Regulation 28: Prevention of Future Deaths Report

Miss Kayleigh BURNS

THIS REPORT IS BEING SENT TO:

1. The Right Honourable Mr Dominic Raab – Secretary of State for Justice.

1. CORONER

I am Sean McGovern, Senior Coroner for Warwickshire, Warwick Justice Centre, Newbold Terrace, Royal Leamington Spa, Warwickshire.

2. CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and

The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3. INVESTIGATION and INQUEST

On 17 June 2022, I commenced an investigation into the death of Miss Kayleigh Burns. The investigation concluded at the end of the inquest on 24th March 2023 at Warwick Coroners Court. The medical cause of death was confirmed as 1a inhalation of Nitrous Oxide compounding Asthma.

4. CIRCUMSTANCES OF THE DEATH

Miss Burns was 16 years old and suffered from asthma.

On the 3rd June 2022, Kayleigh visited a friend's flat in Stratford upon Avon. Whilst there she ingested the contents of a number of nitrous oxide cannisters. She started to wheeze and used her blue inhaler. She declined an ambulance and collapsed as she was going outside to get air. An ambulance was called and her friend performed CPR. She was resuscitated but died the next day at University Hospital Coventry & Warwickshire. The medical cause of death was inhalation of Nitrous Oxide compounding Asthma.

I concluded that her death was drug related (ie inhalation of Nitrous Oxide) in the context of Asthma.

5. CORONER'S CONCERNS

During the inquest, the evidence and information 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:

i. Whether the present legal framework concerning Nitrous Oxide should be reviewed, in the light of this death, having regard to the seemingly increasing use of Nitrous Oxide particularly by young persons.

6. ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that 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 22nd May 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 following:

1. HHJ Teague QC the Chief Coroner of England & Wales Chief Coroner's Office, 11th Floor Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL. chiefcoronersoffice@judiciary.gsi.gov.uk
2. The family of Miss Kayleigh Burns

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

Sean McGovern

Senior Coroner

Date: 27 March 2023