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. **The Rt Hon Jeremy Hunt MP, Secretary of State for Health** Department of Health, Richmond House, 79, Whitehall, London, SW1A 2NS 2. **Coventry & Warwickshire Partnership Trust** Wayside House, Wilsons Lane, Coventry, CV6 6NY
1	**CORONER** I am Jason Pegg, Assistant Coroner, for the coroner area of Coventry & Warwickshire.
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 21st July 2014 I commenced an investigation into the death of Donna Kirkland, aged 30 years. The investigation concluded at the end of the inquest on 24th July 2014. The medical cause of death was, "*Ingestion of alcohol and venlafaxine".* A narrative conclusion was given by the jury, in summary, "*The source of the alcohol was the alco-gel (hand sanitiser) found in the ward area and accessible to patients. The alco-gel was consumed in her room, room 1, Beechwood Ward, Caludon Centre, Coventry.*"
4	**CIRCUMSTANCES OF THE DEATH** Donna Kirkland was admitted to the Beechwood Ward, Caludon Centre, Coventry on 30th July 2013. On 19th August 2013 Donna was detained on the ward under the provisions of section 2, Mental Health Act, 1983. Donna was prescribed appropriate medication for her condition, one such drug was venlafaxine, prescribed at appropriate therapeutic dosage. On 22nd August 2013, at 0730 hours, Donna was found deceased in her bed on the Beechwood Ward. A 500 ml Lucozade bottle was found beside her bed which contained 250 ml of liquid containing alcohol (*ethanol and isopropyl alcohol*). The alcohol content was 66% weight per volume. The alcohol liquid was clear and of gel like consistency. The liquid was an alcohol based hand sanitising gel (*"Purell" manufactured by Gojo*) which was readily accessible to patients from a dispenser installed close to the main doors of the ward. Patients were not only allowed to access the dispenser but were permitted, if they so wished, to fill cups or other containers with the alcohol based hand sanitising gel. Patients were allowed to keep alcohol based hand sanitising gel in their rooms. A polystyrene cup containing 1 cm of alcohol based hand sanitising gel was found on Donna's bed on the morning of 22nd August 2013. 214 mg of alcohol in 100 ml of blood was found in Donna's post-mortem blood sample. A combination of the alcohol and venlafaxine had caused Donna's breathing to be suppressed resulting in her death.

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: (1) Patients having unlimited access to alcohol based hand sanitising gels; (2) Patients being permitted to decant alcohol based hand sanitising gels into cups and other such containers; (3) Patients being permitted to keep cups and containers of alcohol based hand sanitising gels in their rooms; (4) Lack of awareness amongst staff of alcohol content of alcohol based hand sanitising gels and the potential for such gels to be ingested.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 19th September 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 HHJ Peter Thornton QC, Chief Coroner 11th Floor, Thomas More Building, Royal Courts of Justice, London, WC2A and to the following Interested Persons: [redacted] 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	25th July 2014