REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: , Department of Business, Innovations and Skills, General Product Safety Department, 1 Victoria Street, London, SW1H 0ET CORONER 1 I am Dr J R L Hamilton, Assistant Coroner, for the Coroner area of County Durham and Darlington **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. INVESTIGATION and INQUEST On 2 January 2015 I commenced an investigation into the death of Stephen Paul Myers, age 49. The investigation concluded at the end of the inquest on 13 April 2015. The conclusion of the inquest was Misadventure. The medical cause of death was: 1a) Likely Isopropyl Nitrite toxicity 2) Left Ventricular Hypertrophy and Fatty Liver. CIRCUMSTANCES OF THE DEATH A 49 year old man (with a background of heart disease: Left Ventricular Hypertrophy, Coronary and Valvular) was drinking in the pub on Christmas Eve (24.12.14) with friends when he drank a bottler of "Poppers" (isopropyl nitrite) which he had purchased in a local shop. He collapsed and Paramedics attempted resuscitation at the scene. He was taken to Darlington Memorial Hospital where he was pronounced dead. He had previously ingested "Poppers" without ill effects. **CORONER'S CONCERNS** 5 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) Isopropyl nitrite is sold as a liquid in a small (25ml) bottle as "English Room Odoriser". It is known that some inhale the vapour which is thought to cause a shortlived "rush" / euphoria. The label on the bottle says" do not inhale". It is classified in accordance with 67/548/EEC: R 23: toxic by inhalation R28: very toxic if swallowed. (2) I have received a report from West Yorkshire Analytical Services which states

"The labelling was examined with respect to the Chemicals (Hazard Information and

Packaging for Supply) Regulations 2009 (CHIP) and the Regulation Classification, Labelling and Packaging of Substances and Mixtures 2008 (CLP) with the following observations:-

Need upgrading for CLP to include the signal word "danger". Pictograms need updating to CLP standard. Need to include the hazard statements suggested H225 Highly Flammable Liquid and Vapour, H301 Toxic if Swallowed, H331 Toxic if Inhaled. Precautionary statements suggested P210 Keep Away From Heat/Sparks/Open Flames/ Hot Surfaces – No Smoking, P261 Avoid Breathing Vapours, P301 and P310 IF SWALLOWED: Immediately call a POISON CENTRE or Doctor/Physician. The container requires a tactile warning.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 by10 June 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:

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 **15 April 2015**

Signed:



Assistant Coroner, County Durham and Darlington