

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT CUPAR

DETERMINATION in the Fatal Accident Inquiry by CHARLES MACNAIR, Esquire, Queen's Counsel, Sheriff of the Sheriffdom of Tayside, Central and Fife following an Inquiry held at Cupar into the death of Ainslie Alexander Smith, born 14 December 2008, resided at Priestfield Cottage, Pitlessie, Fife

CUPAR, 11 April 2013

The Sheriff, having resumed consideration makes the following determination.

1. That pursuant to Section 6(1)(a) Ainslie Alexander Smith, born 14 December 2008 died on 4 July 2009 between the hours of 20.30 and 22.30. Life was pronounced extinct at 0009 hours on Sunday 5 July 2009 at Victoria Hospital, Kirkcaldy.
2. That pursuant to Section 6(1)(b) the cause of death was asphyxia and mechanical upper airways obstruction.
3. That pursuant to Section 6(1)(c) the following are reasonable precautions whereby the accident might have been avoided:-
 - a. had the cot bed been designed and constructed so that the top part of split end at the foot of the cot bed could not separate from the remainder of the foot end once the cot bed had been constructed. This could have been achieved either by the screw fitting that was used in cot beds produced in

2009 or by the production, prior to the sale of this cot of the connector which was provided subsequent to the accident.

4. That pursuant to Section 6(1)(d) the following are defects in the system of working which contributed to the accident resulting in the death:-
 1. There was a failure during the design process to rectify the fault in the design of the Cosatto Stratford Cot bed. That fault was that the cot had a split foot end which was not secure and would move during normal use. Standard design and engineering techniques would have identified the defect and resulted in a modification of the design such as described above.
5. That pursuant to Section 6(1)(e) there are no other facts that are relevant to the circumstances of the death.

NOTE

INTRODUCTION

At about half past eight in the evening Mrs Smith put her seven month old son Ainslie to bed in a newly purchased Cosatto Stratford Cot bed. When she returned at about half past ten Ainslie had died. This inquiry was held into that tragic and unnecessary death.

On the morning of the first day of the Inquiry the Crown sought to add a further witness to the Crown witness list. I was advised that this witness who was an officer of Fife Trading Standards who was to give evidence about the notification made by the company in relation to a modification of the cot bed post-accident. It became apparent that it was to be suggested that the campaign adopted by the manufacturers, Cosatto Limited ("Cosatto") was to be criticised. Counsel for Cosatto admitted that if this was to be an issue further evidence may have been required to be led by the company and he

would require time to consider the issue. I voiced certain misgivings as to whether this issue could properly form part of my determination as it was hard to see how it would fit with the terms of Section 6(1) of the 1976 Act. After a short adjournment the Crown intimated that they were no longer insisting on raising this issue and would neither lead the new witness nor indeed another trading standards officer who had been on the Crown list of witnesses. Mr Anderson, on behalf of the family submitted that the issue of the modification campaign could properly form part of the Inquiry. In support of that submission he referred to a determination by Sheriff Kearney in *FAI into the Death of James McAlpine* (1985) and Ian H Carmichael *Sudden Deaths and Fatal Accident Inquiries* (3rd Edition), paragraphs 11-19 and 11-46.

Mr Smith, Counsel for Cosatto submitted that this matter did go beyond the scope of an Inquiry of this sort and reiterated that he would require further evidence, including witnesses from consultants who had been instructed by Cosatto in relation to the campaign. He advised me that Cosatto had taken advice from consultants and that the campaign had been overseen by Bolton Trading Standards. It appeared that Fife Trading Standards and Bolton Trading Standards may have been at odds as to the appropriate campaign.

I considered the issue overnight and in the morning I said that whilst I had misgivings about the relevance of this issue to a Fatal Accident Inquiry I would not stop evidence being led and once evidence had been led it would be open to me to make a determination on that evidence. I was, however, clear that if this was to be an issue it could not be raised during the course of the time then available for the Inquiry. It would not have been fair to deny Cosatto the opportunity to lead evidence relevant to this matter. I suggested that with consent of all parties it would be open to me to hold the initial Inquiry in relation to the other issues and to continue the Inquiry in relation to the campaign issue as this was an entirely separate and discreet matter. I was acutely conscious that the family were keen for the Inquiry to proceed as quickly as possible.

Having taken instructions Mr Anderson indicated that his clients no longer insisted on raising the issue of the adequacy of the campaign. The Inquiry accordingly proceeded on the other matters.

The witnesses led by the Crown were the parents, Mr and Mrs Smith; a paramedic, John Brookbank; two police officers, Detective Constable David Bellingham and Police Sergeant Tom Anderson; and the Crown expert witness, John Trinsi.

Despite having lodged a list of witnesses, Cosatto led no evidence.

THE CIRCUMSTANCES OF THE DEATH

There was no dispute about how this death occurred. After Ainslie's birth he first slept in a Moses basket and then a crib. As he grew the parents looked for an appropriate cot. They searched the internet and visited Baby Land in Kirkcaldy and decided to purchase the Cosatto Stratford cot bed. This cot was designed to convert, in to a bed as and when required. It had a drop side and the base could be fitted at three levels depending upon the age of the child. The foot end of the cot bed was divided into two parts so that when converted to a bed the foot board was at a lower height than the headboard. The upper part of the foot board was joined to the lower part by means of two steel pins. These were fixed on the lower part of the foot end and fitted into two holes drilled into the bottom of the top part of the foot board. There was no fixing that prevented the two parts from sliding apart.

The cot was purchased on the 6 June 2009 and put together in accordance with the manufacturer's instructions by Mr Smith. The base was installed at the highest level. The cot bed was erected in the middle of Ainslie's room and once erected Mr and Mrs Smith carried it into the corner where Ainslie was to sleep. Mr Smith carried the foot

end and noticed that the top part of the split end was moving away from the lower part. He accordingly carried the bed for the rest of the way by holding on to the lower part of the end. Thereafter Ainslie slept in the bed. Because the base was in the top position Ainslie could be lowered over the side of the cot without lowering the drop side. The drop side was only lowered in order to check that it worked during the course of construction and when changing sheets.

It is agreed by all parties that when the cot bed was moved, the top part of the split foot end rose above its proper position and a rod on which the drop side travelled came out of its cup. This allowed the drop side to travel on a horizontal plane when minimal force was applied to it. What is equally clear from the evidence that I heard was that this would not have been apparent to Mr and Mrs Smith. At some point after Ainslie had been put to bed on 4 July 2009 he had pushed the side of the cot causing a gap to occur through which he slipped. He became trapped between the drop side and the cot base with his face against the mattress. This caused his death.

When Mrs Smith discovered him she managed to get him clear but he was white and cold. She attempted CPR whilst waiting for the paramedics to arrive and phoned her husband who was checking a patient at his vet's surgery, to come home. A police officer was first to arrive and he started to take over CPR but as Mrs Smith thought that he was being less confident as he was not used to dealing with a small baby, she again took over. CPR was continued until the paramedics arrived. I should say that there was an unfortunate delay in the paramedics arriving as it would appear that their satellite navigation system sent them to the wrong address. This caused a delay of some 8 minutes however there is no question whatever that this would have made any difference to the final outcome. Ainslie was taken to the Victoria Hospital in Kirkcaldy where he was met immediately by medical staff who made every effort to resuscitate him but this was all unsuccessful and life was pronounced extinct at 0009 hours. It was

clear from the evidence that I heard that by the time Ainslie had been found there was never any prospect of successful resuscitation.

After this accident Cosatto made a modification to the cot bed whereby owners were provided with a metal strap which connected between the two halves of the foot end of the cot bed which removed the dangerous defect which caused this death.

THE GENERAL PRODUCT SAFETY REGULATION 2005 (“The 2005 Regulations”)

In order to explain parts of the evidence of Mr Trinsi it is necessary for me to describe the regulations that apply to products such as this cot bed.

Regulation 2 of the 2005 Regulations provides that a “safe product” means a product which, under normal or reasonably foreseeable conditions of use including duration and, where applicable, putting into service, installation and maintenance requirements, does not present any risk or only the minimum risks compatible with the product’s use, considered to be acceptable and consistent with a high level of protection for the safety and health of persons. In determining the foregoing, the following shall be taken in to account in particular –

- (a) the characteristics of the product, including its composition, packaging, instructions for assembly and, where applicable, instructions for installation and maintenance,
- ...
- (d) the categories of consumers at risk when using the product, in particular children and the elderly.

Regulation 5 is the general safety requirement and provides that no producer shall place a product on the market unless the product is a safe product.

Regulation 6 provides a hierarchy of provisions relating to safety starting in paragraph (1) where there are specific rules of law of the community or the United Kingdom laying down health and safety requirements for a particular product. This did not apply in this case.

Paragraph (2) covers cases where there is a standard contained within the Official Journal of the European Union and again that provision does not apply.

Paragraph (3) Provides:- “In circumstances other than those referred to in paragraphs (1) and (2), the conformity of a product to the general safety requirements shall be assessed taking into account –

- (a) any voluntary national standard of the United Kingdom giving effect to European standard, other than one referred to in paragraph (2) -
- (b) other national standards drawn up in the United Kingdom,
- (c) recommendations of the European Commission setting guidelines on product safety assessment,
- (d) product safety codes of good practice accepted and confirmed,
- (e) the state of the art and technology, and
- (f) reasonable consumer expectations concerning safety.

There was a European standard which covered cots namely EN716. When the cot was first designed this standard was dated 1995 but it was revised and superseded by a 2008 version approved on 2 February 2008. There appears to be no material difference between the two standards in so far as they are relevant to the circumstances of this accident.

MR TRINSI'S EVIDENCE

Mr Trinsi is 52 years old and graduated with a BSc in Chemistry. Since 1988 he has been involved one way or another with toy and nursery product safety. He started working for various testing laboratories and in 2004 he began working for Mamas and Papas who manufactured nursery products. He set up a due diligence laboratory as the company wanted to test the products to safety standards. This involved the laboratory being audited by the government run UK accreditation service. He now runs his own safety consultancy company.

I should say that I found Mr Trinsi's evidence of considerable assistance. He appeared to me to be an expert witness of the highest calibre. He was highly experienced in his field. He produced a full and helpful report. He gave his oral evidence clearly. He expanded on his answers where necessary in order to give clarity to his evidence. I detected no hint of any exaggeration during the course of his evidence.

Mr Trinsi explained the regulation system and the general testing system which would have been adopted in this case. He pointed out that the European Standard was not included in the Official Journal and accordingly compliance with the standard was only one factor in determining whether a product was "safe" for the purposes of the 2005 Regulations. He went on to explain the workings of the cot and he described clearly how the accident would have occurred. He said that he had noted that when lifting the split end the guiding rod for the drop side would come out of its fixing. This happened most obviously when the cot base was at the lowest setting but it also occurred at the higher settings, including the top setting. He accepted that he was looking for a fault but his position was that it was inconceivable that any technician in a test lab would not have noticed the movement of the split end and the rod coming free from the fixings. He said however that this did not affect the test result as it did not form part of the test. He was

accordingly not surprised that there were two test certificates, one under the 1995 standards and one under the 2008 standard. His view was that this fault would have been apparent during the design, manufacturing and testing process. His view was that it was surprising that the cot bed was tested in the state that it was in. He would have expected the testing organisations to have notified the manufacturer and further design work carried out prior to formal testing, although he did not rule out testing in its defective state.

Mr Trinsi also drew my attention to the fact that at some point prior to Mr and Mrs Smith purchasing their cot, Cosatto had made a modification which would have rendered the cot safe. They put a screw through the joining pin which would have prevented separation of the two halves of the foot end. He said that he was advised that the reason for this was that it was intended to make the cot into a three way cot namely a cot, a bed and a sofa. He did say however that the instructions which he had for the modified cot made no mention of conversion to a sofa.

Mr Trinsi reached the following conclusions as set out in his report:-

“6.1 the death occurred as a result of a safety defect in the design of the Stratford Cot Bed; namely the combination of a loose fitting split end with a guide rod operating drop side. The safety defect was discoverable and should have been discovered during the design process through standard engineering techniques.

6.2 the Cosatto Stratford Cot Bed is a dangerous product and poses a serious risk because the drop side can be disengaged from the split end during conditions of reasonable and foreseeable use, creating a head/body entrapment hazard which could lead to death.

6.3 use of the “metal safety strap” supplied by Cassato eliminates the above mentioned risk”.

I should add that he did draw my attention to a fact that the cot bed was one centimetre longer than the longest measurement provided in the standard. On one view accordingly the cot bed did not fall within the standard at all, however he did not consider that this was a significant deviation.

SUBMISSIONS

All parties lodged written submissions and I annex these to this determination.

LAW

The hope of an inquiry such as this is as set out by The Lord President (Hope) in *Black v Scott Lithgow Limited* 1990 SLT 612. In that case His Lordship said at page 615H:-

“There is no power in this section (Section 6(1)) to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident. This is in contrast to Section 4(7) of the 1895 Act, which gave power to the jury to set out in its verdict the person or persons, if any, to whose fault or negligence the accident was attributable. It is plain that the function of the Sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only for setting out in his determination the circumstances to which the subsection refers, insofar as this can be done to his satisfaction. He has before him no record or other

written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required.”

Whilst I make no findings in relation to fault that does not mean that I cannot make findings based on evidence from which fault could be inferred. Furthermore whilst I cannot make findings of fault, I should not make findings from which it could be inferred that there was no fault where such a finding would not be in accordance with the evidence.

CONCLUSIONS

There was no dispute that this cot bed had a defect which rendered it unsafe. There were at least two alterations which could have been made to the design of the cot bed sold to Mr and Mrs Smith which would have avoided the death. Firstly there is the insertion of a screw through the pin. This modification had been made prior to the sale of the cot bed to Mr and Mrs Smith but it would appear that old stock was still being sold to customers after that modification had been introduced. The other alteration which would have prevented the death was the modification by a safety strap holding the two parts of the split end together. Such a safety strap was provided post accident. It was also clear, as was accepted by Counsel on behalf of Cosatto that a system of work could have picked up the design defect during the design, manufacturing and testing process. It was suggested during submissions that Cosatto had been over reliant on the testing to the European standard. I am not prepared to find that there was such an over reliance. That would require evidence that Cosatto did not know about the design defect before the cot bed was sold. I accepted the evidence of Mr Trinsi where he considered it inconceivable that the defect would not have been noticed during the process of design, manufacture and testing. It is theoretically possible that the defect was not noticed until the testing stage and that the testing organisation did not draw it the company's attention but without positive acceptable evidence of that happening I am

not prepared to make the finding sought on behalf of the company. Equally it would not be appropriate for me to make a finding that they did know of the defect as that would be going beyond the scope of this Inquiry.

On behalf of the family Mr Anderson invited me to make certain determinations in terms of Section 6(1)(e) in relation to the management of Cosatto and their design process. I was not prepared to do that. It does not seem to me that it is appropriate in a determination in a Fatal Accident Inquiry to make recommendations to an individual company as to how they should manage their business in order to comply with the law. The law requires them to provide a particular result and in this case a safe product. How they do it is a matter for their management.

I would again express my condolences to the family for their tragic loss.