IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Khazna Jane Sara Khalaf
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: St Marien Hospital Trust, St. Marien-Hospital, Kunibertskloster 11-13, 50668 Köln, GERMANY.
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 3 December 2014 I opened an inquest into the death of **Khazna Jane Sara Khalaf** who, at the date of her death, was aged 19 years old. The inquest was resumed and concluded on 6th July 2016. I found that the cause of death to be: - 1a. Hypoxic-ischaemic encephalopathy 1b Cerebral oedema 1c Ecstasy/MDMA toxicity I concluded by way of a narrative as follows: On 12 November 2014 Khazna Jane Sara Khalaf was taken by ambulance to St Marien's Hospital in Cologne, Germany, after ingesting ecstasy under circumstances which remain unclear. Upon arrival she was monitored until she suddenly collapsed. When she was transferred to Merheim Hospital, Cologne, Germany, she was found to have suffered a

	cerebral oedema caused by hyponatraemia, a rare complication of ecstasy use, to which she succumbed and died on 20 November 2014. It is found more likely than not that there were several lost opportunities to monitor and treat her low sodium blood levels whilst at St Marien's Hospital and that, had she been treated, it would have prevented her death.
4	**CIRCUMSTANCES OF THE DEATH** Khazna Jane Sara Khalaf, a UK citizen was studying at Koln University as part of a student exchange. On the evening of 11 November 2014 she attended at the Odonien Nightclub during the carnival celebrations. The circumstances as to how she came to ingest ecstasy remain unclear, but after becoming unwell an ambulance was called at approximately 4.50am 12 November 2014 and when taken to St Marien Hospital in Cologne she was first examined at 5.03am, when records say she admitted to taking a pill of ecstasy. Subsequently she was monitored hourly until 9.20am when she collapsed unresponsive. At 10.30am she was transferred to Merkheim Hospital, where CT head scans revealed that she had suffered a cerebral oedema such that it brought about hypoxic ischaemic encephalopathy as a result of ecstasy toxicity. Thereafter she very sadly succumbed and died on 20 November 2014.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest I noted the full contents of the report provided by [redacted] who could not attend to give oral evidence, and it was his view that upon Jane's initial arrival at the hospital she did not present with sufficient clinical signs to justify a blood sample to determine serum sodium levels, and that there was no evidence to suggest that an early blood sample would have led to a much longer survival. This was at variance to the oral evidence I heard from [redacted] an independent expert in Anaesthesia and Intensive Care Medicine, and I accepted his view that had an early blood sample been taken prior to her collapse, it would have identified her low sodium levels such that she would have received effective treatment that would on the balance of probabilities have prevented her death. The **MATTER OF CONCERN** is as follows. – • The effectiveness of local protocols and the sufficiency of existing hospital guidelines alerting clinicians to the risks of ecstasy toxicity, the symptoms and signs it might present. • To consider the appropriateness of a clinical protocol which

	provides structure to the initial decision to intervene or simply monitor, and guidance on what that monitoring should consist of (and when to be concerned and reassess the initial decision).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that St Marien's Hospital Trust, Cologne, Germany has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] (father) • [redacted] • Chief Coroner
9	**DATED this 18TH July 2016** M. D. Fleming **M.D. Fleming** **Senior Coroner**