Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Cannock Chase Hospital** **2 NHS England**
1	**CORONER** I am Daniel HOWE, H M Area Coroner for the coroner area of Staffordshire and Stoke-on-Trent
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 12 February 2024 I commenced an investigation into the death of Gemma Louise Helen RALPH aged 39. The investigation concluded at the end of the inquest on 03 October 2024. The conclusion of the inquest was that: Drugs related (anaesthesia). On 26 January 2024 Gemma Louise Helen Ralph passed away at her home address due inhalation of the anaesthetic sevoflurane without intent to end life. She had access to sevoflurane as a Theatre Support Assistant at Cannock Chase Hospital and it is probable that is where she gained access to the anaesthetic that she inhaled and led to her passing.
4	**CIRCUMSTANCES OF THE DEATH** As per section 3 above.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Notwithstanding an assurance that "the processes in place for safe supply, storage and use of Sevoflurane in the trust is in line with relevant sources of national guidance and best practice" the following remains a source of concern: That bottles of sevoflurane, whether unopened or partially used after theatre, does not appear to be robustly monitored to the degree that it was possible for a bottle of sevoflurane to be removed from Cannock Chase Hospital without this being flagged by the auditing system. That the trust was unable to confirm or refute that the bottle found at the deceased's home address originated from Cannock Chase Hospital.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 January 3, 2025. 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: • Family of Gemma Ralph who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 08/11/2024**  **Daniel HOWE** **H M Area Coroner for** **Staffordshire and Stoke-on-Trent**