped that the recommendations in this determination will serve to strengthen these additional steps.

[155] All of the participants expressed their condolences to Mr Hill's family. I wish to also express my deepest sympathies and condolences to Mr Hill's parents, Jeremy and Alison Hill, his brothers, Joseph and Joshua and his wider family as well as to Charlotte Beard, his partner at the time of his death.