Professor Paul Marks BA LLM MD FRCS
HM Senior Coroner
City of Kingston upon Hull and the Counties of the East Riding of Yorkshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Simon Stevens, Chief Executive NHS England**
1	**CORONER** I am Professor Paul Marks BA LLM MD FRCS Senior Coroner for **East Riding and Kingston-upon-Hull**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 22/09/2015 I commenced an investigation into the death of John HAUGHEY. The investigation concluded at the end of the inquest 10th February 2017. The conclusion of the inquest was John HAUGHEY was admitted to Hull Royal Infirmary with a nine month history of increasing confusion. Whilst on Ward 80, on the 6th September 2015 he consumed a large amount of a hand wash that contained alcohol in a high concentration and developed acute alcohol toxicity which was treated by elective ventilation in the expectation that the alcohol would be naturally metabolised. His airway was unprotected for a period of seven hours between the 6th and 7th September 2015 and as a result it is likely he developed an aspiration pneumonitis which progressed to a bacterial bronchopneumonia affecting both lungs from which he died at Hull Royal Infirmary, Anlaby Road, Hull on the 12th September 2015. The medical cause of death being: 1a) Bronchopneumonia 1b) Acute alcohol toxicity 2) Acute delirium; coronary artery atherosclerosis.
4	**CIRCUMSTANCES OF THE DEATH** John Haughey had a nine month history of increasing confusion prior to his admission to Hull Royal Infirmary in September 2015. He had a past medical history of agitation and depression and had received treatment with anti-depressant drugs. On the basis of radio diagnosis, it seems likely that he may have been developing vascular dementia by the demonstration on a brain scan of small vessel disease. Mr Haughey was admitted to Ward 80 at Hull Royal Infirmary and was noted to be agitated, combative and confused. On the 6th September 2015, he drank an unknown quantity of an alcohol-based hand sanitiser which was in a dispenser at the foot of his bed. The proprietary name of the sanitiser was "Purell Advanced Hygienic Hand Sanitising Foam". It contains ethyl alcohol at a concentration of approximately 75%.

	Advice was given by the Tox-Based Service about the composition of the hand sanitiser and it was suggested that he should be observed clinically for depression of his level of consciousness and respiration as well as for the development of a metabolic acidosis. He was initially aggressive and combative and was prescribed Lorazepam and Haloperidol. There was an inadequate frequency of observations instituted to record his vital signs, as it would have been predictable in the worst case scenario that he had ingested a considerable amount of alcohol and would have lapsed into coma within two hours. When first measured, his blood alcohol level was 463 milligrams per 100 millilitres of blood at 0153 hours on the 7th September 2015, this fell to 354 milligrams per 100 millilitres by 1157 hours on the same day. He was treated in the intensive care unit and a plan to allow the alcohol to be naturally metabolised was formulated, during this time airway and ventilatory support was given. Following removal of the endotracheal tube in the Intensive Care Unit Mr Haughey's airways were noted to contain foul smelling sputum. He required further sedative drugs following extubation to address his agitation and confusion. On the 11th September 2015 he suffered an episode of aspiration of food and as a result a serious deterioration in his condition occurred. A chest x-ray was taken which showed evidence of pneumonic changes which, on balance, were pre-existing and not caused by the episode of aspiration of ice cream. Mr Haughey's condition progressively deteriorated and he died at 2052 hours on the 12th September 2015.
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. – There is a tension between the need to prevent cross infection in the hospital setting and the possibility of confused patients consuming preparations used to clean clinicians hands. There is increasing public awareness about the desirability of hand hygiene and the need to prevent infection and as a result alcohol-based hand washing gels are found in many public buildings other than hospitals. Whilst incidents such as John Haughey's are thankfully rare, it is my view that similar tragedies could occur given the now ubiquitous presence of such hand washing gels and their dispensers. Whilst I am satisfied that the Hull & East Yorkshire Hospitals NHS Trust has implemented measures to prevent similar incidents occurring in the future, I am not convinced that information about this incident has been disseminated as widely within the NHS, the public sector in general and private sectors as it should be. Such organisations need to be aware of this potential hazard and take appropriate action that might include making formal risk assessments where such materials are deployed.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe NHS England 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 5th June 2017. 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: [redacted], Deputy Chief Executive and Director of RoSPA; Mr Richard Judge, HSE Chief Executive; [redacted], Nuffield Health Chief Nurse; [redacted] BMI Healthcare Chief Operating Officer; [redacted], Spire Healthcare Group Medical Director; [redacted], HEY Chief Medical Officer. I have also sent it to [redacted] of DAC Beachcroft and [redacted] of Neil Hudgell Solicitors 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	06/04/2017 Signature:  Professor Paul Marks BA LLM MD FRCS HM Senior Coroner **East Riding and Kingston-upon-Hull**