Coroner's findings touching upon the death of Jason Roland John Wingate

In the early hours of January 11th 1989 a fire broke out in the Falkland Club - otherwise known as the Gluepot. Sheena Ross, the caretaker of the building, and a friend, Jason Wingate, were asleep in a room in the caretakers quarters (indicate on projector). Sheena tells us Jason had been drinking and had been ill earlier in the night. She had left a light on in the living room in case he was ill again and needed to get up. Sheena was woken about 2am to find smoke in the room. She went out of the room across the small hallway and into the living room (plan) where she saw dense smoke and flames already rising in the opposite corner by the window (indicate on plan). She did not see Jason behind her but sensed he was there and when she said "Jason what shall we do?" he replied "I don't know." Sheena's first reaction was the obvious one, to get water to put out the fire, and to this end she went immediately to the kitchen and attempted to fill a plastic rubbish bin with water. Due to the size of the bin it did not fit under the tap and Sheena had some difficulty filling it. When she turned back to the fire the smoke and flames had cut her off from the rest of the house. She called to Jason whom she could not see. She did not get a reply but heard breaking glass, and assumed that Jason was escaping through the window. Only one exit was available to Sheena - the bathroom window, which she broke and squeezed through. Outside she could not find Jason and when Mr Wallace arrived with a key to the club front door he and Sheena attempted to regain access to the room where the fire was, but without success as the intensity of the fire was such as to make entry to the living room impossible. The fire service had by this time been summoned independently by Mr Les Halliday who had observed the fire from his house. The fire was eventually controlled and Fireman Peter Biggs found a body in the remains of the sitting room. It was obvious that death must have occurred a while previously. The body was certified dead by Dr McAdam at the scene and removed to the KEMH Mortuary. I viewed the body myself there and looked at x-rays of the body and also x-rays of Jason Wingate taken some weeks previously for the purposes of dental treatment. The x-rays were identical. Jason Wingate had not been seen since the fire and I decided that enough evidence had been collected to open an inquest on Jason Wingate which I did on the 13th of January 1989. At that hearing the body was positively identified as Jason Wingate, 18, of Stanley, and I adjourned the inquest and made an order for removal of the body for burial. Those are the facts of the case.

A As Inspector Bullock, Coroners Officer, has so rightly pointed out, my duty as coroner is to investigate the circumstances and cause of Jason's death, and also to make any observations as to the possibility of preventing such a death occurring again in like circumstances. I also have a duty to examine all events surrounding the death. I will first refer to the admirable report prepared by Mr Harris and Mr Gilbert. Mr Gilbert explained in his evidence that the premises known as the Gluepot was re-wired approximately 3 years ago. No faults were found in the main

wiring of the premises, and detailed investigation of all the electrical systems at the scene brought the investigators, by process of illimination to a coiled extension-lead with a lead to a table lamp plugged into one socket and an audio lead attached to a cassette player in the other socket. Mr Gilbert explained that it is the investigator's opinion that a short-circuit took place in the lead to the cassette player. Mr Gilbert demonstrated that arcing would take place between the 2 wires whilst they were still encased in the insulation, and that would account for a buzzing sound which Sheena described as being present when she had used the cassette player, Sheena also said in her statement that moving the player about often stopped the buzzing. Mr Gilbert explained that this description is consistent with the wires being moved so as to make contact again and therefore stop the interference when the wires were examined it was found that the copper wires had melted at the ends. The temperature of melting of copper is 1,080°C, approximately, Mr Gilbert told the court, whereas the temperature generated simply by the fire itself would not be more than about 700°C, as stated by Mr Clarke the Chief Fire Officer. This indicates, therefore, that the wiring was not simply burnt by the fire but must have melted on it's own. At the point of short-circuit the wire was directly under a waste paper basket. It seems to me that beyond any reasonable doubt the fire was caused by the short circuiting wires igniting and setting fire to the waste paper basket and then the curtains before spreading to the rest of the room. This is consistent with Sheena's impression of the seat of the fire being in the opposite corner to the door.

Mr Gilbert pointed out that had the plug of the appliance been fitted with a smaller, more appropriate fuse the effect would have been to simply blow the fuse and the appliance would then simply have stopped working. This is therefore the first, and probably the most important observation to be made in this inquest - that plugs must be fitted with the appropriate fuse for the appliance. This is a fact which is not often appreciated by the general public and plugs which have 13 amp on the outer plastic casing can be misleading; it indicates simply the largest fuse that plug will take for any appliance, that does not mean it will not take a smaller fuse. I will read the conclusions of Mr Harris and Mr Gilbert's report as they have been summarised, in order to make that clearer.

> "The fuse in the plug protects the flexible cable and the appliance connected to it. Any overload in the appliance or any damage to the flexible cable will blow the fuse in the plug, provided this fuse is correctly rated to protect the appliance, it does not matter if the protection (in this case a 30 amp MCB) of the fixed wiring has a higher rating. This latter protection (30 amp MCB) has only to protect the fixed wiring up to the socket outlet. The fixed wiring can, therefore, be designed without consideration for the protection of appliances, which had been given their own protection, by use of the fuse located in the 13 amp plug. This system, in common use throughout industrial and domestic premises, alleviates the need to have different outlets for different classes of appliances, it is therefore possible to standardise on one type of socket and one type of plug. This system depends on matching the fuse in the

plug to the appliance. Fuses for these plugs are made in ratings of 2 amp, 3 amp, 5 amp, 10 amp and 13 amp. It is unfortunate that many people do not realise this and that many retailers sell every 13 amp plug with the 13 amp fuse fitted in it. The result is that many light current appliances, such as radio/cassette recorders, table lamps, tv sets, etc, are not properly protected."

It is virtually impossible to say for certain what the actual physical cause of Jason's death was. It is possible that multiple burns produced trauma and shock to such an extent as to cause death. It is much more likely, however, that Jason was overcome by fumes and was asphyxiated and fell into the fire. The fact that his body was found at the very seat of the fire, and his hands were actually on the ruins of the waste paper basket, leads me to suspect that he saw the waste paper basket alight and was attempting to get rid of it, probably through the nearby window, but was overcome by smoke and fell unconcious into the centre of the fire with the basket in his hands. We can never be absolutely certain what really happened, however.

Associated with this fire, this death and this enquiry a number of issues have been raised, some by mere gossip, others by publication.

There was veiled criticism of the decision made at the scene not to remove Jason's body directly it was found. You will all have heard me question Mr Biggs about the body he found and ask him to view the police photographs of the scene. Mr Biggs agreed that the photographs fully depicted the condition of the body when he found it. the photographs have not been passed around the court for obvious reasons, but I am satisfied that the condition of the body when Mr Biggs found it was such that life was inevitably non-existent. I am satisfied that a body in that condition could not sustain life. Because the decision was taken to leave the body the police and fire authorities have been able to come to certain decisions about the circumstances and likely causes of the fire which would have not been possible otherwise. I am certain that the officer who made the decision made it conscientiously and I am certain that it was the right decision given all the circumstances.

I am aware that criticisms have been levelled at the emergency services. In some respects these are hardly worthy of note since none of the critics appeared in court to put questions today, which of course they could have done had their concern been such. I can only assume that they did not feel strongly enough on the subject to air their views here in a court of law, where they could question the witnesses.

Superintendent Greenland and Mr Marvin Clarke have both answered my questions on emergency services. Policy is that the police co-ordinate the services, calling specialist services where necessary. This is clearly sensible since to have all the emergency services deployed in one place when they may have been more useful elsewhere would be an inefficient system. Since Dr McAdam and the ambulance arrived within ten minutes of being called it is reasonable to suppose that they were ready to respond to just

such a call. Members of the press and public making gratuitous comments should remember that they do not know the facts of the situation. Had Dr McAdam responded to the town siren she would have spent the next half hour or so sitting in the ambulance out of sight of the fire; this would have been necessary because there was no room for the ambulance in the immediate vicinity of the fire. During this time Dr McAdam would have been unable to respond to other emergencies which may have occurred at the hospital or elsewhere. There are good reasons for the policy being as it is and if any of it's critics had bothered to come to court they would have found out what they were.

One further matter arising from these proceedings concerns contempt of court. At the end of the proceedings on 13th January 1989 I made the standard adjournment statement declaring the proceedings to be active as regards offences of contempt of court.

A representative of FIBS was present in court at that time and I was pleased to note that the report on News Magazine was well within what I consider to be reasonable limits of coverage.

Although no member of the Penguin News staff was present at the initial hearing a detailed report of the incident was published. I understand that the police released basic information about the incident which is of course standard practice. However a member of the Penguin News staff made several gratuitous statements regarding the emergency services and even presumed to instruct me as to what my findings should be. This cannot be dressed up as fair reporting. Last night on television a prominent judge attacked the tabloid press for making snap judgements on issues which they know little about, and also observed that one usually finds that those with the most to say have taken the least trouble to find out the truth. The remarks made by Penguin News may very well constitute contempt of court at Common Law and are presently receiving the attention of the Attorney General.

In conclusion I would ask Jason's mother and his twin brother Justin to accept this court's sincere sympathy in their sad loss. I also would extend sympathy and praise to Sheena who acted bravely and quickly in a dreadful situation. We will never know how Jason died but I suspect he also was trying to fight the fire and died in the attempt, which shows great bravery on his part.

The court thanks Mr Harris and Mr Gilbert for their helpful report, and Mr Marvin Clarke, Chief Fire Officer for his report.

This court finds that Jason Roland John Wingate died on Wednesday 11th of January 1989 at Stanley and the verdict is accidental death.

R McIlroy
Deputy Coroner