Department of Health

From Dr Dan Poulter MP
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Mr Jason Pegg
HM Assistant Coroner for Coventry and Warwickshire
The Coroner's Office
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22 SEP 2014

Dear Mr Pegg,

Thank you for your letter to Jeremy Hunt about the death of Donna Kirkland. I am responding on his behalf as the Minister with responsibility for patient safety.

Ms Kirkland was found dead in her bed having drunk an alcohol based sanitising gel. A Lucozade bottle containing 250ml of alcohol based hand sanitising gel was found beside her bed. It was determined there was a reaction between the gel and a drug Ms Kirkland had been prescribed for her condition (venlafaxine). However the level of alcohol in Ms Kirkland's blood was very high and this too would have been a risk to health even had she not been on that particular medication.

Your report explains the circumstances around Ms Kirkland's death and concludes that the medical cause of death 'ingestion of alcohol and venlafaxine'.

You had a number of concerns about this case, including the following,

- Patients having unlimited access to alcohol based hand sanitising gels
- Patents being permitted to decant alcohol based hand sanitising gels into cups and other containers
- Patents being permitted to permitted to keep cups and containers of alcohol based hand sanitising gels in their rooms
- Lack of awareness amongst staff of the alcohol content of alcohol based hand sanitising gels and the potential for such gels to be ingested.

I was concerned to learn that at the time of Ms Kirkland's death the Caludon Centre allowed patients to collect and store an alcohol-based solution of this kind, with the obvious potential for abuse. I know that the Care Quality Commission has inspected the Caludon Centre twice this year and has required immediate improvements.

National guidance is already in place in 'Preventing Suicide- A Toolkit for Mental Health Services', which can be found at http://www.nrls.npsa.nhs.uk/resources/?entryid45=65297&q=0%c2%acsuicide%c2%ac .

In addition, individual and environmental risk assessments should always be completed, evaluating whether the risk associated with hand-sanitizer gel is being managed in particular relation to each person's presenting profile of need.

There is further national guidance detailed in 'Preventing Suicide in England- a cross-government outcomes strategy to saves lives, (Sept 2012). This strategy helps identify high risk groups such as those with both alcohol related and mental health issues.

The strategy document can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf and is also attached for your convenience.

I would expect that the local Post Suicide Review would examine documented local measures of assessing and managing these additional risks and what learning can be gleaned to respond and manage such incidents in the future.

In reviewing medication safety incidents from the NRLS, there have been relatively few incidents of ingestion of this sort. These types of incidents may however be reported to the NRLS under headings other than 'medication incidents' and further work would need to be done to identify these.

Although incidents of this nature have been reported nationally, the number has significantly reduced as a result of local risk mitigation measures as described in the guidance above. However, there will of course be continued national oversight of reports and learning from such incidents.

I hope that this information is helpful and I thank you for bringing the circumstances of Ms Kirkland's death to our attention.

Best wishes,

[redacted]

DR DAN POULTER