Department of Health

Philip Dunne MP
Minister of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

David Hinchliff
HM Senior Coroner – West Yorkshire (Eastern)
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

13 MAR 2017

Dear Mr Hinchliff

Thank you for your letter of 23 August 2016 to Secretary of State about the death of Michael Dundon. I am responding as the Minister with responsibility for patient safety at the Department of Health.

I was saddened to read of the circumstances surrounding Mr Dundon's death. Please pass my condolences to his family and loved ones.

I would also like to apologise for the delay in responding. I am advised that Departmental officials sought further information about the nature of the product to help with their enquiries and I am grateful to you for facilitating this.

The Department has liaised with a number of agencies to ascertain where responsibility lies for determining the most appropriate response to your concerns.

As you may know, as of 1 April 2016, patient safety transferred from NHS England and is now part of NHS Improvement. NHS Improvement provides a leadership role for patient safety in the NHS in England and provides advice and guidance, including through patient safety alerts, to support all providers of NHS-funded care to identify, understand and manage risks to the safety of patients.

The Department approached NHS Improvement for its advice on 23 January. NHS Improvement recognises and shares your concerns that the sachets of solidifying crystals used widely within the NHS in human waste receptacles can present a choking hazard if put in the mouth by patients.

I am advised that since becoming aware of the findings of the inquest into Mr Dundon's death, NHS Improvement's Patient Safety Team has been working to identify an effective method of risk reduction.

This work will include consideration of a warning to staff of the risk presented and the need for risk assessment as you recommend. However, I am advised that initial considerations by NHS Improvement, are that any such warning would have a limited effect, as a high proportion of hospital inpatients have some degree of cognitive or visual impairment, and confused patients might typically pick up urine bottles or other receptacles from other patients.
NHS Improvement has further advised that any blanket restriction on their use potentially also risks patient harm through making handling and disposal of bodily fluids more difficult, with an impact on infection control procedures, as well as affecting patient comfort and dignity.

A further consideration is that the use of the sachets appears very widespread, including outside hospital settings. For example, to aid safe disposal of vomit or urine spills in a variety of settings such as nurseries, nightclubs and police cells. Although the manufacturers of these products label them with clear instructions that they are dangerous if put in the mouth, small children, or people who might be under the influence of drugs or alcohol might not read or understand such warnings. NHS Improvement will follow up this angle with the Health and Safety Executive (HSE).

Finally, NHS Improvement is exploring whether a safe alternative or alternative ways of using the solidifying crystals that would mean reduced risk without a loss of the benefits they bring to infection control and patient comfort, exists.

Once NHS Improvement has identified the most effective way of managing the choking hazard while ensuring infection control benefits can be maintained, it intends to notify providers of NHS-funded care. NHS Improvement will liaise with the Care Quality Commission to ensure that any advice or guidance is also distributed to care homes and hospices.

I would add that the Secretary of State for Health announced a package of measures in December 2016 to improve the way Trusts and Foundation Trusts identify and learn from deaths of patients in their care. This includes a requirement for trusts to collect a range of specified information on deaths that were potentially avoidable and serious incidents and consider what lessons need to be learned on a regular basis.

Department of Health

I hope this information is helpful. NHS Improvement has undertaken to update you as it takes this matter forward and I have asked that my officials are kept informed of developments. Thank you for bringing the circumstances of Mr Dundon's death to our attention.

Yours sincerely,

PHILIP DUNNE