REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Foreign Secretary
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 9th August 2022 I commenced an investigation into the death of Kirsty Margaret McKie. The investigation concluded on the 24th January 2023 and the conclusion was one of **Narrative: Died from the complications of methanol poisoning after she had unknowingly consumed methanol believing it to be alcohol fit for human consumption.** The medical cause of death was **1a) Methanol Toxicity**
4	CIRCUMSTANCES OF THE DEATH Kirsty Margaret McKie was a UK national who lived and worked in Bali. She ran a successful business as a talented ceramicist. On 22nd July 2022 she had consumed what she believed to be alcohol. The following day she felt unwell. She went to a hospital in Bali where she deteriorated and died on the 24th July 2022 despite treatment. Post-mortem examination included toxicology. It was found that she had methanol in her system which had caused her death. Methanol is not meant for human consumption. She had inadvertently consumed methanol believing she had consumed alcohol. The methanol had been sold as being alcohol fit for human consumption when it was not and caused her death.
5	<u>CORONER'S CONCERNS</u> 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. – The Inquest heard evidence that there is a growing problem of methanol being passed off as alcohol for human consumption particularly in places such as Bali. Methanol is used rather than ethanol in spirits aimed at the Western market and sold even through apparently reputable suppliers. The evidence before the Inquest was that : 1. Knowledge of the problem amongst the expatriate/tourist community was very low despite the increase in the problem and the catastrophic consequences of methanol consumption; 2. There was little publicity by the UK Government of the risk in contrast to the approach taken by the Australian Government who had undertaken a campaign to increase awareness to protect their citizens travelling in areas of Asia such as Bali; 3. The UK Government publicising information about the risk of methanol being used in local spirits, steps that could be taken by UK nationals travelling to reduce the risk and warning signs of methanol toxicity would help to reduce the chance of others dying in the way in which Kirsty McKie died.
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 1st April 2023. 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 namely Miss McKie's Father on behalf of the Family, 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	**Alison Mutch OBE** **HM Senior Coroner**  **04.02.2023**