ANNEX A

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. **Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS**
1	**CORONER** I am David Hinchliff, Senior Coroner, for the coroner area of West Yorkshire (Eastern).
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 12th November 2015 I commenced an investigation into the death of MICHAEL DUNDON, aged 73. The investigation concluded at the end of the Inquest on 8th August 2016. The conclusion of the Inquest was Accidental Death. "Michael Dundon suffered with mental health problems which had caused changes to his personality, which had caused him to become violent on occasions, which made him unsuitable to remain a resident at Copperhill Nursing Home. He was admitted to St James's University Hospital, Leeds where he should have been supervised on a one to one basis, but there was a period when he was unsupervised, which enabled him to ingest safety gel liquid absorbing crystals which had been placed in unused urine bottles in his room. The crystals solidified causing a blockage to his airways and causing his death to be confirmed at 0615 hours on 11th November 2015 on Ward J14 at St James's University Hospital. The safety gel was not recognised at the time as being a risk to patients or visitors by ward staff. The cause of death was 1(a) Aspiration of foreign material into the airway and (2) Micro-infarcts in the brain with leukomalacia caused by cerebral arteriolosclerosis.
4	**CIRCUMSTANCES OF THE DEATH** Michael Dundon died due to asphyxiation on safety gel liquid absorbing crystals. He had access to the liquid absorbing crystals as they had been placed in unused urine bottles in his room. The manufacturer's guidance states that safety gel sachets should be placed in urine bottles prior to use. The safety gel was not recognised as a risk to patients or visitors by staff on the ward.
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) I understand that liquid absorbing crystals in sachet form are used throughout NHS

	England. The crystals are a nationally recognised product available from the NHS supply chain and used nationwide. There are variations in practice regarding the use of the gel sachets. (2) The liquid absorbing crystals are a dry granule that quickly dissolve to absorb liquid. The sachet is placed into a urinal bottle, bed pan or vomit bowl to ensure a swift absorption of unwanted liquids. The sachet opens on contact with a liquid and the granules quickly absorb up to 1.2 litres of hazardous/unwanted liquid. A manageable dwell is formed to be safely disposed of which reduces the risk of infections and spillage. In the original form the sachets could be mistaken for salt or sugar. (3) The crystals had been pre-inserted into two empty urine bottles in the deceased's room. The staff did not recognise that such sachets could be hazardous when left in this way. The deceased was able, whilst unsupervised, to swallow crystals, causing a cardiorespiratory arrest and death. (4) The risks associated with the use of these crystals may not be fully understood. (5) The manufacturer of the product has been informed and the packaging has already been changed and a display poster has been produced for display in relevant clinical areas. (6) All relevant staff throughout the country need to be made aware as to the harm to a person if the crystals are ingested, and an appropriate risk assessment should be carried out. (7) I request that the Secretary of State bring this to the attention of all NHS Trusts so that risk assessments, staff awareness and training can be carried out.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 18th October 2016. 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: The Chief Medical Officer of the Leeds Teaching Hospitals NHS Trust [redacted] Department of Corporate Services Division, Leeds Teaching Hospitals NHS Trust Headquarters, St James's University Hospital, Beckett Street, Leeds, LS9 7TF I have also sent it to () who may find it useful or of interest. 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	**Date 23 August 2016 [SIGNED BY CORONER]**