In the Inquest Touching the death of

Narayan Prasad GURUNG

Factual Findings and Conclusions

Ms Anna Loxton
H.M. Assistant Coroner for the County of Surrey
Friday 8th June 2018

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Factual Findings and Conclusions

Forward

My name is Anna Loxton and I am an Assistant coroner for the area of Surrey. The date today is 8th June 2018.

The Inquest into the death of Mr Narayan Prasad Gurung was opened by Mr Simon Wickens on 4th January 2017. Following two Pre Inquest Review hearings, I heard evidence in this matter over the course of three days on 26, 27 and 30th April 2018.

Before I begin my findings and conclusion, I would like to thank Counsel for the Family, Aviva and BMW UK Ltd, and their Instructing Solicitors, for their helpful assistance throughout this Inquest.

I understand that Mr Gurung's son, Dr Dinesh Gurung, is not able to attend Court today due to his work commitments, but I would like to acknowledge and thank him for the composure and dignity he showed during what was at times frustrating and I am sure very difficult evidence for him to hear. I would like to pass on to him, and to the rest of Mr Gurung's family and friends, my sincere condolences in their very sad loss and I am sure that those in Court today would wish to join me in so doing.

At the start of the second day of evidence, I gave a Ruling that Article 2 would apply to this Inquest. The application of Article 2 to this Inquest had been raised in respect of the role of the Driver & Vehicle Standards Agency and I received submissions on this from Counsel for the Family, for BMW UK and for Aviva. I stated that this would be reviewed in light of the disclosure and statements received from the DVSA. Having heard evidence from Mr Ryder of the DVSA, it became clear to me and I ruled that a potential breach of Article 2 had occurred in respect of the Agency's implementation of its code of practice, as the government appointed authority in the UK responsible for product safety in the automotive sector. This did not however alter the agreed scope of the Inquest.

FINDINGS AND CONCLUSIONS

1. I will now set out my findings of fact and conclusions in relation to the death of Narayan Prasad Gurung. Unless otherwise stated, they have been reached on the balance of probabilities.

2. In reaching my findings and conclusions, I have taken account of all the evidence I received, both oral and written. However, I will not detail all the evidence before the Court, but will rather explain by reference to what I consider to be the pertinent parts of the evidence why I have reached my findings of fact and conclusions.

Mr Gurung

3. I am satisfied that the person who died was Narayan Prasad Gurung, who was born in Kaski, Nepal on 23rd January 1950. He was married to Mrs Khari Maya Gurung and they had three children. His younger son, Dr Dinesh Gurung, has described him as very hard working and a great advocate for education, perhaps because his own childhood lacked this, and that in adulthood he strived to broaden his own learning and also sponsored education to family members in Nepal. On his retirement from the Gurkha Regiment in 1988 after nearly 20 years of military service, where his military conduct was graded as Exemplary, he joined his wife as a Housekeeper at Royal Surrey County Hospital. This meant that he could drive her to and from work and spend more time with her. He was an experienced driver and his career included three years working as a taxi driver in Nepal. His son states he was a very active person who helped out within his community. He had no health problems other than hypertension for which he took medication.

Events of Christmas Day 2016

4. Early in the morning of Christmas Day 2016, Mr Gurung was driving his Ford Fiesta car to work at Royal Surrey County Hospital,

with his wife accompanying him. This was a route they had taken every working day, for the previous 9 years. It was before sunrise and the A31 Hogs Back, Seale, is described in the Collision Investigation Report as being a dual carriageway with two lanes in each direction, but in a rural setting without street lighting.

5. Mr Resham Gurung, a work colleague of Mr Gurung, was also making his way to work in Housekeeping at Royal Surrey Hospital in his black 2011 BMW 318i saloon. He described to the Court that whilst driving along the dual carriageway in the nearside lane, shortly after he had passed the end of the slip road coming back onto the A31 from the Hogs Back Hotel, his car suddenly suffered a loss of power, slowed by itself and all the lights went out. He was able to brake and stop the car on the carriageway but when he tried to put on the hazard lights, they did not work, leaving his car in total darkness.

6. Moments later, he stated he saw in his rear view mirror car lights approaching from behind, and a car passed by his vehicle on the offside before suddenly veering left, skidding off the road and into a tree.

7. Russel Greenhouse, Police Staff Forensic Collision Investigation Officer for Surrey Police, gave evidence that although it was dark at the time of the crash, visibility was otherwise good and weather conditions had been dry at the time of the accident. The road surface was in a good state of repair.

8. Mr Greenhouse confirmed there were no street lights or other sources of illumination along the A31 Hogs Back, and the total electrical failure of the BMW would have resulted in it being left in darkness. Although Mr Resham Gurung's BMW had reflectors to the rear of the vehicle, Mr Greenhouse gave evidence that if Mr Narayan Gurung had been using full beam headlights, driving at the speed limit of 60mph, the stationary BMW's rear reflectors would only have become visible at a distance of 106 metres, giving a maximum

of 3.9 seconds for Mr Gurung to react.

9. If Mr Gurung was using dipped headlights, this would have been reduced to 30 metres visibility of the rear reflectors, and a reaction time of just 1.1 seconds. He further stated that these estimated reaction times were in respect of an expected hazard, and an unexpected hazard, as in this case, would most likely decrease these times. He confirmed in evidence that in either scenario, Mr Gurung would not have had sufficient braking time to avoid a collision with the BMW.

10. Ben Wilson, Police Vehicle Examiner, gave evidence that it was not possible to say whether Mr Gurung was using dipped or full beam headlights. Although the light stalk was in dipped position when he examined the Fiesta, he stated it could easily have been knocked into that position during the collision, and therefore I can make no findings in respect of the actual reaction time Mr Gurung had, other than this would have been between 1.1 and 3.9 seconds on the evidence before me based upon Mr Gurung travelling at the 60mph speed limit. I find on the evidence before me that Mr Gurung was left with no option but to attempt to manoeuvre around the BMW with minimal warning. I accept Mr Greenhouse's evidence that had the BMW been displaying hazard warning lights, this would have given Mr Gurung increased warning of the hazard and therefore more chance to negotiate it successfully.

11. Mr Greenhouse outlined in evidence how the road markings showed Mr Gurung's Fiesta swerved into the offside lane to avoid the unlit BMW, causing him to lose control of his car as it rotated in an anti-clockwise direction, mounted the grass verge on the nearside of the road before crashing sideways into a tree on the driver side of the car against the B pillar. Mr Gurung sadly died of multiple injuries at the scene, and his wife was seriously injured.

The Fault with Mr Resham Gurung's BMW

12. Resham Gurung, the owner of the BMW, gave evidence that, prior to the incident, there had been no warning that his car was going to suffer a power failure whilst he was driving it. He confirmed there had been two incidents previously when he could not unlock his car with the key fob, on 10th October 2016 and 11th November 2016. He gave evidence that no one warned him that because he had a problem unlocking his car, it may suffer a complete electrical failure when he was driving it.

13. On both the occasions where he had been unable to unlock his car, Mr Gurung had contacted the AA to attend and they had been able to assist. On 11th November 2016, Mr Gurung stated he was shown that if he wiggled a cable located behind the glove box on the front passenger side of the vehicle, he would be able to start the car. The first AA report on 10th October 2016 recorded "Fuse box poor connection on back of box by passenger feet". The second AA report on 11th November 2016 recorded "No power in the car at all but had good battery voltage, wiggled the main feed to the glove box and heard a click and power resumed, Advice to take to the garage for further investigation of fuse box behind glove box main feed connection and security". Following both occasions Mr Resham Gurung took his car in to an independent garage, Invincible MOT Testing Repair Centre Limited ("Invincible"), to check the fault. In respect of the second occasion, Mr Gurung did not take his car to Invincible until 28th November 2016, as he stated he had been busy and there had been no further problems with the car. From this evidence I find that he was not aware there was any urgency for him to have the car checked.

14. Mr Gurung stated that on 28th November 2016, a mechanic at Invincible informed him that he had found what appeared to be a loose connecting part, and a screw holding this in place was tightened. This is confirmed by the statement of Daniel Kirk, Manager at Invincible, who recalled that on 28th November 2016, he

tightened a nut to rectify a loose power wire. Mr Gurung paid £40, being the examination fee, and he states when he left Invincible with his car, he believed in the absence of any other problem being found, the issue had been resolved. Mr Gurung also stated that having been shown by the AA how to start the car by wiggling a cable located behind the glove box, he did this after the accident and was able to restart his car.

15. I accept Mr Gurung's evidence that he had no reason to believe his vehicle may suffer a total loss of power whilst in motion, and that the two previous occasions when he had been unable to unlock his car had not prepared him for this scenario; indeed I find it highly unlikely Mr Gurung would have continued to use this car and would have delayed taking it to a Garage if he believed it may suffer a total electrical failure at any time.

16. Mr Mohsen Haddad, a Director of Invincible gave evidence regarding the examination of the BMW at his garage when it was brought in by Mr Gurung on the second occasion, 28th November 2016. I have limited my findings in respect of his evidence as I found this to be confused and at times contradictory, not because of any lack of reliability on Mr Haddad's behalf – I found him to be a truthful witness – but because he did not understand the need to differentiate his own knowledge of the investigation into the BMW's fault with information relayed to him by his mechanics. I made note however that whilst the garage used various diagnostic tools, including Snap-on, Bosch and Auto-Diagnostic, none of these were able to diagnose a fault with the BMW. I accept Mr Haddad's evidence that Mr Gurung paid £40 for the diagnostic tests carried out to the car and not for any remedial work undertaken. Mr Haddad confirmed his garage does not subscribe to the on-line BMW fault information services provided by BMW at additional costs and nor do they have the facilities to download car information from the key, which only a BMW dealership would have. He was unable to clarify if his mechanics had themselves seen the reports produced by the AA following the two incidents. I accept Mr Haddad's evidence that

so far as he was aware, the BMW showed no signs of an electrical fault whilst it was at the garage and that an issue with the B+ connector cable being unstable was not identified. I also accept his evidence that Invincible were unable to identify a fault with the BMW, other than tightening a nut in the bonnet area to a loose cable.

17. Ben Wilson, Police Force Vehicle Examiner, gave evidence that he found no mechanical defect with the BMW on an initial inspection of the vehicle. I accept his evidence that he found the BMW to be well kept and in good general condition. Once he became aware the BMW had apparently suffered an electrical fault, he took the key to a BMW dealership for the information on that to be downloaded. He confirmed that specialist diagnostic equipment was needed to do this, which only a main BMW dealer would have. This recorded faults including; "Junction box electronics, electronic fault with various malfunctions". The old fuse board was subsequently inspected and then replaced by BMW.

BMW B+ cable fault

18. Mr Mark Hill, Technical Support Manager at BMW UK, outlined to the Court the fault with the B+ cable. He described how this was caused by vehicle vibrations, frictional corrosion and a high current load, potentially leading to a loss of connection between the power distribution box and the B+ cable. Once the car was stationary and the connection cooled down, contraction would take place and contact would be lost. He stated that would initially result in problems unlocking and starting the car, or a brief loss of engine power whilst driving. Mr Hill stated that if this problem was ignored, further damage to the terminal would be caused by continuous heat, eventually causing the terminal to suffer a break in contact and a total loss of power. However, he stated that this meant there would be prior warning of the fault before any power failure of the car when in motion occurred.

19. He outlined that he believed the recalls which had previously

taken place in other countries in relation to issues with the connection between the B+ cable and power distribution box were in respect of "hot climate" vehicles, i.e. those which had additional features for a warm climate including a larger fan, resulting in a higher engine electrical consumption, and therefore greater strain on the connection. I heard evidence that the "hot climate" package version of the vehicles were recalled in 2013 in the UK due to the B+ cable issue.

20. Mr Hill explained and I accept that BMW AG as the manufacturer of the vehicles make all decisions in respect of recalls and BMW UK as the distributor effectively act as a go-between, relaying information regarding manufacturing issues in this jurisdiction to BMW AG and adopting the response provided. Mr Hill explained this as being because BMW AG, as the manufacturer, have a greater expertise regarding technical aspects. He stated that there were numerous conference calls between BMW AG and BMW UK regarding the B+ cable issue, and BMW AG would then inform BMW UK of their position. There has been very limited disclosure of any documents from BMW AG, or from BMW UK regarding these discussions with BMW AG, in this inquest and therefore the only information made available to the Court has been via BMW UK and the evidence of Mr Hill. However it is clear from Mr Hill's evidence and I find that BMW AG were aware of the incidents involving the B+ cable reported direct to BMW UK and via the DVSA.

21. Mr Hill stated in written evidence that BMW AG issued a PuMA (Problem and Measures management Aftersales) measure in December 2011 to notify all dealers of the issue with the B+ cable and how to repair it, and a repair kit was also released. This issue potentially affected 370,000 vehicles manufactured between March 2007 and September 2011. Mr Hill provided some figures regarding the repair kit; that between 2015 and 13 November 2017, 889 were recorded as having been supplied to independent garages and 67 to the retail network; that further repairs may have been carried out using the cable element only, for which figures are not available

(albeit that the DVSA record in their Minutes of a meeting with BMW UK on 26 February 2016 that 1300 cables had been sold); and that the figures provided for the repair kit were likely to be lower than the amount actually sold as not all sales would have been captured by retailers and passed on to BMW. It is not clear how many of these cases overlap with those reported to the DVSA via the Vehicle Safety Defect Reports. Mr Hill was unable to provide exact figures for the number of vehicles reported to BMW with this fault, and clearly the Vehicle Safety Defect Reports to the DVSA do not cover all affected vehicles. The DVSA's Minutes of the 26th February 2016 meeting record that there had been 388 warranty and goodwill cases in respect of this fault as at that date. I therefore cannot reach a finding on the evidence before the Court on how many of the potentially affected vehicles suffered a power failure due to the B+ cable fault, but it is clear that incidents were occurring in addition to those reported via the DVSA.

The DVSA

22. Mr Martin Ryder, Senior Engineer at the Driver and Vehicle Safety Agency, confirmed that the Agency first received notification of a potential issue with a BMW engine cutting out in motion via a vehicle safety report dated 31st October 2014. There followed a steady flow of vehicle safety reports to the Agency from concerned drivers; on 26th November 2014, 25th November 2014, 5th December 2014, 30th December 2014 and continuing thereafter often at the rate of two per month. Mr Ryder confirmed that this is an unusually high level of reports for the Agency to receive detailing the same complaint and that he managed these complaints.

23. The definition of a safety defect given by the Driver & Vehicle Standards Agency in the Vehicle Safety defects and recalls: Code of Practice states:-

A safety related defect is a failure due to design and/or construction, which is likely to affect the safe operation of the product/aftermarket part without prior warning to the user and may pose a significant risk to the driver, occupants and others. This defect will be common to a number of products/aftermarket parts that have been sold for use in the United Kingdom.

24. Mr Ryder stated he formed the view with BMW UK that the drivers of the vehicles reported to the DVSA were given prior warning of a fault. He cited examples of vehicle alarms going off for no reason; difficulties unlocking the car or the car not starting prior to some of the incidents of electrical failure. He therefore stated he agreed with the response put forward by BMW UK to the Vehicle Safety Defect Reports; that the fault being reported did not fall within the definition of a safety related defect under the code, since he believed the drivers were given prior warning of the fault.

25. A technical campaign was issued by BMW AG in November 2016 for the B+ cable issue in respect of petrol engine models produced between December 2009 and August 2011, as these vehicles were fitted with a plastic rather than metal cable holder, which had a slightly raised incidence of B+ cable connection failure.

26. Further reports of electrical failures continued. On 26th February 2016, a meeting took place between BMW UK and the DVSA. Mr Hill from BMW UK has provided his handwritten minutes of that meeting. In that, it states that the DVSA's concern is "Cut out when driving on an unlit road". "No lights is the biggest concern from Andrew Tudor. Another road user cannot see the powerless car". Andrew Tudor was Martin Ryder's manager at the DVSA.

27. Below this Mr Hill had noted "We don't want a fatality". The note of the meeting ends with "review in 4 weeks". I accept the emphasis Counsel for the Family and for Aviva have placed on Mr Hill's notes of this meeting, since it clearly evidences and I find that the exact scenario which led to Mr Gurung's death was foreseen in

February 2016, some 10 months earlier.

28. Despite this, on 13th May 2016, Mark Hill from BMW UK Limited sent Mr Ryder an email in which he stated the number of cases reported to the DVSA since his last email of 18th March 2016 had dramatically slowed down. In fact I find this was not borne out by the Vehicle Safety Defect Reports filed with the Agency, as there had been reports of vehicles suffering electrical problems on 23rd March, 8th April, 28th April and 5th May 2016, and no evidence was provided to the Court of a reduction in sales of the repair kit during this period.

29. Mr Hill proposed in his letter to Mr Ryder that the DVSA's investigation into the reported fault was halted until the autumn/winter months on the basis of the supposed reduction in reported cases and that electrical consumption is higher during cooler ambient temperatures. Mr Ryder agreed to this suspension, stating in a letter to Mark Hill of 9th June 2016 that; "The concern, as a whole, will be reviewed with the advent of the Winter months".

30. Mr Ryder confirmed to the Court that no risk assessment was carried out within the DVSA before agreeing to this suspension, and it was his opinion that whilst he felt there might be a safety issue, he did not consider he had sufficient evidence at that stage of a safety defect which would justify a recall, albeit this position is not reflected in any notes or correspondence from him at the time. He agreed that the suspension was to allow for new Vehicle Safety Defect Reports to be received, although I find this would inevitably mean that lives would potentially be placed at risk in so doing.

31. Martin Ryder agreed in evidence that at all times BMW had a solution to the problem that was being reported to the DVSA, and therefore more time was not required to find a technical solution to the problem. In essence, BMW were aware both of the fault and how it could be fixed, and indeed had released a repair kit specifically for this fault, costing £12.79 at retail price. Despite this, Mr Ryder stated

the DVSA needed overwhelming evidence of a fault before a recall could be requested.

32. Mr Ryder in fact gave evidence that he considered the prior warnings cited by BMW of being unable to open car doors; problems starting the cars and alarms activating for no reason to be insufficient warning of a total electrical failure. However he stated his superior, Andrew Tudor, overruled this view. No evidence has been disclosed to support this assertion, and Mr Tudor has since retired from the DVSA. I found Mr Ryder's evidence to be contradictory regarding his assessment of whether the B+ cable issue was a safety related defect, but I did not find any evidence he had informed BMW UK that he felt it to be so prior to Mr Gurung's death.

33. Mr Ryder confirmed that the DVSA does not have statutory powers to force a recall but stated it was available to the Agency to publicise a problem if the manufacturer/ supplier were felt to be uncooperative. The DVSA could also refer a manufacturer or supplier to the Secretary of State for Transport or the Transport Select Committee to explain any reticence. However he stated that he has never been involved in such a process and I find there was no evidence that this action was considered in respect of the reported B+ cable fault. Mr Ryder stated in evidence that he was not put under any pressure from BMW UK to avoid a recall, and indeed I find there was no evidence of pressure being exerted on his decision making process.

34. Correspondence from Mr Ryder to drivers who had filed Vehicle Defect Reports with the DVSA, having experienced power failures whilst their vehicles were in motion, adopted the response put forward by BMW AG via BMW UK; namely that these incidents did not fall under the Code of Practice for a recall as there was prior warning of the fault. Mr Ryder also appeared to be reassured by the fact that BMW UK began to undertake "goodwill" repairs of the B+ cable in respect of these reported cases, on an ad hoc case by case basis.

35. Both Mr Ryder and Mr Ian Barlett, Head of Vehicle Safety at the DVSA, were taken through some of the Vehicle Defect Safety Reports submitted to the Agency, highlighting a number of reports of vehicles suffering power failures whilst in motion, including at speeds of 70 miles per hour on motorways, and when pressed they seemingly reluctantly agreed these highlighted serious safety concerns. It was also noted that some vehicle owners reported having taken their cars to independent garages and even to BMW dealerships following incidents of engine failure, but the fault was not recognised due to its intermittent nature, as I find was the case in respect of Mr Gurung's car when taken to Invincible. This failure to diagnose the fault included occasions when a car was taken to a BMW dealership even with the additional BMW diagnostic tests available.

36. Mr Hill confirmed his understanding of the position on behalf of BMW UK; that whilst these reports evidenced a safety related issue, he felt reassured by BMW AG that prior warning would have taken place, even though he acknowledged a number of the reports did not report any previous warnings, such as the vehicle alarms activating without reason; being unable to unlock vehicles or failure of the vehicles to start. Mr Hill acknowledged that this was placing responsibility on the vehicle driver to take the vehicle to a garage, and then on the garage to connect the faulty car alarm, inability to unlock the car or failure to start the car as indicating a potential issue with the B+ cable, and to repair this. He accepted and I find that this potentially placed drivers at risk and evidenced an assumption that when the fault manifested itself via problems with unlocking or starting the car, or the alarm going off for no reason, drivers would recognise a potential fault with the electrical system and have it fixed.

37. I accept and find on the evidence that prior to Mr Gurung's death, no correspondence was sent to registered owners of affected vehicles advising them of a potential issue with the B+ cable.

38. Following Mr Gurung's death in December 2016, a further meeting took place between BMW UK and the DVSA in February 2017. Mr Barlett attended this meeting in place of Mr Ryder who was unable to attend. He gave evidence that he had discussed the on-going issue regarding the B+ cable with Mr Ryder on previous occasions. I find that this meeting heralded a fundamental shift in how the DVSA dealt with the B+ cable fault.

39. Mr Bartlett started his evidence by explaining to the Court that he believed there had been a misinterpretation both within the DVSA and externally of what constituted a "prior warning" under the Code. He gave his view that what had been interpreted as "prior warnings" in this case were actually symptoms of a safety related problem with the vehicle. He stated that there is no training or guidance within the DVSA to interpret the wording of the Code.

40. He stated that following the meeting he attended with BMW UK in February 2017, he was clear in his view that the issue with the B+ Cable was a safety related issue, and that the vehicles potentially affected needed to be recalled. He explained this by stating that he took a simplified approach to the issue by asking BMW if customers had experienced electrical failure without prior warnings, which he stated was confirmed. He then asked for confirmation that if this connection were to fail, all electrical systems within the vehicle would fail, and was again informed this was the case. He stated he considered the effect such an electrical failure would have for the safe operation of the vehicle. He was most concerned that there would be loss of visibility, due to loss of illumination, particularly if the vehicle was being driven at night. He was also concerned there would be impaired visibility in rain without working windscreen wipers if the electrics failed. I agree and accept this evidence; that in such circumstances the vehicle would be rendered unsafe. Of course by the date of that meeting, the scenario of a loss of illumination of the vehicle at night due to the electrical failure had already occurred, resulting in Mr Gurung's collision and death when he came across an unlit stationary BMW on the A31.

41. Mr Bartlett stated that from that meeting onwards, it was therefore the DVSA's position that this fault was a safety related defect. Mr Bartlett stated he did not agree to any further meetings with BMW UK because in his view the position was clear; a recall was required, and if BMW UK disagreed with this view, they needed to provide written explanations for this. I accept that this was Mr Bartlett's view, and I note the email he sent to Mr Ryder following this meeting in which he stated "For this reason I considered this to be a safety defect and needed recalling. They agreed with me and were going to go away and start the process for recalling these vehicles".

42. Mr Bartlett confirmed that there is no set form of written notice given by the DVSA when it decides a recall is required under the Code of Practice, and no such notice was therefore sent to BMW. Indeed I noted a general lack of documentation by the DVSA during the course of the evidence, with no detailed minutes of meetings taken; no notes of internal discussions; and nothing to record the procedure or any timetabling for action to review the reported faults. Mr Bartlett gave the view in his evidence that his department had not been robust enough in documenting the investigations they carried out; had not functioned as it should have done and that this was something he had looked to change. On the evidence before the Court, I find that there was a concerning lack of detailed note taking and records of discussions between BMW UK and the DVSA by the DVSA in relation to this issue.

43. Following the meeting in February 2017, BMW AG subsequently instigated a recall of those vehicles already subject to the November 2016 technical campaign. These were petrol-only versions of affected models manufactured between December 2009 and August 2011, a sub-category of around 36,400 of the potentially affected 370,000 vehicles, which would however have included Mr Resham Gurung's BMW. Mr Bartlett stated that no written response was provided by BMW UK to the DVSA following the meeting in February 2017 and no explanation was offered for the limited recall, albeit it further

meetings were offered. Mr Hill gave evidence that BMW AG still did not consider a recall was necessary at all, as per their position that prior warning of the fault had been given, but nevertheless agreed to this recall in respect of the sub-category of vehicles already subject to the technical measure.

44. Mr Bartlett confirmed that despite it being the DVSA's opinion from February 2017 that all 370,000 potentially affected vehicles should be recalled, as at the date of the Inquest, this had not been achieved. However, based on Mr Bartlett's evidence, I find no action had been taken by the DVSA to escalate the requirement for a recall of all potentially affected vehicles with BMW UK in the intervening 14 months. Indeed Mr Bartlett was not able to provide the Court with any evidence that measures were under way to escalate the requirement for a recall.

45. BMW AG provided to the Court via BMW UK a number of RAPEX assessments carried out in respect of the risk posed by the B+ cable, including one dated February 2016. Emphasis has been placed on these assessments by Mr Webb QC, Counsel for BMW UK, in evidencing that risk assessments were carried out by BMW AG in respect of the B+ cable issue, and that the result of these was a Low Risk was identified. Mr Webb has referred me to the fact that RAPEX assessments are the accepted EU general risk assessment methodology and it is not for the Coronial Court to dictate how a RAPEX assessment is carried out and what information is put into the matrix. Whilst I accept this, I must do so in the context of all the evidence before this Inquest, and the recorded outcome of the RAPEX assessment cannot simply negate the concerns raised in respect of the reported faults received by the DVSA and by BMW UK itself (via warranty claims and through its dealerships direct). It is also of course sadly as a result of the B+ cable issue that this Inquest is necessary, and that is paramount in my mind notwithstanding the Low Risk identified by the RAPEX assessment.

46. It is clear from the evidence in this Inquest and I find that the fault which caused Mr Resham Gurung's BMW to suffer a total power failure on the morning of 25th December 2016 was known about and recognised by BMW UK (and indeed the manufacturer, BMW AG) and the DVSA. However, appropriate action was not taken to address this. The evidence from the DVSA raises serious concerns as to how the Agency responds to Vehicle Safety Defect Reports highlighting safety related issues when the manufacturer or distributor of the vehicle does not agree there is a safety related problem.

47. I also find on the evidence that there is an issue regarding the interpretation of the wording of the Code of Practice within the DVSA itself in relation to what constitutes a "prior warning" of a fault, and that this may erroneously negate a fault being interpreted as a safety related defect. I find in respect of Mr Bartlett's evidence that in the case of the fault with the B+ cable, the lack of guidance as to what constituted a "prior warning" led to the B+ issue being classified as a non-safety related issue, initially by BMW UK and then also by the DVSA, up until Mr Bartlett stated why he did not believe this to be the case at the meeting in February 2017. I find that this misinterpretation of what constitutes a "prior warning" under the Code of Practice delayed the DVSA calling for a recall of BMWs with the potential B+ Cable fault until after Mr Gurung's death, notwithstanding the scenario which led to his death being foreseen by the Agency and raised with BMW UK a year earlier, at the meeting between the Agency and BMW in February 2016.

Medical Cause of Death

48. I accept the medical cause of Mr Gurung's death provided by Dr Brett Lockyer at Post Mortem, namely;

1a. Multiple Traumatic injuries

Conclusion as to the Death

49. I have received submissions from Counsel for the Family, Aviva and BMW UK in respect of the conclusions available to me. The Family submitted a conclusion of Unlawful Killing may be appropriate if I consider on the evidence that the offence of Corporate Manslaughter can be found against BMW UK, under section 1 of the Corporate Manslaughter and Corporate Homicide

Act 2007, namely that:-

(1) An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised-

(a) causes a person's death, and
(b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

50. In order to return a conclusion of Unlawful Killing, I would have to find all the elements of the criminal offence of Corporate Manslaughter have been made out on the evidence before me to the higher criminal standard of proof. If I cannot be sure that any one element of the offence is available, I cannot give a conclusion of Unlawful Killing. I have therefore reviewed my findings against the necessary element of a gross breach of a relevant duty of care by BMW UK to Mr Gurung.

51. I accept that BMW UK, although not the manufacturer of the vehicle, was under a duty of care in negligence as the importer and distributor of the vehicle to the Deceased, Mr Gurung.

52. Guidance in respect of the duty owed by BMW UK under the General Product Safety Regulations 2005 may be found in the Vehicle Safety Defects and Recalls: Code of Practice, which would have extended to:-

(a) notifying and liaising with the DVSA regarding known faults with the vehicle;
(b) issuing appropriately worded notices to the registered keepers of the affected models to inform them of the potential risk;
(c) implementing appropriate measures to address the potential risk; and
(d) liaising with BMW AG, as the manufacturer of the vehicle, regarding the risk.

53. I accept that BMW UK liaised with the DVSA, as the relevant authority responsible for the management of the safety recall scheme in the UK, from October 2014 regarding the fault. It is clear on the evidence that BMW UK also liaised with BMW AG, the manufacturer and corporate entity responsible for recalls, in respect of the reported fault and the potential risk this posed, and relied upon the RAPEX assessment provided by BMW AG, which identified a low risk.

54. I am mindful that at the meeting between BMW UK and the DVSA on 26th February 2016, the consequences which could arise if a BMW suffered an electrical failure in darkness were discussed. Despite highlighting the exact circumstances which were to lead to Mr Gurung's death, the DVSA still did not at that stage conclude there to be a safety related defect requiring a recall, and in fact agreed to a suspension of the investigation into the fault pending more reports of incidents being received during the Winter months.

55. I agree with the submissions put forward by Counsel for Aviva, Mr Williams, that whilst BMW UK cannot hide behind the shortcomings of the DVSA, prior to Mr Gurung's death, the DVSA as the Regulator:-

(a) never declared the defect to be a safety defect;
(b) accepted BMW UK's safety case;
(c) decided to close down the individual investigations; and
(d) made no recommendations that a warning be issued.

As Mr Williams states, and I agree: *There is clear room for a conclusion that BMW UK was negligent in failing to take the required measures notwithstanding the indolence of the Agency but, given the indolence of the Agency, no evidence to support the conclusion that these failures amounted to gross negligence.*

Taking the above factors into account I have concluded that there is insufficient evidence for me safely to reach a conclusion that BMW

UK was grossly negligent in failing to issue a recall, or to notify registered keepers of affected vehicles.

56. Consequently, one of the elements of corporate manslaughter has not been proved to the requisite standard and, as such, a conclusion of Unlawful Killing is not available to me.

57. I accept that a narrative conclusion is most appropriate in this Inquest and that the short form conclusion of Road Traffic Collision would not allow me to detail sufficiently the circumstances of Mr Gurung's death. I will therefore record a narrative conclusion at Box 4 to take into consideration the circumstances surrounding Mr Gurung's death.

Regulation 28s

58. At the close of evidence on 30th April 2018, I stated my intention to prepare two Regulation 28 Prevention of Future Death Reports, one of which to be addressed to BMW UK Limited. This highlighted my concern that no written explanation had been provided by BMW for only instigating a recall for a sub-group of the vehicles potentially affected by the issue with the B+ cable, being petrol-only versions manufactured between December 2009 and August 2011. Further no clear evidence had been offered to support the assertion that only those vehicles included in this recall would potentially suffer a B+ cable loss of connection.

59. Since that date, Mr Webb QC stated in his submissions on behalf of BMW UK that BMW AG confirmed that it would be carrying out a full recall of the entire fleet of potentially affected vehicles within the UK. BMW's Solicitors have since provided the Court with confirmation from BMW AG that the recall will apply to all right hand drive vehicles, whether petrol or diesel engine, produced between March 2007 and October 2011. I have received a copy of the Notification of Intention to Recall a Registered Product submitted to the DVSA by BMW UK dated 11th May 2018, confirming the details of the recall. On that basis I accept that a Prevention of Future Death Report is not now necessary in this regard, the recall of all potentially affected vehicles having been instigated in the interim.

60. The second Regulation 28 Report I proposed to make was in respect of the DVSA. The evidence in this Inquest highlighted a number of areas of concern, namely that;

> i. There is no set protocol to be implemented by the DVSA for investigating, managing and responding to safety related defects within a reasonable timeframe once potential areas of concern have been identified;
> ii. There is no internal guidance within the DVSA to assist with interpreting the Codes of Practice;
> iii. There is a lack of any written critical analysis undertaken by the DVSA of the reported defect and how this may give rise to safety related incidents

61. I have received a letter from Mr Bartlett dated 8th May 2018 in response to this proposed Regulation 28 report, but this simply informed me; *"Over the last 12 months DVSA has been working with the Society of Motor Manufacturers and Traders (SMMT), Department for Transport and industry, looking at the current processes surrounding Safety Defect reporting and the management of Recalls. This work will include published timescales and escalation processes for managing defects and recalls. The outcome of this will be a revised Code of Practice. This work is due to be completed later this year."*

62. Given the crucial role the DVSA should play in safeguarding drivers from safety related defects, I believe the concerns highlighted by the evidence in this Inquest must be addressed as a priority and I will therefore be making a Regulation 28 report in the terms outlined above.

63. I intend to send the report to the following people:-

a. The Rt Hon Chris Grayling MP, Minister of State for Transport.

b. Gareth Llewellyn, Chief Executive, Driver and Vehicle Standards Agency

CONCLUSIONS

Record of Inquest

Box 1:

Narayan Prasad GURUNG

Box 2:

1a Multiple Traumatic Injuries

Box 3:

See Box 4

Box 4:

Early in the morning of 25th December 2016, Mr Gurung died from traumatic injuries he sustained whilst driving his Ford Fiesta motorcar, when he swerved to avoid a stationary unlit black BMW car, spun out of control and collided with a tree on the A31 Hogs Back, Seale. The BMW he swerved to avoid had suffered a complete

electrical failure as a result of a problem with the B+ power cable. Both BMW UK Ltd and BMW AG were aware of the potential B+ cable fault in categories of vehicles manufactured between March 2007 and September 2011 and the fact that this could lead to a total loss of power at any time and without warning to the driver. Despite that knowledge no recall of the vehicles affected was instigated. Incidents involving this fault had been reported to the Driving Vehicle Safety Authority from October 2014 and were subject to an on-going investigation. During a meeting between the DVSA and BMW UK Ltd on 26th February 2016, some sixteen months after the initial reports had been received by the DVSA, the DVSA recognised and highlighted the risk this fault posed to other road users, as they would not be able to see the powerless unilluminated car on an unlit road. However, despite recognising this risk the DVSA failed to call for and BMW AG and BMW UK Ltd failed to initiate a recall until after Mr Gurung's death.

Box 5:

(a) 23rd January 1950 at Kaski, Nepal
(b) Narayan Prasad GURUNG
(c) Male
(d) N/A
(e) 25th December 2016, A31 Hogs Back, Seale
(f) Husband of Khari Maya Gurung, Aldershot, Hampshire

That formally concludes this inquest, and I would like to thank all those that have assisted with the Inquest process. I would also like once more to offer my sincere condolences to Mr Gurung's family and friends in their very sad loss.