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SUPREME COURT
OF THE STATE OF WASHINGTON

ON
CERTIFICATION FROM UNITED STATES COURT
OF APPEALS FOR THE NINTH CIRCUIT

MARI DANIEL, individually and as the personal representative of the Estate of Melvin Daniel and as Guardian for the minor children, and as the personal representative of the Estate of Fred Ramiskey,

Plaintiff-Appellant,

v.

COLEMAN COMPANY INC., a Delaware Corporation,

Defendant-Appellee.

BRIEF OF APPELLANT ON CERTIFIED QUESTION

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A. INTRODUCTION

The present appeal involves a wrongful death products liability action initially filed in the United States District Court for the Western District of Washington at Tacoma. Melvin Daniel and Fred Ramiskey succumbed to carbon monoxide ("CO") poisoning after using a Coleman Powermate 5045 heater while on a hunting trip. Robert Haney, a third hunter, survived his exposure to CO. The hunters died after reducing the fuel flow on the heater because the heater produces lethal levels of CO when used indoors.[1] Mari Daniel, the personal representative of the Daniel and Ramiskey estates, alleged that the heater was defectively designed and that Coleman Co., Inc. ("Coleman") failed to provide adequate warnings, including post-manufacture warnings, even though the company was aware of other similar CO incidents involving its heaters.

The district court refused to instruct the jury on Coleman's post-manufacture duty to warn under the Washington Product Liability Act ("WPLA"), RCW 7.72.030(1)(c), even though the court had previously denied Coleman's motion for summary judgment on that issue. Under Washington law, the district court should have instructed the jury on Coleman's post-manufacture duty to warn of hazards associated with the

[1] The Powermate 5045 was capable of producing even greater CO levels when operated at the very lowest possible level. One of Daniel's experts tested the heater, operating it as Haney did the night of the accident, and found it produced copious amounts of CO when operated in that manner.

Powermate 5045 of which the company became aware after the heater's manufacture. Coleman knew consumers were dying as a result of using its large commercial heaters indoors, despite the presence of time-of-manufacture warnings affixed to the heaters. In an effort to mitigate the high heat the heaters produced, outdoorsmen used the heaters in a reduced-fuel mode. The resulting deaths provided notice to Coleman of a specific danger posed by the heaters, imposing upon it the duty to provide post-manufacture warnings to consumers about the risk of death when using the heaters indoors in a reduced-fuel mode.

The United States Court of Appeals for the Ninth Circuit has certified the issue of post-manufacture duty to warn to this Court.

B. CERTIFIED ISSUE

Where a manufacturer has warned at the time of manufacture of a danger posed by a product, does the manufacturer have an additional duty to warn after the time of manufacture under RCW 7.72.030(1)(c) when the manufacturer is on notice that the danger is greater than was known at the time of manufacture and the initial warnings have not eliminated the danger?

C. STATEMENT OF THE CASE[2]

[2] The statement of the case is taken largely from Daniel's opening brief in the Ninth Circuit appeal. Citations to the record are generally omitted. However, in certain instances, the record cites for critical factual matters are provided herein, conforming to

Robert Haney is a chief warrant officer with a United States Army aircraft maintenance unit. In September, 2006, while stationed at Fort Lewis in Washington State, Haney went on a week-long hunting trip with his friends Fred Ramiskey and Melvin Daniel. All three men were avid hunters and experienced outdoorsmen. Haney was related to both Ramiskey and Daniel by marriage.

The men went to Chambers Lake, approximately an hour and a half from Tacoma, Washington, to hunt elk. The weather had been dry until the final day of their hunt when the temperature plunged and a freezing rain blew in. When the men returned to their camp at about 8:30 on the evening of September 15, they were cold. The batteries in Daniel's travel trailer had run down during the week, making the trailer furnace inoperable. Haney suggested that he bring his portable propane heater, a Coleman Powermate 5045, into the trailer to "knock the chill off."

Haney took the heater into the trailer, opened the window by the dinner table four inches for ventilation, turned the heater on to its highest setting, and began cooking chili. When dinner was ready about 25 minutes later, the other men came into the trailer. Ramiskey had been complaining of an upset stomach and did not want to make it worse by eating chili, so instead of eating dinner he went to bed. Because Ramiskey

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the federal terminology (RT = Reporter's Transcript; ER = Excerpt of Record; SER = Supplemental Excerpt of Record).

did not like to be hot at night, Haney turned the propane heater down to its lowest setting. Haney and Daniel went to bed after dinner, but before retiring, Haney turned the heater off and shut the window "to about a half an inch."

Haney was awakened at 4:30 a.m. by Ramiskey's alarm clock, which sounded very loud in the dark, quiet trailer. The alarm continued to blare, and Haney could not understand why Ramiskey did not turn it off. He struggled two or three times to sit up, but found he was intensely sore – his body was stiff, his back ached, he felt "gritty," and had a throbbing headache. He felt as if his head was in a fish bowl.

At last, he was able to get his feet over the edge of the bed, but, when he stood up, he was so dizzy that he sat right back down again. He noticed that Ramiskey was not in his bed. He was cold, so he turned the heater on. He then made his way to the bathroom and opened the door. He found Ramiskey slumped over the side of the toilet with his head in the shower stall. Taken aback, Haney reached out and touched Ramiskey's shoulder. Ramiskey was cold to the touch. Fearing that Ramiskey had suffered a heart attack, Haney went to the back of the trailer to awaken Daniel. Daniel was also cold to the touch and did not respond. Haney began to panic. Despite being dizzy and disoriented, he realized they might all be victims of CO poisoning. He immediately turned off the

heater, threw open the trailer door and stood there in his underwear gasping for air.

Haney realized he had to get help, but was so disoriented he had trouble finding the clothes he had laid out the night before. He found his cell phone, but could not get a signal. He then scoured the trailer looking for his keys, only to discover them in his pocket.

Fighting nausea and dizziness, he drove down the hill with his windows rolled down for air. Two or three times, he found himself swerving off the road. At one point, he pulled over to throw up. It was then he realized that the grittiness he noticed during the night was, in fact, dried vomit. He eventually reached a fire station in Packwood. From there, he was taken by ambulance to a hospital where he was treated for CO poisoning.

In December 2006, Mari Daniel, the widow of Melvin Daniel and daughter of Fred Ramiskey, filed suit in the United States District Court for the Western District of Washington at Tacoma against Coleman, the manufacturer of the propane heater, alleging that the company was liable under the WPLA for damages flowing from the CO deaths of her husband and father. Daniel asserted that the type of Coleman heater used by her husband produced lethal levels of CO when operated at a reduced fuel setting.

The heater in question was the Powermate 5045 manufactured by Coleman. The Powermate 5045 is a large outdoor heater. When consumers used it indoors at a reduced fuel flow setting, it produced large quantities of CO. Coleman learned of this new hazard only after the Powermate 5045 was manufactured. From the time of its initial manufacture in 1995, the Powermate 5045 contained the following general warning:

> For outdoor or well ventilated construction use only. Never use inside house, camper, tent, vehicle or other unventilated or enclosed area.[3]

The label, which was affixed to the side of the heater, is smaller than a pop can, and not readily seen by consumers.

Subsequent to its manufacture, Coleman was aware that despite the warning on the Powermate 5045, consumers continued to be injured or killed by CO poisoning from its indoor use. Coleman learned that heater users were dying of CO poisoning when they operated Coleman's heaters on low heat settings in tents, campers, and other confined spaces. The Consumer Products Safety Commission ("CPSC")[4] specifically noted that

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[3] Coleman has argued that the instructions supplied with the heater when it was sold should also be considered as warnings. Haney, however, bought a used heater without a box or documentation. RCW 7.72.030(1)(c) requires a manufacturer to warn product *users*, not merely owners who might be in possession of original documentation.

[4] The CPSC report was filed under seal. Daniels asks that the report be considered under seal. GR 15(g).

product users were being killed when they operated the heater on low settings in tents, campers and vehicles. ER 1405, 1407. *See* Appendix.

Coleman was aware of specific incidents involving its larger heaters. The Focus 15 and 30 were camping heaters. The Coleman Powermate 5045 is one of a line of large commercial heaters which includes other Powermate models such as the Powermate 5012, 5014, and 5017. Coleman was aware of numerous deaths involving these heaters.

Coleman also produced a summary of all heater incidents involving CO poisoning through October 10, 2005.[5] ER 549-50. The summary lists three incidents resulting in six deaths involving the Powermate 5012; eleven incidents resulting in 17 fatalities involving Powermate 5014, 5017, and 5045 heaters, two of which involved the Powermate 5045; nine incidents resulting in twelve deaths involving the Focus 15 heater and four incidents resulting in six deaths involving the Focus 30 heater. The summary also listed 11 incidents resulting in 19 deaths involving the small Focus 3 and 5 heaters. The CPSC report was instigated by the death of two soldiers who used a Powermate 5014 inside a tent during a training exercise. (The report noted that after the evaluation began, CPSC staff learned of a second fatal incident involving the same heater model.)

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[5] *See* Appendix. This report, too, was filed under seal and should be considered under seal by this Court.

Five similar incidents of fatalities involving the Powermate 5045 were presented to the jury at trial. In November 2000, an elderly man was killed and three people were injured by carbon monoxide when he used a Powermate 5045 in a boarding house in Sacramento, California. RT 600-01. A man succumbed to carbon monoxide poisoning after bringing a Powermate 5045 inside after he lost power in his home. RT 589-90, 598. In April 2005, a father and son were killed by carbon monoxide produced by a Powermate 5045 while they slept in a small shack in Santa Fe, New Mexico. RT 601-02. A family of three died using a Powermate 5045 inside a van in Packwood, Washington in May 2005. RT 602-03. And in December 2005, a man died using a Powermate 5045 to heat a small apartment. RT 608.

Coleman moved for summary judgment on the post-manufacture duty to warn issue, which the district court denied. RT (3/20/08): 77-80. However, the court refused to instruct the jury on Coleman's post-manufacture duty to warn about the danger posed by its heater. Similarly, the court precluded Daniel from introducing evidence of warnings Coleman had provided the public in the early 1990s regarding the dangers of high CO levels produced by other heaters the company had produced,

evidence which would have established that Coleman should have issued similar post-sale warnings for the heater type in question.[6]

The case was tried to a jury which found in Coleman's favor on defective design, and time-of-manufacture failure to warn. The district court entered a judgment on the jury's verdict. Daniel appealed the judgment to the Ninth Circuit which ruled in favor of Coleman, but, upon a motion for rehearing, withdrew its opinion, certifying the present issue to this Court.

D. SUMMARY OF ARGUMENT

Coleman's warnings post-manufacture for the Powermate 5045 were inadequate. Its initial warning was far from clear, but after the heater's manufacture, the company was on notice from other similar incidents involving its large heaters, including the Powermate 5045, that consumers were using the heater indoors, in confined places such as tents and travel trailers. The use of the Powermate 5045 indoors at a reduced-fuel setting was a new and separate danger arising after the heater was manufactured, triggering Coleman's post-manufacture duty to warn under RCW 7.72.030(1)(c). Moreover, Coleman's notice of deaths associated with the use of its heaters indoors dictated that additional post-

[6] Prior to trial, the district court ruled that Daniel could not introduce evidence of substantially similar CO poisoning incidents related to Coleman's other propane heaters, or evidence that Coleman engineers knew as early as 1992 that reducing fuel flow in its propane heaters would result in significant production of CO.

manufacture warnings be given by Coleman to consumers. The district court erred in not presenting to the jury the issue of Coleman's notice of a new hazard and its attendant duty to warn.

E. ARGUMENT

(1) Statutory Construction Principles

This case presents the Court with an issue of statutory construction. The purpose of judicial interpretation of a Washington statute is to effectuate the intent of the Legislature. *State v. Campbell & Gwinn, LLC,* 146 Wn.2d 1, 9-10, 43 P.3d 4 (2002). Ascertaining that intent is gleaned initially from the plain language of the statute. *Id.* at 10-12. Of course, in reviewing the statutory language, the plain meaning of the Legislature may be discerned from an examination of "everything the legislature has said in the statute itself and any related statutes that reveal legislative intent regarding the provision at issue." *In re Custody of E.A.T.W.*, 168 Wn.2d 335, 343, 227 P.3d 1284 (2010). Courts will also assess the subject and purpose of the enactment. *Id.* If the statute is subject to two or more reasonable interpretations, it is ambiguous and courts may then employ tools of statutory construction such as legislative history materials to ascertain a statute's meaning. *Cerrillo v. Esparza*, 158 Wn.2d 194, 201, 142 P.3d 155 (2006). In interpreting the WPLA, this Court has frequently utilized the report of the Senate committee (found in

the 1986 *Senate Journal*) that developed the bill. *See, e.g., Washington Water Power Co. v. Graybar Elec. Co.*, 112 Wn.2d 847, 854, 774 P.2d 1199 (1989); *Falk v. Keene Corp.*, 113 Wn.2d 645, 649-53, 782 P.2d 974 (1989).

(2) The District Court Erred in Refusing to Instruct the Jury on Coleman's Post-Manufacture Duty to Warn

(a) Washington Law on Post-Manufacture Duty to Warn

In denying Daniel an instruction on Coleman's post-manufacture duty to warn, the district court's understanding of RCW 7.72.030(1)(c) was too restrictive.

The WPLA was enacted in 1981. It was based on the United States Commerce Department's Model Uniform Product Liability Act. 1981 Senate Journal, reg. sess. at 624. *See* 44 Fed. Reg. 62, 714-62, 750. As noted in the comments to the Model Act, RCW 7.70.030(1)(c) is consistent with traditional case law on post-manufacture duty to warn. *Id.* at 62725. *See, e.g., Comstock v. General Motors Corp.*, 99 N.W.2d 627 (Mich. 1959) (GM learned of brake problems in some 1953 Buicks after putting the car on the market; Michigan court recognized post-manufacture duty to warn consumers of such latent problems); *Cover v. Cohen*, 461 N.E.2d 864, 871 (N.Y. 1964) (sudden acceleration problem in GM car; court held manufacturer could be liable for failure to warn of

defects learned through experience or through advancements in the state of the art: "Although a product may be reasonably safe when manufactured and sold and involve no then known risks of which warning need be given, risks thereafter revealed by user operation and brought to the attention of the manufacturer or vendor may impose upon one or both a duty to warn...").

Under Washington law, a manufacturer may be found liable for the failure to warn of a product's hazards of which the manufacturer receives notice after the product is placed into the stream of commerce. RCW 7.72.030(1)(c) provides that:

> A product is not reasonably safe because adequate warnings or instructions were not provided after the product was manufactured where a manufacturer learned or where a reasonable manufacturer should have learned about a danger connected with the product after it was manufactured. In such a case, the manufacturer is under a duty to act with regard to issuing warnings or instructions concerning the danger in the manner that a reasonably prudent manufacturer would act in the same or similar circumstances. The duty is satisfied if the manufacturer exercises reasonable care to inform product users.

This Court has expressly held that liability under this provision is based on *strict liability*, not negligence. *Ayers v. Johnson & Johnson Baby Prods. Co.*, 117 Wn.2d 747, 759-63, 818 P.2d 1337 (1991).

In order to understand the scope of the post-manufacture duty to warn, the starting place for any analysis is the plain language of RCW

7.72.030(1)(c). *Nothing* in that statute indicates that the manufacturer is exonerated from any post-manufacture duty to warn where the manufacturer develops greater knowledge of a product's danger after the manufacturer provided a time-of-manufacture warning about the product's potential harm to consumers.

This statement is consistent with the context of .030(1)(c). Indeed, the specific language of RCW 7.72.030(1)(b) and (c), differentiates between time of sale warnings and post-manufacture warnings.[7] RCW 7.72.030(1)(b) states as to time of manufacture warnings:

> A product is not reasonably safe because adequate warnings or instructions were not provided with the product, if, at the time of manufacture, the likelihood that the product would cause the claimant's harm or similar harms, and the seriousness of those harms, rendered the warnings or instructions of the manufacturer inadequate and the manufacturer could have provided the warnings or instructions which the claimant alleges would have been adequate.

Under the plain language of RCW 7.72.030(1)(c), the Legislature did not say that the danger had to be a "new" danger not previously addressed in time-of-manufacture warnings that are the subject of RCW

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[7] RCW 7.72.030(3) permits proof of a post-manufacture duty to warn claim by showing that the product "was unsafe to an extent beyond that which would be contemplated by the ordinary consumer." *Thongchoom* approved of the duty to warn issue being addressed under RCW 7.72.030(3). 117 Wn. App. at 299. The consumer-expectations approach of RCW 7.72.030(3) is an alternative, independent means of proving inadequate warnings. A plaintiff need prove only one of the alternatives, either under RCW 7.72.030(1) or 7.72.030(3) to recover. *Ayers*, 117 Wn.2d at 765. Daniel's post-manufacture duty to warn theory could also have gone to the jury under RCW 7.72.030(3).

7.72.030(1)(b). In fact, the Legislature advisedly referenced the claimant's "harm" in (1)(b), while using the language of "danger" in (1)(c). To be liable under (1)(b), the manufacturer's warning had to fail to apprise the claimant at the time of the product's manufacture of "the likelihood that the product would cause the claimant's harm or similar harms, and the seriousness of those harms . . . By contrast, RCW 7.72.030(1)(c) is *broader* in its scope, indicating that evolving knowledge of the manufacturer clearly comes into play. It provides for liability if the manufacturer failed to warn about a "danger" connected with the product after its manufacturer about which the manufacturer learned or a reasonably prudent manufacturer should have learned. "In such a case, the manufacturer is under a duty to act with regard to issuing warnings or instructions concerning the danger in the manner that a reasonably prudent manufacturer would act in the same or similar circumstances."[8] *Id.*

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[8] Harm is defined in RCW 7.72.010(6) as "any damages recognized by the courts of this state . . ." Danger is not defined in the statute, but the comments on the United States Department of Commerce Model Uniform Product Liability Act, upon which Chap. 7.72 of RCW was based, are instructive.

The comments to the section of the Model Act adopted by Washington state in RCW 7.72.030(1)(c) provide that danger is similar to risk:

> Subsection (C)(6) recognizes a manufacturer's duty to warn after its product has been produced. The Subsection places an obligation on a manufacturer to act with reasonable prudence to learn about serious risks connected with products after they are manufactured. When it learns of such a risk, it is to act as a reasonably prudent manufacturer in the same or similar situation. This obligation is satisfied if the

In providing for liability under either standard, the Legislature meant for post-manufacture situations to be distinct both as to the nature of the risk *and* qualitative/quantitative changes in the nature of the original risk to impose liability. A reasonably prudent manufacturer of a product might not be aware at the time of the product's manufacture that the claimant's actual harm would ensue. A manufacturer might even warn in general terms of the theoretical risk of harm to the claimant and a jury could find the manufacturer satisfied its duty to warn under RCW 7.72.030(1)(b). But where that reasonably prudent manufacturer learned of dozens of deaths from the use of its product around the country, interacted with government agencies notifying it of a specific danger associated with a product, experienced numerous lawsuits, or faced a product recall, RCW 7.72.030(1)(c) commands that the reasonably prudent manufacturer cannot continue to rely on a time-of-manufacture warning that ignores such an evolving reality, *and does not work to protect consumers*. It must do more.

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manufacturer makes reasonable efforts to inform product users or appropriate persons about the risk.

44 Fed. Reg. at 62725 (1979).

Moreover, the concept of "danger" is broader than the statutory definition of harm in RCW 7.72.010(6). Bryan A. Garner, *Black's Legal Dictionary* (8th ed.) defines danger at 421 as "Peril; exposure to harm, loss, pain, or other negative result."

A limited number of Washington cases have addressed a product manufacturer's post-manufacture duty to warn. This Court has held that a product is not reasonably safe because of a danger connected with the product that the manufacturer learned about, or should have learned about, after the product was manufactured. *Timberline Air Serv., Inc. v. Bell Helicopter-Textron, Inc.*, 125 Wn.2d 305, 327-30, 884 P.2d 920 (1994). There, this Court explained the purpose of the WPLA's warning provisions: "[S]tate tort law duties to warn have the objective of helping those who use or come into contact with the product to protect ... their own safety." *Id.* at 327.

In *Esparza v. Skyreach Equipment, Inc.*, 103 Wn. App. 916, 935, 15 P.3d 188 (2000), *review denied,* 144 Wn.2d 1004 (2001), the Washington case most extensively analyzing the post-manufacture duty to warn, the Court of Appeals reversed a judgment for a defendant and ordered a new trial where a trial court had concluded that there was insufficient evidence to prove the manufacturer's liability under RCW 7.72.030(1)(c).

Esparza fell off a manlift, resulting in serious injuries. He sued Skyreach, the manlift's lessor. According to the *Esparza* court, the evidence adduced by Skyreach, which included testimony that there was a prior similar incident three years earlier, that users had complained about

the reliability of the circuit cards for the manlift, people had purchased replacement circuit cards, and the manufacturer decided not to issue any warnings, was sufficient for a jury to conclude that the manufacturer breached its duty to warn:

> The general rule is that a post-sale duty to warn arises after a manufacturer has sufficient notice about a specific danger associated with the product. Whether the manufacturer, which is held to the standard of an expert in the field, had sufficient notice is a factual question, generally to be decided by the jury. The most convincing proof that a manufacturer knew of a dangerous condition associated with its product is that manufacturer knew previous substantially similar accidents involving the product.

Id. at 936 (citations omitted). The *Esparza* court concluded, "We have no difficulty concluding that there was a duty to warn in this case, so long as a rational trier of fact determines that [the manufacturer] had or should have had sufficient notice about the specific danger associated with its product, namely the danger of both circuit cards failing at once due to a current surge, for our Legislature has already made that determination." *Id.*

From *Esparza*, it is clear that Washington courts must apply a two-step analysis in a post-manufacture duty to warn case. First, a court must analyze whether a product's manufacturer had notice of a danger associated with the product about which it learned after the product's manufacture. Other similar incidents ("OSI") evidence is crucial to the

notice question. *Esparza*, 103 Wn. App. at 935. Moreover, given the fact that RCW 7.72.030(1)(c) requires assessment of the danger "in the manner that a reasonably prudent manufacturer would act in the same or similar circumstances," the notice issue is one for the jury. *Id.* at 936. Second, the court determines whether a duty to warn is present as a matter of law upon the resolution of the factual question of notice of the specific danger associated with the product. *Id.* at 935-36.

Coleman argues that because the jury found the time-of-manufacture warnings affixed to the Powermate 5045 heater were adequate, it was absolved of any duty to provide further warnings of the CO danger posed by the heater. In making this argument, Coleman relied principally on *Thongchoom v. Graco Children's Products, Inc.*, 117 Wn. App. 299, 71 P.3d 214 (2003), *review denied,* 151 Wn.2d 1002 (2004). That case is readily distinguishable.

In *Thongchoom*, a baby was burned when he grabbed the cord of an electric tea pot while moving about in his walker. *Id.* at 302-03. The court affirmed summary judgment dismissal of the Thongchoom's time-of-sale and post-manufacture warnings claims. *Id.* at 306-07. The Thongchooms claimed the warnings provided by the defendant were inadequate because they failed to warn of every possible injury. *Id.* at 306. Specifically, they contended the warnings should have stated that

babies can move quickly in the walker and that they often move backward first. *Id.* at 306. The court noted that the manufacturer had warned of the risks of a baby's mobility at the time of the walker's manufacture, and held that no further warnings were needed. *Id.* at 306.[9] The court's analysis, upon which Coleman relies, involved a single paragraph in the court's opinion.

Washington law is largely silent on whether a warning which was adequate at the time of a product's manufacture can shield a product manufacturer from liability for failing to provide post-manufacture warnings to supplement the warnings originally provided when the manufacturer acquires additional knowledge of product hazards. Nevertheless, the district court deprived Daniel of the opportunity to present a post-manufacture duty to warn case to the jury. A *jury*, not the district court, should have made the decision whether the defect at issue in this case was distinct from the hazard known to Coleman when the Powermate 5045 was first manufactured. Simply stated, despite

[9] The dangers associated with the baby walker in *Thongchoom* arose from the myriad actions a baby might undertake while in a walker. The manufacturer could not warn of every situation in which a baby might place itself in harm's way while using the product. The danger lay in a baby's unpredictable behavior; it did not lie in the product itself. This stands in stark contrast to the Powermate 5045 heater. Like all of Coleman's large commercial heaters, the 5045 is an inherently dangerous device. In addition to depleting oxygen and producing CO, the heater poses a serious risk of fire, and Coleman was subsequently put on notice of *numerous* deaths associated with the Powermate 5045 (and its other commercial heaters) when consumers continued to use those heaters indoors despite the warning Coleman had provided.

Coleman's intention that its heater be used only outdoors or in well-ventilated construction sites, and despite the Powermate 5045's greater size and output compared to Coleman's other bulk mount heaters, consumers nevertheless used the heater indoors, or in other locations lacking proper ventilation, and were consequently dying of CO poisoning while using the heater at a low setting.

The district court concluded that Coleman had no duty to warn about the Powermate 5045 after its manufacture because Coleman was already aware of a CO danger for the unit when it was manufactured. The court's analysis misses the entire point of a post-manufacture duty to warn. That duty arises based on *a manufacturer's experience with the product*. *Esparza*, 103 Wn. App. at 935. Whether Coleman's experience with the Powermate 5045 after its manufacture notified it of a new risk requiring warning to consumers is an issue to be decided by a jury.

The district court's formulation of Coleman's post-manufacture duty to warn is far too simplistic. The court concluded that Coleman knew of a potential hazard with Powermate 5045 that could result in CO-related injuries and deaths and warned about that hazard. However, the court intruded upon the jury's role to determine that exposure to high levels of CO from using the large Powermate 5045 indoors at a low setting was not a new and distinct hazard about which Coleman was obligated to warn.

Merely because *the result* of the two distinct hazards – CO exposure – was the same does not equate to only one hazard being present. Similarly, the court deprived the jury of the chance to assess whether Coleman's knowledge of CO-related deaths from the use of its heaters indoors should have prompted the need for expanded warnings.

The *Esparza* court never limited an RCW 7.72.010(1)(c) cause of action as the *Thongchoom* court allegedly did. In fact, the *Esparza* court discussed in some detail the manufacturer's evolving awareness of the product's risk, and cases discussing such an evolving awareness, 103 Wn. App. at 931-36, concluding "The most convincing proof that a manufacturer knew of a dangerous condition associated with its product is that the manufacturer knew about previous substantially similar accidents involving the product." *Id.* at 935. Clearly, such accidents occur post-manufacture.

Even if this Court were to find the statutory language was not plain, requiring it to resort to the WPLA's legislative history, that legislative history clearly indicates that the Legislature intended a jury in a warning case to:

> engage in a comparison between the likelihood and seriousness of harm in whether or not adequate warnings or instructions could have been provided. This determination should be made in conjunction with an analysis of the expectations of the ordinary consumer.

Senate Journal, 1981, Reg. Sess. at 631. Similarly, in connection with post-manufacture duty to warn, the legislative direction was:

> a claimant is required to show that the manufacturer learned or should have learned about a products dangerous condition after it was manufactured and that the manufacturer failed to act in a manner in which a reasonably prudent manufacturer would have acted. The reasonable expectations of the ordinary consumer should also be considered by the trier of fact in this situation.

Id.

The Legislature intended that a jury in a post-manufacture warnings case should be apprised of the reasonable expectations of the ordinary consumer in connection with such warnings both at the time of manufacture and post-manufacture. An ordinary consumer would expect a reasonably prudent manufacturer, as that manufacturer acquired additional information in connection with a product's risk, particularly if that risk was the death of consumers, to take appropriate steps to update and expand product warnings.[10]

The construction of RCW 7.72.030(1)(c) offered by Daniel better comports with the concept of post-manufacture warnings as discussed in the treatises and in other jurisdictions. For example, Daniel's analysis is

[10] Under Coleman's analysis, if a product manufacturer in a post-manufacture duty to warn case was subject to a product recall, the basis for such a recall would not be communicated to the jury if the subject of the recall had been generally considered at the time of the product's manufacture. That is not the legislative intent.

consistent with the test outlined in section 10 of the *Restatement (Third) of Torts* on post-manufacture warnings, a test firmly rooted in the evolving knowledge of the manufacturer of the hazards in its product:

> (a) One engaged in the business of selling or otherwise distributing products is subject to liability for harm to persons or property caused by the seller's failure to provide a warning after the time of sale or distribution of a product if a reasonable person in the seller's position would provide such a warning:
>
> (b) A reasonable person in the seller's position would provide a warning after the time of sale if:
>
> > (1) the seller knows or reasonably should know that the product poses a substantial risk of harm to persons or property; and
> > (2) those to whom a warning might be provided can be identified and can reasonably be assumed to be unaware of the risk of harm; and
> > (3) a warning can be effectively communicated to and acted on by those to whom a warning might be provided; and
> > (4) the risk of harm is sufficiently great to justify the burden of providing a warning.

Under the *Restatement's* test in § 10, Coleman could not continue to rely on its obviously inadequate warning as ever-increasing numbers of people died from using heaters like the Powermate 5045 indoors. As stated in comment c to the *Restatement (Third) of Torts* § 10:

> As a practical matter, most post-sale duties to warn arise when new information is brought to the attention of the seller, after the time of sale, concerning risks accompanying the product's use or consumption. When risks are not actually brought to the attention of sellers, the

> burden of constantly monitoring product performance in the field is usually too burdensome to support a post-sale duty to warn. However, when reasonable grounds exist for the seller to suspect that a hitherto unknown risk exists, especially when the risk involved is great, the duty of reasonable care may require investigation. With regard to one class of products, prescription drugs and devices, courts traditionally impose a continuing duty of reasonable care to test and monitor after sale to discover product-related risks.

The post-manufacture duty to warn is an evolving responsibility for a manufacturer based on the acquisition of new information. Coleman cannot turn a blind eye toward the actual information it was receiving about the Powermate 5045 because it was aware of a *theoretical* hazard associated with the heater when it was initially manufactured. RCW 7.72.010(1)(c) requires more.

Some courts have also analyzed a manufacturer's duty under a continuing duty to warn approach. *See Jablonski v. Ford Motor Co.*, 923 N.E.2d 347 (Ill. App. 2010), *appeal allowed*, 236 Ill.2d 555 (2010). The *Jablonski* court concluded that if a manufacturer knew of a hazard at the time of manufacture, as Coleman allegedly did here with respect to the hazard of indoor use of its heaters like the Powermate 5045,

> if a manufacturer later develops safety features or safety information for the purpose of protecting consumers from a hazard of which it had knowledge at the time the product was originally sold, it has a duty to use reasonable care to inform users of the product of the existence of those safety features and information.

Id. at 254. The court adopted a continuing duty to warn analysis:

> We believe that this is a common sense rule. It would make no sense for a duty to warn, which already exists, to disappear after a hazardous product leaves the control of the manufacturer. Sound public policy requires that a manufacturer be held to a continuing duty to warn of a hazard and to notify consumers of its product if the hazard can be avoided. We hold that a manufacturer has a continuing duty to warn of a hazard of which it had a duty to warn at the time the product was manufactured, including using reasonable care to inform foreseeable users of product developments designed to eliminate the hazard.

Id. at 257. This continuing duty to warn concept has support in Washington law. *Lockwood v. A.C.& S., Inc.*, 109 Wn.2d 235, 260, 744 P.2d 605 (1987) ("We believe that where a person's susceptibility to the danger of a product continues after that person's direct exposure to the product has ceased, the manufacturer still has a duty after exposure to exercise reasonable care to warn the person of known dangers, if the warning could help to prevent or lessen the harm.")

Thus, Coleman had a continuing duty to users of its heaters like Melvin Daniel and Fred Ramiskey to apprise them of its evolving knowledge of the hazards of its heaters like the Powermate 5045 when used indoors, particularly where they were not the initial purchasers of the heater and Coleman knew of the existence of an aftermarket in such heaters among outdoorsmen. Whether phrased as a post-manufacture duty

to warn or a continuing duty, Daniel was entitled to such an instruction on the evidence adduced here.

Finally, Daniel's analysis of RCW 7.72.030(1)(c) better comports with Washington public policy on the duty of a product manufacturer. The focus of Washington product liability law has been upon the reasonable expectations of the average consumer. RCW 7.72.030(3). This Court indicated in *Seattle-First Nat'l Bank v. Tabert*, 86 Wn.2d 145, 150-51, 542 P.2d 774 (1975) that comment i to the *Restatement (Second) of Torts* § 402A wherein the reasonable expectations of the ordinary consumer as to whether a product was "unreasonably dangerous," controls in Washington. The Court adopted the following analysis of the Oregon Supreme Court:

> A dangerously defective article would be one which a reasonable person would not put into the stream of commerce if he had knowledge of its harmful character. The test, therefore, is whether the seller would be negligent if he sold the article knowing of the risk involved. Strict liability imposes what amounts to constructive knowledge of the condition of the product.

Id. at 153. This Court summarized its holding as follows:

> Thus, we hold that liability is imposed under section 402A if a product is not reasonably safe. This means that it must be unsafe to an extent beyond that which would be reasonably contemplated by the ordinary consumer. This evaluation of the product in terms of the reasonable expectations of the ordinary consumer allows the trier of the fact to take into account the intrinsic nature of the

> product. The purchaser of a Volkswagen cannot reasonably expect the same degree of safety as would the buyer of the much more expensive Cadillac. It must be borne in mind that we are dealing with a relative, not an absolute concept.
>
> In determining the reasonable expectations of the ordinary consumer, a number of factors must be considered. The relative cost of the product, the gravity of the potential harm from the claimed defect and the cost and feasibility of eliminating or minimizing the risk may be relevant in a particular case. In other instances the nature of the product or the nature of the claimed defect may make other factors relevant to the issue.

Id. at 154.

(b) Daniel Was Entitled to an Instruction on Coleman's Post-Manufacture Duty to Warn

Daniel met the two-part test in *Esparza, supra*. First, Coleman was on notice of the danger at issue here, both the hazard of operation of the heaters at reduced fuel flow indoors and the increasing number of CO-related deaths.

Other similar incidents ("OSI") are relevant to prove both a defendant's knowledge of a condition as well as negligence, as the *Esparza* court observed when it stated that "the most convincing proof that a manufacturer knew of a dangerous condition associated with its product is that the manufacturer knew about previous similar incidents." 103 Wn. App. at 935. *See also, Slaton v. Chicago, Milwaukee & St. Paul Railway Co.*, 97 Wash. 441, 166 P. 644 (1917) (prior fires along a railroad to show

the defendant's knowledge of the danger and the defendant's negligent toleration of the danger); *Porter v. Chicago, M., St. Paul & Pac. R.R. Co.*, 41 Wn.2d 836, 252 P.2d 306 (1953) (trial court abused its discretion in refusing offer of proof on other accidents at railroad crossing). During a pretrial hearing on OSI evidence, the district court noted that Coleman had acknowledged in its pretrial order that the heaters intended for outdoor use were being taken inside. Coleman knew there was a CO-related problem with the use of its heaters indoors. It also knew people were dying.

The CPSC report is damning. Following the CO deaths of two soldiers in 2001, the CPSC conducted a series of tests of the commercial grade, bulk-mount Powermate 5014 heater. The two soldiers had used a Powermate 5014 for a maximum of 3.5 hours inside a tent during a training exercise. ER 1405. The report noted that after the evaluation began, CPSC staff learned of a second fatal incident involving the same heater model. ER 1407. A total of 31 tests showed that the maximum CO level produced by the heaters ranged from 20 ppm to more than 3,000 ppm, the upper limit of the CO sensor. ER 1410. The report concluded that: "When used inside small volume or poorly ventilated environments...the subject radiant heater can rapidly produce life-threatening CO exposure or prolonged sub-lethal CO exposures that can have serious, lasting adverse effects.... The use of 20-lb. fuel tanks with

these heaters and the poor reliability of the flame failure sensor indicate that dangerous CO exposures will be extremely prolonged and more likely to result in serious or fatal outcomes." ER 1412.

The report provided compelling evidence that bulk-mount commercial heaters other than the Powermate 5045 were capable of producing lethal CO levels.

In response to discovery in another suit, Coleman produced a summary of all heater incidents involving CO poisoning through October, 2005. ER 549-50. *See* Appendix. The summary lists three incidents resulting in six deaths involving the Powermate 5012; eleven incidents resulting in 17 fatalities involving Powermate 5014, 5017, and 5045 heaters, only two of which involved the Powermate 5045; nine incidents resulting in twelve deaths involving the Focus 15 heater and four incidents resulting in six deaths involving the Focus 30 heater. The summary also listed 11 incidents resulting in 19 deaths involving the small Focus 3 and 5 heaters.

These other incidents involving Coleman's heaters put it on notice that there were multiple CO deaths throughout the country, notice that should have prompted it to warn consumers after the manufacture of the Powermate 5045 of the circumstances that resulted in the deaths of Daniel and Ramiskey.

Second, under the *Esparza* test, the district court was obligated to properly formulate the duty to warn under RCW 7.72.030(1)(c) in a jury instruction. *See* WPI 110.03.01. Coleman does not get a free pass on any CO-related deaths, despite its increasing knowledge of the hazards of the Powermate 5045, and the need to refine its warnings in light of that knowledge, merely because it offered a generic warning at the time of the heater's sale. That position defies the touchstone for that law – the reasonable expectations of the average consumer. RCW 7.72.030. A reasonable consumer would justifiably expect that Coleman would refine its warnings as its knowledge regarding the use of its product increased, particularly where consumers were *dying*.

Coleman knew that people were dying, putting it on notice that its product continued to pose a substantial risk of harm.[11] The time-of-manufacture warning on the Powermate 5045 *made no mention of CO*. Thus, those to whom a warning might be provided can reasonably be assumed to be unaware of the risk of harm. Finally, what harm is greater than death?

[11] Outdoorsmen who might purchase Coleman's heaters are an identifiable group to whom warning could be provided. Coleman had previously undertaken a post-manufacture warning campaign in connection with a much smaller indoor heater in order to alert the public to the dangers of CO.

Coleman's insistence that it was under no duty to provide post-manufacture warnings because it was already aware of the CO dangers, and the jury found the time-of-sale warning sufficient, was rejected by the court in *Van Den Eng v. The Coleman Co., Inc.*, 2006 WL 1663714 (E.D. Wis. 2006).[12] In reviewing the history of Coleman's warnings, it noted:

> In 1992, Coleman . . ., agreed to revise its warnings for the Focus 5 heaters to add a specific reference to carbon monoxide poisoning . . . However, *Coleman elected not to include a warning about carbon monoxide poisoning on any of its Powermate heaters until it added a brochure explaining the dangers of carbon monoxide to new Powermate 5012 models after May 1997.* Even then, Coleman did not add the brochures to heaters already in the chain of distribution or attempt to distribute them to individuals who had already purchased the heaters.

Id. at 6 (emphasis added).[13]

---

[12] Under federal rules, this opinion, though unpublished, may be cited. Federal Rules of Appellate Procedure allow citation to unpublished opinions issued on or after January 1, 2007. FRAP 32.1(a). As to unpublished decisions filed prior to that date, each circuit court has its own rule. *S.S. v. Alexander*, 143 Wn. App. 75, 93, 177 P.3d 724 (2008). The majority of the circuit courts, however, now allow for the unrestricted citation of these decisions. *Id.* The *Alexander* court applied the majority approach and held that unpublished federal court decisions could be cited where appropriate. *Id.* Seventh Circuit Rules permit the citation of unpublished opinions issued before January 1, 2007, to support a claim of preclusion (e.g. res judicata or collateral estoppel). U.S. Ct. of App. 7th Cir. Rule 32.1. Under the rule, Coleman is precluded from denying the findings and conclusions of the *Van Den Eng* court.

[13] The *Van Den Eng* court also grappled with the distinction between the various Focus and Powermate heaters and reached a very different conclusion from the district court here:

> All but one of the "Focus" models and all of the Powermate models allowed the user to vary the heat outputs by selecting a lower b.t.u. setting. The output could be reduced further from the lowest setting by adjusting the fuel flow at the propane tank or by manually holding down the control valve. When operated on reduced fuel flow, the

The Powermate 5045 was first manufactured in 1995, two years before Coleman began adding a brochure explaining the dangers of CO poisoning. Coleman did not add the words "carbon monoxide" to the on-product warnings of the Powermate 5045 until 2004. Coleman offers no explanation why it chose to provide post-manufacture warnings for its smaller Focus 3, 5, and 10 heaters, but neglected to do so for its much larger Powermate heaters until years after they were introduced into the market. It was evident to Coleman that consumers were continuing to bring its commercial heaters indoors, using them with a reduced fuel flow, and dying as a result. Even as it relied on the heaters' size, noise, and tremendous heat output, along with the generic warning against indoor use to dissuade consumers from doing so, Coleman should have recognized that consumers' persistent indoor use of the 5045 with reduced fuel flow constituted a new danger and acted accordingly.

> heaters produced increased, and potentially lethal, levels of carbon monoxide. Other than the b.t.u. per hour output, which ranges from a maximum of 3,000 b.t.u. in the smallest Focus 5 to 45,000 b.t.u. in the largest Powermate model, the size of the propane canister to which they attach, and the size and shape of screens, the evidence suggests that the Powermate and Focus brands propane heaters are essentially the same. Each produces radiant heat in the same manner, involving the mixing of propane and air which are forced into a double-screened area where combustion occurs and heat is generated.

Van Den Eng at 2. The *Van Den Eng* court correctly recognized the substantial similarities among the Coleman heaters.

The *Van Den Eng* court drew an analogy to Coleman's original warning, comparing it to a sign at the top of a cliff warning the public to stay away, when the actual danger was a hidden pool of quicksand at the cliff's edge. *Id.* at 6. Similarly, Coleman was on notice that the general admonishment not to use the heaters indoors was insufficient warning.

Coleman was obligated under RCW 7.72.030(1)(c) to upgrade its time-of-manufacture warning for the Powermate 5045 when people continued to die as a result of its indoor use. Death is different. Coleman should not be able to hide behind a generic warning and not revisit the efficacy of that warning after notice of subsequent deaths. It should have provided post-manufacture warning on the Powermate 5045, just as it did on the Focus 5. The use of the heater at a reduced fuel flow was also a new danger. Thus, Coleman's duty to issue post-manufacture warnings should have gone to the jury. To hold otherwise, is to immunize manufacturers who provide only minimal warnings on their products and then fail to take reasonable, necessary measures to warn the public when evidence of subsequent dangers and injuries emerges.

F. CONCLUSION

The district court's decision on the instruction of the jury on Coleman's post-manufacture duty to warn was erroneous. This Court should answer the certified question with a "YES."

DATED this 7th day of September, 2010.

Respectfully submitted,

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APPENDIX

SUMMARY OF ALL HEATER INCIDENTS (INVOLVING CARBON MONOXIDE)
(Updated 10/10/05)

Name	Date of Incident	Date of Notice	Location	Model No.	Possible Alcohol/Drugs	
Coleman Powermate 5012						
Names Unknown (2 fatalities)	DOI: 9/22/96	9/27/96	Ft. McMurry, Alberta, Canada	5012		No Claim
Drossart/VanDenEng (2 fatalities)	DOI: 10/21/00	12/7/00	Price County, WI	5012	Y	Lawsuit Filed
Neether/Schwartz (2 fatalities)	DOI: 6/3/02	10/4/02	Glacier Park, MT	5012		Lawsuit Filed
Coleman Powermate 5014, 5017, 5045						
Truax/Davis (2 fatalities)	DOI: 12/13/98	1/5/99	Oklahoma City, OK	5014		No Claim
Mayhew/Delara (2 fatalities)	DOI: 2/5/99	2/22/99	Farmington, NM	5014	Y	No Claim
UK Female (1 fatality)	DOI: 12/8/99	1/31/02	Denver, CO	5014		No Claim
Reid (1 fatality)	DOI: 3/5/00	6/3/03	Seattle, WA	5014	Y	Lawsuit Filed
Lopez et al. (1 fatality, 3 injuries)	DOI: 11/22/00	3/1/01	Sacramento, CA	5045		No Claim
Sims, J.D. (1 fatality, 1 injury)	DOI: 12/7/00	10/4/02	Atlanta, GA	5014		No Claim
Ruiz/Norem (2 fatalities)	DOI: 1/12/01	1/15/01	Barstow, CA	5014		No Claim
Hancock/Harrison (2 fatalities)	DOI: 11/5/01	6/3/02	Salt Lake City, UT	5017	Y	No Claim
Luna/Martus (2 fatalities)	DOI: 11/15/02	11/18/02	Flint, MI	5014	Y	Lawsuit Filed
Earl VanStory (1 fatality)	DOI: 2/13/03	8/5/03	Greensboro, NC	5045		No Claim
Anderson/Anderson (2 fatalities)	DOI: 8/18/04	Unknown	Sturgis, SD	5014		No Claim
Focus 3 and Focus 5						
Cartee (1 fatality)	DOI: 11/13/95	11/19/96	Independence, MO	Focus 3		**Claim Made**
Brown (1fatality)	DOI: 10/20/90	10/24/91	Witts Springs, AR	Focus 5		Lawsuit Filed
Barry (?) (1 fatality)	DOI: 10/23/90	Unknown	Oswego, NY	Focus 5	Y	No Claim
Souza/Demoura (6 fatalities)	DOI: 04/20/91	4/21/91	Bourne, MA	Focus 5	Y	Lawsuit Filed
Buff/Peterson (2 fatalities)	DOI: 11/21/91	12/3/91	Skagit County, WA	Focus 5		Claims Made
Sheridan (1 fatality)	DOI: 05/08/94	1/30/97	Woodbury, PA	Focus 5	Y	No Claim
Clark (1 fatality)	DOI: 10/14/94	7/31/96	Grays River, WY	Focus 5	Y	No Claim
Smyth (1 fatality)	DOI: 03/05/95	Unknown	Clatskanie, OR	Focus 5		No Claim
Corcoran(DeGaynor) (1 fatality)	DOI: 10/07/95	8/5/96	Middlefield, NY	Focus 5		Lawsuit Filed
Schmidt/Trautman (2 fatalities)	DOI: 10/23/95	12/31/96	Ariel, MS	Focus 5	Y	No Claim
Covas/Reyna (2 fatalities)	DOI: 11/29/99	3/3/00	Taylor County, FL	Focus 5	Y	Lawsuit Filed

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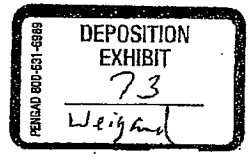

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Focus 15

Like, Casey (1 fatality)	DOI: 3/22/92	Unknown	Santa Rosa, NM	Focus 15		Lawsuit Filed
Kabes, Richard (1 fatality)	DOI: 1/18/95	Unknown	Rice County, MN	Focus 15	Y	Lawsuit Filed
Hubbard, Estel (1 fatality)	DOI: 10/11/95	9/22/97	Portland, OR	Focus 15	Y	No Claim
Force, Clarence (1 fatality, 1 inj.)	DOI: 11/6/95	9/21/96	Pole Patch Camp	Focus 15		No Claim
Pointer/Wilson (2 fatalities)	DOI: 1/13/96	7/16/96	Hugo, MN	Focus 15	Y	Lawsuit Filed
Schoggins (1 fatality)	DOI: 10/1/96	4/3/97	Philomath, OR	Focus 15	Y	Lawsuit Filed
Anderson/Oliver (2 fatalities)	DOI: 10/16/98	10/27/98	Fillmore, UT	Focus 15	Y	Lawsuit Filed
Smith, Daniel/Angela (2 fatalities)	DOI: 4/23/00	5/11/00	Edgewood, WA	Focus 15		Lawsuit Filed
Blankenship (1 fatality)	DOI: 11/16/02	10/14/03	Grocketts Cove, VA	Focus 15		No Claim

Focus 30

5 Iditarod Mushers (5 injuries)	DOI: 03/07/94	Unknown	Finger Lake, AK	Focus 30		No Claim
Mazac (1 fatality)	DOI: 03/15/94	10/31/96	Adrian, OR	Focus 30		No Claim
MacRae (3 fatalities)	DOI: 04/09/96	4/22/96	Japan	Focus 30		No Claim
Arocho /Schiess (2 fatalities)	DOI: 04/16/96	11/19/96	San Carlos, AZ	Focus 30	Y	Lawsuit Filed

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Summary of CPSC Evaluations of
Coleman Company Powermate, Model # 5014-751, Radiant Heater
CPSC P1000004

The U.S. Consumer Product Safety Commission (CPSC) has evaluated the combustion characteristics of Powermate, Model # 5014-751 commercial grade propane-fired radiant heater samples manufactured by the Sunbeam Corporation and it subsidiary the Coleman Company (hereinafter known as "Coleman"). These catalytic heaters are marketed by the manufacturer as "safe for indoor use" and is "designed for recreational use in enclosed areas".

The tank-top style radiant heater mounts to a 20-lb. (9.07-kg) tank of propane gas. The heater consists of a radiant burner surrounded by a reflector assembly. A fuel control knob on the heater is used to turn the heater on/off and is used to vary the energy input rate of the heater from 9,000 Btu/hr to 15,000 Btu/hr (2.64 kW to 4.40 kW). The propane gas is ignited using an integral piezo-type electronic igniter. The heater incorporates a flame failure device to shut off the flow of gas in the event the flame is extinguished. The flame failure device uses a thermocouple to sense the temperature between the reflective and the back of the burner. When the flame is extinguished, the thermocouple cools, causing the gas valve to close. Figure 1 is a photograph of the heater attached to a 20-lb. tank of propane gas. Figure 2 is a close-up of the thermocouple that is part of the flame failure device. Figure 3 is a photograph of the box in which the heater was packaged, illustrating some potential uses of the heater.

Although this heater is considered a commercial grade heater, the product can easily be purchased at retail hardware stores, such as The Home Depot. The manufacturer of the heater states that the product is for outdoor use only, but the design of the heater does not prohibit it from being used in an enclosed environment.

Background: Use of the subject product, a Coleman Powermate unvented propane radiant heater (model #5014-751), inside a large relatively airtight tent is believed to have caused the fatal CO poisoning of two 5th mtn army personnel, aged 23 and 23 years old, respectively. The men had apparently used the heater during a frigid night training exercise on 1/12/01. They were last seen retiring to their tent at 4:00AM before being found unresponsive in their cots at about 7:30AM, indicating that the heater was likely used for a maximum of about 3.5 hours. When found, they were noted to be "pulseless and apneic" (not breathing), and unsuccessful resuscitation attempts were made for some time because it was believed that they were suffering from hypothermia. The men were declared dead in the local hospital at about 11:00AM, where subsequent autopsy tests revealed that the older victim had a carboxyhemoglobin (%COHb) level of 50.9%. The army conducted their own tests on the heater but their final report and conclusions are not yet available to staff. Three heater samples (which included, but did not identify, the incident heater, 01-540-1679 – subunits 1, 2, and 3) and the tent that was involved in the fatal incident were collected from the army by field staff for CPSC testing (see ID: 010328RCC3752).

EX No. 2
DKT 273 MEB Decl re: DEF's MIL
Filed 05/13/08
Under Seal

COL-19225

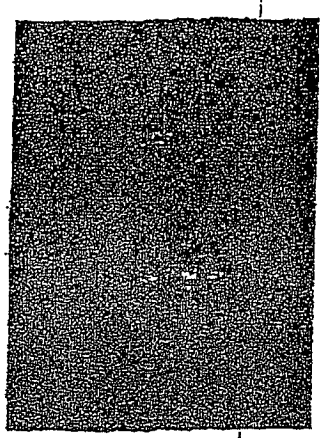
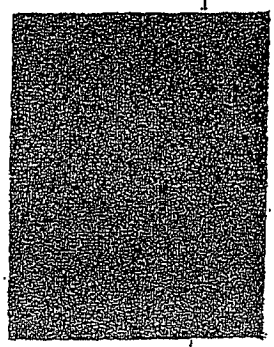
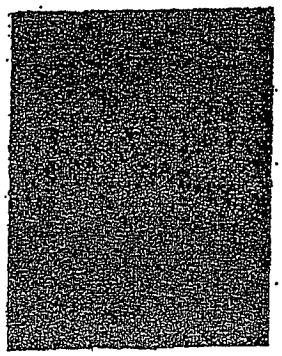


Figure 1. Sample 01-302-8099: Propane-fired radiant heater. The Coleman Company, Inc., (Powermate, 15,000 Btu/hr, Model # 5014-751).

Figure 2. Close-up of thermocouple used by the flame failure device.



(a) front view with heater illustrating heater



(b) close-up of the side of box some potential uses of the

Figure 3. Box in which the Coleman propane radiant heater was packaged (Sample # 01-302-8099).

(Note: Since the evaluation was initiated, The CPSC staff has learned of a second fatal incident involving this same heater model. In December 1999, a 49 year-old woman was found dead inside a passenger van she apparently had been using as temporary accommodation (IDI 010927HCC3452). At autopsy, she was found to have a COHb level of 61.4 %. A Coleman Powermate propane heater (model # 5014-751) was found inside the van, but not operating although the control knob was turned on. Investigators removed the heater from the van; they turned it off and then on again, and found it was able to function. This suggests that the heater's gas valve had automatically closed sometime during the fatal CO exposure.

It is important to note that, unlike portable radiant-type camp heaters that are typically fueled by 16.4-ounce propane cylinders and operate at BIR up to 12,000 Btu/hr, this larger radiant heater is designed to attach to a 20-lb. propane tank. However, its BIR can be manually set between 9,000 to 15,000 Btu/hr by rotating its control knob. The heater has a thermocouple sensor safety feature that is designed to close the gas valve in the event of flame failure. Laboratory Science Engineering (LSE) staff conducted multiple heater combustion tests, first in a controlled small chamber (100 ft^3, 2.83m), and then in the less controllable army tent environment (~300 ft^3, 8.50m).

CPSC Human Factors' Findings

CPSC Human Factors (HF) staff evaluated the packaging, product, and instructions to determine the manufacturer's targeted users, and the adequacy of instructions and warnings concerning the CO poisoning hazard associated with indoor usage. HF staff found that: (1) the packaging promotes product use at both industrial and consumer level but does not have any safety text specifying that the product should be used outdoors, or at least with adequate ventilation, nor does it mention the potential for CO poisoning; (2) a warning, advising that the heater is for outdoor use and should not be used in unventilated or enclosed spaces because it will deplete oxygen and endanger life, is included within the assembly instructions and is also marked on the product; (3) this warning does not specifically mention CO or explain the consequences of the CO hazard, and can likely be overlooked because it uses small cramped type and is presented with other information that the user will focus on; (4) a pamphlet included with the product which features "Camping Tips from the Coalition of Portable Radiant Heater Safety" does provide explicit information on the CO hazard together with general camping tips and product advertisements; (5) non-camper users may discard the pamphlet without reading it since its outward appearance is that of an advertising brochure.

Relevant Standards: The maximum BIR of the subject radiant heater is 15,000 Btu/hr, so technically speaking, it is not subject to the voluntary standard for smaller radiant camp heaters that operate at less than 12,000 Btu/hr, i.e., ANSI Z21.63-1999 Portable Type Gas Camp Heaters[1]. Rather, it is subject to the requirements of ANSI Z83.6-1990, Gas-Fired Infrared Heaters, which applies to infrared heaters "intended for installation in and heating of outdoor spaces or non-residential indoor spaces". ANSI Z83.6-1990 applies to both vented and

[1] The draft ANSI Z21.63-1999 standard was approved at the 4/15/99 meeting of the Z21.63 Accredited Standards Committee, published by ANSI on 11/2/99, and became effective 4/1/2000 (personal communication, Don Sumner, BS).

unvented infrared heaters that are used most frequently in commercial/industrial premises, rather than domestic premises. While CPSC staff could not find a maximum HIR specified in this standard, it notes that part of the standard's ignition system requirements applies to extremely large commercial grade heaters with HIRs up to 400,000 Btu/hr (section 1.12.1b). The combustion requirements of this standard specify that "A heater shall not produce a concentration of carbon monoxide in excess of 0.04% (400 ppm) in an air-free sample of the flue gases when the heater is tested in an atmosphere having a normal oxygen supply" (section 2.5). Thus, the standard assumes an adequate oxygen supply and contains no provision for circumstances where the heater can seriously deplete the available oxygen.

Considering that about 50% of the heater's variable HIR falls below 12,000 Btu/hr, a 20-lb. propane tank can be moved fairly easily (is portable), and consumers will likely purchase and use the product in poorly ventilated spaces without recognizing the hazard of oxygen depletion and CO generation, the requirements of ANSI Z21.63-1999 are arguably more relevant to the subject heater than those of ANSI Z83.6-1990. The combustion requirements in ANSI Z21.63-1999 (section 2.4) specify that when the heater is operated in a 100 ft^3 (2.83m^3) chamber at target air exchange rates (AER) of 0.5, 1.0, and 1.5 air changes per hour (ACH), the oxygen level should not be depleted below 16%, and the CO concentration should not exceed 100 ppm. The CO limit of 100 ppm was adopted based on technical feasibility of camp heaters. Constant exposure to 100 ppm CO will eventually result in an equilibrium level of about 14.5 % COHb. Close to 90% of the equilibrium COHb level can be reached with exposure durations of approximately 3 hours at high activity, 5 hours at moderate activity, and 10 hours for light activity. Thus, the 100-ppm CO performance limit should prevent COHb levels from exceeding 14.5%, where only relatively mild health effects such as fatigue and headache might be expected in healthy adults.

LSE Array Samples Chamber Tests

Preliminary chamber tests assessed consistency of heater subunit performance at two target air exchange rates (AER) (3.0 and 6.0 air changes per hour [ACH]), when the fuel control knob was set at the maximum HIR (13 tests). (The control knob of subunit #2 did not function correctly and was found to operate near the minimum HIR, regardless of setting.) Eighteen further tests using subunit 1 were conducted to investigate heater combustion characteristics; these tests were conducted at both minimum and maximum HIR and at targeted AERs of 1.5, 3.0, 4.5, and 6.0 ACH. All tests proceeded until either: (1) the heater flames self-extinguished, (2) it produced more than 3000 ppm CO, (3) the CO, CO_2, and O_2 concentrations reached equilibrium, or (4) the hydrocarbon concentration exceeded 20% of the lower explosion limit for propane. The heater was then switched off manually, if necessary, and the AER of the chamber measured by following the decay of the tracer gas, sulfur hexafluoride (SF_6).

LSE Tent Tests

Ten initial tests on the tent investigated how positioning of the front liner, rain cover, and door and vent flaps affected its AER. Nine further tests investigated how different

door/vent configurations affected the combustion performance of heater subunit 1. For these latter tests, CO readings were taken at the estimated breathing zone of an army cot user (~1.67 ft; 0.51 m) and at the tent floor and ceiling (~3.5 ft; 1.07m) to account for the anticipated heater-generated temperature gradient effect of gases. Most tent tests were conducted under dry conditions, but since an army communication noted that there was "a high amount of precipitation" on the night of the double fatality, LSE staff elected to run some tests after a sprinkler was used to saturate the tent fabric. As with the chamber tests, all tent tests proceeded until either: (1) the heater flame self-extinguished, (2) it produced more than 3000 ppm CO, (3) the CO, CO_2, and O_2 concentrations reached equilibrium, or (4) the hydrocarbon concentration exceeded ~20% of the lower explosion limit for propane.

Exemplar Retail Sample Chamber Tests

Sixteen tests were conducted to investigate heater combustion characteristics; these tests were conducted at both minimum and maximum HIR and at targeted AERs of 1.5, 3.0, 4.5, and 6.0 ACH. All tests proceeded until either: (1) the heater flame self-extinguished, (2) it produced more than 3000 ppm CO, (3) the CO, CO_2, and O_2 concentrations reached equilibrium, or (4) the hydrocarbon concentration exceeded ~20% of the lower explosion limit for propane. The heater was then switched off manually, if necessary, and the AER of the chamber was measured by following the decay of the tracer gas, sulfur hexafluoride (SF_6).

Health Sciences Assessment

CO poisoning effects result primarily from oxygen (02) deprivation (hypoxia). Compared to 02, CO has approximately a 250-fold higher affinity for hemoglobin. Thus, inhaled CO rapidly enters the bloodstream and effectively displaces 02 from red blood cells, resulting in formation of COH-b. The brain and heart are the tissues most susceptible to hypoxia. COHb formation is affected by several important variables, including the CO level (ppm) and the duration of exposure. For any given CO ppm level, the activity level of exposed individuals plays a key role in the rate at which COHb levels rise prior to attainment of equilibrium COHb levels. Individuals engaged in strenuous activities, breathe rapidly; therefore, their CO intake is greater and COHb formation faster than in resting individuals. HS staff considers that campers are unlikely to be engaged in prolonged strenuous activity within a tent or in a recreational vehicle, and that a light to moderate activity level is most likely representative of average campers. This is equivalent to breathing rates or respiratory minute volumes (RMV) of 10-20 liters/minute. Clearly, the severity of symptoms associated with CO poisoning cannot be explained simply in terms of the maximum % COHb reached (or a maximum CO ppm level of exposure). They are also influenced by the length of time that the victim's % COHb has been elevated, and by an individual's susceptibility to CO. On reaching COHb levels of 20% or more, less active individuals are likely to be more seriously compromised than active individuals because they will have been exposed to hypoxia conditions for a more prolonged time during their slower buildup to this level. Thus, symptom severity is a function of the level and duration of tissue hypoxia which are primarily determined by the maximum CO level (ppm), duration of exposure, and the exposed

individual's activity level, as well as their general health.

While it is convenient to use discrete COHb levels to categorize symptom severity, each CO poisoning effect should be regarded as part of a continuum of effects with overlapping transitions. At 20-30% COHb, throbbing headaches and nausea are likely initially, and severe headache, nausea, vomiting, cognitive impairment, and possible loss of consciousness can result if levels are sustained for a long time, or rise above 30% COHb. Such symptoms can seriously compromise the ability of exposed individuals to remove themselves from the hazardous environment. Furthermore, the prolonged brain hypoxia and consequent brain damage associated with such sustained COHb elevations may ultimately result in the phenomenon of delayed neurological sequelae (DNS). DNS is typically manifested within a few days or weeks after the apparent recovery from the initial CO exposure. Symptoms can include emotional lability, memory loss, dementia, psychosis, Parkinsonism, incontinence, blindness, paralysis, and peripheral neuropathy. Symptoms of DNS may respond to hyperbaric oxygen therapy and/or may resolve spontaneously over a two-year period, but victims exhibiting the most severe symptoms such as Parkinsonism, blindness, and paralysis are often permanently afflicted

LSE Test Results

LSE conducted a total of 31 chamber tests on the army heater units (01-340-1679; 23 tests on subunit 1; 4 tests with subunit 2; 4 tests of subunit 3). Nineteen tests were conducted at the mean maximum EIR (14,060 ± 270 Btu/hr) and six were conducted at the mean minimum EIR (8,050 ± 310 Btu/hr). The tests found that the heater depleted the O_2 level below 16% in 20/31 tests, and exceeded the 100 ppm CO limit in 24/31 tests, but automatic gas valve closure was only activated by flame failure in 6 cases. The maximum CO level reached in each individual test ranged from 20 ppm to more than 3000 ppm, the upper limit of the LSE CO sensor. A total of 16 chamber tests were conducted on the exemplar sample (01-302-0099) with half conducted at the mean maximum EIR (12,430 ± 570 Btu/hr) and half at mean minimum EIR (6,160 ± 246 Btu/hr). The exemplar sample depleted the O_2 level below 16% in 8/16 tests, and exceeded the 100 ppm CO limit in 14/16 tests, but automatic gas valve closure was only activated by flame failure in 2 tests. The maximum CO level reached in each individual test ranged from 49 ppm to more than 3000 ppm. In the majority of all army and exemplar sample tests, the heater was switched off manually after reaching equilibrium levels of CO, O_2 and CO_2. This suggests that the heater would have continued operating to maintain CO levels at or above these equilibrium values for many hours, until the 20-lb. fuel tank was emptied.

To assess the worst case scenario, HS staff calculated the estimated equilibrium COHb levels that would result from constant exposure to the maximum CO level attained for each test. However, in cases where the army heater flame self extinguished so that the heater's CO production was self-limited, HS staff also used the CO time course data provided by LS staff (personal communication, Dave Tachofski) to calculate corresponding COHb time course profiles. (Note: the raw data for the exemplar sample were not available to HS staff). For all COHb calculations, HS assumed exposed individuals were normal healthy adults engaged in

moderate activity (RMV ~20 L/min). To facilitate this assessment, HS staff combined the projected % COHb levels with salient findings from the LSE chamber test results into Table 1 for the army samples and Table 2 for the exemplar sample. The chamber test results of the four individual heater samples were relatively consistent. It is evident from Tables 1 and 2 that, when used in enclosed and/or poorly ventilated environments, this commercial-type radiant heater does not come close to meeting the combustion requirements of ANSI Z21.63-1999. Furthermore, it is capable of producing serious, life-threatening CO exposures and as would be expected, as CO levels increased, a concomitant decline in O_2 and an increase in CO_2 generally occurred.

The heater does not appear to pose any significant health risk when operated in enclosed environments having AER equivalent to 6 ACH in a 100-ft3 (2.83m) chamber[7]. However, reduced ventilation (AER below 4.5 ACH to 1.5 ACH) seriously compromised the heater's combustion efficiency. The worst case performance also varied with the EIR. At the maximum EIR, the worst case scenario was seen with 3.0 ACH. Under these conditions, CO levels in excess of 2000-3000 ppm, and O_2 depletion to about 13% were seen, but the heater's automatic fuel shut-off mechanism was not reliably activated (activation in only 2/7 tests) despite the grossly inefficient combustion process. This suggests that the heater would likely sustain these gas levels for many hours under similar field use conditions. This would ultimately cause sustained COHb levels above 70% in exposed individuals, which would likely result in a lethal hypoxia. At maximum EIR and 1.5 ACH, the automatic fuel shut-off mechanism was reliably activated (5/5 tests), but not before CO levels ranging from ~1000 to 3000 ppm were reached. The rapid CO elevations would still be capable of relatively short-lived COHb increases of about 50 to 60% (in most cases), which could cause symptoms of confusion, loss of consciousness, coma, TINS, and possibly death.

At the minimum EIR, the worst case scenario was seen at 1.5 ACH where sustained lethal CO exposures above 3,000 ppm, and O_2 levels between 13.1 to 14.3% were noted without activation of the automatic fuel shut-off mechanism. Again, lethal hypoxia caused by >70% COHb would be the expected outcome of exposed individuals. At lower AERs, sustained exposure to CO levels of about 145-310 ppm would likely cause serious sub-lethal CO poisoning symptoms ranging from severe headaches and nausea to vomiting and fainting.

The LSE tests of the 300 ft^3 (8.50M^3) army tent sample revealed that it was possible to reduce the AER of the tent to less than 0.3 ACH by closing the vents, exhaust port, and all tent doors (including rain cover and frost liner) and simulating rain conditions. Combustion tests of the heater in the tent environment demonstrated that a temperature-driven CO gradient existed within the tent with the ceiling levels being as much as 1000 ppm higher than the breathing zone levels. CO levels ranging from 1430 to >9000 ppm could be measured in the breathing zone at low AER of about 0.26 to 1.43 ACH per-300 ft^3 (8.50m^3). Although the heater flame self-extinguished in 2/3 of these low AER tests, projected COHb levels were estimated to range from 54% to more than 70%. The LSE test results provide evidence to support the premise that use of a non-faulty subject heater in the poorly ventilated, closed tent environment was responsible for causing the death of the army personnel.

[7] Note: unless otherwise specified, all ACH refer to a 100 ft^3 (2.83m) chamber

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In addition to the direct hypoxia effects attributed solely to CO, as the CO2 rises from its normal level of 0.3% to approach 5%, it stimulates the breathing rate and this further increases the rate of CO uptake. The CO_2 test levels did not reach 7-10%, where unconsciousness would be expected within a few minutes. However, HS staff notes that even 5% CO_2 is above OSHA's proposed 15-minute short-term exposure limit of 3% CO2 and prolonged exposure to this level is not advisable. The reduced O_2 levels of about 13% would reduce the partial pressure of oxygen in inspired air to about 100 mm Hg at sea level. Though not advisable, this alone would not seriously compromise healthy individuals since the unique O_2 binding properties of hemoglobin ensure that it is still 89 % saturated at alveolar O2 partial pressures of 60 mm Hg. However, the concomitant reduction of O_2 and increased CO_2 would exacerbate the hypoxia driven by CO levels as high as 5000 ppm (0.5%) and would serve to hasten the development of lethal hypoxia. Since propane is a simple asphyxiate that displaces O_2 from the lungs, its presence (and that of other undefined hydrocarbon species generated during inefficient combustion) would also contribute to reduced oxygen availability and developing hypoxia. However, fatal hypoxia from propane exposure alone is unlikely to occur, and levels reached during tests did not approach the lower explosive limit for propane so are unlikely to pose an explosion hazard.

CPSC Staff Conclusions

When used inside small volume or poorly ventilated environments (up to 4.5 ACH/100 ft^3 (2.83m) chamber, the subject radiant heater can rapidly produce life-threatening CO exposures or prolonged sub-lethal CO exposures that can have serious, lasting adverse effects. This can occur with both maximum and minimum EIR. Individually, acute depletion of the O_2 level to about 13%, or elevation of the CO_2 level to a maximum of 5.2% would cause mild to moderate discomfort. However, combustion efficiency is affected by reduced O2 availability and CO production can rise dramatically below 16% O_2. When CO levels are elevated, these combined disturbances of O_2 and CO_2 will exacerbate the developing hypoxia caused by the CO. The use of 20-lb. fuel tanks with these heaters and the poor reliability of the flame failure sensor indicate that dangerous CO exposures will be extremely prolonged and more likely to result in serious or fatal outcome.

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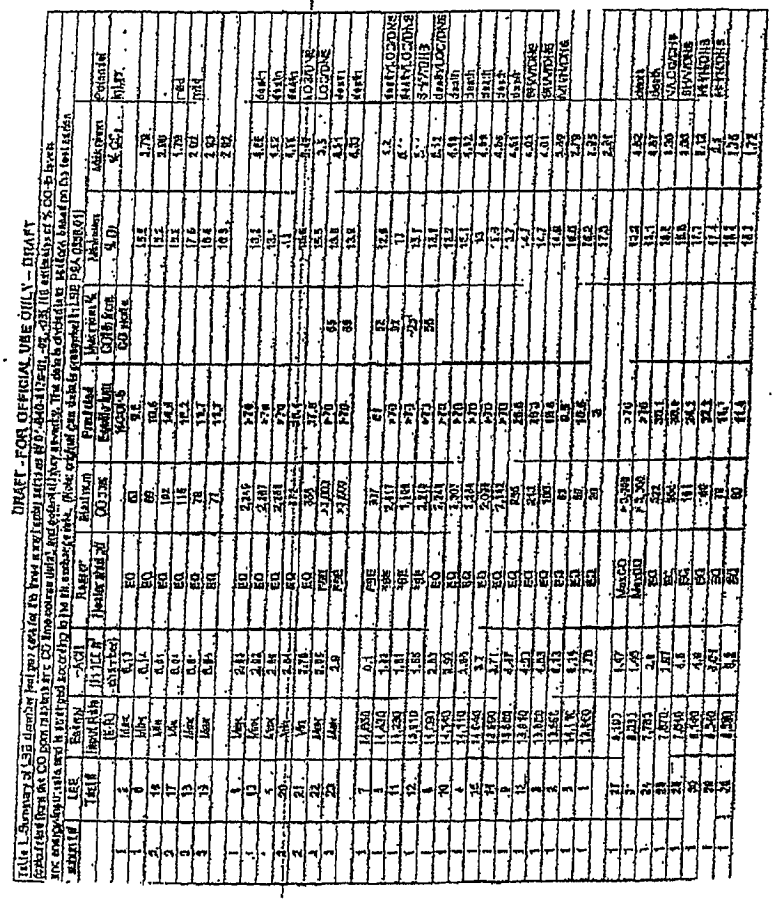

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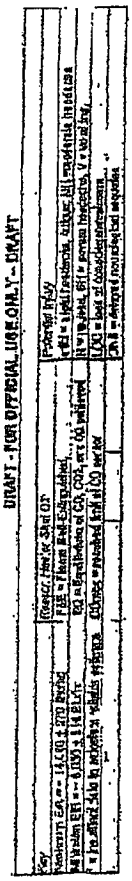

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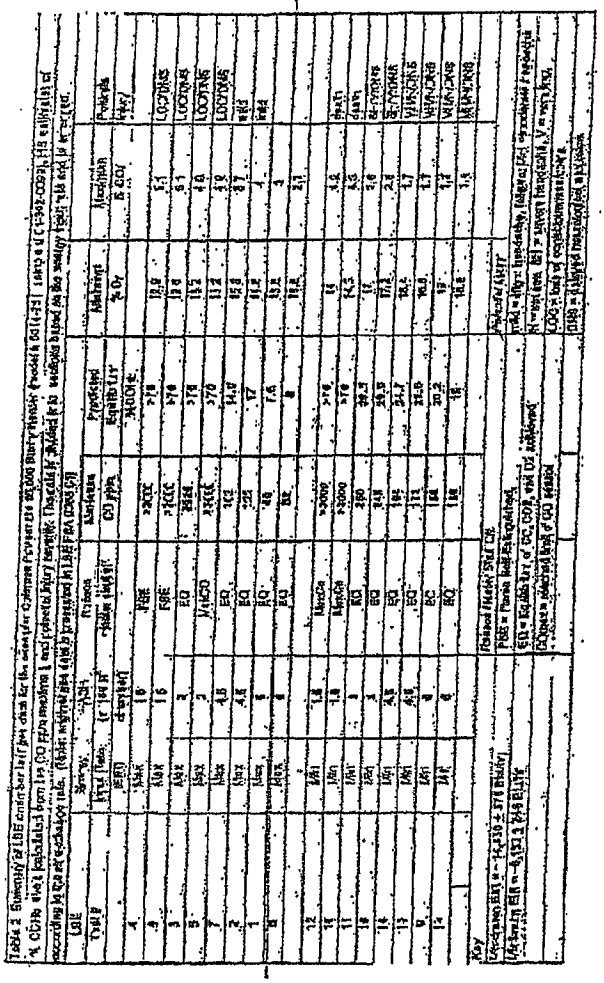

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16 C.F.R. § 1115.13(d) FULL REPORT INFORMATION REQUESTED

(1) The name, address, telephone and fax number, and title of the person submitting the "full report" information to the Commission.

(2) The name and address of the manufacturer (or importer) of the product and the addresses of the manufacturing plants for each product brand and series/models manufactured.

(3) An identification and description of the product(s). Give retail prices, brand name, series/model numbers, and date codes, along with all information necessary to decipher the date codes. Describe any identifying marks and their location on the product. Please also provide the inclusive dates of manufacture for each product series. Provide a picture or sample of the product.

(4) A description of the nature of the defect, failure to comply, or risk. Provide copies of all technical drawings, test results, schematics, or diagrams, blueprints, catalogs or other graphic depictions of the products.

(5) The nature of the injury or possible injury associated with the product defect, failure to comply, or risk.

(6) The manner in which and the date when the information about the defect, noncompliance, or risk (e.g., complaints, reported injuries, quality control testing) was obtained. If any complaints related to the safety of the product or any allegations or reports of injuries associated with the product have been received, copies of such complaints or reports (or a summary thereof) shall be attached. Give a chronological account of facts or events leading to the report under section 15(b) of the CPSA, beginning with receipt of the first information which ultimately led to the report. Also included may be an analysis of these facts or events. Even if no defect, noncompliance, or risk is acknowledged, please provide copies of all claims (including warranty claims and reports from distributors, retailers, and service centers) and court complaints in which it is alleged that the subject product (i) malfunctioned; (ii) is defective; (iii) fails to comply with an applicable standard; (iv) presents a risk of injury; and/or (v) has caused or contributed to personal injury or death. If copies of consumer complaints and other documents requested above are unavailable, indicate the reason they are unavailable and provide a summary containing the names, addresses and telephone numbers of the consumers or of the plaintiffs' attorneys.

(7) The total number of products and units involved.

(8) The dates when products and units were manufactured, imported, distributed, and sold at retail.

(9) The number of products and units in each of the following: in the possession of the manufacturer or importer, in the possession of private labelers, in the possessions of distributors, in the possession of retailers, and in the possession of consumers.

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(10) An explanation of any changes (e.g. designs, adjustments, and additional parts, quality control, testing) that have been or will be effected to correct the defect, failure to comply, or risk and other steps that have been or will be taken to prevent similar occurrences in the future together with the timetable for implementing such changes and steps. Even if no defect, failure to comply, or risk is acknowledged, please provide a summary description of all design changes made to each model during it's production and a copy of all engineering change notices.

(11) Information that has been or will be given to purchasers, including consumers, about the defect, noncompliance, or risk with a description of how this information has been or will be communicated. This shall include copies of drafts of any letters, press releases, warning labels, or other written information that has been or will be given to purchasers, including consumers.

(12) The details of and schedule for any contemplated refund, replacement or repair actions, including plans for disposing of returned products (e.g. repair, destroy, return to foreign manufacturer).

(13) A detailed explanation and description of the marketing and distribution of the product from the manufacturer (including importer) to the consumer (e.g., use of sales representatives, independent contractors, and/or jobbers; installation of the product, if any, and by whom).

(14) Upon request the names and addresses of all distributors, retailers, and purchasers, including consumers. At this time, please provide the names of distributors and retailer chains currently in the distribution chain for the subject product.

(15) Such further information necessary or appropriate to the functions of the Commission as is requested by the staff.

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DECLARATION OF SERVICE

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I declare under penalty of perjury under the laws of the State of Washington and the United States that the foregoing is true and correct.

DATED: September 7, 2010, at Tukwila, Washington.

Christine Jones
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Talmadge/Fitzpatrick

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