Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
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Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health, Health and Wellbeing Richmond House, 79 Whitehall, London, SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 8th January 2015 I opened an inquest touching the death of Arti Hasmukh Lakhani , Aged 25 years old. The inquest concluded on the 22nd May 2015. The conclusion of the inquest was "Accident", the medical case of death was 1a Multiple Organ Dysfunction 1b Cardiac Arrest leading to Hypoxic Brain Injury 1c Acute Toxic Effects of Nicotine following ingestion of E-Cigarette fluid.
4	**CIRCUMSTANCES OF THE DEATH** On the 11th January 2015 Arti Hasmukh Lakhani was taken to hospital having become unwell at home. Miss Lakhani had drunk 1 bottle of e-cigarette fluid before becoming unwell. Despite attempts by the doctors to save Miss Lakhani her condition deteriorated and she died on the 13th January 2015. Doctors discussed the case with National Poisons Information Service and received advice that they only treatment following the ingestion of e-cigarette fluid was to support the patient and that nicotine had a short half life of around 2 hrs. Toxicology analysis showed an AM Serum level of 4.70 ug/ml.
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. – That the sale of e-cigarette fluid is not regulated or or licenced
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 Tuesday 5th August 2015 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;- Representatives of the family. 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	**10th June 2015** [redacted]