Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Office of Product Safety and Standards (OPSS)** **2 National Fire Chief's Council** **3 The Chief Coroner**
1	**CORONER** I am Anita BHARDWAJ, Area Coroner for the coroner area of Liverpool and Wirral
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 14 August 2024 I commenced an investigation into the death of Luke Marshall ALBISTON O'DONNELL aged 8. The investigation concluded at the end of the inquest on 05 December 2024. The conclusion of the inquest was that: Cause of death: 1a Hypoxia and Carbon Monoxide Poisoning Conclusion: Accident
4	**CIRCUMSTANCES OF THE DEATH** Luke Marshall Albiston O'Donnell was an 8-year-old boy who died in hospital following a fire at his home address. A full investigation was carried out by Merseyside Fire and Rescue Service which found an e-bike was on charge in the front room of the house. The fire commenced as a result of the ignition of a lithium battery, from the e-bike, which has come into contact with combustible materials. The failure of the battery cells has enabled the fire to develop rapidly.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The general public do not appreciate the life-threatening risks involved with having lithium iron batteries, from electronic bikes in this case, stored in domestic properties. There appears to be a lack of communication/media coverage about the dangers involved with

	storing appliances such as electronic bikes/scooters in domestic properties. There have already been 3 deaths associated with lithium batteries in the home in Merseyside and we have been informed there a number of similar fatalities across England.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have 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 3 February 2025. 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 The family of Luke O'Donnell I have also sent it to i. Merseyside Fire and Rescue Service ii. The National Fire and Rescue Service who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 09/12/2024**  **Anita BHARDWAJ** **Area Coroner for** **Liverpool and Wirral**