ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Office for Product Safety and Standards Department for Business and Trade
1	**CORONER** I am James Edward Thompson, HM Assistant Coroner, for the coroner areas of Newcastle Upon Tyne and North Tyneside.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 5th July 2022 an investigation was commenced into the death of Karlton Noah DONAGHEY. An inquest into his death was opened on 7th September 2023. On 25th September 2023 I resumed and concluded an inquest into his death. I concluded that medical cause of death for Karlton was; 1a Diffuse hypoxic ischaemic encephalopathy 1b Asphyxia from a helium balloon accident (on 23/6/22)

4	**CIRCUMSTANCES OF THE DEATH** Karlton was a 5 year old boy at the time of his death. He was made a present of a large helium filled balloon at local fairground in the days prior to his death. On 23rd June 2022 whilst momentarily alone in his home he placed the balloon over his head He became quickly overcome by the helium and despite prompt rescue, he suffered a hypoxic brain injury and subsequently died in hospital on 29th June 2022.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – - the balloon which caused the death are freely available to purchase without restriction, particularly at locations of places of entertainment for children. - Parents and those responsible for supervision of children are not fully aware of the risks posed to young children of helium filled balloons. - the balloon in question displayed no warning as to the potential risk to young children
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th December 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Karlton Donaghey's Family Public Health Department - Newcastle Upon Tyne City Council I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	 **J.E THOMPSON** **Assistant Coroner** **23/10/2023**