	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Central Manchester University Hospitals NHS Foundation Trust 2. Department of Health 3. Oldham Metropolitan Borough Council Trading Standards Department 4. Family of the deceased
1	**CORONER** I am the Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 5th April 2013 I commenced an investigation into the death of **Eliza Bashir** (aged 1 year) for whom the cause of death was given as being that of 1a) Fatal Exsanguination due to Perforated Retro-Oesophageal Right Subclavian Artery, 1b) Perforated Oesophagus, 1c) Ingested button battery and at an Inquest held at the Rochdale Coroners Court Heywood on the 7th October 2014, the conclusion of an 'Accidental Death' was made.
4	**CIRCUMSTANCES OF DEATH** On the evening of the 22nd March 2013 Eliza was playing with her siblings in their parents bedroom. A torch with which they were playing broke and Eliza swallowed one of the button batteries that came from the torch. Parents initially assumed that the battery would be expelled naturally but the family were subsequently advised to take Eliza to the local Accident & Emergency Department where x-rays revealed that the battery was stuck in the oesophagus. She was transferred to the Royal Manchester Childrens Hospital where on the 24th March 2013 the battery was removed by rigid endoscopy. Eliza was discharged home on the morning of the 25th March 2013 and remained well over the next five days. On the morning of the 30th March 2013 she collapsed and by the time of her arrival at the Accident & Emergency Department of the Royal Oldham Hospital she was in cardiac arrest. Extensive resuscitation failed to avert death. Eliza's case was unusual in that the battery was removed quite quickly after swallowing and she was quite well for almost a week before her final collapse. Additionally, Eliza had an aberrant right subclavian artery which lay just behind the oesophagus. Damage to the oesophageal wall was caused either by :- a) Damage due to pressure from the battery, or b) Electrical discharge from the battery, or c) Leakage of alkaline material or heavy metals from the battery core
5	**<u>CORONER'S CONCERNS</u>** 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:- 1. Evidence from the Trading Standards Officer confirmed that because the torch was not classified as a toy, it did not require a lockable battery compartment, notwithstanding compliance with safety regulations. 2. Consultant Paediatric Surgeon frankly asserted that both he and his colleagues were still worried as they did not know how best to deal with incidents such as this and whilst awareness of the risks and complications arising from ingested button batteries were being raised locally, there was a need for the profile of those risks to be raised nationally. 3. Oldham Council in collaboration with ROSPA, the Department of Business Innovation and skills and the National Trading Standards Board have initiated a local poster campaign. Following the reporting of this case both locally and nationally, a communications have been received from both Central Manchester University Hospitals NHS Trust and from [redacted], Director of the Queensland Injury Surveillance Unit has helpfully provided a link to the following site which she developed to raise awareness again both locally and nationally in Australia.http://www.qisu.org.au/modcorefrontend/upload/Disc-Batteries-QISU.pdf 4. Concern remains that such batteries are sold in supermarkets and other retail establishments and are often on display at a level that would enable small children to gain access to them whilst unobserved.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of you respectively, 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 19th December 2014. 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 namely **1.** Central Manchester University Hospitals NHS Foundation Trust **2.** Department of Health **3.** Oldham Metropolitan Borough Council Trading Standards Department **4.** Family of the deceased 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 from.

	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	Date: 24th October 2014 Signed: